

Methadone Today

The official newsletter of DONT--by patients, for patients April 2006 Volume XI Number IV

Discharge for continued substance abuse

From TIP #43, "Medication-Assisted Treatment (MAT) For Opioid Addiction in Opioid Treatment Programs," CSAT. [a government agency--Call 800-SAY NO TO to order free TIP/TAP publications.]

The consensus panel recommends that patients receive every chance to continue treatment and that treatment last as long as it is effective. Program effectiveness may be determined by comparing a patient's substance use and overall adjustment at admission with his or her current status. The Addiction Severity Index (see chapter 4), an assessment tool used in many substance abuse treatment programs, lends itself to such comparisons. Studies have shown significant improvement in patients even when complete abstinence was not achieved (e.g., Strain et al. 1999); therefore, caution should be used in judging patients' progress in MAT based solely on drug tests. Treatment for other substance use and addiction should be offered to patients coping with dual addictions (see chapter 11). Patients should understand that the ultimate goals of treatment are abstinence from heroin and other illicit drugs and appropriate use of prescription medications.

Editor's Comments: We believe that some methadone clinics are too quick to 'terminate' patients for illicit/non-prescribed drug use. One way to look at cases is to consider the probable consequences of involuntary withdrawal from methadone: Will that patient likely be worse off? This is particularly worth considering in cases where a clinic is considering discharging a patient for continued marijuana use--while marijuana abuse is not condoned, the likely result of involuntary methadone withdrawal is relapse to opiate abuse as well as continued abuse of marijuana].

Many such patients eventually achieve total abstinence from non-prescribed/illicit drugs if they remain in treatment long enough. In many of these cases, although not completely abstinent from all drugs, the patient has improved considerably from when treatment began--not only when it comes to illicit drug use itself, but also in related areas, such as criminal activity, employment, and health. Eliminating i.v. drug use is particularly important given the risk of contracting hepatitis C, HIV, etc.

Dear Methadone Today,

Hello! The reason I'm writing is because I have a major problem, one in which I have been trying to outrun for the past three years. I had started at a methadone clinic in 1993, and all went just fine until the day that they announced that they were going to do drug testing for marijuana.

I should have been going to a pain clinic, because I did have chronic back pain, but I didn't bother, because between the methadone and the marijuana, my back wasn't hurting all that bad. It got to a point when they started testing for the pot that I went to a pain clinic and left the methadone clinic. The very first day that I started at the pain clinic, they decided that they would test me for pot. I was up front with them and told them that I had smoked pot and that it would be in my system. One of the nurses told me that I should have lied, because if they thought that I never smoked, they never would have started checking.

I had been on methadone and pot together for 13 years; no problems whatsoever until they started testing! Now, they say that if they find pot in my system one more time, then they are

Dear Methadone Today,

Hello, I was looking up some information on methadone and breast feeding. I recently gave birth to a very healthy baby girl just a little over four months ago. I started methadone maintenance at the very beginning of my pregnancy because of a Lortab addiction. It has helped me gain my life back and has taught me so much about myself; however, my baby seems to be going through a neonatal abstinence syndrome (NAS) or something....

I am not really sure, but I am sure that I am very concerned and worried about her. Two weeks after she was born she began to have cold like symptoms meaning stuffy nose sneezing, etc. They haven't gone away. After researching methadone, I found that these symptoms are a sign of withdrawal in infants, as well as high pitch cry, trouble nursing, and the need to suck constantly. My baby seems to have all of these signs.

I am currently on 30 mg daily, which is a low dose, but I worry that it is affecting her, and I don't know if I should get off of it, stop nursing her, or go up in my dose to help her. She just recently started this high pitch cry, but the other signs such as stuffy nose, and sneezing have been ongoing since two weeks old. She couldn't be in withdrawal for this long could she?

I don't like that she might be suffering from methadone, but at the same time, I need it in my life right now. So I feel stuck as to what I should do. Is she experiencing NAS? What should I think of this? Please ease my mind. Thank you. **-A Worried Mother**

Dear Worried Mother,

We appreciate your concerns about your baby; --judging from this letter, you are a good, caring mother. Although this does not answer the question you asked, we would like to point out that starting on methadone maintenance treatment at the very beginning of your pregnancy was the best thing you could have done for your fetus/baby, as well as for yourself. Methadone maintenance does not harm the fetus*, but abuse of short-acting opioids (**Cont. p. 3**)

going to start to detox me. I live in Wisconsin, and our laws are ridiculous! I've seen drunks do more damage to people than I could ever conceive of, and they want to pick on people who use marijuana for medical reasons?

