The Curbsiders: Internal Medicine Podcast
Episode 259: *"Addiction Medicine: Triple Distilled"*
Audio Transcription

Matt 2:31
Carolyn, why don't you start us off with a case prompt that uh, to get the conversation going.

Carolyn 4:03
Today we have Mr. Brandywine. He is a 68 year old male who has a history of spinal stenosis and alcohol use disorder, who has had one prior hospital admission for alcohol withdrawal. Currently, he's coming to you today because he's drinking about one handle of vodka a day. And he's presenting to your clinic looking versus sense for treatment for his alcohol use disorder. His last drink was about 12 hours ago and he comes to you and he's he's really nervous about his alcohol withdrawal. So my first question to everybody is how do you guys approach the management about alcohol withdraw?

Stuart 4:36
Can I ask what a handle is first?

Paul 4:39
Oh, thank you. Yeah, I the same question.

Matt 4:42
Taking taking me back to my college days. The the, I believe it is the it's the bottle that's big enough that it has a handle on it. It's usually a bottle of liquor.

I think it was pretty substantial. I think it's like 1.5 liters. Say it's like twice the normal bottle size.

Carolyn 4:59
Yeah. 1.75 and I did have to Google that though because I never remember.

Matt 5:06
Yeah. Well, okay, Carolyn, maybe you'll have some more experience than this, but Paul, we were talking about this before. Is your number greater than mine? My number is zero for the number of patients I've treated outpatient for alcohol withdrawal. What's your number?

Paul 5:21
It is it is also zero.

Matt 5:23
Okay. Yeah, most of these patients I was my most of my experience with alcohol withdrawal, which is quite a bit is treating them in the hospital.

Stuart 5:31
I've had about between five and 10 that I've done outpatient, a lot of them were veterans who were drinking anywhere from like six to 12 beers per day, and they wanted to cut back and they had very minimal symptoms, certainly CIWA less than 10.

Matt 5:50
But did you just treat them with it, like you just were like, just drink one less beer per day until you're

Stuart 5:57
So no, it really kind of dependent on what their motivation was for quitting. So if their motivation was, hey, I want to go cold turkey, then that kind of changed what the discussion, at least for, for me looked like. And looking at the different symptoms that they had with alcohol withdrawal before to address those symptomatology in addition to addressing the underlying drive to drink, whatever that was. And whenever I have a patient who tells me that they want to quit drinking in the clinic, I probably had have had a lot more than 10, I'm probably under estimating here. But the first thing that we do, because I've got a list that I go through, the first thing we do is try to find a support group before they leave something like Alcoholics Anonymous, we actually call them together and on the phone together, and I introduce myself as their physician, and I have them introduce themselves to and then I leave the examination room and I let them talk together for about 10-15 minutes while I go see next patient. And then afterwards, have them set up a meeting either like the next appointment, sometimes sometimes someone from AA comes with them and we sit down together, or if their spouse is their support network, then I have their spouse come in, we sit down together and have like a discussion about it. Like what the pros and cons are to address underlying sort of drinking, things like that. I have used acomprosate not an insignificant amount of times for these patients. But it really depends on what their risk is for withdrawal. And what exactly that we're treating at that time. I do use a lot of gabapentin, though.

Paul 7:15
Let me take a step back. Because I think that's great. I feel like I have less issue connecting people to resources. Those certainly it sounds like you spend a lot of time and are really utilizing continued support structures, and that's terrific. I think for me, the concern is more about the potential lethality right. I don't want to right inadvertently kill my patient by telling them Oh, yeah, no, you should probably stop today, though. It sounds like I mean, that's the overwhelming minority or people that had to get into trouble with that. The question before is, is who is safe to manage in the outside in the outpatient setting? How do we figure that out? And I might actually toss that to Carolyn, who probably has more experience with this than I do?

