OPIOID AGONIST THERAPY INITIATION

BOOST COLLABORATIVE LEARNING SESSION 1

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Faculty Disclosure

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Disclosure of Commercial Support

This program has not received any financial or in-kind commercial support.

Potential for conflicts of interest:

No commercial organization has supported this program.

Mitigating Potential Bias

All grants, research support, honoraria, and consulting fees are administered by the institution (BC-CfE and/or VCH).

Generic names of medications are used in place of brand names.

OBJECTIVES

- Review oral OAT options: buprenorphine, methadone, SROM
- Review up-titration schedules
- Review missed doses protocols

A Medical Treatment for Diacetylmorphine (Heroin) Addiction

A Clinical Trial With Methadone Hydrochloride

Vincent P. Dole, MD, and Marie Nyswander, MD

A group of 22 patients, previously addicted to diacetylmorphine (heroin), have been stabilized with oral methadone hydrochloride. This medication appears to have two useful effects: (1) relief of narcotic hunger, and (2) induction of sufficient tolerance to block the euphoric effect of an average illegal dose of diacetylmorphine. With this medication, and a comprehensive program of rehabilitation, patients have shown marked improvement; they have returned to school, obtained jobs, and have become reconciled with their families. Medical and psychometric tests have disclosed no signs of toxicity, apart from constipation. This treatment requires careful medical supervision and many social services. In our opinion, both the medication and the supporting program are essential.

ough review of evidence available in 1957,[1] concluded that "The advisability of establishing clinics or some equivalent system to dispense opiates to addicts cannot be settled on the basis of objective facts. Any position taken is necessarily based in part on opinion, and on this question opinions are divided." With respect to previous trials of maintenance treatment, the Council found that "Assessment of the operations of the narcotic dispensaries between 1919 and 1923 is difficult because of the paucity of published material. Much of the small amount of data that is available is not sufficiently objective to be of great value in formulating any clear-cut opinion of the purpose of the clinics, the way in which they operated, or the results attained." No new studies bearing on the question

