Opiate Replacement Therapy: What to Know and Why It Isn’t Enough

Matthew A. Felgus, MD
mafelgus@wisc.edu
6333 Odana Rd, Suite 3, Madison, WI 53719
(608) 257-1581
Board Certified in Addiction Medicine
Board Certified in Psychiatry
matthewfelgusmd.com

Opioids

- Full mu agonists
- Oxycodone
- Hydrocodone
- Hydromorphone
- Fentanyl series
- Propoxyphene
- Methadone
- Levorphanol
- Meperidine
- Oxymorphone

- Partial mu agonist
- Buprenorphine (.3 mg = 10 mg Morphine)

- Mixed Agonist/Antagonist
- Pentazocine
- Butorphanol
- Nalbuphine
- Tramadol (Ultram)
Opioid Withdrawal

- Onset and Peak symptoms dependent on opioid or opiate abused – Variable to the individual
- Heroin - onset 8 hours with peak symptoms 24 to 48 hours after last use
- Methadone - onset 24 to 48 hours with peak symptoms within 48 to 96 hours after last use
- Subjective symptoms may persist for days-weeks

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OPIATE REPLACEMENT TREATMENT

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WHY?

- OPIATE USE HAS EXPLODED AMONG YOUNGER PEOPLE AND SHOWS NO SIGN OF SLOWING!!!
WHY?

- Effective, proven treatment in reducing use

- Keeps clients in treatment (carrot)

- Blocking agent for other opiates
WHY?

- Effective, proven treatment in reducing use
- Keeps clients in treatment (carrot)
- Blocking agent for other opiates
- Less likely to be abused (but not impossible)

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WHY?

- If used properly (lowering doses) clients can be tapered off opiates

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- This is important with a younger population

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WHY?

✦ If used properly (lowering doses) clients can be tapered off opiates
✦ This is important with a younger population
✦ One component of a well-rounded treatment program

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WHY NOT?

✦ Over reliance on medication vs. recovery tools

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✦ Doses can be too high (clients appear ‘stoned’)

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WHY NOT?

- Over reliance on medication vs. recovery tools
- Doses can be too high (clients appear ‘stoned’)
- Establishing a pattern of dependence on opiate medications at a young age

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WHY NOT?

- Less clinical data of success in a younger (teen) population

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- Opiate Replacement for a less severe habit

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WHY NOT?

- Less clinical data of success in a younger (teen) population
- Opiate Replacement for a less severe habit
- It is possible to abuse opiate replacement meds (methadone and suboxone)

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Methadone

- In use since 1960s
- Blocks other opiates and reduces cravings
- Can be overdosed
- At high doses, individuals can appear to ‘nod out’

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Opiate Replacement Therapy: Methadone

Yes, you can get high

High doses (150+ mg.): necessary to maintain abstinence OR treating sx of other disorders (dep, anx)? OR BOTH??

Why are we as treaters so avoidant of discomfort of withdrawal solely in this population?

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Buprenorphine

- Partial mu agonist with high affinity
  - Will displace any other mu agonist precipitating withdrawal
- Buprenex® - injectable form - only indication is for analgesia
- Subutex® – 2 & 8mg sublingual tablets
- Suboxone® – Buprenorphine/naloxone combination 2/0.5mg, 4/1mg, 8/2mg & 12/3 mg sublingual films

Buprenorphine/Naloxone

- Zubsolv® -- Buprenorphine/naloxone combination 1.4/0.36 mg, 5.7/1.4 mg, 8.6/2.1mg, NEW: 0.7/0.18 mg
  - Equivalent to 2, 8, and 12 mg suboxone dosages (new tab = 1mg)
  - Better bioavailability
  - Pills tend to crumble when cut

- Bunavail® -- Buprenorphine/naloxone combination 2.1/0.3mg, 4.2/0.7mg, 6.3/1mg (equal to 4, 8 and 12 mg suboxone)
  - Sticks to inside of cheek
  - Better bioavailability?
  - Ok to cut in order to taper?
**Suboxone®**

- Dosage Range: not agreed upon
- Research shows receptors saturated at 16mg although some prescribers go MUCH higher
- Manufacturer does NOT recommend >24
- Quick detox vs. slow (1+yr.) detox vs. maintenance
- Issue of Withdrawal: is it possible to taper off?

