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Translating science into care

Substance Use Warmline

Reducing the Harms of Substance Use

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Key Points

- Addiction is a chronic brain disease
- Medications saves lives
- Relapse is a part of the process
- Preventing mortality is primary goal
- It’s not so tricky—just call us!

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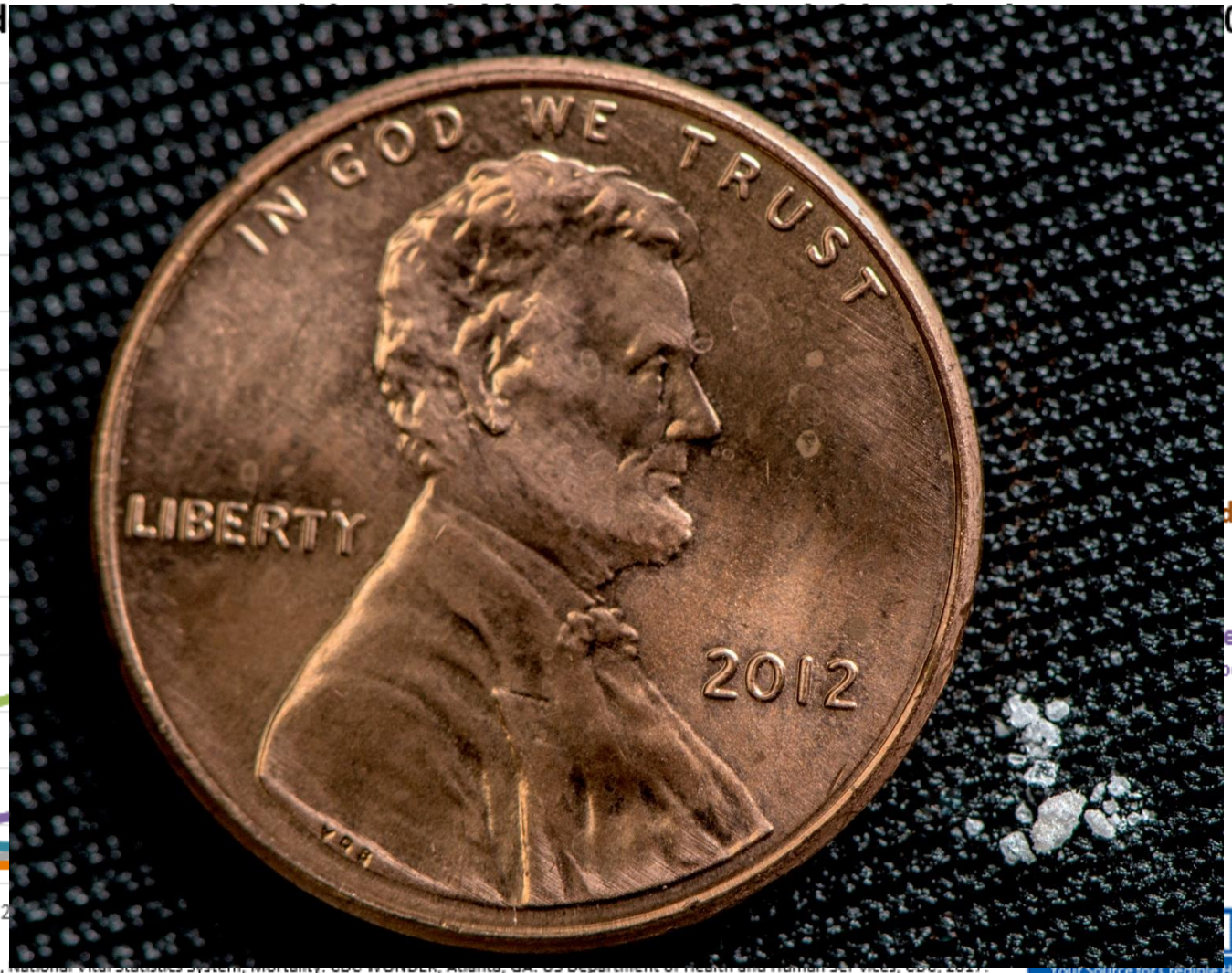
Polls