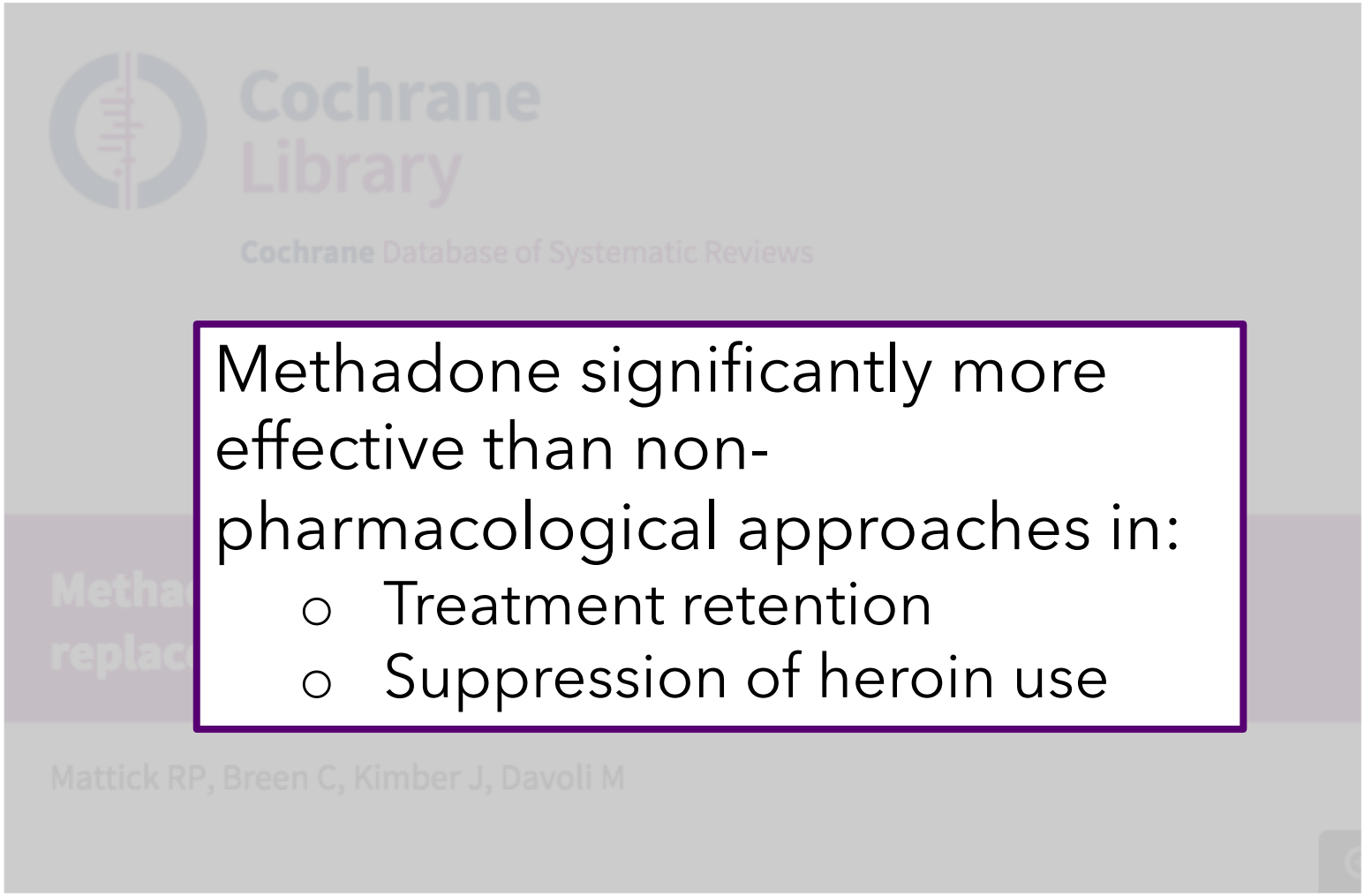
JAMA. 1965;193(8):646-650

Cochrane Library

Cochrane Database of Systematic Reviews

Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence (Review)

