NEWVISION™

SpecialCare Hospital Management Corporation

"New Vision™ offers hope to those seeking relief"

-Scott Erickson, MD
Medical Director- SHMC

Quarterly Clinical Newsletter- April 2018

Treatment of Methadone Withdrawals with Buprenorphine

-Dr. Scott Erickson

During the course of clinical treatment of addiction, it is hopeful that patients will ultimately transition from maintenance therapies to abstinence by careful medication regiments and motivation reinforcement. Like most physicians would ideally hope for, a patient would benefit from the short-term use of medication maintenance and slowly transition to abstinence in sobriety. However, when circumstances present in which a patient can no longer, or will no longer be managed with medications such as methadone, a patient will inevitably withdrawal.

So how would one comfortably transition patients from a full-agonist such as methadone, to a partial-agonist such as buprenorphine?

New Vision™ aids physicians willing to treat Methadone withdrawal

Assuming the patient is motivated, New Vision™ offers hope to those seeking relief from methadone by treating the withdrawal process with buprenorphine.

The process is within the timeframe in which a patient has last dosed. Time is imperative to the transition of a patient to a partial-agonist, like buprenorphine, to prevent the possibilities of precipitated withdrawals. "Precipitated withdrawals can occur when a partial agonist, such as buprenorphine, is administered to a patient dependent on full agonist opioids" (National Alliance of Advocates for Buprenorphine Treatment, 2015). Patients seeking to part from methadone dependency will need to be abstinent for roughly 48 hours before becoming eligible to receive a partial agonist, like buprenorphine. This period of time is further confirmed by the presentation of withdrawal symptoms which accompany abstinence. Patients presenting to New Vision™ will be evaluated and scored on a clinical withdrawal scale to establish the extent of the withdrawal process. Once withdrawal is active, patients may receive the first dose of buprenorphine and continue the taper as recommended over 3-5 days. Additional medications are offered according to the protocols as needed for break through symptoms. It is important for patients and physicians to be aware that manifestations of withdrawal will likely continue for several days to several weeks following discharge. Patients should be encouraged to follow-up with a primary care physician for additional monitoring and support.

Use of the Methadone Taper

For practitioners unfamiliar and uncomfortable with the transition between methadone and buprenorphine, New Vision™ offers a methadone taper to accommodate the withdrawal process. This taper consists of 3 days of medically managed protocols for patients withdrawing from less than 40mg daily. Patients and physicians should be aware that due to the long-acting effects of methadone, a patient may continue to experience discomfort for several days following discharge.

Title 21 and Methadone Treatment

In patients seeking to continue methadone while presenting for withdrawals from other substances, such as: alcohol and benzodiazepines, Title 21 of the Code of Federal Regulations allows physicians to treat patients accordingly by continuing their' methadone treatment while hospitalized for withdrawal of other substances.
This unique opportunity allows patients to remain current with their' methadone treatment while safely withdrawing from other substances (Title 21 Ch.11 Pt.1306.07).

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Mitigating the Risks of Precipitated Withdrawals: Misconceptions of Buprenorphine/Naloxone

In the medical community, it is widely misunderstood the function and purpose of naloxone in combinations such as buprenorphine/naloxone (Suboxone®) treatments. This misunderstanding leads to the belief that if a patient is prescribed or using Suboxone® outpatient, that giving them medications on admission would precipitate withdrawals in the presence of other opioids. The presence of other opioids is a potential cause of withdrawals, but naloxone isn't the culprit in this circumstance.

Image: STL Today, 2017

Understanding Precipitated Withdrawals
Precipitated withdrawals are adverse reactions manifested by the acute onset of withdrawal symptoms in a patient actively therapeutic on a full-opioid agonist, who takes a partial-opioid agonist, which results in sudden onset of acute withdrawals.

Dosages of buprenorphine can precipitate withdrawal in opioid dependent persons and the likelihood of this withdrawal increases with increased levels of physical dependence.

Possibilities of Buprenorphine-Related Withdrawals
The risk of buprenorphine-precipitated withdrawal is increased as a function of three parameters: higher doses of buprenorphine, a shorter time interval between the exposure to the full agonist and buprenorphine administration (which may vary as a function of the half-life of the full agonist), and higher levels of physical dependence.

Accordingly, patients dependent upon full-agonist opioids who receive partial-opioid-agonists while still experiencing therapeutic or illicit effects, are likely to experience withdrawals from Mu site competition. This competitiveness removes the full-opioid and replaces with a substance of higher affinity, in this case, buprenorphine.

Function of Naloxone in Suboxone®
It is a common misconception that the naloxone in Suboxone® precipitates withdrawal. This is false as the naloxone is inactive when taken orally or sublingually. Precipitated withdrawal occurs if the medication is altered and subsequently injected into a person tolerant to opioids. Thus, taken sublingually or orally, naloxone has virtually no effect on the individual.

Timeliness of Administration
When a patient presents for treatment of withdrawals, timing is imperative to avoid risks associated with worsening withdrawals. Patient's presenting to New Vision™ will be in mild-moderate withdrawal, requiring early intervention.

Knowing now that patients are at risk of deteriorating and there is a risk of precipitated withdrawals, the question of "how soon is too soon" to administer buprenorphine to a patient withdrawing from full-opioids?

It is particularly easy to assume that the answer is a standard 24-hour period after the last use. In reality, this is not an accurate depiction of patient status or the need for treatment.

The prominent clinical innuendo is alive and true as ever, "treat the patient not the data." Thus, considering clinical implications of half-lives and metabolism, when a patient presents in withdrawal of moderate severity, it is appropriate to begin the administration of buprenorphine as there is a significantly decreased risk of site competition, which could otherwise result in precipitated withdrawals.

In summary, naloxone, when administered orally or sublingually, has no bioavailability implicating precipitated withdrawals. When given timely, buprenorphine has a stark advantage compared to other medication regiments to control withdrawal symptoms resulting in higher-levels of patient comfort and experience.

Interested in learning more about New Vision™?
Contact Matthew Walters, Director of Clinical Services to schedule an introductory call.
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2. NAABT, 2017. *What is precipitated withdrawals?* www.naabt.org
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