

# Methadone Today

The official newsletter of DON'T—BY PATIENTS, FOR PATIENTS October 2001 Volume VI Number VIII

Dear Methadone Today,

I just read your newsletter for the first time and it changed my life. I felt so alone as a "methadone person"! I felt no one cared or would take the time to bother. I feel like it is me against the world.

To start with, I was in four accidents--none my fault--over a period of ten years where I became a pain med addict after twelve operations. I ended up in a pain clinic, and the doctor prescribed methadone. Therefore, I used methadone before heroin.

As the insurance ended so did the pain clinic, and the doctor did not provide a professional detox! I ended up in quite a bind, as I was on 80 mg of methadone with no doctor providing any help. Of course I turned to street drugs, and it ruined my life. We all know the same sad story addicts experience--loss of money, family, friends and health. I ended up finally in a methadone clinic.

Today, I sit here writing this letter with one hand, as I have Carpal Tunnel Syndrome. My doctors feel surgery may be necessary. Also I need ingrown toenail surgery. I have put off a colonoscopy now for six months. Today, I found out the lump in my left breast has to come out. Okay, it sounds crazy to have all this hanging over me, but I have a fear after what happened during my last operation.

I went in for a hernia operation and came home after eight hours. I was on 100 mg of methadone. What happened was I could not sit still for twenty-four hours, as I felt like I was on a bad acid trip and was dope sick at the same time. It took a very good friend twenty-four hours to talk me down. All everyone told me in the medical field was that I'd be okay in time. No one cared or tried to help, as who wants to go the extra length for a methadone user? Since then I have this fear of going under an anesthesiologist's care, as they get that look on their faces when I tell them I am on methadone. I don't trust them anymore.

So I sit here writing this letter in hopes of getting some true help, as I am in terrible pain and no one will prescribe any medication to help me. They are all operating under the "methadone is enough" stigma. What do I do? I continue to ask my treating doctors for help but get roadblocks. I have ended up getting increases of dosages which I feel I don't need just so I can have some relief. The clinic is all too glad to allow me more methadone, as it is like job security for them.

(Cont. p. 3)

## Vermont Bans Oxycontin

DRCNet reported in their August 16 issue that Governor Howard Dean of Vermont recently prohibited the prescription of Oxycontin to individuals on state-funded health care programs, and "banned the use of state welfare funds to pay for Oxycontin prescriptions." This was in response to the recent rise in Oxycontin abuse. We feel that this is a big mistake and the same kind of thinking that led to excessive restrictions on methadone--restrictions which benefit no one but harm many.

Of course, there are many other prescription opioids with similar effects, but the philosophy behind such a ban is very dangerous. Some drug warriors, like the Governor, are willing to sacrifice the welfare of patients who really need opioids for adequate pain relief. Such an attitude is reminiscent of the former federal regulations on methadone maintenance treatment, which were based on the idea that methadone patients should be presumed to be selling their doses if given the opportunity, unless the individual patient provided evidence to the contrary. Even among highly trusted methadone patients, take-home

## Dependency

[The following is reprinted from the handbook, "About Methadone," published by The Lindesmith Center-Drug Policy Foundation. See page 1 of the September issue for the introduction section of this excellent handbook. To order a copy of the 47-page handbook, contact: The Lindesmith Center-Drug Policy Foundation, 925 Ninth Avenue, New York, NY 10019. Tel: (212) 548-0695.

Web site: <http://www.drugpolicy.org>

Opioids have been used for thousands of years, and it has long been known that many people who have become dependent on opioids have extreme difficulty permanently ending their use of them.

Suffering through the withdrawal sickness is only part of the problem. The real difficulty has always been staying off the drugs once the period of withdrawal is over.

Just as in the case of those who are unable to stop smoking, it is difficult to explain why it is so hard not to return to the use of opioids. Reasons include long-term depression, lack of energy, drug cravings, and sudden attacks of physical withdrawal sickness. Some people find that these problems diminish over time and eventually disappear altogether--but others continue to suffer these symptoms indefinitely, and many of them eventually relapse to their regular use of opioids.

The reason that people relapse often has nothing to do with lack of will power or other personality problems. Instead, it appears that people with a long history of opioid problems have experienced changes to the part of their brains that allows a person to feel and function normally. This part of the brain makes and uses its own natural opioids.