- Who here is a:
  - Prescriber
  - Behavioral health
  - Administrator
  - Other direct patient care

- Does your clinic provide buprenorphine:
  - No, none of our prescribers are X licensed
  - Yes, we have a few patients on buprenorphine or are starting a program
  - Yes, we have many patients on buprenorphine and feel fairly comfortable



Overd 0-2016

Deaths per 100,000 population

14
13
12
11
10
9
8
7
6
5
4
3
2
1
0

2000

ds

etic Opioids

ocodone)

SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Services, CDC, 2017. https://wonder.cdc.gov/.

lc.gov

Your Source for Credible Health Information

Chronic illness model

Similar to diabetes, high blood pressure

- Biologically mediated
- Psychologically mediated
- Socially mediated
- Life style changes may help
- Symptoms are relapsing and remitting
- Meds may be necessary for life

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Behavioral Health

- Counseling is invaluable—but not mandatory for medication ***addiction*** treatment
- Outpatient options:
  - Harm reduction/syringe exchange
  - Contingency management
  - 12 step
  - Embedded behavioral health
  - Outpatient rehab
  - Intensive outpatient program

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Setting Up for Success

- Understand that slips happen, set ground rules:
  - Use does not mean that treatment stops
  - Missed visits do not mean that treatment stops
  - Diversion, threatening may → alternate treatment
  - Behavioral issues may be a symptom of the disease, trauma

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Mr. J

- 35 yo MSM on PrEP with hx of pituitary adenoma, depression, HTN
  - Meds: Emtricitabine/tenofovir (Truvada), hydralazine
  - Social: graduate student, around 3-4 sexual partners a month

Mr. J

- Substance use:
  - Alcohol (5-7 drinks on Friday and Saturday)
  - Methamphetamine (every other week, after drinking
  - Alkyl nitrites (poppers)
  - Tobacco (1ppd)

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Mr. J

- His PCP calls (**855) 300-3595** between 9am and 8pm ET
- Talks to intake coordinator, gives demographics, callback, basics of case
- Called back by addiction specialist
- Talk through the specific case and send resources

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ALCOHOL

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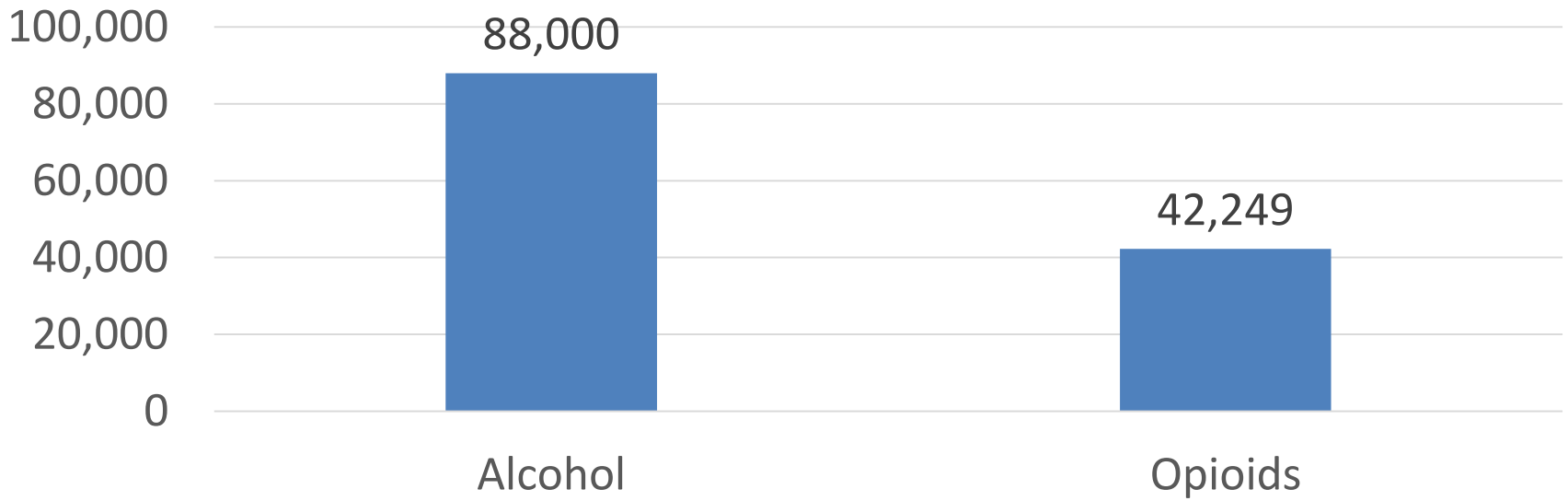
Annual deaths from substances



