Methadone Today

The official newsletter of DONT--by patients, for patients December 2005 Volume X Number IX

Medication Interactions--Patients Beware

Patients in opiate agonist treatment (i.e., methadone or buprenorphine maintenance) should be acutely aware of medication interactions. The extent of these interactions can range from the clinically insignificant to severe. Sometimes the dosage of either methadone/buprenorphine or the other medication simply needs to be adjusted accordingly. But in other cases, a medication may be completely contraindicated, which means that the medication should NEVER be given as long as the patient remains on methadone or buprenorphine.

This is one of the reasons methadone patients should notify all their doctors that they are in methadone treatment. The consequences of taking certain prescribed medications while on methadone can be very serious--even fatal. For example, taking the anti-depressant fluvoxamine while on methadone could result in oversedation or even death, because it slows the body's metabolism of methadone. Note that the slower the metabolism of a medication, the greater its effects, so medications that slow down the metabolism of methadone can cause symptoms of overdosage, and medications that speed up the metabolism of methadone can cause withdrawal symptoms.

Medication interactions are a significant issue, not only when starting a new medication or raising the dose of a medication you are already taking, but also when stopping or decreasing the dose of a medication you are already taking. For example, if you have been on a medication for awhile that somewhat slows down the metabolism of methadone and you stop taking it, you may start feeling as if your methadone dose is no longer holding you. In this case, a methadone dose increase may be indicated.

In many cases, medication interactions can be minimized or avoided by the prescribing/use of alternate medications. For example, cimetadine (a.k.a.: Tagamet) is an acid reducer, available over-the-counter or by prescription to treat heartburn and other stomach problems. Although cimetadine's interaction ***(Cont. p. 3)***

Methadone Clinic Safety

(Name Withheld by Request)

My methadone clinic, along with many other methadone treatment facilities, could do a much better job with security. As the editors of ***Methadone Today*** seem to recognize, public perception of methadone treatment is an important issue. For this reason, providing good security is important for public relations purposes. But patients at my methadone clinic are learning the hard way that, contrary to public perception, methadone patients are sometimes the victims, rather than the perpetrators of crimes.

Let me preface this by saying that I am not suggesting that the average methadone clinic is the hotbed of crime that the public thinks it is. There are many methadone clinics that are so inconspicuous and free of, not only crime, but loitering and other negative things that people associate with methadone clinics that residents would not even realize that there is a methadone clinic operating out of a given building if it were not pointed out to them.

Methadone clinics reduce area crime; it is well established that methadone treatment eliminates or drastically reduces the criminal activity of opiate addicts. Yet, like it or not, the public associates methadone clinics with crime, so methadone treatment providers must be conscious of the impression their facilities foster.

Unfortunately, my methadone clinic has a less than ideal location for the provision of methadone treatment to a fairly large number of patients. It is located on a major street, and patients must park in the street. Furthermore, during peak times, available parking for patients becomes scarce. It should be said that for the most part, the methadone clinic cannot be blamed for inadequacies of the location. Because of NIMBY (Not in My Backyard) and other issues, many residents mistakenly believe that methadone clinics will bring a crime wave to their neighborhood. Methadone clinics generally do not get a large choice of locations, and there is really no place to build another parking lot or expand the very small staff parking lot even if they wanted to. To make matters worse, there is a gas station next to the methadone clinic.

Recently, the wrong people have capitalized on the fact that patients going to the methadone clinic often have ***(Cont. p. 3)***

Dear Methadone Today,

Hi my name is Stacy, I've been on methadone for almost four years. I was a prescription drug addict following a surgery and the birth of my 5-year-old son. I want to let you know if I can get off methadone anyone can, and I want everybody to know that the methadone clinic does not give a shit about you; they want your money and your business.

Their idea of help cost me over $10,000, and I'm still going through withdrawal. They almost cost me my husband and child. I live in a small town and I'm about 30 miles from the nearest methadone clinic. I used to live on a Navy base--that's were I got hooked on the painkillers. I was getting them filled every five days. Lets just say 80 Perocet plus 50 extra strength Vicodan, and the military doctor was also prescribing 30 mg of methadone for the pain.

Well a year or more of this was killing everything but the pain. After asking the doctor to help me get off, I visited a rehab for 15 or 16 days. Well that didn't help--all I got was a bigger addiction problem.