The best known of these natural opioids are the chemicals known as endorphins. The word endorphin literally means "the morphine within." Indeed, these chemicals are functionally identical to morphine or heroin.

We don't yet understand everything that these natural opioids do in the body, but evidence suggests that they are involved with pain control, learning, regulating body temperature, and many other functions.

It is possible that people who develop a dependency on opioids were born with an endorphin system that makes them particularly vulnerable. For example, we know that (Cont p. 3)

supplies were limited, per the law, and patients had to be carefully observed while ingesting their dose multiple times per month, on top of regular drug testing.

We hope that the governor and members of the legislature in Vermont think carefully about the ramifications of such a medication ban. Almost certainly banning Oxycontin will result in little or no benefit to anyone. Those who were using Oxycontin to get intoxicated will merely find a similar drug to abuse. But this will result in significant harm to legitimate pain patients, if only by sending the message to doctors that prescription of pain medications will be frowned upon and scrutinized by the government. This is akin to the recent prosecution of several doctors for prescribing such pain medications, which almost certainly renewed many doctors' deep concerns that they may be prosecuted for the "crime" of aggressively managing pain. Such actions have led doctors to chronically under prescribe for pain. Methadone patients should be especially concerned, as doctors are already leery of prescribing pain medications to them for various reasons. We hope that politicians come to their senses--or are voted out.

## Column From the Doctor



### Buprenorphine Reductions Fail in U.S. Trial

by Dr. Andrew Byrne, General Practitioner (NSW, Australia)

*\*Gradual Dose Taper Following Chronic Buprenorphine. Becker AB, Strain EC, Bigelow GE, Stitzer ML, Johnson RE. (2001) American Journal on Addictions 10:111-121.*

In this study\*, eight "volunteer" heroin addicts were paid up to \$375, contingent on continued attendance and abstinence, proven by urinalysis, for participation in a five week study involving gradual "blind" withdrawal of buprenorphine to zero. The final (somewhat arbitrary) taper was 8 mg (7 days), 6 mg (4 days), 4 mg (5 days), 2 mg (5 days), 1 mg (5 days), 0 mg (9 days). The totally predictable result was that below the known therapeutic dose of 2 mg, three quarters of the patients rapidly relapsed to street heroin and cocaine use. Follow-up for the remaining two patients was limited to the days of the trial, and there is no evidence presented of their continued abstinence.

The inescapable conclusion of this and other trials of opioid reductions is that they don't work for the great majority of dependent patients. Such an intervention should be reserved for those who are genuinely disposed to this option, and then only where there are "safety net" provisions for "maintenance" when dose reductions fail. Buprenorphine maintenance is an established modality, unlike "withdrawal" which must still be considered experimental in my opinion.

This well-published and well-funded group from Johns Hopkins University has been performing similar research on drug users for many years. It is disappointing that their research rarely compares existing "best practice" with other interventions and often involves placebo-type conditions for some patient groups. The act of paying addicts to improve compliance introduces yet another artificial variable to their protocols. In the community, most patients actually pay for prescribed treatment rather than the other way around! The usual way of improving compliance is to give better quality treatment rather than paying people to take less than optimal treatment and then observe less than optimal results.

The "disposal" of volunteers in their trials is not always documented. One would hope that a noble institution such as John Hopkins would ensure that all dependent subjects had rapid access to a standard methadone treatment service after their investigations were completed, where necessary.

In a region with wait-lists for standard treatment, the nature of a "volunteer" is different from the usual subject in a medical trial. The matter of valid free choice arises since "any port in a storm" may induce addicts to enter a trial as the only perceived option.

It is instructive that Dole and Nyswander [who performed the first methadone maintenance research], in their 1965 classic JAMA (Journal of the American Medical Association) description of methadone treatment, suggested--if I recall correctly--that most patients needed an extended period in treatment and that a minority may need life-long treatment. Buprenorphine "reductions to abstinence" are just as illogical as methadone or indeed heroin reductions which few institutions enforce in modern times. However, maintenance patients who are stable and "ready" for reductions should always be accommodated, with all the available supports.