All of the regular doctors I've ever seen tell me to get off the marijuana, yet they push physical therapy, which I did for three years, and I only ended up in traction! They want me to try different drugs, which only make me sick, or they don't work at all. When you find something that works, they want to take it away!

I truly believe that if pot was dispensed through a pharmacy, people would be dumbfounded as to how many people would actually use pot for a pain killer! People are telling me to join NORML and to find a doctor who believes in medical marijuana. I'm just afraid that Wisconsin is so slow and behind in their thinking that by the time they fix the problems I'm having now, it would have already cost me over \$60,000 so far.

If they detox me and try to get me off methadone after 13 years, I think I'm going to have one hell of (**Cont p. 4**)

Study of buprenorphine in pregnancy has reassuring results

by Dr. Andrew Byrne, Dependency Medicine
(New South Wales, Australia)

Methadone versus buprenorphine in pregnant addicts: a double-blind, double-dummy comparison study. Fischer G, Ortner R, Rohrmeister K, Jagsch R, Baewert A, Langer M, Aschauer H. Addiction (2006) 101;2:275-281.

This small but meaningful study from Vienna gives us more confidence in the safety and effectiveness of (pure) buprenorphine in pregnancy when compared with traditional methadone treatment. These authors performed a randomised, double dummy trial using flexible dosing, daily attendance and psychosocial supports for 18 patients.

They used flexible doses of 8-24 mg buprenorphine and 40-100 mg methadone in women at 24-29 weeks of pregnancy.

There was a still birth at 38 weeks in a woman who had been abusing opioids, cocaine and benzodiazepines. Another had a late spontaneous abortion at 28 weeks. Both were methadone subjects. Another two patients were withdrawn from the study due to non-compliance (one buprenorphine and one methadone patient).

Of the remaining subjects who went to term, neonatal abstinence syndrome (NAS) was equal across the two groups. Only about 50% of babies needed treatment for NAS (for an average of 5 days in both groups). The signs were noted slightly earlier in the methadone subjects (60 hours; versus 72 hours after birth for buprenorphine). Intercurrent drug use, determined from urine toxicology, was significantly less in the methadone subjects. Retention rates were not significantly different owing to the low numbers.

Again, these researchers have provided further evidence of the safety and effectiveness of buprenorphine in pregnancy. With a lack of adverse reports and widespread use in many countries, we can probably now prescribe buprenorphine with more confidence for pregnant women in whom methadone has proven unsatisfactory. It is still not 'first line' in my view, but an excellent alternative when indicated. It also is an indirect reminder that the combination drug should never be used in pregnancy (and probably ought not to be used in women who are at risk of becoming pregnant since safety data are absent).

Editor's Note: While this and other studies indicate that buprenorphine--the pure formulation [Subutex], and NOT the formulation where naloxone is added [Suboxone]--is safe for pregnant patients to use, [as Dr. Byrne suggests] all things being equal, methadone should be the first choice.

Unsuccessful transfer of pregnant women from methadone to buprenorphine

by Dr. Andrew Byrne, Dependency Medicine
New South Wales, Australia

Transferring Methadone-Stabilized Pregnant Patients to Buprenorphine Using an Immediate Release Morphine Transition: An Open-Label Exploratory Study. Jones H, Suess P, Jasinski D, Johnson R. American Journal on Addictions (2006) 15;1:61-70.

Four pregnant women (22-30 weeks), stabilised for at least 4 weeks on methadone, who 'requested a change... to buprenorphine' were first transferred to oral morphine for 5-7 days (using equivalence ratio of 1:6 but less in some cases) and then transferred to sublingual (pure) buprenorphine using a variety of

multiple daily increments and supplementary drugs (daily doses 12-28 mg).

The four transfers were marred by problems including relapse to illicit drug use, symptoms of 'feeling different'. On each occasion, the authors seemed confident to separate such symptoms from withdrawals. There were also reports of acute biliary disease, fever, anhydramnios, panic attack, nausea and vomiting, the latter in a number of separate instances. All patients requested transfer back to methadone by day 10.