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Medication Treatment for Alcohol

Drug	Pros	Cons
Naltrexone	FDA approved Strongest evidence PO or IM, daily or monthly	Blocks opioid pain medications Some GI upset, LFT elevation Avoid if LFTs >5x ULN, on opioids

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Gabapentin	Off label Treats withdrawal, neuropathy Can combine w/naltrexone	Sedation 3 times a day

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Mr. J: A Patient Centered Decision

Drug	Our patient
Disulfiram	“Not a chance”—not ready to quit fully
Topiramate	“I need to stay sharp”
Gabapentin	Tried for pain before, didn’t help his drinking. No hx withdrawal.
Naltrexone	“I’ll give it a shot”

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STIMULANTS

Stimulant Use Disorder

- Behavioral
  - Cognitive behavioral therapy: build coping skills
  - Contingency management: contrived reinforcements
- Medications
  - No FDA approved treatments
  - Cocaine: TCAs, SSRIs, ondansetron, varenicline, **disulfiram**
  - Methamphetamine: methylphenidate, naltrexone, **mirtazapine**

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TOBACCO

Tobacco

- Leading cause of preventable death
- Short acting NRT: nicotine gum 4 mg—chew and park
- Long acting NRT: 7 mg, 14 mg, 21 mg
- Buproprion (lowered seizure threshold)
- Varenicline (depression—black box removed)
- Combination!