Editor's Note: This is an important finding, as proponents of buprenorphine claim that one of its greatest advantages (over methadone and LAAM--the only opioids approved for opiate addiction treatment purposes in the U.S.) is that it doesn't cause the same degree of dependence... and therefore is easier to detox off of. This study disputes this claim and calls into question the whole assumption that buprenorphine is "better" than methadone or LAAM [for maintenance or detoxification purposes].

This study finds that detoxification using buprenorphine yields no better a success rate than detoxification using methadone. One question that the researchers did not attempt to answer is whether withdrawal symptoms are milder when tapering from buprenorphine than from methadone. This question is not trivial--an opiate addict intent on undergoing a detox/taper rather than maintenance may still prefer to detox using buprenorphine if the withdrawal symptoms will be less severe.

Unquestionably, buprenorphine treatment will be invaluable to some opiate addicts. Just so long as providers and patients alike realize that detox is successful for a very small percentage of opiate addicts--no matter what medication is used.

#### Dear Doctor,

My methadone clinic adds tap water to take-home doses (they use Methadose, which is a liquid [and not wafers/diskettes that must have water or juice added to them]), supposedly to deter diversion.

I want to know what happens to our methadone that's been sitting in stagnant tap water in a sealed bottle for two weeks (or more)\*. Water that may be chlorinated or have fluoride in it. Do those chemicals affect that methadone? And what kind of germs can grow in tap water that's left to sit around for such a long period of time? What if the containers aren't sterile? -Terri

#### Dear Terri,

We [CAP] are changing to dry medication for greater than 6 day take-home supplies.

The label on Methadose recommends addition of liquid, which we think is ridiculous, but have been doing so, per adding Tang, for years. There have been instances of doses going bad in this scenario, even exploding. The truth is that this is rare, but, if avoidable, dilution should be abandoned as a practice.

**Marc Shinderman, M.D.**

**Center for Addictive Problems (CAP), Chicago, Illinois**

\*Editor's Note: This question is all the more relevant now, because the new federal regulations allow for extended take-homes (14-30 day supplies). Unlike the former federal regulations, the current regulations allow "dry" medication to be used (tablets or pills may be provided to patients without adding water or juice). We feel that there are other advantages to dry medication, and that dry medication should at least be an option for most patients.

The rationale some clinics give for diluting take-home doses is that it makes diversion of doses more difficult, but we are skeptical of this claim. Diluting take-home doses only adds inconvenience to the vast majority of patients who are not diverting their doses. The dispensing of doses in liquid form is done for the same reason, which we also believe does nothing to stop diversion [which is uncommon anyway] and, if anything, may make accidental overdose by children more likely [though accidental overdose of methadone is already rare].

**Dear Methadone Today (from p. 1).**

I take over-the-counter medications but am running out of funds, as I am a 52-year-old single male who is on SSI and can't afford much more over-the-counter help. I am also concerned that I take too much acetaminophen [which can harm organs, such as the liver].

I also have a bad back, knee, hip and other problems. After more than ten operations, my fear has taken over, and I find it hard to go back into a hospital. Everyone tells me to just go have the next four operations I need. Well I say to them, how do I trust you if you will not even prescribe pain medication for me now? The answer is simple: I DO NOT TRUST THEM! What do I do? The pain is terrible. I wake up three or four times a night in pain. **-Charlie**

Dear Charlie,

We find your story very disconcerting. Individuals in the medical profession have wronged you not just once, but several times. We could devote a large amount of space to commenting on this mistreatment--which certainly qualifies as medical malpractice in our opinion. But we would like to respond to your statements regarding the methadone clinic raising your methadone dose and the implication that they have no problem doing this, "it is like job security for them." We feel that it is unfair to essentially criticize your methadone clinic for actually doing the right thing.

In your case, it may or may not have been better for you to be prescribed a short-acting opiate for your pain, but as you know, methadone is a pain medication, and raising your methadone dose will provide pain relief. You state that you "feel [you] don't need" these increases in your methadone dose--perhaps, you do not need an increase for maintenance purposes (e.g., to prevent the onset of withdrawal symptoms or opiate cravings), but if you are in pain, you need medication on top of your maintenance dose--the dose increase is to relieve the pain. However, you state that at present you are in terrible pain, so clearly the increases in methadone dose have not been sufficient to treat the pain.