Carolyn 7:48
Yeah, I think especially because of COVID. I've been not wanting to send patients to the emergency department. And I've been having my patients go to the emergency department not experience withdrawal symptoms and then get discharged home. So making it more difficult to decide how do we manage this because I think sending someone to the ED now is not a zero harms game. So I think if somebody is high risk, so someone's had seizures, been in the ICU has had complicated withdraw DTs, those are patients I'm absolutely going to send to the hospital or a detox, there's no way I'm going to feel comfortable managing that and that outpatient setting just because they're high risk, but for other patients, you know, who have a relatively stable home environment, someone who's going to be around to help them out, hasn't experienced some of these complications maybe has been admitted, but there CIWAs don't get much higher than moderate, you know, you know, 10 to 15. I will do it outpatient. I like to do it on a Monday or Tuesday because sending someone home on Friday always makes me nervous and not knowing if they'll have a backup. And my go to regimen is it's pretty simple. For diet, I use diazepam, and I do like 4321. So I send people home what 10 milligrams of diazepam, I tell them for the first day, they can take up to four doses, so about every, you know, six hours, then the next day up to three doses, so every eight hours, then two every 12 and then one and my patients seem to do pretty well with it. I send them with an extra tab just in case and I've had a decent amount of success with it.

Matt 9:19
And Dr. Suzuki, I think his cut off for CIWA was see what less than 10 and he said and but many of the same things he didn't want anyone have like a super high alcohol level when he's seeing them like but he basically said that, that gabapentin is an option. And the dose typical dose is like 1800 to 2400 milligrams per day. Continue that for several days and then taper the patient off of it. Personally I've never done that. And I don't know. I don't know how comfortable I would feel doing that. Is that something you're seeing done Carolyn?

Carolyn 9:55
I have not done it myself. though. I they though I have have had colleagues who've done it or we're probably a lower risk, you know, I'm in terms of withdrawal and are really, you know, stopping alcohol for the first time and, and

Stuart 10:10
it almost seems like a fairly high dosage to start at though.

Carolyn 10:12
So I do we do like 300 every six hours to see if they titrate it and again, sort of taper down from there with extra doses. Or at least that's what I've heard colleagues do. ACM actually has these really great like pocket guidelines for dosing of alcohol use and alcohol withdrawal that are helpful, which we'll make sure to like link in the show notes. But I think they're pretty user friendly

Paul 10:37

74 typed pages.

Matt 10:38
So to recap, Stuart was giving a lot of advice about more of like the connecting to resources, acamprosate is a maintenance medication, not for that will not help you during the detox period. And then Carolyn's regimen is diazepam 10 milligrams. And again, this is all expert opinion. I don't think there's a lot of like strong guidance on what we're doing here. But we'll, we'll check out those resources you showed us so Carolyn, it was 10 milligrams for three to one, basically, the number of tabs they be taking over successive days and you're really trying to select a low risk population, ideally, someone with some resources at home It sounds like.

Blank 11:18
Exactly and then the beauty of it is if you do it during the week, you know and something goes awry. You know, your office is open Yeah, I make sure people know that they go to the ER if they're, they aren't feeling right, that they're feeling worse.

Matt 11:29
This is someone that you want to have your office on speed dial and that you're kind of waiting for that that call okay. I think I can get on board with that I that that might be something I think it was the right patient and if I had some familiarity with them, I might be likely to try something like this use the gabapentin or the diazepam, just depending on on the patient. And their comorbidities like if they were on high dose opioids I probably wouldn't be doing the diazepam taper. Okay,

Blank 12:02
let's say Mr. Brandywine, though we decided to risk so I decided that I want to admit him to the hospital because on my history, he's clearly saying that he has a history of seizures related to alcohol withdrawal. So how would you guys actually decide to treat his alcohol withdrawal in the hospital? Like how would you decide whether you're wanting to do like a symptom triggered fixed benzo taper or maybe even phenobarb?

Stuart 12:25
So so for me if they have a history of seizures, I usually put them on scheduled benzodiazepines with PRN and I try to use the same benzodiazepine. My favorite is actually diazepam as well because of the pharmacokinetics. But I mean, I've seen Lorazepam and I don't know, you know, when there had been a night float around there lorazempam, I don't like scream at them, but certainly would would prefer that as a Pam, and then taper down from there. And then I also taper down the fixed dose as well. So it's kind of a little bit of both. That's the way that I approach it though.