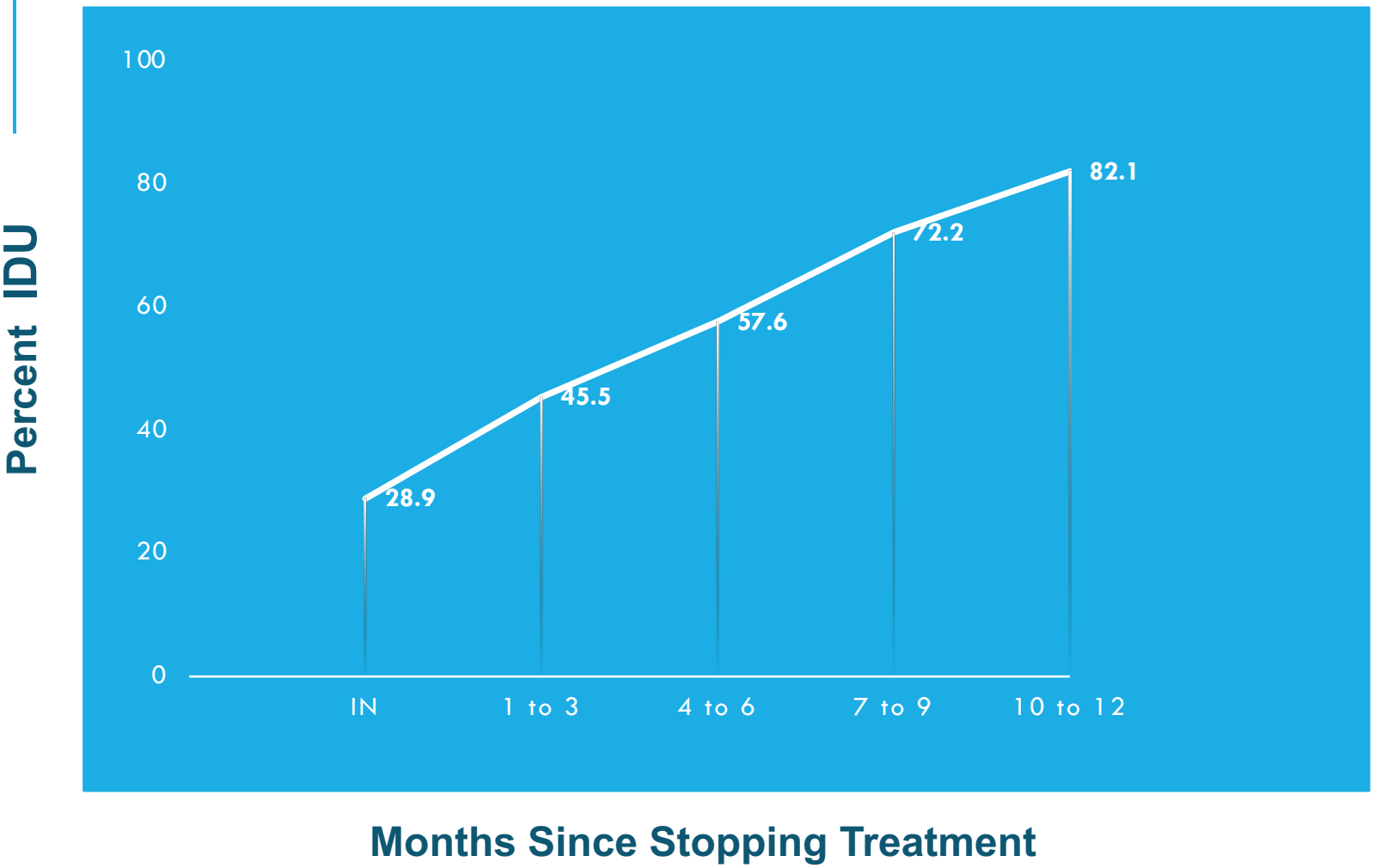
Mattick RP, Breen C, Kimber J, Davoli M



Methadone significantly more effective than non-pharmacological approaches in:

- Treatment retention
- Suppression of heroin use

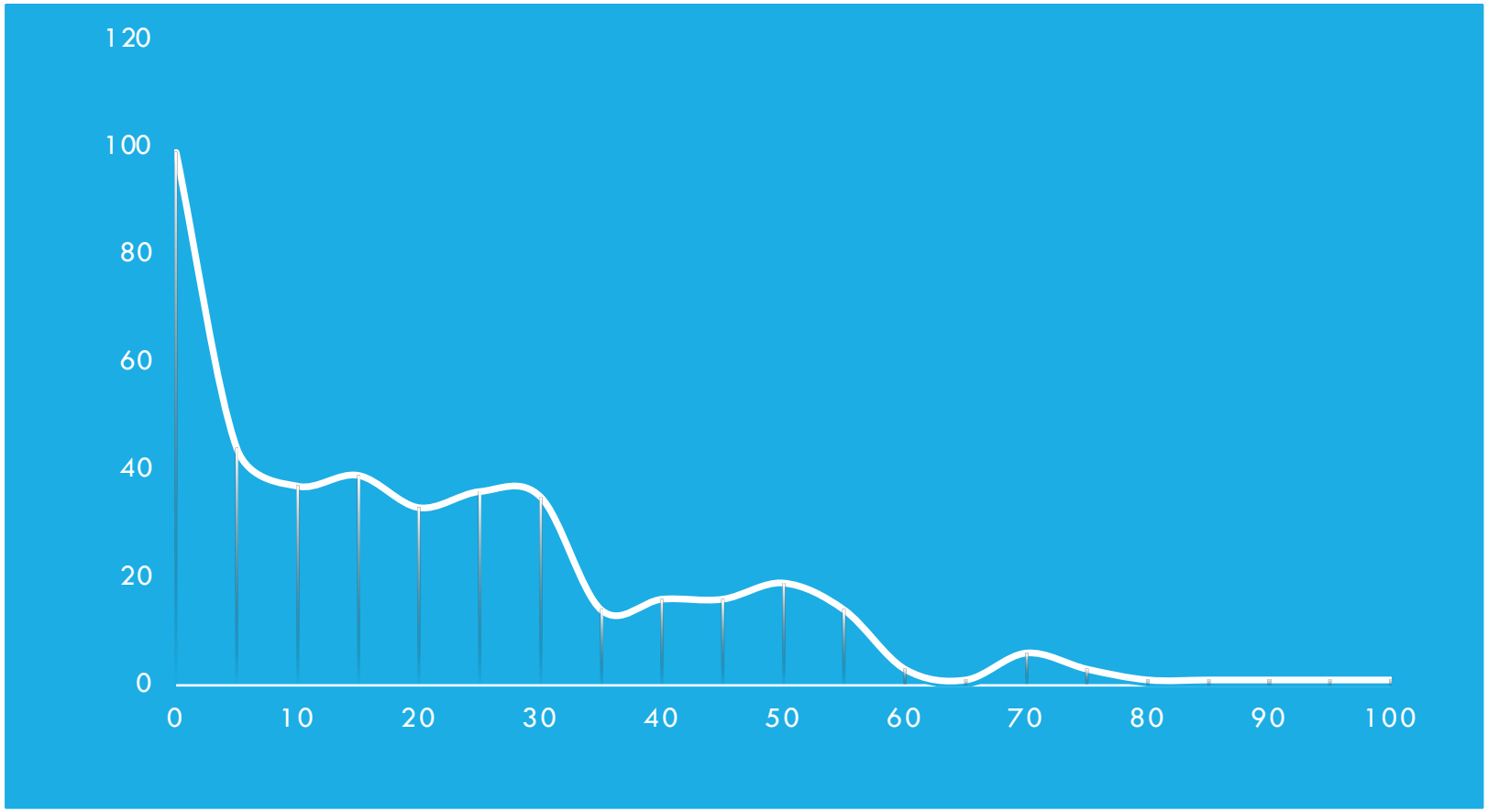
RELAPSE TO IDU AFTER METHADONE CESSATION