We cannot offer definitive advice regarding whether to go through with the additional surgeries you supposedly need. If you do decide to undergo the surgeries, we would suggest that you conduct a serious search for physicians that are dedicated to aggressive pain management; it would be great if they also had an understanding of methadone maintenance treatment and proper pain management of methadone

maintained patients, but physicians that believe in aggressively treating pain are likely to handle your pain adequately and be willing to conduct the necessary research. Sorry we don't have more advice for finding good physicians--try to get recommendations from other methadone patients, your clinic physician, etc., and when you go to an appointment with a physician you are considering, ask him openly about the issue of pain relief--explain that you are a methadone patient and concerned about pain relief. If the physician seems to have a negative reaction, states that your maintenance dose will take care of most of the pain, etc., you will know to find a different doctor.

As we have said in the past, you should bring a "dear doctor" letter, preferably signed by your clinic physician, with instructions to contact him/her if the doctor has any questions. The letter explains that methadone patients get virtually no pain relief from their maintenance dose, that these patients need greater doses of pain medication at more frequent intervals than an opiate naive patient, etc. (contact **Methadone Today** or order CSAT's TIP/TAP publications, which contain the dear doctor letter and other information [ph: 1-800-SAY-NOTO]).

If you opt for surgery, make sure you have a patient advocate willing to be your voice after your operation. It's difficult enough to advocate for yourself in the best of times; after surgery, you won't be in any condition to do so. Your advocate should be willing to learn about methadone and insist that you be given adequate pain medication after surgery. S/he will be able to make sure that you aren't made to choose between your dose or medication for pain.

At the risk of becoming a broken record, we would again like to point out that there is a difference between "physical dependence" and "addiction" (see the Editor's Note for the article below) and that most pain patients--even those who take opioid pain medications for an extended period of time--do not become addicted to opioids.

If you haven't ordered your personalized laminated Medical Alert card yet, you may want to seriously consider it (see pg. 4 for order form). Also, check with your clinic to find out what their "Emergency Policy" is in case of a natural or other disaster in which the clinic may not be able to open. The new accreditation standards require programs to have an emergency procedure in place.

**Dependency (from p. 1)**

addiction appears to run in some families. Addiction might also be related to changes in the brain caused by the overuse of heroin or other opioids. Or it may be the result of a complex relationship between genetics and the environment.

We do not yet know exactly how this malfunctioning occurs or even whether all people who feel unable to stop using opioids have this damage. There is, however, an increasing amount of evidence that many people who find it difficult to end their use of opioids have experienced these physical changes--which are likely to be permanent. There is not yet any test that can determine how much damage a person may have done to his or her natural opioid system or how hard it may be for that person to stay away from opioids. All that we know for sure right now is that relapse is a major feature of opioid dependency.

Methadone is not a cure for the problem of opioid dependency. It is a treatment--and one that is effective for only as long as a person continues to take it appropriately.

**Editor's Note:**

One of the few criticisms we have of this handbook is that the terminology is difficult for the lay person to follow. In this section, "dependency" and "addiction" are used interchangeably--leading to potential confusion in anyone who does not have a real understanding of physical "dependence" and how it differs from "addiction." Unfortunately, it is this very confusion that leads to the common misconception that methadone maintenance patients are addicted to their medications and, therefore, have simply swapped one addiction for another.

In simple language, physical dependence means that the individual requires the drug to feel physiologically normal. If s/he does not take the drug, s/he will experience physical withdrawal symptoms. In fact, an individual may be physically dependent on a drug--even for a long period of time--and not be addicted to it. Addiction connotes a whole set of behaviors that are not present with dependence. The classic example of physical dependence without addiction is a chronic pain patient who takes prescribed opioids for a long period of time. Conversely, addiction may exist without physical dependence.

For practical purposes, when reading the above section, "opioid dependency" or "dependence on opioids" refers to individuals addicted to opioids.

## Guide to Medications--Additional Notes

We printed a two-part guide to medications used for the treatment of opiate addiction in the August and September issues. We would like to append this guide with a couple of medications we left out and a few notes.