Matt 12:54
It's interesting, I want you to expand on the diazepam pharmacology. I just wanted to point out

Stuart 12:59

so it depends on if it's IV or PO. Yeah, so so IV diazepam has about the same half life as Lorazepam. But the PO has a slightly longer half life than the PO Lorazepam. And I'd have to look at the actual lipophilicity, but my understanding is that diazepam is also a little bit more lipophilic than Lorazepam. So it sticks around longer, even though it's half life. So it's even beyond its half life. It helps for like, prolonged symptoms as more like a controlled medication. But what I don't like to do, I don't like to mix different benzodiazepines because they have different pharmacokinetics at the receptor itself. So one is going to be slightly more affinity has slightly more affinity than the other so they're always going to work as like partial agonists or antagonists to one another. And I don't know which is which when it comes to like a Lorazepam diazepam, so it makes sense to do like pure and Lorazepam with diazepam.

Matt 13:51
I remember Dr. Suzuki said that he he prefers diazepam because it has a quick onset. And like you said it has by orally at least it has a little bit of a longer half life. Though I think one of the tiebreakers was if someone has liver dysfunction then there's a couple different agents, Lorazepam being one of the ones that is not metabolized by the liver. Carolyn, how do you think about the fixed dose versus versus the symptom triggered symptom trigger being like the CIWA protocol, probably what most people are used to.

Carolyn 14:22
Along the same lines as Stuart if someone has had you know, someone comes in and they end up in the ICU nearly every time for alcohol withdrawal. I'm just going to start them at a fixed taper if I think they're at high risk of developing a complicated withdrawal. Otherwise I think symptom is preferred for most individuals just because it prevents overmedication and you know, you can always adjust course you know, early on if you do symptom triggered there, CIWA still going up and you feel like you're getting behind you can always just switch to fixed plus the symptoms plus symptom trigger on top.

Stuart 14:53
The only times I've had a negative outcome when it was an alcohol or benzo withdrawal patients. The patient is when I didn't use a fixed benzo dosage when I just use symptom trigger dosing. Now granted, they may be overly sedated if you put them on a fixed dose, but at least from my experience a very limited seems to be a safer option for these patients.

Matt 15:12
Yeah, I think Dr. Suzuki one thing that he was mentioning is that he, he does see that some patients sometimes you can't tell if they're delirious from the withdrawal, or if it's the benzo toxicity. Carolyn, do you have any tricks for for avoiding that other than symptom driven? I don't really know. It just seems like a hard thing to figure out.

Carolyn 15:34
It is hard, I think time you know, timing onset during the course looking at their CIWAs, I feel like it's playing a lot of information together. And then making sure before you stop and pull back that they're really out of that withdraw period. I think Dr. Suzuki made a good point to that, like

the first two days of withdrawal are really the golden period that we really want to like try and get symptoms managed as well as we can then it'll help us minimize complications further down the line.

Matt 16:04
Yes, that was like one of those things that stick that has like stuck in my head. And I like to point that out to, you know, whenever I'm working on this on the service, and we have somebody admitted with alcohol withdrawal, I'm like, Okay, these first 48 hours, this is really crucial. It's going to dictate how the course goes. So we want to keep a close eye on this person and make sure we don't get behind. Paul, you look like you're gonna say something?

Paul 16:27
I just I remember back in the days of early residency, when we were, you know, you know, adjusting humors and stuff that we were using like a PRN Lorazepam just kind of per nursing discretion, like it was just like, you know, baby dose of Lorazepam every four hours, PRN, like it was not protocolized in any way, shape, or form. Yeah. And then you'd never had seven bad things would happen. And then it's just so I think that my bigger takeaway from all this is to have something protocols, whether it's sort of a fixed dose, or it is a CIWA protocol, but don't just try to wing it, because that will not go well for you.