Adapted from Ball & Ross - The Effectiveness of Methadone Maintenance Treatment, 1991

Opioid Agonist Treatment of Addiction - Payte - 1998

RECENT HEROIN USE BY CURRENT METHADONE DOSE

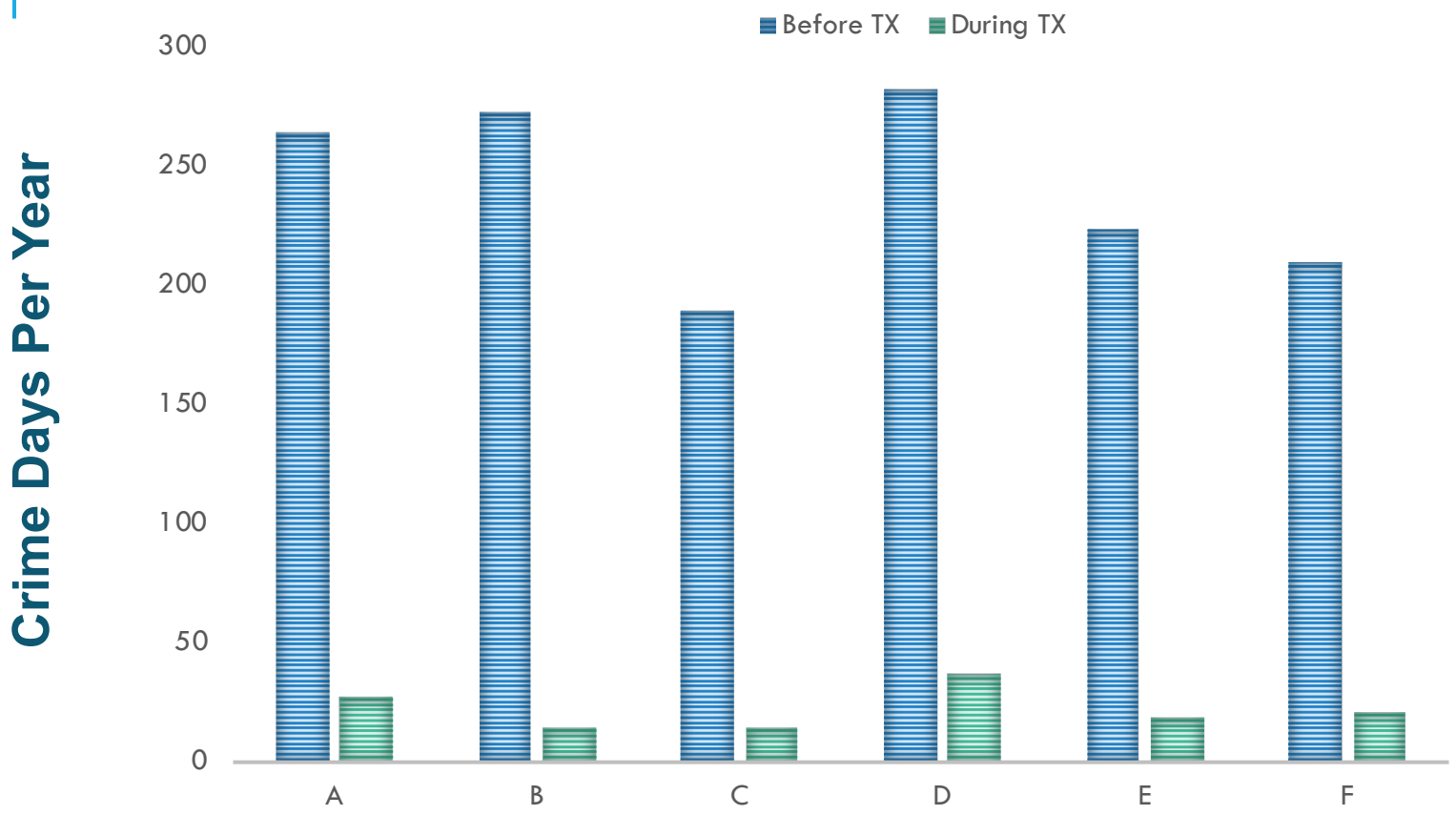


Opioid Agonist Treatment of Addiction - Payte - 1998

J. C. Ball, November 18, 1988

CRIME