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OPIOIDS

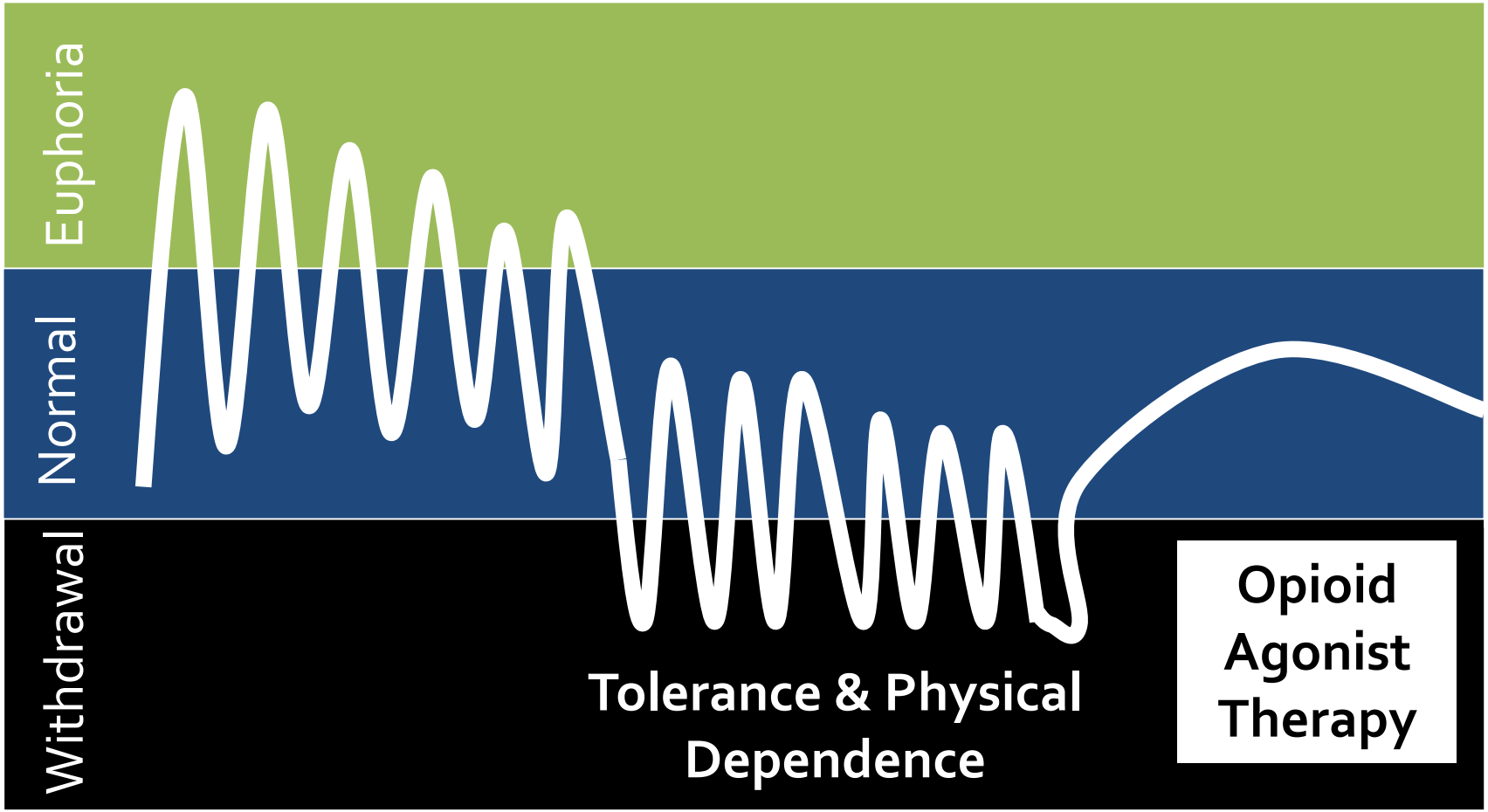
Mr. J

- 35 yo MSM on PrEP with hx of pituitary adenoma, depression, HTN
  - Returns 2 years later after lost to follow up
  - Had a meniscal tear, car accident given norco
  - Chronic pain and euphoria → rapidly increased use
  - Now buys oxycodone on street, uses heroin when unable to get it

Staying well

ASAM American Society of Addiction Medicine

No longer in the cycle



ASAM American Society of Addiction Medicine

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Opioid agonist therapies

- Prevent withdrawal
- Reduce cravings
- Prevent intoxication
- Avoid sedation

- Methadone
- Buprenorphine (Subutex®), buprenorphine-naloxone (Suboxone®)

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Decreased morbidity

- Reduce injection and illicit drug use
- Reduce HIV and HCV transmission
- Reduce bacterial infections
- Reduce criminal behavior
- Promotes return to work and family obligations