Matt 17:00
And I think for time, we should move on to a little bit of the maintenance treatment, which we had hinted at a little bit earlier. Let's say we get this guy through the course Actually, he got a fixed dose of phenobarbital because we thought they thought he was high risk. And he did just fine itself tapers, you can listen to the episode 212 with Dr. Suzuki, if you want to hear more about that. And now, Mr. Brandywine is Carolyn, we're going to discharge him. And one of the things that struck me about this, the maintenance medication is that that I think it was our our guests when we were talking more about outpatient alcohol use disorder, she said she recommends you start an inpatient because a lot of the times the primary doctor will not start it. But they will continue it, which I thought was great advice.

Stuart 17:47
Can I ask a quick question first? What what percentage of patients would you say, who have been admitted for alcohol withdraw should be started on a long term treatment option at discharge? Carolyn?

Carolyn 18:01
I'd say 100%. If they're interested, and that's their motivation. Right. I think that if someone's not interested, or it doesn't feel like a good fit, I don't think every patients, I don't think we forced this upon patients. But I do think it's under prescribed and it could benefit many of our patients, especially in Addiction Medicine hospital, it's such a reachable moment, like we talked about with Dr. Weimer to actually engage patients in treatment for their substance use.

Stuart 18:29

So the reason why I ask is because it's it's actually one of the quality metrics for your TJC, that at discharge, you have to offer it to them, if they've been admitted for alcohol withdrawal. It's a requirement actually. And that's one of the metric measures that hospitals are measured against. If you don't document that was offered, it actually counts against your metrics. And for those patients who are interested, who are not prescribed at discharge, that's a huge fail. But a lot of us don't realize it's actually a requirement.

Matt 18:59
So Carolyn, if if someone has never prescribed naltrexone for a patient before they're going to be discharging somebody or it can proceed, tell us what's your approach? And what would that sound like if you were about to start Mr. Brandywine on naltrexone own, like, what do you have to look out for? And what would you tell them? What side effects or anything?

Carolyn 19:18
Yeah, I want to say first of all, these medications are really easy to prescribe. So don't be worried. Don't be afraid about it. You can always call your local addiction, console service if you aren't sure and maybe even just turn it into a Curbside Consult. And so I think generally for most of our patients, we recommend naltrexone as first line therapy, it's really important to know when is now trek zone country indicated. So it is contraindicated and patients were using opioids because it is an opioid antagonist. Patients who I foresee having surgery you know, in the next week or two patients who have some of those factors should not be started on it, and it should be used cautiously and patients with decompensated liver or acute liver disease Because there is there are some small studies suggesting that it could cause hepatic toxicity. Though in general, mild LT elevations are not a contraindication. And generally, they often improve because an individual has cut back on their alcohol use. The starting dose I use is 50 milligrams. And the most common side of extra is like a little stomach ache, a little bit of nausea. But generally, it's pretty well tolerated. And you can always just cut it in half for a couple days. And then have the patient increase, and it's great like the number needed to treat for now Trek's own to prevent someone to return from heavy drinking is 12. Like, these meds are pretty effective. I think it's important to know too, if a patient comes in and is on naltrexone, and they're still presenting and saying they're having alcohol use, you don't need a complete abstinence to continue these medications. Right. cutting back that is a successful metric and an outcome for these patients.

Matt 20:54
That that was part of what blew my mind during our journey into substance use disorder, which is something I had no treatment, I had no real education on it in medical school, at least not that I remember. But the fact that abstinence was just all that it was ever, like, in my view, when when ever substance use was talked about alcohol, opioids, anything, it was always like abstinence, abstinence, abstinence. And then when you actually meet patients who have it, it's not always in the cards for them to become totally abstinence and where that's where this like harm reduction, just like getting them to cut back is a it's a small win, but it's it's a win. And you just work with them. And eventually, if they get to the point where they can be abstinent, that's great. But these are any any tools you can give them to cut back, I think is a win.

