Methadone Today

The official newsletter of DONT--by patients, for patients **February 2005** **Volume X Number II**

Letter to Doctors Regarding MMT

(Editors' Preface)

The December 2004 issue of ***Methadone Today*** included an article, "Hospitalization and the Treatment of Pain for MMT Patients," that discussed pain management in methadone patients. Nancy Rose, the author of the article, advised patients to obtain a letter from their methadone clinic physician to give to the doctors in the event of hospitalization or simply to give to a new doctor to educate him/her about methadone treatment. Such a letter would include information about pain management, as well as other important topics relating to methadone treatment (i.e., what medications are contraindicated, etc.).

We feel that this is such an important issue that we have decided to reprint a sample letter that originally appeared in an issue of the MALTA Messenger several years ago.

A close friend of the Managing Editor is about to undergo major surgery, in which he is expected to be in the hospital for 5 - 7 days. We advised him to provide such a letter to the doctor who will be performing the surgery and overseeing aftercare in the hospital. However, it again occurred to us that Ms. Rose's idea to carry a copy of the letter with her at all times was excellent. In the case of the aforementioned friend of the Managing Editor, the surgery had been scheduled in advance, almost two weeks ahead of time, but one can never predict when a medical emergency will arise. We have also urged patients to carry a medical alert card *[see p. 4 for order info.]* that informs medical personnel in case of an emergency that the individual is on medication and states what medications are contraindicated. The card also contains the name and phone number of the methadone clinic the person attends. In a medical emergency it is vital that medical personnel are aware that the patient is in methadone treatment, because if they do not know the patient is taking methadone, they may give medications that interact with methadone--including drugs that may trigger severe withdrawal symptoms. Having a copy of the letter helps ensure that proper pain management is provided. Even if the patient does not want to carry this letter around all the time, it could be left at home so that in an emergency, a close family member could bring it to the hospital. ***(See p. 2 & 3 for Sample Letter)***

Dear Methadone Today,

In the mid 70s, I lived in Michigan and attended a methadone clinic in Kalamazoo. I noticed that you are an advocate for patients in the state of Michigan. When I was there, they did "blind dosing", in which they do not tell what your dose is, they required you to attend the clinic every day (no take homes), and you had to go to group meetings and individual counseling every week. I was there almost a year and a half, and it became too much to attend every day, as I was in college and had to get my daughter to her school. At that time, there was no mention of exemptions or "take home" medications. I now am living in the state of Missouri and attend a clinic in Overland Park KS. I go to the clinic once a month and consult with the "counselor" once every three months. This is a huge improvement over how it used to be, not to mention that the patient knows what their dosage is. You may also request an increase if you feel you need one!

Do you know anything about the clinic in Kalamazoo? I should hope that over the years that they have improved their services. Do you know if they still have the "blind dose" policy? In thinking about that, what would a patient tell an emergency room doctor or any other doctor for that matter when asked what dosage they are on? "Oh gee, I have no idea!" Another thing was, they did not raise your dose; they just gave you more counseling! *(Ed. Note: in methadone clinics with a blind dose policy, patients are usually not even told whether their dose was increased.)* I was never compliant the whole time I was there, and I never got to a "blocking dose" either. I am curious to know how treatment is in the state of Michigan. I would appreciate anything you could tell me. Thank you. **-Beth C.**

Dear Beth C.,

We do not know much about the clinic in Kalamazoo, as we are located in the Flint and Detroit areas. If we get some information about this clinic, we will let you know. It is quite possible that they have changed some of their practices, such as blind dosing. Although there are still many methadone ***(Cont. p. 4)***

Dear Methadone Today,

I have a criticism about my methadone clinic that I think should be aired in your newsletter--especially since there are probably many other methadone clinics that do the same thing. You see, I believe that methadone clinics have a responsibility to educate patients as much as possible about opiate addiction and methadone/opiate agonist treatment. Periodically, they have patients who have been in treatment awhile sign another consent to treatment form. This form is a brief, one-page form that basically states that the patient consents to treatment and provides very basic information about the treatment.