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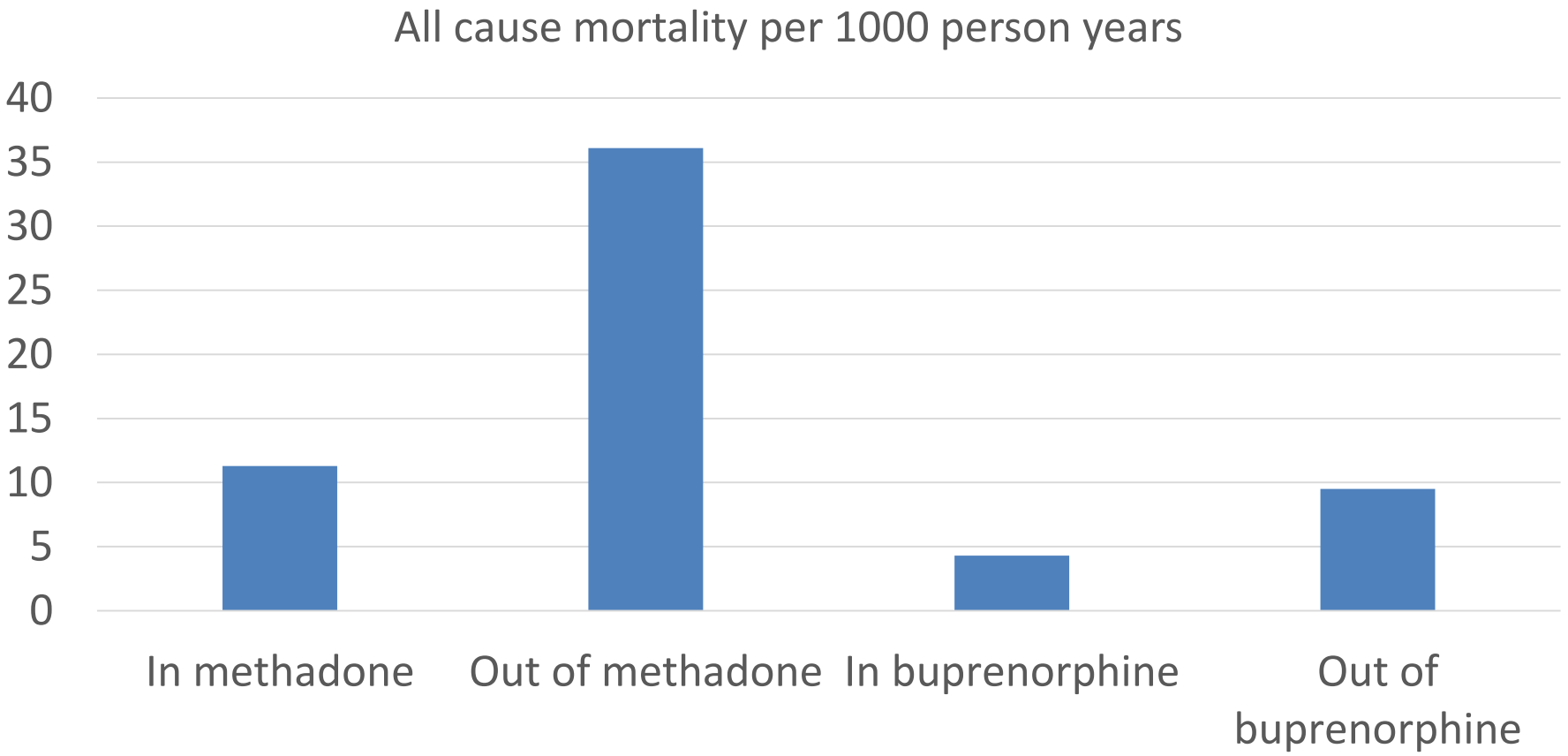