Paul 21:42
Absolutely. Let me ask about one of the other agents. So you mentioned naltrexone. I think acamprosate is the other one that is commonly used is disulfiram. I think there's a very small sliver that might be that might be appropriate board for the acamprosate. I wonder if you couldn't talk us through who that's best for. And then also, I feel like I'd heard there, there's a recommended use a period of abstinence before starting it. And I wonder if if I'm misunderstanding that or if that's correct or not. So if you can sort of talk us through who gets acamprosate now you prescribe it for them? That would be really helpful for me.

Carolyn 22:11
Yeah, I think everybody else gets acamprosate, generally. not currently. Right. So it sort of has the benefits of it's not contraindicated for the same reasons that naltrexone are right. You know, you can use it in people who have hepatic dysfunction and severe liver disease. You can use it in people who are on opioids, it is renally dosed, I always have to like double check and make sure that someone's creatinine clearance is okay. And you can use that it is a high pill burden, it's like 666 milligrams three times a day. So 2 pills TID, those sort of like expert opinion, my patients are not taking this medication necessarily six pills a day, but I do think that anecdotally Some are describing benefit from it. And in regards to, again, it's like effectiveness, the number needed to prevent number needed to treat to prevent return to any drinking is 12. So pretty effective. And then Paul, you alluded to the there are comments about how we often ask patients to be abstinent before we start these medications for a couple days. And that really is because that's how the studies were done. So there were a period of abstinence and that they started the medications is when they're completed detox and had a certain number of days which I can't recall off the top of my head. So oftentimes, you know this is just like how they studied it right. And I think in the real world, you know, we're more flexible. Generally I will just started at discharge for a patient and not start in the hospital per se but if somebody is nervous about it and wants to try it, you know, I say go ahead of anything that will help the patient feel comfortable trying some of these medications.

Matt 25:31
Well, I think we need to move on to talking about opioid use disorder. Carolyn, do you want to tell us about our second case prompt here?

Carolyn 25:40
Yeah, we have Mr. Lotot. He's a 56 year old man who has spinal stenosis, who's currently on chronic opioid therapy. And his doctor was prescribing his pain management regimen. And he recently retired and he's coming to your office today for you to establish as his new primary care doctor. Currently he is taking Oxycontin 20 milligrams twice a day and oxycodone 15 up to four times a day as needed, he does tell you that he sometimes takes extra doses of his pain medications. And at this time, he actually doesn't feel like any of his opioids are adequately controlling this pain. And actually, it's coming to you to see if you can increase his dose. My first question to you guys is how would you approach this this patient who's establishing with you? I

feel like this is a common scenario where patients on opioids and you're you're inheriting them for, you know, x y&z reason?

Matt 26:32
Yeah, I think Paul, you should, you should take this one.

Paul 26:35
Sure, I can give it a go. And then you can you can critique after I'm done, but I feel like I don't know since I started dealing more with opioid use disorder and actually prescribing few fairly frequently, I become much less militant about this. I don't know about you all. But the story that I hear over and over again, is I was prescribed higher and higher doses of pain medication for my chronic whatever. And then my doctor got nervous and cut me off. And then I had to get something somewhere. And now here I am. So I, I've become less excited about sort of decreasing chronic opioid use without consent or a patient conversation. And I'm much more likely now to continue a medication regimen while we kind of figure out what our goals are and how to get them there. So for for me and this particular patient, obviously, this theoretical patient, but I would probably actually continue things and have a long and measured conversation about where I hope to go from here where the patient has to deal with this and sort of what our mutual goals are and how to best address those things. I know this is all kind of vague, nice, Nellie isms. But I think I would not immediately cut off or refuse this patient care for their chronic pain. And I would probably discuss where to go from here and how we can get the patient to a safe and effective place.