I have noticed that the form is identical to the original form I signed several years ago when I started going to this clinic. One of the reasons I know it is the identical form is that a portion of it is dedicated to LAAM, which according to your newsletter is no longer even available. The problem is that some of the information in the form appears to be outdated. In particular, the information on pregnancy and breast-feeding needs updating. The form advised against methadone patients breast-feeding their infants--yet, it is my understanding that it is perfectly okay for methadone patients to breast feed.

It is a shame that a form that is intended to give patients the information to make an informed decision on whether to initiate or continue opiate agonist treatment is actually misinforming patients. This is the second time I have brought it to the clinic staff's attention, and I am hoping that this oversight will be corrected. **-PJ**

Dear PJ,

Thank you for writing in with your concerns, and we completely agree with your letter. As you stated, hopefully the information will be updated on the form. In regard to breast feeding, you are absolutely correct. At the time this form was originally written, methadone patients were discouraged from breast-feeding, as there was not enough research to confirm that breast-feeding while on methadone was safe for the infant--the medical community is very cautious about pregnancy and breast feeding ***(Cont p. 4)***

DEAR DOCTOR LETTER

(Reprinted from the MALTA Messenger)

J. Thomas Payte, M.D. is the Founder and Medical Director of Drug Dependence Associates, an outpatient chemical dependency treatment program in San Antonio, Texas that blends pharmacotherapies with self-help and behavioral concepts.

Dr. Payte has worked in both the public and private sectors of treatment since the 1960's. He developed his "Dear Doctor" letter for methadone maintenance patients who, for various reasons, must visit private physicians for medical conditions unrelated to their addictions. These patients are very often discriminated against with regard to their care and their need of pain medications for the medical problems for which they are seeking care. This is due to the ignorance of physicians in general practice about addictive disease and methadone treatment.

Dr. Payte puts it very clearly to patients, "I instruct patients to give this letter to their new doctor in their presence and ask them to read it. If the letter goes in the trash, the patient should go to the door and find a new doc." The reaction to the letter may give some clue as to the type of doctor-patient relationship that might develop.

Finally, let me add that Dr. Payte is an advocate for the development of Medical Maintenance to be made available throughout the United States. He is indeed a champion for those of us trying to recover.

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If your clinic does not have a similar letter, give this to the clinic doctor to use as a guideline and have him or her sign it, furnishing your clinic's address, phone number, etc.

Dear Doctor,

The bearer of this letter is a patient in a methadone maintenance treatment program. Methadone patients frequently need treatment for other medical, surgical, and dental conditions. At times the health professional is not familiar with addictive disease and the various forms of treatment, including maintenance pharmacotherapy using methadone. The reaction to being informed about the addictive disease/methadone treatment often includes fear, anger, prejudice, disgust, and other negative subjective responses, none of which contribute to the objective delivery of quality health care. Many patients are very reluctant to provide information to the other health professional about their addiction and treatment with methadone because of previous unpleasant experiences. The most common reaction is based on fear which is inversely proportional to the professional's level of familiarity with addiction medicine and patients with addictive diseases. The purpose of this brief letter is to touch on the most common problems encountered and to offer any assistance I might be able to provide.

Addiction is now widely accepted to be a disease or a group of diseases. Addictive disease can be characterized as a chronic, relapsing, progressive, probably incurable, and often fatal (if untreated) disorder. The principle diagnostic features are obsession, compulsion, and *continued use despite adverse consequences* (loss of control).

Methadone has been used in the treatment of opioid dependence for about 40 years. It has been found to be both effective and safe in long-term administration. An adequate, individualized daily dose of methadone eliminates drug craving, prevents the onset of withdrawal, blocks (through complete opiate cross tolerance) the effects of other opiates, such as heroin or morphine. Efficacy of treatment is based on elimination of or reductions in illicit/inappropriate drug use, elimination or marked reduction in illegal activities, improved employment, pro-social behavior, and improved general health. Such treatment has been shown to be effective in reduction of the spread of HIV and other infections. Dramatic reductions in mortality rates are seen in methadone-maintained patients in comparison to untreated addicted populations.