So I joined a methadone clinic where I never spoke to a doctor for almost four years. If that's hard to believe, you're going to love this: I recently went to the clinic with my father, who I just asked to help me get off the methadone. I wanted them to dose me off of the methadone fast... they told me it's not medically advisable. Then they took away all six of my steps [take homes] I had earned since starting there, and let's not forget $200 a month for almost four years. And they told me to dose off of the lousy 50 mg I was on, I would have to commute an hour and a half to the clinic every day to take the methadone.

Let's just say that after clean drug tests and going there for two of those four years every single day, I should get a little better care for that $10,000+ I spent--and you won't either. If anybody has a complaint about methadone practices, I urge you to complain to the drug and alcohol program of the state you live in and keep these people from getting rich on our problems.

Signed, Life doesn't have to suck if you're hooked. ***(C. p. 4)***

Medication Interactions

The following is a list of medications reported to interact with methadone or buprenorphine, taken from TIP #43: Medications-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs (Exhibit 3-5). The TIP and TAP series are produced and distributed by Center for Substance Abuse Treatment (CSAT)--part of the U.S. Department of Health and Human Services (a federal government agency). ***Note: this is not a complete list and does not include opiate antagonists (i.e., naloxone, naltrexone) or opiate agonist-antagonists (i.e., Talwin), which are contraindicated for methadone patients.***

Reported Drug Interactions With Methadone

Agent	Effect on Methadone
Amitriptyline	Decreased clearance
Amprenavir	Decreased serum levels; possible decreased opioid effects
Amylobarbitone	Increased clearance
Ciprofloxacin	Increased opioid effects
Diazepam	Increased opioid effects
Efavirenz	Decreased plasma levels and opioid effects
Ethanol [e.g., alcohol]	Increased opioid effects and added sedation
Fluconazole	Decreased methadone clearance and increased SMLs
Fluoxetine	Increased SMLs
Fluvoxamine	Increased SMLs and increased opioid effects
Fusidic acid	Decreased opioid effects
Moclobemide	Increased opioid effects
Nelfinavir	Decreased SMLs
Nevirapine	Decreased SMLs and opioid effects
Paroxetine	Increased SMLs
Phenobarbital	Decreased SMLs and opioid effects
Phenytoin	Decreased SMLs and opioid effects
Rifampin	Decreased SMLs and opioid effects
Ritonavir	Decreased SMLs and opioid effects
Sertraline	Increased SMLs
Spironolactone	Increased clearance

Opiates Better Than Sedatives for Treating NAS

Reprinted from http://www.atforum.com

Medical News Today; July 27, 2005 –

Sedatives have been the gold standard for treating newborns suffering from neonatal abstinence syndrome (NAS); however, new research suggests that opiates are superior to sedatives for treating infants born to women who used heroin or were treated with methadone while pregnant.

Opiates appear to better "ameliorate the withdrawal, facilitate feeding, and potentially reduce the likelihood of seizures," according to new systematic reviews done by David Osborn, a neonatologist at the Royal Prince Alfred Hospital in Sydney, Australia, and colleagues. The researchers also found that infants treated with opiates regained birth weight more quickly than those who only received supportive care, and the duration of necessary care was shortened by an average of 4 days. Also, when compared with diazepam, opiates reduce the incidence of treatment failure.

In the examined research studies, newborns suffering from NAS were treated with opiates (morphine, methadone, paregoric, or tincture of opium), sedatives (phenobarbitone, diazepam, or chlorpromazine), or supportive care only. None of the studies compared opiate treatment with placebo.

"The interesting information," Osborn says, "suggests that these infants can be treated without admission to the special care nursery unless withdrawal is complicated and that this is facilitated by the use of morphine instead of phenobarbitone. This helps keep mothers and babies together, helps in educating the mothers in mothercraft skills and to recognize signs of infant withdrawal, and helps in assessment of the quality of the mother-infant interaction in a supervised environment."

Methadone Today would like to thank our Medical Advisory Board for their participation.

Our Medical Advisory Board includes:

Dr. Vincent Dole, Rockefeller University;
Dr. Marc Shinderman, Director/Owner of Center for Addictive Problems in Chicago;
Dr. Andrew Byrne from New South Wales, Australia, who has written two books about methadone and addiction;
Dr. Brian McCarroll, Director/Owner of Bio-Med in Clinton Township, MI;
Dr. Charles Schuster, Director of the University Psychiatric Center in Detroit, MI and former head of NIDA; and his associate
Dr. John Hopper, Medical Director of UPC.

