OPIOID REPLACEMENT THERAPY

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Disclosures

- Nil

OBJECTIVES

- Overview opioid crisis
- Opioid replacement options Methadone /Suboxone /Kadian
- Treatment goals and outcomes
- Identifying treatment barriers
- The science of it – Does it make a difference ?

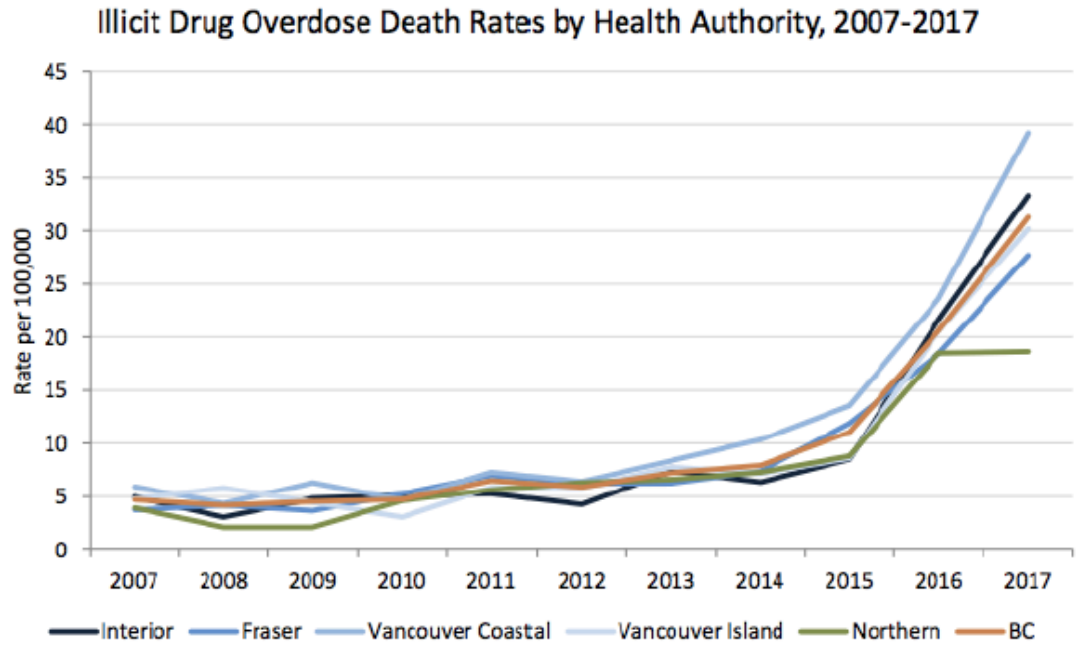
TEAM APPROACH - each & every member can have an impact

"If you want to go fast, go alone. If you want to go far, go with others."

Ancient African Proverb

OPIOID CRISIS – A VIEW FROM THE FRONTLINE

The current opioid crisis



http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

METHADONE SUBOXONE KADIAN

- Treatment ready
- Bloodwork hbg/lft/HIV/ Hep B/C /pregnancy test
- Baseline urine drug screen
- Naloxone training and kit
- Not hinder starting treatment

PHARMACOLOGY

METHADONE	SUBOXONE
• LONG-ACTING SYNTHETIC OPIOID • mu OPIOD RECEPTOR AGONIST	• SEMI-SYNTHETIC OPIOD • mu PARTIAL OPIOD AGONIST • KAPPA PARTIAL RECETPTOR ANTAGONIST -inhibits dysphoria
• HALF-LIFE 24-36 HRS Can accumulate and lead to resp. depression (half-life 4-90 hrs)	• HALF LIFE 2-5 HRS Lasts >24hrs due to slow dissociation from the receptor mu Rc
• PEAK EFFECT 4 HRS	• PEAK EFFECT IN 90 MIN
• PREVENT OPIOD WITHDRAWAL • REDUCE CRAVING OPIODS • BLOCK EUPHORIA FROM HEROIN	• CAN DISPLACE FULL OPIOID AGONIST heroin /morphine SEVERE WITHDRAL
• RESPIRATORY DEPRESSION • INTERACTIONS WITH DRUG ie Ciproflaxin	• LESS LIKELY RESPIRATORY DEPRESSION • CAN USE NARCAN TO REVERSE 15MG

INITIATION

Methadone	Suboxone
• SLOW WEEK TO MONTHS	• FAST 2-3 DAYS
• INCREASE EVERY 5-7 DAYS	• PT NEED TO BE IN WITHDRAWAL MILD TO MODERATE COWS

COWS
5-12 MILD
13-24 MOD
25-36 SEVERE

- 4 RESTING PULSE 80 - above 120
- 4 SWEATING
- 5 RESTLESSNESS
- 5 PUPIL
- 4 BONE /JTS ACHES
- 4 RUNNY NOSE
- 5 GI UPSET
- 4 TREMOR
- 4 YAWN
- 4 ANXIETY
- 5 GOOSEFLESH SKIN

SUBOXONE

LAST DOSE

- MORPHINE 8-12 HRS
- HEROIN 12-24 HRS
- OXYCODONE 12-24 HRS

SUGGESTION TAKE YOUR LAST DOSE BY 23:00

AND WE WILL MEET AT 1300 FOR INITIATION

SEE THEM AGAIN IN TWO HOURS AND AGAIN IN TWO HOURS

ON FIRST DAY .

