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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

CHALLENGING CASES IN MOUD

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project ECHO

SPEAKER DISCLOSURES

✓ Any conflicts of interest?

PLANNER DISCLOSURES

The following series planners have no relevant conflicts of interest to disclose; other disclosures have been mitigated.

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OBJECTIVES

1. To Review OUD cases from the Provider Consultation Call.
2. Use the cases to develop clinical questions that need to be addressed.
3. Review the evidence base of the clinical questions.
4. Highlight the use of the PCL for clinical questions.

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CASE 1

- Patient is a 61yo female patient in the ICU. She was admitted yesterday in the context of acute renal failure after missing dialysis this past week. In addition to ESRD and HCV, she is on Methadone maintenance for OUD. She has also been smoking Fentanyl four times daily.

- Since admission, she's undergone HD x 2 and has been exhibiting symptoms of opioid withdrawal. She has reported an outpatient regimen of 240mg daily of Methadone but her clinic reports recent dosing of 185mg daily due to gaps in care from hospitalizations. Her first dose was thrown up and subsequent dosing timed before HD.

- Her COWS has been up to 20 today. She is reporting severe anxiety, nausea and GI distress. Ondansetron and Clonidine have been ordered. IV fentanyl has also been used.

Question: What do you recommend for managing her symptoms?

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CLINICAL QUESTIONS

- Why is she in so much opioid withdrawal?
  - Is hemodialysis playing a role in her clinical picture?
  - What is the best way to treat it?

- Can hospitals increase her methadone dose to treat opioid withdrawal?

DOES HEMODIALYSIS IMPACT MOUD?

- Hemodialysis and Methadone
  - Not significantly removed (~2% to ~15%)
  - Titrate gradually
  - Post dialysis dosing is not needed

- Hemodialysis and Buprenorphine
  - Not significantly dialyzed.
  - No dose changes needed

Lexidrug

CAN HOSPITALS ADJUST METHADONE DOSES FOR OUD WITHDRAWAL?

- Yes
- CFR 42 Part 8, Subpart C, 8.11.h.3
  - Certification as an OTP under this part is not required for the initiation or continuity of medication treatment or withdrawal management of a patient who is admitted to a hospital, long-term care facility, or correctional facility, that is registered with the Drug Enforcement Administration as a hospital/clinic, for the treatment of medical conditions other than OUD, and who requires treatment of OUD with methadone during their stay, when such treatment is permitted under applicable Federal law.

RECOMMENDATIONS

- Titrate back up on her methadone dose to address her withdrawal symptoms.
- Continue to monitor her COWS
- Continue to use supportive opioid withdrawal medications

CASE 2

- Patient is a 67yo female patient who is eager to taper off the buprenorphine-naloxone she's been using for the past year to treat OUD. She has been sober from opioids since April of last year and has found the Suboxone to be helpful. She denies current cravings or urges to use.

- She currently takes half of a 2mg/0.5mg film four times daily

Question: How would you recommend tapering off her Buprenorphine-Naloxone?

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CLINICAL QUESTIONS

- When is it time to taper off buprenorphine?
- How is the best way to do it?

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HOW LONG SHOULD A PERSON BE ON MOUD?

- Patients who remain on medication for at least 1 year appear to do better around relapse, overdose, and other recovery measures.
  - Overall trend→the longer the better
- A “Difficult clinical juncture”
  - High rates of buprenorphine discontinuation predicted by a history of overdose!
- Limited evidence on best practices for safe discontinuation

Shulman M, et al. Discontinuation of medication treatment for opioid use disorder after a successful course: The discontinuation phase of the CTN-0100 (RDD) trial. Contemp Clin Trials. 2024 Jul;142:107543. doi: 10.1016/j.cct.2024.107543. Epub 2024 Apr 23. PMID: 38657730; PMCID: PMC11180567.

M. Burns, *et al.* Duration of medication treatment for opioid-use disorder and risk of overdose among Medicaid enrollees in 11 states: a retrospective cohort study. Addiction, 117 (12) (2022), pp. 3079-3088.

I. Maremmani, et al. Substance use and quality of life over 12 months among buprenorphine maintenance-treated and methadone maintenance-treated heroin-addicted patients J. Subst. Abus. Treat., 33 (1) (2007), pp. 91-98.

A.R. Williams, H. Samples, S. Crystal, M. Olfson Acute care, prescription opioid use, and overdose following discontinuation of long-term buprenorphine treatment for opioid use disorder Am. J. Psychiatry, 177 (2) (2020), pp. 117-124.

Samples H, Williams AR, Olfson M, et al: Risk factors for discontinuation of buprenorphine treatment for opioid use disorders in a multi-state sample of Medicaid enrollees. *J Subst Abuse Treat* 2018; 95:9–17

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DISCONTINUING BUPRENORPHINE?

- 2 parts to the story
  - Duration of MOUD
  - Did the patient engage successfully in recovery processes?
    - Relational changes
    - Identity adjustments
    - Mental Health
    - Physical Health
    - Personal and family security
    - Recovery capital?

- Current Study
  - Optimizing Retention, Duration, and Discontinuation Strategies for Opioid Use Disorder Pharmacotherapy

H.S. Connery, R.D. Weiss Discontinuing buprenorphine treatment of opioid use disorder: what do we (not) know? Am. J. Psychiatry, 177 (2) (2020), pp. 104-106.

DISCONTINUING BUPRENORPHINE?