Medication Interactions (from p. 1).

with methadone is relatively mild (it slows down the metabolism of methadone), there are other over-the-counter medications with similar effects that do not interact with methadone, such as ranitidine (a.k.a.: Zantac) and famotidine (a.k.a.: Pepcid AC). Even when a medication is prescribed by a doctor who is aware that you are taking methadone and knows what other medications, if any, you are currently taking, it is advisable to consult with a pharmacist, read the information about the medication that accompanies the prescription, and/or look up the medication in a reference book. Pharmacies and many book stores sell such books written for patients, nurses, or doctors, that contain information about most common prescription medications, including known drug interactions. A doctor could be unaware that the medication is known to interact with methadone, so double checking is always a good idea.

The majority of commonly prescribed medications are not going to have a serious interaction with methadone or buprenorphine. But doctors really should be aware of ALL the medications you are currently taking, including seemingly innocuous over-the-counter medications and herbal remedies. Due to negative attitudes held by some medical professionals about methadone patients and drug addicts generally, methadone patients have been reluctant to tell their doctors that they are in methadone treatment. While this is understandable, the potential for dangerous medication interactions is too great to withhold such information from your doctors. The best advice is to be honest with your doctors, and if they treat you disrespectfully, find another doctor who is willing to treat you with respect.

Editor's Note: See page 2 for list of some medications that interact with methadone.

Clinic Safety (from p. 1).

significant cash on them. Most of the patients do not have health insurance that will cover methadone treatment, and they pay the entire bill out of pocket. At least a few patients have been robbed. I understand that crime can happen anywhere, and the methadone clinic cannot be responsible for what happens off the premises, but I think that they could take steps to make patients feel more secure and make such crime less likely to occur. Instead, I feel that they have been somewhat lax in their response.

First of all, I think that the methadone clinic should recommend that patients pay by check or money order. I understand that many people do not have a checking account, but anyone can get a money order--in fact, there are stores that will provide them without charging a fee. I am not necessarily suggesting that the clinic should REQUIRE payment by check or money order, but the clinic could urge patients that such payment methods would be safer for them, eliminating the need for carrying a large amount of cash. Second, patients should be instructed to avoid soliciting the neighboring gas stations or stores before coming into the methadone clinic, and after leaving the clinic if the patient has received any take-home medication. This may seem like common sense, but it is possible that patients are unaware of the crime that has recently occurred or just do not think their actions through. Finally, one clinic security guard should be instructed to be outside the clinic at all times, patrolling all around the building. It amazes me how seldom I see a security guard outside at the front or the sides of the building. Clinic security should do more than protect clinic staff and staff vehicles. I am not suggesting that security guards are at fault; they are just following management's instructions.

The methadone clinic could probably offer other suggestions that I have not mentioned or even thought of. They should be providing all patients with a handout about safety in and around the clinic--or at least posting a notice on the bulletin board about the recent muggings that have occurred near the clinic. Many simple suggestions may make a big difference in curbing crime against patients. For example, it may be wise to recommend that patients put their take-home medication in smaller lockboxes that are less conspicuous and may even fit into a purse or jacket pocket, as opposed to a big, clunky cashbox-style lockbox that is easy for a burglar to see and grab. Of course, the term 'lockbox' is a misnomer--its lock may keep children from getting into it, but a burglar would have no trouble forcing most lockboxes open. Similarly, patients should probably be urged to avoid using a lockbox made of clear plastic or plexiglass that can be seen through. Do you really want prospective thieves to see that you have a week's worth of take-home bottles rather than only one bottle?

Editor's Comments: This author has some good ideas. As s/he suggests, methadone treatment providers are not always able to choose an optimum site to locate their methadone clinics. Methadone patients need to be mindful of their safety this time of year when there are fewer hours of daylight. It may be dark out when they attend their clinic, making safety a bigger concern.

We also agree that some methadone clinics could do a better job with security outside the facility. This would help prevent burglaries, as well as deter drug dealing and loitering. Though the amount of drug dealing that occurs around methadone clinics is often exaggerated by the media, drug dealing does occur to one extent or another at many clinics.

Contrary to public perception, most of the dealing that does occur seems to be with benzodiazepines (i.e., Xanax), rather than methadone, and many of the dealers may not even be methadone patients. The point is that the presence of a security guard outside the building would go a long way towards deterring the drug transactions that ***are*** going on.