The methadone-maintained patient develops **complete tolerance to the analgesic, sedative, and euphoric** effects of the maintenance dose of methadone. Tolerance does not develop to the effect of *preventing the onset of withdrawal syndrome.* Methadone has a half-life in excess of 24 hours which makes single daily dosing possible. Methadone has a relatively flat blood plasma level curve that will prevent the onset of abstinence syndrome for over 24 hours *without* causing any sedation, euphoria or impairment of function.

Second to discrimination, the management of pain in a methadone-maintained patient is the most common problem we encounter. Since the patient is fully tolerant to the maintenance dose of methadone, **no analgesia is realized from the regular daily dose of methadone**. Relief of pain depends on maintaining the established tolerance level with methadone and then providing additional analgesia. Studies have shown that exposure to adequate doses of narcotics for the relief of acute severe pain does not compromise treatment of the addiction.

Non-narcotic analgesics should be used when pain is not severe. In the event of more severe pain, the use of opioid agonist drugs, such as morphine, often needs to be increased due to the opioid cross tolerance established by the methadone. Also, the duration of analgesia may be less than usual. Doses must be individually titrated to ensure adequate analgesia. Best results are obtained with a scheduled dosing as opposed to PRN. Morphine may be required q 2-3 hours in whatever dose provides relief. (***Over***)
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There is no justification for subjecting a maintenance patient to unnecessary pain and suffering because of their disease or its treatment. Adequate treatment of pain will ensure a more pleasant hospital stay as well as enhance healing and recuperation.

Opioid partial agonist and agonist/antagonist drugs such as Buprenex, Talwin, Stadol, and Nubaine should *never* be used in the methadone-tolerant individual. Severe opiate withdrawal syndrome can be precipitated by drugs of this type.

Both propoxyphene and meperidine are known to produce CNS excitatory metabolites. Due to the cross tolerance, the higher doses required to achieve analgesia could increase the risk of seizures. For this reason, propoxyphene and meperidine should be avoided in the maintenance patient.

The administration of opioid agonist drugs should be closely supervised in terms of quantities and duration. Prescribing for self administration by the patient should be carefully monitored. If it is necessary to prescribe for self administration, caution should be exercised in the amounts prescribed and refills carefully supervised.

Similar precautions are indicated in the prescribing of sedative/hypnotic and CNS stimulant drugs. The abuse potential of ALL benzodiazepines is quite high.

At times, the attending physician is tempted to treat the opioid dependence itself. This is usually attempted by doing a methadone graded reduction of dose. If successful, the graded reduction may result in a reduction or elimination of the physiologic dependence but has no effect on the disease itself. Even after the methadone is discontinued, significant signs and symptoms of abstinence may persist for several weeks and even months. The relapse rate associated with detoxification alone approaches 100%. A relapse to street/illicit drugs increases risk of overdose, hepatitis, AIDS, and a host of other biomedical, psycho-social, legal, and other complications.

Under some circumstances, some form of intervention can be accomplished during a hospital stay for other conditions when desired by the patient and in consultation with the methadone program physician. Such a process should involve experienced addiction professionals with a strong emphasis on continuity of care upon discharge.

If you have any questions or concerns about our mutual patient in relation to methadone or drug dependency, please call me. I would be delighted to hear from you.

Sincerely,

Clinic Doctor

Phone: Fax:

Address:

Memoriam: Danny Sugerman

Danny Sugerman recently passed away after a long bout with lung cancer. Danny Sugerman is most famous for being the manager of the rock band, **the Doors**. He wrote a book about the experience. In life, he was very candid about his battle with drug addiction, writing another book, *Wonderland Avenue,* chronicling his experiences.

Simply by speaking so candidly about addiction, he helped those suffering from, and those in recovery from, drug addiction Almost certainly, he changed at least a few people's minds about drug addicts--from viewing a drug addict as a "bad" person (i.e., someone with weak morals and willpower), to realizing that an addict is simply a human being who has an illness.

Danny Sugerman also contributed his support to ***Methadone Today*** financially and by writing articles. We valued his praise and contributions, and we are very saddened by his passing.