STABILIZATION

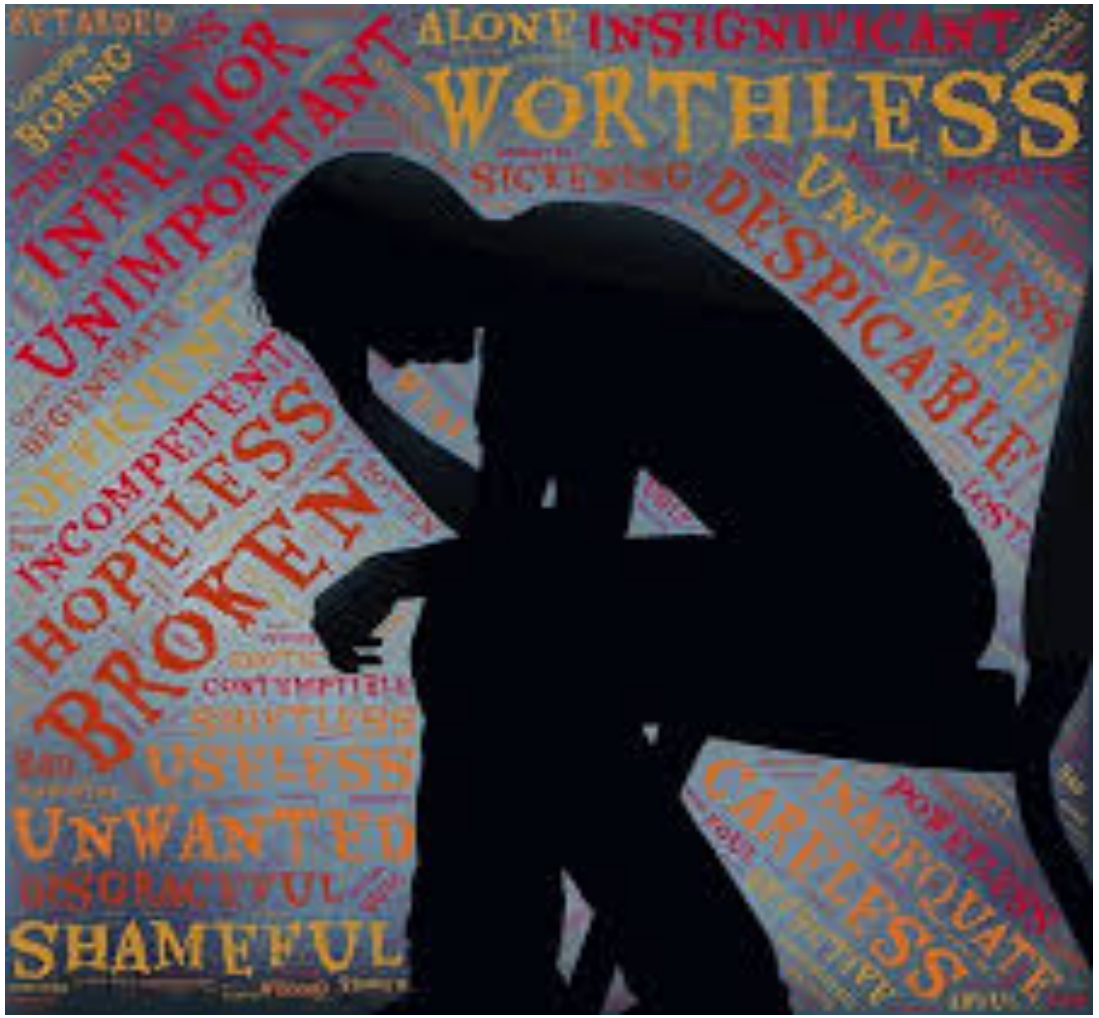
METHADONE	SUBOXONE
MISSED 3 OR MORE DAYS LOWER DOSE	MISSED DOSE CAN RESTART AT PREVIOUS DOSE
MISSED 4-5 DAYS NEED TO RESTART	
DWI / CARRIES ONLY AFTER 8 M STABLE	DWI/ CARRIES ONLY AFTER 8M STABLE

KADIAN

rhythmic flow

- EXTEND RELEASE MORPHINE SULPHATE
- ORAL DOSE PEAK CONCENTRATION 8 HRS
- RESPIRATORY DEPRESSION CAN OCCUR MAINLY AT DOSE INCREASE OR INITIATION
- START LOW AND TITRATE UP
- DWI - if pellets crushed etc uncontrolled delivery of drug resulting in overdose - do no harm