Twelve additional patients met trial criteria but were excluded for a variety of reasons. They may have been the lucky ones as, despite a positive-sounding abstract based on complex withdrawal scores rather than clinical outcomes, this trial was highly unsatisfactory in a number of respects. The very title could mislead readers since none of the four experimental subjects was 'transferred to buprenorphine' successfully.

Case A (85 mg methadone but only given morphine equivalent of 75 mg) left the hospital on the first evening of buprenorphine and used heroin and cocaine. She returned to methadone on day 10 after an episode of foetal tachycardia and anhydramnios.

Case B (65 mg methadone) withdrew from the study on day 10 after a panic attack, vomiting, withdrawal episodes and anxiety over 'feeling different' on the buprenorphine. 'The withdrawal demonstrated... was either precipitated or spontaneous' we are told. It seems academic as the patient chose to return to methadone after only 2 or 3 days on buprenorphine

Case C (65 mg methadone) developed nausea, vomiting, fever, white bowel motions and abdominal pains on days 9/10 yet it took 4 days or more before she was transferred back to methadone and received treatment for probable cholestatic disease.

Case D (50 mg methadone) transferred back to methadone on day 10 after suffering from severe constipation, anxiety and 'spacy' feelings; although she reported missing the 'numbing feeling of methadone' the authors state that although she 'reported no withdrawal', she 'withdrew' for the study.

All we are told about foetal progress was that a review of the medical records yielded "...outcomes typical of this population." I since learned that all delivered healthy neonates (JH, pers comm). The paper does not reveal possible prematurity, abstinence syndrome, mortality, etc. These are rather fundamental omissions for a peer reviewed, NIDA/NIH funded study.

While these authors speculate on reasons behind the findings of the study, at the same time they appear to skirt their own main findings. Almost predictably, each of the four pregnant women treated under a risky protocol (which would be contraindicated under all existing clinical recommendations) fared poorly. While morphine seemed to be reasonably well tolerated (as might be predicted from research e.g. Fischer, 1999), each patient in turn failed to transfer successfully to buprenorphine and each one had serious associated problems causing risks to both mother and developing foetus. Buprenorphine is not approved for use in pregnancy although many doctors now believe that it is a reasonable alternative to methadone in appropriate cases. Others feel that it has an unacceptably high rate of reported problems.

If there is a message from this study it is that pregnant women should not become involved in research of this nature. Each was chosen because of their stability on methadone and then given a protocol of two changes of pharmacotherapy, the second one a partial agonist known to induce withdrawals in a proportion of patients.

It is to be wondered on what basis the Johns Hopkins Bayview Medical Centre Institutional Review Board allowed a study as potentially dangerous and unorthodox as this to take place in their institution.

The abstract starts with an assumption (**Cont. p. 3**)

Dear Worried Mother (p. 1).

[such as Lortab] during pregnancy is potentially very harmful. Basically, the highs and lows (withdrawal) experienced with short-acting opioid abuse isn't good for fetal development and can trigger premature labor or miscarriage--whereas, a stabilized methadone maintenance patient does not experience such highs and lows.

Medical experts do NOT recommend attempting to withdraw from opioids of abuse, whether via 'cold turkey' cessation, using non-opioid medications like clonidine, or via a methadone taper, nor do they recommend withdrawing from methadone during pregnancy. Withdrawal is dangerous for the fetus. The other reason experts advise against withdrawal from methadone or opioids of abuse is that the risk of relapse associated with withdrawing from opioids is high--and relapse to opioid abuse is definitely bad for the fetus and mother. Besides, in many cases, people suffering from serious opioid addiction do not take good care of themselves--and good diet and pre-natal exams are important to ensure the health of the fetus.

It is true that following birth, a percentage of infants born to methadone maintained mothers develop opioid withdrawal symptoms (AKA: NAS--neonatal abstinence syndrome). Fortunately, NAS is easily managed, and does not result in any long term health or developmental problems for the infant. If NAS does occur, withdrawal symptoms usually appear within 72 hours (TIP #43, Medication-Assisted Treatment For Opioid Addiction in Opioid Treatment Programs"). However, according to p. 218, "[w]ithdrawal symptoms may begin from minutes or hours after birth to 2 weeks later," so it's possible for it to take as long as 2 weeks for symptoms to appear. It's very unlikely that withdrawal symptoms would continue nearly this long [4 months], but we would still advise you to take your baby to her pediatrician to ensure that her symptoms aren't NAS or another medical issue.