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**Buprenorphine/Naloxone**

- Half-life is 22-40 hours (average 35 hrs.) so only needed once daily
- Safer in OD since less respiratory depression than other opiates
- Best if used as part of a treatment program

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**Buprenorphine/ Naloxone**

- Yes, you can get high….if not opiate dependent
- Diversion of prescription
  - Party drug for those without an opiate habit
  - Prevention of opiate withdrawal in those using
  - Self detox for those trying to quit

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Buprenorphine/Naloxone

+ MDs take an 8 hour class to prescribe
+ Not enough prescribers for demand
+ No addiction training needed

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Buprenorphine/Naloxone

+ 100 Patient Cap Removed 8/2016
  + Better access vs. increase in ‘buprenorphine mills’?
  + Allow NPs and PAs to prescribe?

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Buprenorphine/Naloxone

+ MDs over-rely on medical model
  + “Everyone with chronic pain should be on Suboxone.”
  + Safer than other opiates, yes…but
  + Are opiates truly the best treatment for chronic pain?

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Opiates and Anxiety

- Extremely common presentation
- High degree of overlap between withdrawal and anxiety symptoms
- While anxiety isn’t responsible for the opiate epidemic, it is a major barrier for individuals to stop using
- Opiates are wonderful numbing agents and individuals with anxiety want to be numbed
- We as treaters need to be more mindful of our messages about anxiety

Treatment Model (Felgus)

IN THE BEGINNING (approx. 60-90 days:)
- Educate about anxiety vs. withdrawal differences and to distinguish
- Don’t call anxiety ‘cravings’
- Use anxiety medication (non-addicting) when indicated

IN THE MIDDLE (3-12+ mos. or above 2 mg:)
- Step-down gradual decrease better (2+ yrs.) vs. detox vs. lifelong
- Mental preparation for decreases
- Anxiety may ‘unmask’ as opiate dose lowered
- Plan decreases for times of lower life stress
- Q 2-3+ months based on individual progress
Treatment Model (Felgus)

**IN THE MIDDLE**
- Don’t fall into trap of ‘status quo’/false sense of security (opiates mask emotions)
- Utilize other medication when indicated
- Encourage anxiety management
- Therapy, individual and group
- Relaxation/yoga/acupuncture
- Exercise

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Treatment Model (Felgus)

**AT THE END (2 mg. and less:)**
- Very important to continue therapy
- Preparation for being opiate-free (vs. clean)
- May need to step up recovery work
- Slow down taper (2→1.5→1→.5→.25→.25 every other day)

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Opiate Receptor Blockade

- Naltrexone
  - Oral
  - Daily
- Vivitrol
  - Injection of naltrexone
  - Lasts 4 weeks

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WHY?

✦ It’s not an opiate

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✦ It can not be abused (no high)

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✦ No street value

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WHY?
- It's not an opiate
- It can not be abused (no high)
- No street value
- It saves lives

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WHY?
- It's not an opiate
- It can not be abused (no high)
- No street value
- It saves lives –
  - Injection as leaving incarceration or rehab does help prevent overdose

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WHY NOT?
- Injection is expensive ($800-1200/vial)

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WHY NOT?

- Injection is expensive ($800-1200/vial)
- Not an opiate and does not numb (still can have cravings)
- May be done under duress
- Patients may try to overcome block as injection wears off and overdose

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Naltrexone (oral)

- Approved in 1994 for treatment of alcohol dependence
- Decreases alcohol consumption by likely blocking positive reinforcing effects
- Blocks opiate receptors
- Biggest challenge is compliance (continuing medication)

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Naltrexone (oral)

- Side Effects
  - Nausea
  - Sleepiness
  - Abnormal rise in liver enzymes
  - Possible mood blunting in individuals prone to depression

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Vivitrol Concerns

- Young users may attempt to overcome the block (OD as shot is waning at end of month)
- Pain medication will not be as effective (accident or emergent surgery)
- Mood blunting or depression/lack of ‘runner’s high’ type of feeling possible (less likely with injection)

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Final Thoughts…

✦ Addiction is a condition of body, mind and soul
✦ Nearly all individuals who become addicted are trying to numb something, and need our help to learn to feel again
✦ Medication alone will not solve the issue of substance abuse and addiction but may be one piece of the puzzle

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Final, Final thoughts...

✦ Healing is a s-l-o-w process and relapse is the rule rather than the exception
✦ The medical profession has a lot to learn about the above, and the majority of MDs are not trained in treating addictions

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THANK YOU
Patient Case 1

“Doc, I need more Suboxone®. Since I went down, I’m having more back pain. That's always my sign that I'm in withdrawal.”