As many of you already know, certain short-acting opiates have been used in a handful of countries for detoxification or maintenance purposes. Especially with regard to the use of heroin, some would regard these trials as harm reduction measures and not actual treatment for opiate addiction. This raises an important issue; however, we do not have the motivation or space to address it here. For purposes of this guide, we are informing you of medications used to treat or deal with opiate addiction.

The handful of countries that have allowed the use of short-acting opiates to treat opiate addiction vary widely in how they handle such treatment and to whom they make it available. Germany has basically allowed codeine to be used for maintenance and detox purposes for some time; many German opiate addicts have successfully maintained for years on codeine without apparent problems. Many countries that have conducted heroin maintenance pilots chose/choose to only make such programs available to opiate addicts who have failed at conventional treatments. At least in the pilot programs, many countries have provided heroin maintenance on a completely supervised basis. Great Britain's heroin maintenance program is the exception to this. Addicts were given heroin to administer at home on an unsupervised basis, and addicts need not have failed at conventional treatments to participate. In Great Britain's case at least, heroin maintenance was designed and run as a harm reduction measure rather than a medical treatment. Evidence of the harm reduction nature of Britain's program includes the fact that they have tried to curb or cease i.v. drug use by dispensing heroin in cigarette form. Fortunately or unfortunately, depending on your outlook, heroin maintenance is not available in most areas of Britain.

In at least one pilot, heroin was provided in conjunction with methadone; a relatively low methadone dose was ingested in the morning, and heroin was used in the evening. It remains to be seen whether this is superior to provision of heroin alone [at least in some individuals]. Whether heroin was administered by itself or in conjunction with methadone, studies of these pilots indicate that heroin maintenance served to reduce crime--this demonstrates its utility in harm reduction. Whether heroin maintenance can be rightly regarded as a medical treatment is another question, but it apparently has great potential to reduce the harm to addicts and society associated with opiate addiction.

When speaking about the use of various opioids for maintenance purposes, most experts regard short-acting opiates as inferior to methadone for a few reasons. **Methadone Today** has

touched upon many of these issues in the past when speaking of the differences between heroin abuse and methadone treatment. Nearly all the reasons are related to the relative duration [or "half-life"] of these opiates. The short-acting nature of opiates such as heroin result in the user bouncing from a state of intoxication to withdrawal--thus, functioning is impaired (in contrast to methadone maintenance, in which a patient stabilized on the proper dose experiences virtually no intoxicating effects. It is apparently more difficult to maintain on a constant dose of a short-opiate for a long period of time--many would need to periodically increase the dosage just to avoid withdrawal. Methadone often only needs to be taken once a day, so it is presumably more convenient than short-acting opiates, which would have to be taken at least a few times a day, depending on the opiate being used. Often, short-acting opiates must be injected for sufficient effects, whereas methadone works well for maintenance purposes when taken orally--there may be health problems with regular injecting. Worth noting is that methadone is also considered superior to short-acting opiates for detox purposes, as it is generally far easier to slowly taper off methadone than to do so with short-acting opiates, as those who have attempted to slowly "wean" themselves off heroin know. Most would agree that for maintenance purposes, methadone is superior to heroin and other short-acting opiates for all but a very small number of opiate addicts.

Regarding the use of methadone in the treatment of opiate addiction, we neglected to mention that there has been some experimentation in Britain with injectable methadone. We will not delve too deeply into the issue of whether this is necessary, though most experts would agree that oral administration of methadone is preferable for the vast majority of methadone maintenance patients. Anecdotal evidence suggests that many of these patients are able to effectively maintain on a constant dose of methadone. Such patients give various justifications for why they supposedly need to inject their methadone, such as a needle fixation (e.g.: they are addicted to the ritual of injecting). Many experts reject these justifications and believe that most, if not all, of these patients could do well on oral methadone or, in a few cases, sublingual buprenorphine. They argue that these patients, most of whom were first treated with oral methadone, had difficulties while on oral methadone because they were/are underdosed and would do fine if their dose were raised to an adequate level. They certainly have a point, as underdosing is common, especially in Britain.

Certainly, there are other herbs or medications that have been used to treat opiate addiction, but we either have not heard of them or do not have enough information to include them here. Partially for this reason, we did not include Tetrodin; those interested in reading about it may read the article on it in page 1 of the Spring 2001 issue of **ARMed with facts** (ARM's newsletter).

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