Matt 27:35
One thing that I think is just so important, that was not being done, probably from the 90s, mid 90s to early 2000s. Whenever this opioid craze started, was, you have to have an exit strategy. If you're going to start someone on opioids, you have to have the conversation upfront like so that the patient respects the medication, the risks of the medication. I think our guests when we were talking about chronic pain, they said you tell patients that there is a not insignificant risk of opioid use disorder, if they do this. There's osteoporosis, there's hypogonadism is a is another side effect. And you know, some of that will turn patients off when they when they hear the word that they might be when they hear that they might become like dependent on the substance. They're just like, some patients will just say no, I don't want that. Yeah, so have an exit strategy. And then yeah, there's I think this is a very common scenario. Carolyn, what do you for patient? for this case? I mean, it seems to me a red flag with the patient's taking extra doses. So how would you assess this? And because they're asking for increased medication, and probably the gut reaction is like that, should we should we taper them off?

Carolyn 28:45
Yeah, it's, uh, I feel like these cases, they sound so simple. And yet they're so complicated. They're so complicated. So it seems simple. And but I think on first meeting this patient, building rapport is really important and getting to understand them, their history, their story of pain. And, you know, depending on the situation, if there really no adverse harms, or effects that I can see, I sort of probably go with what Paul is saying, you know, let's continue, let's to get to know each

other, and let's see what the long term goals are. But I think overall, I'm thinking in my head in terms of like, thirdly, really big buckets, which is, you know, maintaining long term opioid treatment versus tapering down or switching to buprenorphine, really as as the three options and if someone's pain is poorly controlled, you know, they could have a component of opioid induced hyperalgesia where you start to taper and they actually start to feel better. And we discuss this too with with Dr. Azhari. And I have anecdotally you know, I mean, I have seen that in practice.

Matt 29:49
Yeah, the taper. There was I think we mentioned this on a show before there was a I think it was on fresh air Terry Gross hat on. I think he was a journalist of some sort who had been in a motorcycle accident needed a surgery and then became opioid dependent. And the surgeon just like abruptly cut him off and he went through horrible withdrawals. Then he went down the rabbit hole of trying to find out about this and realizing that doctors don't know what they're doing. They know how to prescribe opioids. They don't know how to taper them. So Carolyn, what's the recommended strategy for someone like this guy? He's been on opioids for years. So how long might it take to taper him if he's taking? What is this guy on a day? Is it like 100 of oxycodone equipped something around there?

Stuart 30:32
Yes. 100 total. Yeah.

Matt 30:35
Which is like a lot. Yeah, I say

Carolyn 30:39
that a lot. So first, step number one, calculate the total MME, that's very helpful. And then you know, you do it slowly taper slowly go taper down to the 10% of the total mme per month. Sometimes you can do a little bit faster per week. But if someone's been on opioids for years, generally, the taper is very slow, very patient centered, patient driven. Sometimes you even slow it out and extend it sort of in the middle. And towards that end.

Matt 31:05
Have you done this in the hospital, because I've noticed, sometimes I'll get a patient that comes out of intensive care. They've been here for a month, they're still on opioids, and they're like, using a lot of the doses and and then I'm like, Oh, my gosh, this person has been here for three weeks or four weeks, and they've been on continuous opioids. Now I'm gonna have to send them out with a taper. That's just kind of a mess that I would prefer not to get myself into, but it happens from time to time. Are you seeing that to Carolyn? I saw Paul.

Carolyn 31:32
Oh, yes. It's It's a mess. And I send them to me and an outpatient. Right. Right. And then I'm calling like, you know, short term rehabs and doing all of these care coordination things? They're, they're challenging situations, for sure.

Paul 31:46
Well, I guess it goes like Dr. Gertz wrote a really beautiful piece. I think for some other authors about like the the actual ethics behind nonconsensual tapering of chronic opioids, which is we can link to it in the show notes. It's really beautifully written. But I you raised the both of you raised a great point. Like I think it's also really important to address why you're tapering with the patient, like we shouldn't be doing it just because the CDC says to do it, or because you just don't like the dose because the number of seems weird to you. Like that's probably not a sufficient reason in and of itself. But if they're, I feel like oftentimes, these patients end up on chronic opioids for things that chronic opioids aren't indicated for. So if you'd like, I'd like to actually get you to a treatment that is effective for you, that's a reasonable thing to do, or I think this dose is unsafe, and that's why we need to decrease it because there are behaviors that I'm concerned about, that's a reasonable thing to do, or I'm worried about the side effects and on and on and on. But I think it's, it has to be shared. And you have to be explicit as to your reasons why because if you're doing it just cuz you're like, I just don't like it. Like I don't know, any patient who's going to buy into into that treatment plan that they feel like their pain is adequately managed on the dose that they have.