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No other withdrawal symptoms by questioning and exam.
Patient Case 1

On further discussion, he had a back injury at work over 10 years ago. He had forgotten, so did not disclose this at the initial evaluation. The injury was never evaluated or treated. He was taking illicit opiates from prior to the injury until starting buprenorphine 2 years ago.

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Patient Case 1

This step down on buprenorphine allowed him to feel the chronic discomfort of his old injury.

Do I increase his opiate replacement?

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Patient Case 2

“I’m feeling more stressed. This past month, I’ve gotten in more trouble with the IRS and I don’t know if I’ll be able to pay my mortgage. Can I get an increase so I can feel more comfortable?”

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About Opiates
- All animals have opiate receptors throughout their brains
- Related to ‘survival of the species’
- Opiates do not eliminate pain, but decrease the arousal that accompanies pain
- Cause an increase in norepinephrine

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About Opiates
- Mistaken belief that they are safe
- Creates a challenge in medicating depression (e.g. methadone)
- Pain can be physical OR emotional

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About Opiates
- CNS depressant similar to effects of alcohol
- Greatest risk is of respiratory depression
- Opiate + Benzodiazepine = recipe for an overdose

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Almost always underlying substance use....

- Anxiety
- Trauma
- Depression
- Insomnia

WHY?

- GENETIC VULNERABILITY
- STRESSOR

Dual Diagnosis: Depression

- Depression is frequently overlooked
- Poor historians: often out of touch with feelings
- In treatment under duress
- Behavioral problems may be the primary manifestation
Opioids (and Alcohol) are CNS depressants that cause and worsen depression.

“Medicate” depression.

Depressed opiate users often can not maintain sobriety if depression is not treated.

Opiates may “depress” medications for depression.

Opiate abusing depressed individuals often have their use brought to attention before their depression.
Dual Diagnosis: Depression

- BEST TREATMENT IS A COMBINATION OF THERAPY AND MEDICATION MANAGEMENT

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Dual Diagnosis: Anxiety

- Extremely common presentation
- High degree of overlap between withdrawal and anxiety sx
- While anxiety isn't responsible for the opiate epidemic, it is a major barrier for individuals to stop using

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Dual Diagnosis: Anxiety

- Anxiety
  - Can present as panic attacks, social withdrawal, phobias, obsessions and compulsions
  - Common for teens and adults to treat anxiety with substances

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Dual Diagnosis: Anxiety

✦ Opiates are wonderful numbing agents and individuals with anxiety (and PTSD) want to be numbed

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Anxiety and Substance Use

✦ Anti-Craving medications do not address the underlying MH ‘driver’
✦ What exactly is driving a craving?

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Anxiety

Increased BP
Increased HR
‘Heart attack’ feeling/Chest pain
Shortness of Breath/Breathing/Choking
‘Room closing in’
Fear of going crazy/losing it
Out of Body
Depersonalization/Numb

Sweating/Chills/Hot flashes
Restlessness
GI Cramps/Diarrhea
Shaking/Tremor
Inability to Concentrate
Dizzy/Lightheaded/Tingling
Opiate Withdrawal

- Increased BP
- Increased HR
- Sweating/Chills/Hot flashes
- Restlessness
- Dilated Pupils
- GI Cramps/Diarrhea
- Gooseflesh
- Nausea/Vomiting
- Feeling of Dying
- Tremor
- Yawning
- Runny nose/Watery eyes
- Bone Pain
- Muscle Aches

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Anxiety Vs. Opiate Withdrawal

- Inc. BP
- Inc. HR
- Sweating/Chills
- Restlessness
- GI cramps/diarrhea
- Shaking/Tremor
- Feeling of Dying

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Anxiety Vs. Opiate Withdrawal

- Take a good history
- Corroborate with family and friends
- Symptoms when abstinent
- Symptoms prior to use
- Look for physical evidence (e.g. gooseflesh, runny eyes/nose)

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Substance-Induced Disorders

- Can last past acute withdrawal
- Individual differences vary widely
- Noted by improvement with cessation of use

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Substance-Induced Disorders

- Higher risk of suicide and self injury in Substance Induced Depression vs. Major Depression
- Higher likelihood of panic attacks with Substance Induced Anxiety

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Case Study 3

- Jack is a 26 year old computer programmer who presents for evaluation as a transfer from another buprenorphine provider. He has been prescribed Suboxone® 36 mg. per day for the past 10 months. He reports he isn’t sure that medication is working.