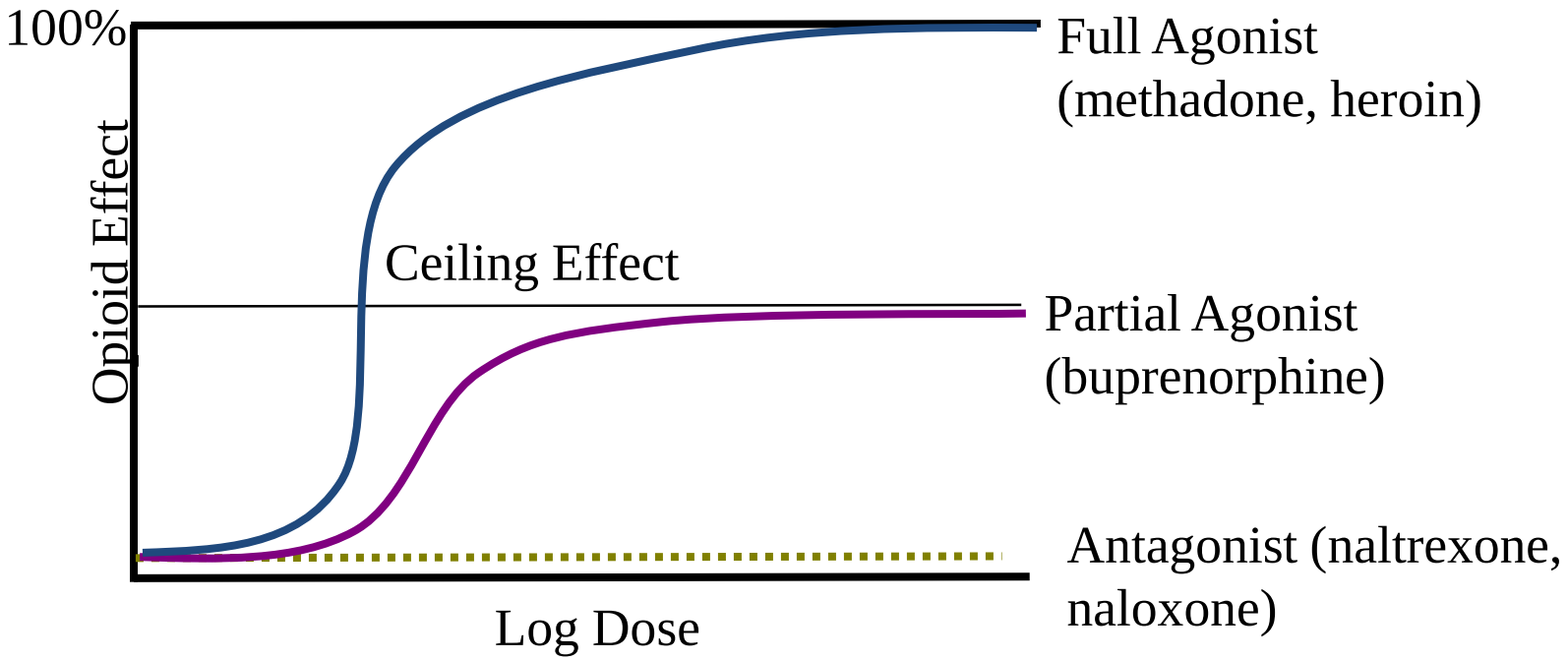
Decreased mortality