- Review reasons for discontinuation
- Assess risk for return to use
  - Where are they in their recovery?
  - How long have they been in recovery?
  - Life stability: family, work, friends
  - Mental health
  - Other substance use

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BUPRENORPHINE DISCONTINUATION TIPS FROM REDDIT

- Reviewed 16,146 posts about buprenorphine from 1933 people
- More success with longer tapers
  - Notable for taper from 2.0 to 0 mg (Mean 95 days)
    - Most challenging
- Diarrhea, insomnia, restlessness and fatigue most common symptoms
- Physical exercise, clonidine and Imodium were most helpful
- The most frequentfinal dose was .063mg

Graves RL, Sarker A, Al-Garadi MA, Yang YC, Love JS, O'Connor K, Gonzalez-Hernandez G, Perrone J. Effective buprenorphine use and tapering strategies: Endorsements and insights by people in recovery from opioid use disorder on a Reddit forum. bioRxiv. 2019 Jan 1:871608. doi: 10.1101/871608.

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INJECTABLE BUPRENORPHINE FOR DISCONTINUATION

Case Series, Ritvo AD, et al

Case 1: Patient could not tolerate lower then 4mg of Bup

- Switched to 100mg Sublocade x 1
- 1st 2 weeks: slight, tolerable malaise
- 2 weeks after injection constipation improved and resolved eventually
- 4 weeks after injection “mild depersonalization episodes” resolved which he had felt since using SL Bup

Case Series, Rodriguez, C, et al

Case 1: OUD stable on 16mg Bup total daily dose x 5 years.

- Switched to Sublocade
  - 300mg x 2
  - 100mg x 6
- 9 weeks after last injection→mild, transient, and tolerable restless sleep x 1 week. No other w/d or cravings.
- 1 year after last injection: no return to use. Sees provider every 3 months

Rodriguez CP, Suzuki J. Case series: Voluntary discontinuation of sublingual buprenorphine treatment for opioid use disorder using extended-release buprenorphine. Am J Addict. 2023 May;32(3):314-317. doi: 10.1111/ajad.13414. Epub 2023 Mar 20. PMID: 36941795; PMCID: PMC10121911.

Ritvo AD, Calcaterra SL, Ritvo JI. Using Extended Release Buprenorphine Injection to Discontinue Sublingual Buprenorphine: A Case Series. J Addict Med. 2021 May-Jun 01;15(3):252-254. doi: 10.1097/ADM.0000000000000738. PMID: 32925232.

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RECOMMENDATIONS

- Yes, it is ok to taper off MOUD

(No clear taper guidelines-specific rec for this caller)

- Taper by approximately 20% every week
- Reduce by 1mg/0.25mg each week; i.e. take away one daily dose each week
- This should have her off the Suboxone in about a month; however, advise that she pause the taper at any time should cravings resurface

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CASE 3

- 41yo M with a history of Bipolar Disorder and Polysubstance Use Disorder with prior regimen of quetiapine 50mg daily and hydroxyzine 50mg (last prescribed several years ago) presents in the setting of opioid withdrawal and depressive symptoms. Pt describes trouble sleeping with resulting fatigue, increased anger and impulsive decisions for a month or so. Also learned of the death of his son recently who died several years ago.

- Pt last used fentanyl yesterday, uses 1-2points a day. Current COWS score in clinic is 11. He uses methamphetamine several times a week, last used 2 days ago. He denies SI, HI, AVH.

Question: What would be your starting buprenorphine dose? Is it appropriate to restart quetiapine?

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CLINICAL QUESTIONS

- What is going on with this patient clinically? Diagnoses?
  - How do you diagnosis bipolar in a patient with regular meth use?

- What treatments are needed?
  - Does he need both meds? Start only one?

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DISTINGUISHING METH USE FROM BIPOLAR

- Temporal Relationship
  - Do symptoms start during abstinence or resolve with abstinence?
  - Onset of symptoms in relationship to onset of drug use
  - Mania can last for weeks-months
- Mania more impairment vs intoxication
- Mania psychosis: more grandiose and paranoid (generally)
- Meth and physical symptoms: tachycardia, dilated pupils

ASAM Principles of Addiction Med: Chp 101, Nunes, E., et al

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WHAT TREATMENTS ARE NEEDED

- What would you prioritize and why?
- Would you start a mood stabilizer?
- How to address the meth use?

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RECOMENDATIONS

- Start him on Bup-Naloxone 16/4mg now. As you are discharging him from clinic with follow-up with your suboxone clinic, it would be appropriate to start with 8/2mg TID and give him a 7-14 day supply to bridge to follow-up.
  - As needed symptomatic meds could also be considered (clonidine, methocarbamol.)
  - https://scalanw.org/

- Given the discussion of substance use contribution to mood symptoms, it is difficult to say that pt is in a depression episode rather than meth withdrawal. There are no treatments for meth use, though there is some limited success with bupropion and injectable naltrexone (contraindicated in Bup pts), or with mirtazapine.
  - For problems with insomnia and substance induced symptoms, off-label second generation antipsychotics can be helpful for some. It may be reasonable to start quetiapine 50mg qhs and titrate to 100mg qhs if indicated. An alternative would be olanzapine 5mg qhs.

QUESTIONS

Provider Consultation Line

Prescribing providers call anytime, 24/7

Non-prescribing providers call Mon-Fri, 8-5 (excluding holidays)

877-WA-PSYCH (877-927-7924)

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