Stuart 32:42
How about the fact that it's super easy to prescribe these but not really super easy to give them? Anything else to get them off of it? We were talking about that during the pre recording. I don't know how you want to talk about that. With the buprenorphine?

Matt 32:57
Yes, That's a good question. And that is a good point. The many of our guests have said to us, there's this super dangerous group of medications, opioids that have a lot of harm associated with them that anybody can prescribe pretty much. And then there's this medication that's fairly safe, buprenorphine, and very easy to use, that you have to go through a training course and do all this pay extra money. So in some cases to get to get wavered to do this. I guess recently in news, we were all hoping this was going to go away. But it looks like that's not going to be the case. But it's just there. There is I think appropriately. So a lot of people advocating for this doesn't make sense. Like we have this. You have if you're going to prescribe a medicine that has this harm associated with it, then you need to be able to treat that harm. And buprenorphine is the most easily available medication to do that, because most of us cannot prescribe methadone. We're not working at methadone clinics.

Stuart 33:54
Right. And, Carolyn, you had an interesting point that you that you made about this, that one of the concerns behind the whole X waiver process is diverting buprenorphine to the community. What does the data show about communities that have a higher buprenorphine diversion rate?

Carolyn 34:15
Now you're gonna know I'm gonna have to pull up that paper they cited in the show notes. Exactly. So so we may have to cut this but I believe there is a paper out there that supports that

communities with rates of diversion of buprenorphine actually have lower overdose rates because, you know, we want to keep buprenorphine out of the hands of opioid naive, naive people, you know, we don't want like kids teens, you know, to be exposed and develop opiate dependence, but the majority of the people are using it to prevent withdrawal and to self medicate because they can access you know, evidence based treatment. I think that is what the vast majority probably 99.9% of people are, you know, expert opinion or are using these medications for

Matt 35:01
Can we talk about the Oh, go ahead, Paul, then

Paul 35:03
what I know this is one of those no formed thoughts, but there's that great vague statistic that I'm not gonna build remember now about diverted antibiotics being misused far more commonly then divert it's so easy to read is, is used appropriately for the things that it's used for the indication that it's made for I suppose the antibiotics are often diverted very commonly, and are not used appropriately at all. So it's just it's funny, sort of where our priorities,

Matt 35:24
I can't tell you how many times someone goes, Oh, yeah, my brother in law or my sister had some antibiotics. So I just took that.

Okay, so Mr. Long term opioid treatment, he actually says, You know what, this has never worked for my pain at this point. You know, we we get his we get some buy in where we're seeing him for a while, we taper him down a little bit. He says, You know, I think I want to come off this, but I'm just worried like, what am I going to do for my pain, and he's been on it for so long. So I guess one of the options you already mentioned is you can taper him to to 10% per month, maybe you can even go down weekly, depending on how long they're on it. But it let's if we didn't calculate it exactly. But if he's on like 200 milligrams morphine per day, then that means we might go down by 20 milligrams per month. So that might take him 10 months to get off of it. And we might even have to go slower. That would be if we weren't at 10%. So we might even have to go slower. So this guy might, it might take a year or two to taper this this patient, which is why this situation is such a mess. There's so many patients in this situation. Carolyn have you cross tapered over to buprenorphine as like their long term controller and using it for both pain and just to satisfy their the opioid use that they were on for so long?

