High dose Methadone to LAIB transfers

Victorian Opioid Management ECHO
Department of Addiction Medicine
St Vincent's Hospital Melbourne 10 March 2021

UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

Definition of HDM

Arbitrary

But for these purposes > 80mg/d methadone

Risks

Precipitated withdrawal

Destabilisation during transfer process

SE from buprenorphine

Failure to stabilise on buprenorphine

Why?

As a step to withdraw from OAT

To increase flexibility of treatment

Ease of travel

Lack of tolerability of methadone

Lack of effect from methadone

SE/interactions with methadone treatment

Cost/access

So where do we go to find guidance?

1) Google- first link is to this presentation!

2) National Clinical Guidelines on the Medically Assisted Treatment of Opioid Dependence

3) Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence.NSW Ministry of Health 100 Christie Street ST LEONARDS NSW 2065 Tel. (02) 9391 9000 Fax. (02) 9391 9101 TTY. (02) 9391 9900 www.health.nsw.gov.au

f. Induction from other opioids: prescription opioids and methadone

Patients should be initiated onto at least 7 days of SL BPN treatment prior to initiating depot BPN treatment. Longer periods of SL BPN treatment may be required if the patient reports adverse events, drug-drug interactions or if finding it difficult to stabilise on a dose of BPN – for example following a transfer from methadone (which can take 1-2 weeks to stabilise). Guidance on initiating SL BPN treatment from other opioids (including prescription opioids and methadone) can be found in National Guidelines for Medication Assisted Treatment of Opioid Dependence (2) (Section A.4).

Page 32. Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence.NSW Ministry of Health. Lintzeris et al.

options

- **Admit to ward/medically supervised withdrawal unit for cross-over**
  - Withhold methadone for 48 hrs then introduction of buprenorphine
  - Day 3 8mg qid, then 32mg on Day 4
  - 2mg test dose, then 2mg q2h until on 8mg then decide if to give another 4-8mg or more (to max of 24-32mg)

- **Bernese method/other microdosing variant**

ST VINCENT'S HEALTH AUSTRALIA

CASE SERIES

Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method

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Background: Buprenorphine is a partial μ-opioid receptor agonist used for maintenance treatment of opioid dependence. Because of the partial agonism and high receptor affinity, it may precipitate withdrawal symptoms during induction in persons on full μ-opioid receptor agonists. Therefore, current guidelines and drug labels recommend leaving a sufficient time period since the last full agonist use, waiting for clear and objective withdrawal symptoms, and reducing pre-existing full agonist therapies before administering buprenorphine. However, even with these precautions, for many patients the induction of buprenorphine is a difficult experience, due to withdrawal symptoms. Furthermore, tapering of the full agonist bears the risk of relapse to illicit opioid use.

Cases: We present two cases of successful initiation of buprenorphine treatment with the Bernese method, ie, gradual induction overlapping with full agonist use. The first patient began buprenorphine with overlapping street heroin use after repeatedly experiencing relapse, withdrawal, and trauma reactivation symptoms during conventional induction. The second patient was maintained on high doses of diacetylmorphine (ie, pharmaceutical heroin) and methadone during induction. Both patients tolerated the induction procedure well and reported only mild withdrawal symptoms.

Discussion: Overlapping induction of buprenorphine maintenance treatment with full μ-opioid receptor agonist use is feasible and may be associated with better tolerability and acceptability

Project ECHO®
St. Vincent's Hospital, Melbourne
Australia

Quite commonly used in USA/Canada- high levels of fentanyl use

CASE STUDY Open Access

Case report: Successful induction of buprenorphine/naloxone using a microdosing schedule and assertive outreach

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Abstract

Background: The requirement for moderate withdrawal prior to initiation can be a barrier to buprenorphine/naloxone induction.

Case presentation: We aimed to use a microdosing regimen to initiate regular dosing of buprenorphine/naloxone in a high-risk patient with a history of failed initiations due, in part, to withdrawal symptoms. Using an assertive outreach model and a buprenorphine/naloxone microdosing schedule, we initiated treatment of an individual's opioid use disorder. There was a successful buprenorphine/naloxone microdosing induction as the team reached a therapeutic dose of buprenorphine/naloxone. Including the induction period, the medication was used consistently for 4 weeks.

Conclusions: A microdosing schedule can be used to induce a patient onto buprenorphine/naloxone with no apparent withdrawal; gradually reducing illicit substance use. This case report builds on previous literature, highlighting ways to minimize barriers to induction of buprenorphine/naloxone, using a microdosing schedule and assertive outreach. Given the safety profile of buprenorphine and its potential to be a lifesaving intervention, a larger study of microdosing is indicated.

Keywords: Opioid use disorder, Buprenorphine/naloxone, Microdosing, Bernese method, Induction method

Mechanism

Buprenorphine is a partial mu-receptor agonist at mu-opioid receptor and ORL-1 receptors

K-opioid receptor antagonist

High receptor affinity (displaces other opioids)
and slow dissociation

Partial opioid agonism may precipitate withdrawal

“typical” microdosing schedule

Day I	**0.25mg od**
Day 2	**0.25mg bd**
Day 3	**0.5mg bd**
Day 4	**1mg bd**
Day 5	**2mg bd**
Day 6	**4mg bd**
Day 7	**12mg od**

and cease pure mu-agonists

HAT- methadone 40mg + DAM 200mg iv bd

Switched to oral diacetylmorphine 400mg bd + methadone 40mg

Any TAD were methadone

SOWS daily

Day 1 0.2mg byuprenorphine SL

Day 2 0.4mg bd

Dose increased by 0.4mg daily to 3.4mg then increased daily by 20-30%

Mild withdrawal symptoms on Day 8 (3mg) and Day 11 (4.8mg)

Then went on vacation (!!!) and experienced withdrawal symptoms (7 on SOWS) Days 13-16

Opioid craving on Days 15-16 only

Day 22 dose of buprenorphine increased

Full agonists all ceased day after reaching 24mg buprenorphine (Day 29)

Lots to discuss