BARRIERS TO TREATMENT



BARRIERS

- TRUST/RAPPORT
- KNOWLEDGE : WHO WHAT WHEN HOW
- BIAS " METHADONE DRUG ADDICTS"
- ACCESS : FOOD SHELTER MONEY
- PHARMACY DWI
- HEATH VS LAW ENFORCEMENT
- POISONED DRUGS SUPPLY FENTAYL
- HOW TO USE COWS – WHEN PT IS DIFFICULT TO ASSES
- HOW TO MANAGE WITHDRAWL AND SX
- SUBOXONE NEEDS MIN 12 HRS ABSTINENCE
- CO MORBITIY – MENTAL ILLNESS /COGNIITVELY COMPROMISED / CHF / DM
- RISK OF RESPIRTORY DEPRESSION – DO NO HARM

GOALS & OUTCOMES

- TREATMENT RETENTION
- WITHDRAWAL SUPPRESSION
- DECREASE ILLICIT OPIOD (& COCAINE) USE
- REDUCED RISK OF HCV/HIV
- INCREASED ANTIRETROVIRAL ADHERENCE, LOWER HIV VIRAL LOAD
- DECREASED CRIMINAL ACTIVITY
- SIGINIFICANTLY REDUCED MORTALITY

BOTH ALL- CAUSE AND SUBSTANCE –RELATED

THE SCIENCE – what does the research show ?

OPEN ACCESS

Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies

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ABSTRACT

OBJECTIVE

To compare the risk for all cause and overdose mortality in people with opioid dependence during and after substitution treatment with methadone or buprenorphine and to characterise trends in risk of mortality after initiation and cessation of treatment.

DESIGN

Systematic review and meta-analysis.

DATA SOURCES

Medline, Embase, PsycINFO, and LILACS to September 2016.

STUDY SELECTION

s in people
aths from all
ods in and out
hadone or

ta extraction
s in and out
methadone
ariate

22 885 people
s and 15 831
1-4.5 years.
nd 36.1 per

1000 person years in and out of methadone treatment (unadjusted out-to-in rate ratio 3.20, 95% confidence interval 2.65 to 3.86) and reduced to 4.3 and 9.5 in and out of buprenorphine treatment (2.20, 1.34 to 3.61). In pooled trend analysis, all cause mortality dropped sharply over the first four weeks of methadone treatment and decreased gradually two weeks after leaving treatment. All cause mortality remained stable during induction and remaining time on buprenorphine treatment. Overdose mortality evolved similarly, with pooled overdose mortality rates of 2.6 and 12.7 per 1000 person years in and out of methadone treatment (unadjusted out-to-in rate ratio 4.80, 2.90 to 7.96) and 1.4 and 4.6 in and out of buprenorphine treatment.

CONCLUSIONS

Retention in methadone and buprenorphine treatment is associated with substantial reductions in the risk for all cause and overdose mortality in people dependent on opioids. The induction phase onto methadone treatment and the time immediately after leaving treatment with both drugs are periods of particularly increased mortality risk, which should be dealt with by both public health and clinical strategies to mitigate such risk. These findings are potentially important, but further research must be conducted to properly account for potential confounding and selection bias in comparisons of mortality risk between opioid substitution treatments, as well as throughout periods in and out of each treatment.

Retention in methadone and buprenorphine is associated with substantial reductions in the rate of all cause and overdose mortality

The induction phase and the time immediately after leaving treatment with both drugs are periods of particularly increased mortality risk.

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Introduction

Opioid dependence is a rising drug use disorder with substantial contribution to the global disease burden. The absolute number (age standardised prevalence) of people with opioid dependence worldwide increased from 10.4 million (0.20%) in 1990 to 15.5 million (0.22%)

http://www2.gov.bc.ca/assets/gov/public-safety-and-emergency-services/death-investigation/statistical/illicit-drug.pdf

Best-Practices in ORAL OPIOID AGONIST THERAPY Collaborative

What I have learned ?

- EP -on suboxone for 8m

  - no overdose for 5 m

  COWS GUIDELINE / USE CLINICIAL JUDGEMENT –

  REINITIATE TREATMENT IMMEDIATELY AFTER HOSPITAL D/C

- TR – on methadone for 6 months

  - no overdoses for 4 m

  KEEP SHOWERING THEM WITH KINDNESS

  " I AM MORE MINDFUL OF MY USE "

What have I learned ?

- LF - new start Kaidan

  -able to initiate treatment at first meeting

  TEAM WORK /EMPOWERING THE PATIENT

RS – active use / marginal living 24 yrs old

- first visit decline treatment

MADE EYE CONTACT / SHOWED CARE

STUDIES SHOW EVEN A FIVE MINUTE INTERACTION CAN HAVE AN IMPACT

GOAL HARM REDUCTION

Thank for all your care !

If you choose, even the unexpected setback can bring new and positive possibilities.
If you choose, you can find value and fulfillment in every circumstance.
Ralph Marston