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Case Study 3

Jack reports that for the first several weeks of treatment, he had been given 16 mg. He used no other opiates during this time. However, 4-5 hours after taking his dose, he would experience shortness of breath, increased heart rate, sweating, edginess.

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Case Study 3

His MD increased his buprenorphine to 20 mg for 2 days, then 24 mg. per day in a divided dose. He reported good effect, but after 1 week, all of his "withdrawal" symptoms returned, this time 4 hours after each dose. He had no use of other opiates but admitted thinking about it, only to relieve sx.

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Case Study 3

Suboxone® increased to 32 mg, then with continuing complaints of withdrawal up to 36 mg. (16 mg in the morning, 20 mg in the evening.) After one month, he did try to decrease to 32 mg. but began to worry that his symptoms would come back so his MD increased and kept him at 36 mg.

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Case Study 3

✓ Diagnosed with Generalized Anxiety Disorder
✓ Started on citalopram and gabapentin. Later added propranolol
✓ Started individual CBT and group therapy. Over past year, Brainspotting.
✓ After 3 months of above, did decrease buprenorphine to 28 mg. Five years later, dose is 0.5 mg. per day.

Medication management: anxiety

Use an alternative to benzodiazepines, please

ANTI-ANXIETY

✓ BENZODIAZEPINES
  ✓ Immediate relief
  ✓ Tolerance, mental dependence can result if used long-term in a susceptible individual
  ✓ Binds in the same area of brain as alcohol
  ✓ Numerous studies have stated contraindicated in PTSD as can be disinhibiting
ANTI-ANXIETY:
non-addictive (prn vs sched)

- Gabapentin
- Clonidine
- Propranolol (situational)
- Quetiapine
- Tiagabine
- Trazodone
- Hydroxyzine
- Buspirone

How to Minimize Abuse of Medication in a Substance Abusing Population

- Avoid meds with potential for abuse whenever possible
- Education
- Limited Use of benzos if at all: e.g. small quantities (5 pills per month) for panic attacks

PDMP (Pt Drug Monitoring Program for controlled substances)
- Shorter time frames filled
- Other opiates when on replacement
- Surprises (‘I forgot to tell you…’)

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Medication management: insomnia

***Use an alternative to benzodiazepines +———-+ Ambien®/Lunesta®/Sonata®

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Insomnia: non-addictive

• Trazodone
• Clonidine
• Quetiapine
• Hydroxyzine
• Diphenhydramine
• Doxepin

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Dual Diagnosis: Trauma

✦ Use Alcohol or drugs to cope
✦ Drink/use not to feel anything
✦ 29-59% of women in AODA treatment have trauma. Likely much higher.
✦ Women with PTSD have a 1.4-3.6x higher likelihood of substance abuse.

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Dual Diagnosis: Trauma

+ Lack of validation in many AODA programs
+ “All that matters is the use.”
+ “Stay in the present.”
+ AA concept of the ‘pity pot.’
+ 66% of residential programs believe they’re trauma-informed. Not what patients are telling us.


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Dual Diagnosis: Trauma

+ Never learned to manage feelings in a healthy way (bad modeling)
+ Drugs are the ‘perfect’ solution to getting rid of memories and unpleasant feelings

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Dual Diagnosis: Trauma

+ Notice the connections between use and feelings
+ Recognize that as use lowers, uncomfortable feelings will increase
+ As coping increases, feelings will be more manageable (hang in there)
+ Decrease use if unable to fully stop
+ Work on both trauma and use together

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Trauma Treatment

- DBT
- Seeking Safety
- EMDR
- Brainspotting
- “Trauma-informed care”

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Almost always underlying the use....

- Anxiety
- Trauma
- Depression
- Insomnia

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In summary....
Dual Diagnosis

- Avoid addictive medications
- Focus on treatment of sx: sleep, anxiety, GI upset

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Dual Diagnosis

- Relapse is a part of recovery
- Shame is a part of relapse
- We can not make anybody ready for treatment
- We can offer compassion along with good boundaries

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Dual Diagnosis

- We can offer our best advice and expertise
- Each patient has to walk his/her path
- Their success or failure is not our responsibility

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THANK YOU