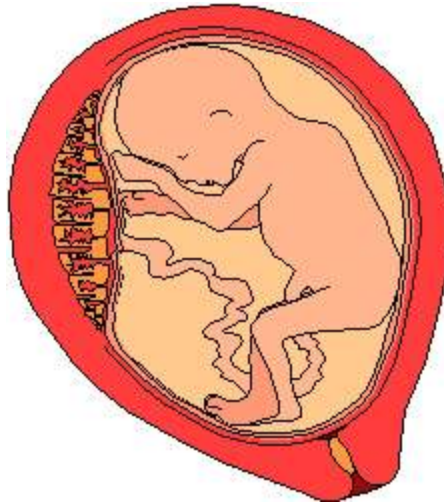
Breastfeeding by methadone-maintained mothers has been found to be safe for the baby--and should even be encouraged, assuming there is no other reason it should be contraindicated (i.e., the mother has HIV). Breastfeeding is harmless and safe, even if the mother is on a higher methadone dose. In any case the amount of methadone that is actually passed through breastmilk is very small--even if you were on a much higher dose of

methadone, you would not be passing on enough methadone to your baby to have an impact.

Thus, whatever is going on with your baby, breast feeding connected to methadone is not likely contributing to the problem. We do not feel you should stop breastfeeding, and there is certainly no reason for you to withdraw from methadone. We are not doctors, so please don't construe any of this as final medical advice. You should definitely take your baby to her pediatrician to get to the bottom of this. Good luck, and thanks for writing in.

Additional Notes:

**There has been considerable research on methadone maintenance treatment and pregnancy. Babies born to methadone-maintained mothers fare just as well as other infants--and researchers have made comparisons in a broad range of categories, such as physical development and intelligence. In fact, the only difference that has been found is the size of baby when first born: for some reason, the average size of newborns of methadone-maintained mothers is a little smaller than the average size of newborns generally. However, they quickly caught up [in size] to the general population of babies, so this difference has no long-term impact on size, development, etc.*



**In regards to methadone dose and pregnancy, experts recommend that the mother maintain an optimal dose of methadone during pregnancy. An optimal dose of methadone suppresses opioid withdrawal for a full 24 hours and prevents opiate cravings. Note that methadone dosage adjustments are sometimes needed during pregnancy--in particular, a

dose increase is sometimes needed in the third trimester, due to increased renal blood flow.

***Thus far, experts have recommended that buprenorphine not be used during pregnancy (opiate addicts not in treatment when they become pregnant are advised to initiate methadone maintenance, and buprenorphine patients are advised to transfer to methadone), since not enough research has been conducted on buprenorphine and pregnancy. However, all the recent research in this area suggests that buprenorphine maintenance treatment is probably as safe for pregnant mothers [and their fetuses] as methadone maintenance treatment is. See page 2, "Study of buprenorphine in pregnancy has reassuring results," for information about one study of the safety of buprenorphine vs. methadone in pregnant patients. On the other hand, in cases where the woman is already on methadone treatment when she becomes pregnant, there is no significant research that suggests that transferring to buprenorphine treatment is advisable. See page 2, "Unsuccessful transfer of pregnant women from methadone to buprenorphine," for information about a very small trial where researchers attempted to transfer pregnant methadone patients to buprenorphine.

Transfer to buprenorphine (from p. 2).

many would find unjustified: "A transition from methadone to buprenorphine without intervening withdrawal symptoms is critical for advancing the treatment of opioid-dependent patients." "Critical to whom" one wonders. They state that the aim of the study was "to develop a protocol transitioning [sic] methadone-stabilized pregnant women to buprenorphine." They do not state any reasons for this goal. A footnote states: "Dr. Johnson is now employed by Rickett [sic] Benckiser (the manufacturer of buprenorphine)".

Editor's Note: Given the complications encountered in this attempt to transfer pregnant methadone patients to buprenorphine, it seems to be a bad idea. Perhaps stabilized methadone patients who become pregnant are best advised to remain on methadone until they give birth. Normally methadone patients are told to taper down to 30 mg/d before transfer to buprenorphine.