Opioid effect



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Patient centered decision

	METHADONE	BUPRENORPHINE/SUBOXONE
Mechanism	Full agonist	Partial agonist—with built in antagonist

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Patient centered decision

	METHADONE	BUPRENORPHINE/SUBOXONE
Mechanism	Full agonist	Partial agonist—with built in antagonist
Location	Specialty clinics, daily	Any provider, weekly-monthly

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Location	Specialty clinics, daily	Any provider, weekly-monthly
Sedation	Risk higher	Risk lower
Pain control	Doesn't last	Can be split TID to control chronic pain Approved for pain control

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Patient centered decision

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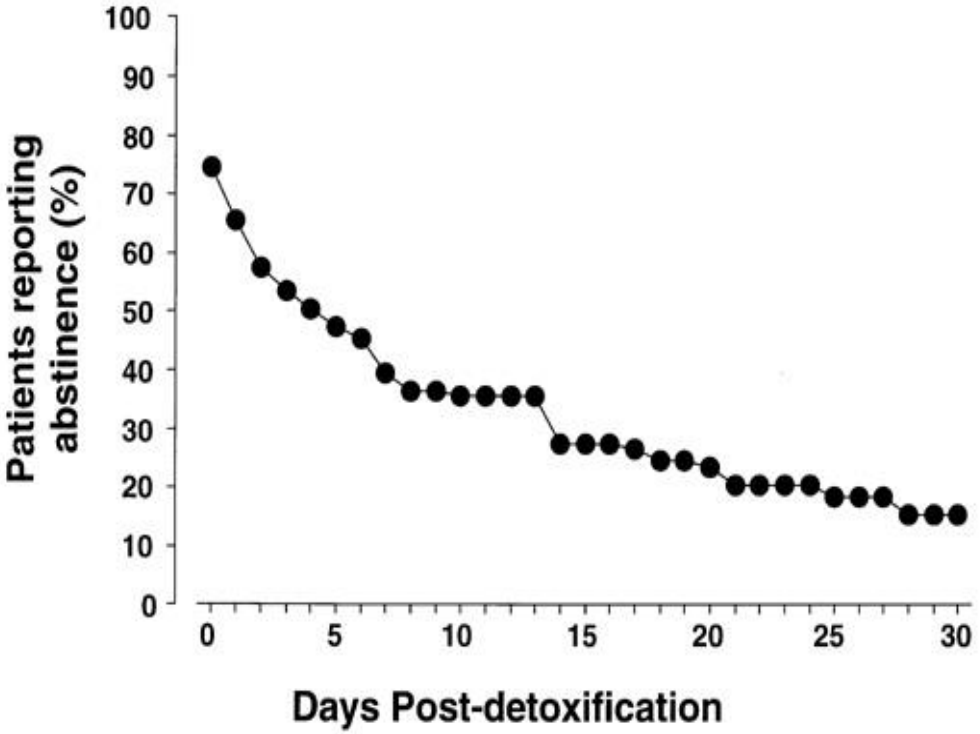
Mechanism	Full agonist	Partial agonist—with built in antagonist
Location	Specialty clinics, daily	Any provider, weekly-monthly
Sedation	Risk higher	Risk lower
Pain control	Doesn't last	Can be split TID to control chronic pain
Side effects	Decreased libido Arrhythmia Constipation Sweating	Precipitated withdrawal GI upset, constipation Headache Insomnia, mania

Naltrexone

- Antagonist—prevents intoxication, decreases cravings
- Monthly shot only for opioids
- May be preferred by 12 step, criminal justice
- High rates of drop out: 28% didn't get first dose vs 6% of bup
- May be equally effective to buprenorphine—after detox
- Risk of overdose, blocks opioid analgesics

Detox for opioids



- Just say no (usually)
- Medically supervised withdrawal
- Dose to treat withdrawal, then slow decrease
- Opioid agonists + adjunctive meds
- May be preferred by 12 step, law enforcement

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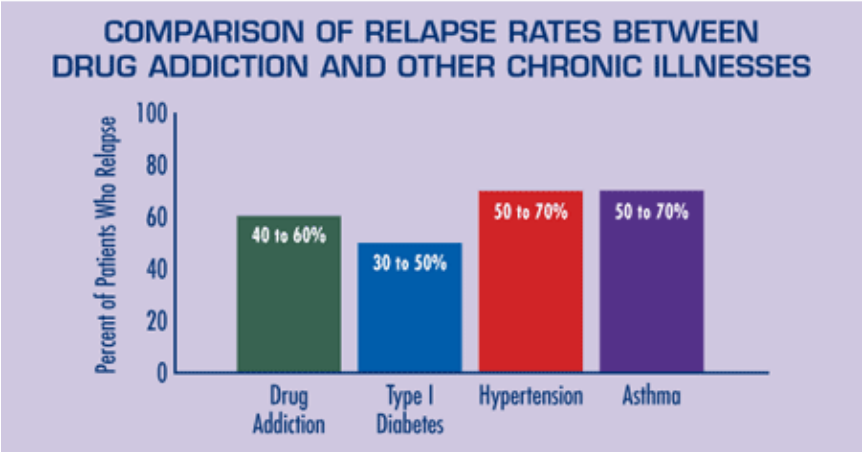
Mr. J