If you have any questions for our Medical Advisory Board, do not hesitate to send them to us and we will pass them along to the doctors. There are no stupid questions!

We need patient stories also. Don't worry about spelling or grammar. Just send your story.

Now what?

Cartoon by Ken Thompson - Roseville

Dear PJ (from p. 1).

when it comes to prescription medications until there is sufficient research to determine that the medication does not harm the infant. In particular with breast-feeding, the philosophy is to err on the side of not breast-feeding.

Research has demonstrated that breast-feeding while on methadone poses no danger to the infant. As long as there is no other reason breast feeding is contraindicated (i.e., the mother has HIV/AIDS), doctors should inform methadone patients that it is perfectly fine to breast-feed.

The recommendations concerning pregnancy and methadone treatment have also changed somewhat over the years, and methadone clinics should make sure that the information they give patients on this subject is current and accurate. At one time, many doctors felt that keeping the methadone dose as low as possible during pregnancy was the safest option for the fetus. Based on research and experience over the last 10+ years, medical experts now believe that upon becoming pregnant, a methadone maintenance patient should remain on the same dose. In fact, the patient may even need a dosage *increase* to remain comfortable at some point during pregnancy, as a result of factors such as increased renal blood flow.

So methadone clinics need to stress to patients that there has been enough research and medical experience with methadone treatment and pregnancy to definitively state that methadone, when taken on a maintenance basis, will not harm the developing fetus but that dropping the methadone dose or otherwise attempting to taper off of methadone during pregnancy may endanger the fetus both directly and indirectly by potentially triggering a relapse to short-acting opiate abuse, which could harm the developing fetus.

The form is also clearly outdated when it comes to LAAM. As you stated, LAAM is no longer available, so it really doesn't matter--but we have a problem with treatment providers utilizing a form that has so much outdated and inaccurate information. The LAAM section says nothing about the risk of cardiac arrhythmia and the need for regular testing to ensure that the medication is not causing such a heart problem.

Finally, it is disturbing to us that the clinic staff did not catch these inaccuracies sooner and bring it to the attention of their superiors (i.e., the clinic doctor)--or alternatively, if members of the staff did bring it to the attention of the powers-that-be, it is disturbing that the higher-ups did not change the form accordingly.

Dear Beth C. (from p. 1).

clinics that do not provide the greatest quality treatment, in general, dosing practices have improved--to some degree--since the 1970s.

On the surface, the philosophy behind blind dosing seems to make sense. The idea is that the patient should concentrate on recovery instead of worrying too much about the particular dose s/he is on. But the reality is that many methadone clinics that practice blind dosing tend to under dose patients. Oftentimes, such clinics seem to have a low opinion of patients and rarely listen when a patient complains that s/he feels under dosed.

We have a fundamental problem with blind dosing and the attitude of staff in methadone clinics with blind dosing practices. At issue is whether patients should have a say in decisions concerning their treatment--not only in dosing matters, but in other areas of treatment. Don't patients have a right to be thoroughly informed and educated about their treatment--including what dose they are taking?

The only time we believe that blind dosing is acceptable is in cases where the patient wants dosing information to be kept from him/her. One reason a patient might want to be "blind dosed" is when the patient is tapering off of methadone and s/he might feel that s/he would have a more difficult time knowing when and by how much the dose is to be reduced.

As for not giving take-homes to any patients, we think it is ridiculous. As you are aware, this clinic could have given take-homes to eligible patients but apparently chose not to. If one of the main goals of methadone treatment is to make the patient more functional, it seems contradictory to require daily attendance to stable patients. This obviously interferes with patients' lives and makes holding down a job difficult and sometimes even impossible. Several years ago, new federal regulations were adopted that allow long-term stable patients to obtain larger take-home supplies (up to a month's supply).

We are glad that you live within driving distance of a methadone clinic in a state (Kansas) that permits up to one month take-home supplies for eligible patients. Unfortunately, the state of Michigan still has regulations that prohibit more than a 6-day take-home supply for most patients. It is long past due for Michigan to amend its regulations to permit longer take-home supplies for long-term stable patients. Many patients have demonstrated that they would be responsible with extended take-home supplies.

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