Using Medication Assisted Treatment with Veterans for Opioid, Alcohol, and Tobacco Use Disorders
February 11, 2014

Q: Is there a pharmacologic alternative for a patient who develops urinary retention with 10mg of methadone?
A. If the patient is in need of opioid maintenance treatment, at present buprenorphine is the only other alternative. One might also consider the use of bethanechol and/or a urology consult to make sure there is no correctable pathology in the urinary tract.

Q: What strategies is the VA using to increase the use of pharmacotherapy for alcohol?
A: There is a project doing academic detailing with an evaluation component to see how effective it is.

Q: Do you have any sense of differential rates of opioid use disorder for male and female vets?
A: I have not seen any data on this topic. Typically outside the VA opioid use disorder is about 2:1 or 3:1 male to female.

Q: Does the use of Medication Assisted Treatment (MAT) for opioid use disorder require a special facility license (as in methadone clinics?) Is it legal for standard outpatient clinics to do this?
A. It is fine for any physician in any setting to do it using buprenorphine or buprenorphine/naloxone as long as the physician has completed the requisite training and has obtained a DEA X number and stays within the mandated patient limits (30 the first year of prescribing; may request to go up to 100 after the first year).

Q: Have you noticed a decline in criminal behavior with the study of MAT?
A: Yes, several studies show substantial decreases in criminal behavior when patients with opioid use disorder enroll in MAT.

Q: How much harm happens when patients on NRT continue to use tobacco?
A. None. It is absolutely not dangerous to smoke while using NRT. A hallmark symptom of nicotine toxicity is nausea. When people experience nausea from too much nicotine, they invariably stop their immediate nicotine use and half-life of nicotine is very short.

Q: Is the VA looking at the use of electronic cigarettes for nicotine replacement therapy?
A. E-cigarettes are not FDA approved products. Thus, the VA would not supply them. That doesn’t mean individual providers cannot support their use if patients buy them on their own. The use of e-cigarettes is controversial at the present time. There is no quality control in their manufacture so some may have toxic components. However, many tobacco experts feel they are less dangerous than tobacco cigarettes. More rigorous research needs to be done.

Q: How would you handle a veteran who was started on buprenorphine/naloxone and continues to use heroin? The provider increased the dose believing that when the veteran reaches the therapeutic dose he will stop using heroin. The patient is now on 16mg.
A. We have data suggesting that treatment retention and decrease in illicit opioid use are a function of dose, and the dose may need to go higher than 16 mg. I would definitely push to 24 mg and consider 32 mg if 24 mg not fully effective.
Q: What is the DEA view on harm reduction model for opioid dependence? I agree it is better than not treating, but will a doctor be in trouble?
A. The DEA is only likely to come after physicians running pill mills. A physician prescribing opioids for pain for a few patients who also have opioid use disorder is unlikely to have a problem. However, it is certainly illegal for a physician to prescribe opioids for opioid use disorder and not pain. For those patients it is best for the physician to obtain an X number to prescribe buprenorphine and use that medication to treat opioid use disorder. Then one is practicing within the law.

Q: Smoking is highly correlated with increased pain in chronic pain patients. Reduction or cessation of smoking has been demonstrated to reduce levels of chronic pain. Can you comment on whether or not nicotine replacements contribute to pain levels in chronic pain?
A. I have not seen any studies that address this point directly, though there may be some out there. I think it is likely other toxic components of tobacco smoke plus carbon monoxide reducing oxygen delivery to inflamed tissues that probably account for the adverse effects of smoking on pain. Thus, I would not worry too much about using nicotine replacement in this situation.

Q: How long do you keep patients on buprenorphine? What are your thoughts on Suboxone® vs. Subutex® (I feel more patients should be on the former despite their % side effects.)
A. I would keep patients on it as long as possible since relapse rates after stopping are very high. Patients can remain on buprenorphine and have very functional lives with virtually no interference from the medication. There is no evidence of worse side effects with Suboxone® vs. mono buprenorphine. We very rarely use the mono, and we get very few requests for it. If patients are insistent on wanting the mono, I would tend not to fight that battle and would let them have it unless I see evidence of misuse.

Q: We have many veterans who attend our methadone treatment facility. I have had numerous doctors in the VA that have had issues with methadone maintenance. Does the VA have a general stance on this or is related more to the doctor? Also, are they able to limit patients’ treatment due to them being on methadone?
A. You’re right. These patients face a lot of stigma. Unfortunately, I do think the battle against stigma has to be fought on a physician by physician and facility by facility basis. A mandate cannot end prejudice. Open communication and trying to establish collegiality and educating our peers about the science behind methadone sometimes helps.

Q: Can I continue prescribing buprenorphine/naloxone if a urine drug screen is positive for THC or opioids?
A. Yes, you should continue. That is a sign that treatment should be intensified. I worry less about the cannabis. No one ever died of a cannabis overdose. For opioids I would strongly consider increasing the dose of buprenorphine/naloxone, trying CBT relapse prevention and encouraging 12 step attendance with proper education about the 12 steps.
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Q: Do you have any idea of if whether opioid attrition is mostly in inhalant or oral opioids?  
A. Are you asking about attrition from treatment? And by inhalant do you mean smoking or nasal insufflation? It seems to be all of the above plus injection.

Q: Could SL or rectal buprenorphine be a second line treatment for opioid OD if naloxone is not as quickly available?  
A. Not studied, and I wouldn’t recommend it. I would call 911 if naloxone is not available.

Q: From a Forensic Pathology perspective most jurisdictions will rule manner of death in overdose situations with opiates or combined drug toxicity as 'Accidental" unless a witness or suicidal ideation plan or intent can be documented by collateral sources.  
A. Correct. So it is hard to know whether an overdose is accidental or intentional. Nevertheless, people are dying by overdose after inpatient treatment without MAT so that is a highly vulnerable situation that requires extremely careful monitoring. That is why I overwhelmingly recommend MAT with buprenorphine, methadone, or injectable naltrexone in this situation.

Q: What is the role of Campral ® and Topamax® in MAT for alcohol addiction (i.e., in comparison to naltrexone)?  
A. Campral® (acamprosate) is FDA approved and has a good track record in Europe, but has failed to beat placebo in two large clinical trials in the U.S. I did not discuss it during webinar because there are no studies on it specific to Veterans. However, it is a perfectly reasonable option for patients who cannot take or have failed naltrexone or disulfiram and who can comply with a three times per day regimen. Clinically, I have seen patients benefit from it. It has been used less in VA up until now because it is non-formulary. Topamax® (topiramate) is not FDA approved for alcohol use disorder, but the data supporting its efficacy are very solid. Unlike the other medications it does require a gradual upward dose titration over weeks. It is also a very reasonable alternative if it seems right for a patient or if the patient has failed other options. Subtle reversible cognitive problems such as slight memory difficulties have been noted with topiramate.

Q: Who is qualified to be started on buprenorphine therapy?  
A. Any patient with a diagnosis of opioid use disorder, moderate or severe. For mild opioid use disorder naltrexone is probably a better first line treatment.

Q: Do you think the number patients we treat with buprenorphine will go above 100 at any time?  
A. Since it would require Congress to amend the law, I wouldn’t expect to see that any time soon.

Q: What is the reasonable minimum effective starting dose?  
A. Of buprenorphine? I recommend the initial dose be 2-4 mg, and then if that is well tolerated the dose be escalated rapidly to the range of 12-16 mg within 1-2 days. If patient does not stabilize with 3-4 days continue to go up to a maximum of 32 mg per day.