- 35 yo MSM on PrEP with hx of pituitary adenoma, depression, HTN
  - Methadone: “I have to go to work, I can’t go to a clinic every day”
  - Naltrexone: “I’m afraid of it’s impact on my pain”
  - **Buprenorphine:**
    - Chronic pain + OUD: TID dosing
    - Flexibility in visit schedule
    - Not contraindicated in alcohol

Mr. J

- Starts buprenorphine via home induction: Rxed 4/1 mg tabs #12
  - Waits for withdrawal, then takes 1 tab
  - Day 1 takes 12 mg, day 2 16 mg, then stable
- Weekly visits
  - Offered behavioral health
  - Urine toxicology and patient report: ongoing intermittent heroin, meth, alcohol
- Increased to 20 mg, warm handoff to behavioral health

A Chronic Disease of the Brain



- 40-60% of people relapse within a year of treatment
- Similar rates of symptom recurrence to other illness
- Slips are a normal part
- Treatment works, but needs to be ongoing

Harm reduction

- Reduce use
- Safe use
  - Needle exchanges, clean works
  - Fentanyl—test doses, public injection
  - Safe injection sites
- Door always open
- Stay alive long enough to enter treatment

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Naloxone

- Universal **naloxone** prescribing
  - OUD
  - Chronic opioids
  - Stimulants
- Friends, families, bystanders

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HIV, HCV and Substance Use

The NEW ENGLAND JOURNAL of MEDICINE

EDITORIAL
Is Culprit-Lesion-Only PCI in Cardiogenic Shock Still Better at 1 Year?

IMAGES IN CLINICAL MEDICINE
Hemolacria — Crying Blood

ORIGINAL ARTICLE
Genomic Analysis of Lassa Virus during an Increase in Cases in Nigeria in 2018

Perspective

Stretching the Scope — Becoming Frontline Addiction-Medicine Providers

Alison B. Rapoport, M.D., and Christopher F. Rowley, M.D.

Article | Figures/Media | Metrics

5 References 5 Citing Articles

August 24, 2017
N Engl J Med 2017; 377:705-707
DOI: 10.1056/NEJMp1706492

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www.hiv-druginteractions.org/
www.hep-druginteractions.org/

Antiretroviral	Effects on ART levels (buprenorphine, methadone, naltrexone)	Effects on MAT levels	Management
Integrase inhibitors	No significant changes	Elvitegravir/cobicistat→ incr bup levels	No dose adjustment, monitor clinically
Protease inhibitors	Atazanavir: possible decr concentration with bup coadministration	Darunavir: minimal decr bup levels, decr methadone levels Atazanavir: incr bup levels, decr methadone levels	Monitor clinically Avoid buprenorphine+ unboosted ATV
Non-nucleoside reverse transcriptase inhibitors	No changes	EFV: decr bup ETR: decr bup NVP: decr methadone RPV: decr methadone	Monitor clinically RPV+methadone: monitor QTc

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Mental Health and Substance Use

- Behavioral health team debunks stigma of SUD and meds
- Key techniques:
  - Motivational interviewing
  - Cognitive behavioral therapy
  - Contingency management
- Buprenorphine prescribers must be able to offer counseling

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Mental Health and Substance Use

- Don’t wait to start treatment of either
- Break the cycle of withdrawal → able to address underlying issues

- Buprenorphine: antidepressant effect, can→ insomnia, hypomania
- Varenicline: can worsen depression
- Gabapentin: can mitigate anxiety

- Treatment of each is chance to engage on other

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Thank you!

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