AMONG 491 PATIENTS BEFORE AND DURING MMT AT 6 PROGRAMS



Adapted from Ball & Ross - The Effectiveness of Methadone Maintenance Treatment, 1991

METHADONE

- Starting dose?
- Up-titration schedule?

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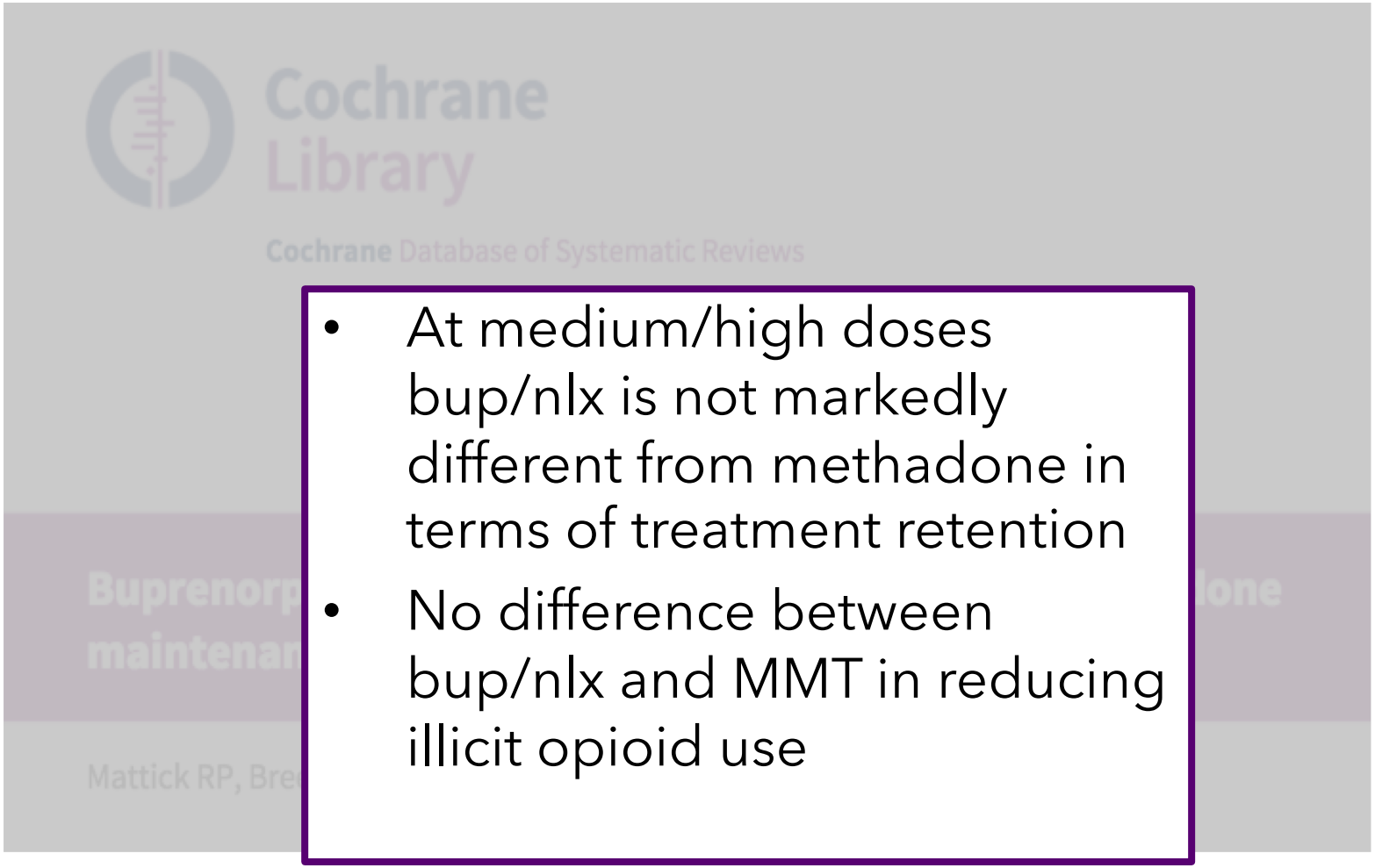
Cochrane Database of Systematic Reviews

Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence (Review)

Mattick RP, Breen C, Kimber J, Davoli M



- At medium/high doses bup/nlx is not markedly different from methadone in terms of treatment retention
- No difference between bup/nlx and MMT in reducing illicit opioid use

BUPRENORPHINE/NLX

- Starting dose (traditional induction)
- Up-titration schedule?

Cochrane Library

Cochrane Database of Systematic Reviews

Slow-release oral morphine as maintenance therapy for opioid dependence (Review)

Ferri M, Minozzi S, Bo A, Amato L

- as effective as methadone in reducing non-medical opioid use and retaining individuals in treatment
- superior to methadone in terms of overall treatment satisfaction

SLOW RELEASE ORAL MORPHINE (SROM)

- Starting dose?
- Up-titration schedule?

MISSED DOSES

MISSED DOSES METHADONE

Suggested Protocol for Managing Missed Doses

Missed Days (consecutive)	Dose	Suggested Dose Adjustment
1-2	Any dose	Same dose (no change)
3-4	30 mg	Same dose (no change)
	31-60 mg	Restart at 30 mg (lower dose if safety concerns)
	>60 mg	Restart at 50% of previous dose
5 or more	Any dose	Restart at 5-30 mg (depending on tolerance)

BC Centre on Substance Use- Opioid Use Disorder Clinical Management Guidelines

MISSED DOSES BUP/NLX

Buprenorphine/Naloxone Missed Doses

Five or less days missed:

- For missed doses ≤ 5 days, resume previous dose

Six or more consecutive days missed:

- For missed doses ≥ 6 days, a conservative dosing guide is:

Dose	Missed Number of Days	Suggested Dose Adjustment
2 mg/0.5-4 mg/1mg	≥6 days	No change
6 mg/1.5 mg-8mg/2mg	≥6 days	Restart at 4 mg/1mg
>8 mg/2mg	6-7 days	Restart at 8 mg/2 mg
>8 mg/2mg	>7 days	Restart at 4 mg/1mg

BC Centre on Substance Use- Opioid Use Disorder Clinical Management Guidelines

MISSED DOSES
SLOW RELEASE ORAL MORPHINE

Numbers of missed days	Example prescribed dose = 200 mg	Example prescribed dose = 800 mg
1	200 mg	800 mg
2	120 mg (40% reduction)	480 mg (40% reduction)
3	80 mg (60% reduction)	320 mg (60% reduction
4	40 mg or starting dose (eg. 60 mg), whichever is higher (80% reduction)	160 mg (80% reduction)
5	Resume at initiation dose (e.g. 60 mg)	Resume at initiation dose (e.g. 60 mg)

BC Centre on Substance Use- Opioid Use Disorder Clinical Management Guidelines

ASK YOURSELF

Do I have the right OAT agent?

- What are my patient's goals?

Do I have the right dose?

Do I know what my patient needs to continue on OAT?

- Carries?
- Separate Rx's for travel?
- Reminder calls?
- Other ideas?

RESOURCES

Collaborative Website: http://stophivaids.ca/oud-collaborative

Hosp Q. 2003;7(1):73-82.The expanded Chronic Care Model: an integration of concepts and strategies from population health promotion and the Chronic Care Model. Barr VJ, Robinson S, Marin-Link B, Underhill L, Dotts A, Ravensdale D, Salivaras S. Source: Vancouver Island Health Authority.

BC Centre on Substance Use- Opioid Use Disorder Clinical Management Guidelines: http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

IHI Open School courses: http://www.ihi.org