Dear Methadone Today (from p. 1).

a time. When they started testing for the pot, the methadone clinic that I was going to had to stop testing for awhile, and they even told their staff to give people more time to get off pot because they were losing almost every person going to their clinic. Almost everyone tested positive! The clinic couldn't survive without these people, but yet, they made me feel like that old picture of the jackass trying to reach that carrot that was dangling at the end of the line that was attached to a stick and was held just out of reach!

Do you have any ideas on what I can do? I WAS having a perfectly normal life until this damn drug testing started. I know that there's a lot of people in the same boat. I'd hate to have to move to one of the 11 states that now recognize medical marijuana. My life is here in Wisconsin. I just am at a loss here as what to do next. Got any ideas?

P.S.: I know there are a lot of bad drugs out there. I did my share, and those days are over. I haven't drunk alcohol for over 13 years, either. I just don't see marijuana as something bad when it's given me so much relief from pain! -P.

Dear P.,

We are sorry that you are in such a predicament. The medical marijuana issue is beyond the scope of **Methadone Today**, but we will comment about it as it pertains to methadone treatment.

As far as state regulations, there is more than one issue involved here. There is the issue of states permitting medical marijuana. In a state that permits medical marijuana, certain individuals using marijuana for medical use may buy and use it without being subject to state prosecution. A doctor would have to give the individual documentation indicating the diagnosed medical condition[s] and recommending marijuana for treatment.

There are many complications with these regulations. The biggest problem is that the purchase and possession of marijuana for medical use still violates federal law. The federal government has threatened doctors who recommend marijuana to any patient. So, many doctors are reluctant to provide the letter you need to demonstrate that your marijuana use is 'medical' in nature.

Another issue that more directly affects you is whether the state requires methadone treatment providers to test for marijuana. If Wisconsin does not require methadone clinics to test for marijuana, you may be able to find another clinic in the state that does not test for it. If Wisconsin clinics have to test for it, you could go to an out-of-state clinic that doesn't test for it. [Note: we are not implying that anyone should lie to their clinic about marijuana use!]

One question we have with regard to states that allow

medical marijuana is how methadone clinics in such states handle medical marijuana use. Just because a methadone patient has the appropriate documentation from a doctor to use marijuana for medical purposes does not necessarily mean that the methadone clinic will regard marijuana as a 'prescribed drug'. It is unclear whether take-homes would be permitted by the clinic. Even if you meet the eligibility requirements, your clinic does not have to give you take-homes. At any rate, your clinic would have to treat the doctor's documentation--recommending that the patient use marijuana for medical treatment like a prescription or you would not even be considered eligible for take-homes. Worst case scenario is that they would terminate you for marijuana use.

Your best bet may be to find a private doctor or pain clinic to prescribe you methadone. The federal regulations alluded to above cover the provision of methadone for the treatment of opiate addiction. These regulations do not apply to the prescription of methadone for pain control. Pain patients are not subject to the same rules that patients on methadone for the treatment of opiate addiction treatment are--nor do pain patients have to go to OTPs (opioid treatment providers). . .and drug testing isn't legally required.

From your letter, we gather that you are on methadone for both opiate addiction treatment and pain control. As long as pain control is one of the reasons you are being prescribed methadone, you should be able to go to a private doctor outside of the OTP system. There may be numerous advantages to going to a private doctor. Doctors who specialize in the treatment of chronic pain likely have more experience with pain management.

If you are convinced that marijuana, along with methadone, is the best way to manage your pain, maybe you can find a doctor that is more open minded about the use of marijuana for medical purposes. Or you can find a doctor that has a regimen that will properly control your pain **without** marijuana. You may find that simply increasing your methadone dose and perhaps splitting the dose will control your pain without severe side effects.

Doctors are discovering other methods of pain relief--which may not replace drugs or surgery but will compliment and maybe reduce the need for conventional treatment. All we are saying is that you should keep an open mind and find the doctor that's right for you. We are not doctors and cannot say whether marijuana is an appropriate pain medication for you or any other patient, although we feel that the government should be allowing, rather than blocking, medical marijuana research.

Editor's Note: You suggest that the majority of methadone patients use marijuana. In fact, only a small proportion do (See TIP #43).

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