Finally, while the author is partially correct that a smaller lockbox would be less conspicuous, there is a more basic problem that has to do with the dispensing of liquid medication. With a 6-day take-home supply, and certainly with extended take-home supplies, the bottles are just too big to conceal from potential robbers. Medication in solid form, even if inside a small lockbox, would be much easier to conceal and protect from theft. Under the new federal regulations, methadone may be dispensed in solid form, though some states still require medication be dispensed in liquid form.

Remember, there will be no *Methadone Today* in January 2006. There *will* be an issue in February. Thank you for your support in 2005.

Happy Holidays,

Aaron & Beth

Dear Methadone Today (from p. 1).

Dear Stacy,

Thank you for sharing your story. We are sorry that you had a bad experience with your methadone clinic. As hard as you may find it to believe, there are a few methadone clinics out there that actually do care about their patients.

If you really did not speak to a doctor for 4 years, you should indeed report them to your State Methadone Authority. You should have been seeing a doctor for periodic rechecks at least every 90 days. A doctor should be the one making decisions regarding whether/how to withdraw off of the medication. A doctor would also be the one to make changes to a take-home schedule. There are a few exceptions to this---patients withdrawn from the medication per a discharge due to inability to pay for treatment or because the patient threatened or assaulted the clinic staff or another patient, but generally the above are the responsibilities of a clinic physician.

Furthermore, there is no reason that to taper off of methadone you should have to go back to attending your methadone clinic daily. If there was no other reason they took away your take-home 'privileges', then we think that doing so was unjustified. Perhaps they got the impression that you were not going to use the medication as prescribed (i.e., use the take-homes to attempt to rapidly withdraw from methadone on your own).

We think that it's worth mentioning that given the government requirements and regulations that methadone clinics have to deal with, $200 a month is not an excessive charge--at least, if good quality treatment is indeed provided. In many areas of the U.S., methadone clinics charge considerably more--between $60 and $100 per week, and occasionally, even more than that. The cost of the medication is only a very small portion of the treatment cost, which is why you were charged just as much money for 50 mg/d, as a patient on a higher [or lower] daily dosage. In fact, one of the major costs of treatment is the counseling sessions. The cost of individual counseling sessions outside of the methadone clinic setting is not much different--and unlike the methadone clinic, that would not include the cost of medication and drug testing.

This is not to say that private methadone clinics do not make a healthy profit--in our opinion, many methadone clinics make an excessive profit while providing less than high quality treatment. But as we said, $200 a month is not out of line, and depending on government regulations, the cost of leasing or buying a building to operate a methadone clinic out of in the area, etc., methadone treatment providers sometimes need to charge more than that just to make a profit. In many cases, appropriate regulatory changes would result in more reasonable methadone clinic rates.

It is not our job to defend the actions of your or any methadone clinic, but to be fair, they were absolutely correct that withdrawing from your maintenance dose of methadone fast is not "medically advisable". Some methadone patients think that clinics discourage them from withdrawing from methadone--especially rapid withdrawal--because they are more interested in continuing to profit from them than in helping their patients. But methadone clinic physicians who discourage rapid or untimely withdrawal from methadone are doing so with the patients' best interests in mind. Rapid withdrawal seldom results in long-term opiate abstinence. Furthermore, withdrawing from methadone prematurely is very likely to result in relapse. Relapse to illicit opiates is serious business--the patient could be arrested for possession or use of illicit drugs, or even overdose. Illicit drug use, especially i.v. drug use, could result in serious medical problems, including the patient being infected with HIV or Hepatitis C. Even if a patient is ready to withdraw from methadone via a gradual taper, the odds of eventual relapse are high; this is the nature of opiate addiction, which explains why so many addicts require methadone maintenance treatment to begin with.

Methadone maintenance treatment is a highly effective treatment for opiate addiction. Just because you were able to withdraw off of methadone without subsequently relapsing does not mean that any methadone patient can. Opiate addiction appears to be physiological in nature. Opiate addicts have a chemical imbalance, that in some may correct itself after a period of time in opiate agonist treatment but in many others may be permanent. As you letter indicates, many of the problems methadone patients experience with the treatment has more to do with clinic policies and government regulations than with the treatment itself.

Federal regulations now allow patients to obtain up to a 30-day supply of take-homes (once a month clinic attendance). It is the regulations of some states and the policies of some methadone clinics that are forcing long-standing, stable patients to attend a clinic once a week or more often. If you want to help change this, advocacy organizations like Advocates for Recovery through Medicine are working on this and need volunteers and monetary support. Methadone treatment will improve, but it will take patients, their families, and other concerned individuals to make the necessary changes .

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