Carolyn 37:05
Yeah, there's this wonderful opioid reassessment clinic and this is a portion a portion of what they do for patients who are on long term opioid therapy. And when we talk about switching, you know, it's nuanced, and every patient is different. And for patients who do opt to switch and try buprenorphine, we started presenting like two options to them, we could do sort of a standard induction where we stop all the opioids, you know, wait until they're in mild withdrawal and then start the buprenorphine. Or we can do a process called like micro dosing, where we give small, tiny amounts of buprenorphine over a period of a week or so a patient doesn't have to

experience withdrawal, because withdrawal is pretty unpleasant. And it's, it's, it's a tough buy-in and and something that probably isn't necessarily needed, depending you know, on what the situation is and patient preference.

Matt 37:59
Okay. Yeah. And the reason you can't give buprenorphine and I think we should go into talking about buprenorphine initiation, maybe for a different situation, but buprenorphine has a super high affinity for the opioid receptor, right the mu opioid receptor. So even if someone's on a full agonist like hydromorphone, morphine, the buprenorphine will knock it off the receptors and they'll have a relative decrease in how much opioids are in their system or how much mu opioid agonism they're feeling is how you think about it. That's kind of how I think about the precipitated withdrawal from Buep.

Carolyn 38:37
My co fellow I should say, he gave me this great analogy. I'm Sean Koh, and if you have you listening, so he likes to use like the speeding car analogy. So he says, imagine, you know, you're on opioids, and it's like a car that's racing down the highway at 100 miles per hour, right. So you have like full activation, full speed above your mu receptors, and then say all of a sudden somebody gives you buprenorphine, which is a partial agonist with a high affinity. It's like you're slamming your brakes down. So you're going from 100 to 50 miles per hour, you're gonna feel that, alright, well, you're gonna feel that acute drop. And that's what happens if you pull opioids in your system. So micro dosing is the idea that I'm giving teeny tiny amounts, so they aren't going from 100 to 50. They're going slowly from like 100 to 95 to 90, so it's much more gradual, and most patients and individuals don't feel much at all of that deactivation and breaking process.

Matt 39:31
A situation that comes up a lot. I know we have a lot of hospitalists that listen to our show, or or if even if we just have somebody that you're seeing as an outpatient, and they want to start buprenorphine, they let's say they have an opioid use disorder, and they now want to be switched over to buprenorphine for maintenance therapy. Carolyn, what would we what would that conversation sound like? How would you instruct that patient? What do we need to do to in order to get them on buprenorphine without too much discomfort?

Carolyn 40:04
Yeah, so I always make sure I offer my patients all three evidence based medications. So methadone, buprenorphine, and naltrexone. Most patients have experience with a lot of these. And if a patient starts buprenorphine, what I do is in the hospital, it's relatively easy because I can monitor their symptoms and check their COWs scores. So I'll monitor their cow scores. And if they don't have exposure or known exposure to fentanyl, I'll wait until their cutoff scores are greater than eight. And then I will give them four milligrams of buprenorphine a couple hours later, they're still feeling like they're in a little bit of withdrawal. I'll give them another four milligrams and see how they do and add add drugs like clonidine, hydroxyzine, trazadone,

things like that tohelp make it more comfortable until they feel like they're no longer experiencing withdrawal.

Matt 40:52
And for patients who have a pub, have you run into this because I have had one or two people and I felt totally awful for this where I thought that they were in enough withdraw. We gave them the four milligram dose or in one case, I gave them a two milligram dose they were fine. Then we gave them a four milligram dose couple hours later, and then they precipitated. Have you have you had issues with that? And do you are you are you skittish about it? I think there was some long acting opioids involved in these cases I'm talking about.

Paul 41:22
It's I've been very fortunate that I've not done that because I do live in terror of it. And I think I am very skittish about it and tend to ask very explicitly about fentanyl even though that's not a guarantee of anything, just because sometimes you don't even know if it's present in sort of the substances you're using. So I've not been I've not personally sent anyone screaming to precipitated withdrawal, but I'm still waiting for it to happen. I think that's just a matter of being lucky and not wise.

Matt 41:45
Do you know Carolyn, do you know what this is? The fentanyl it's supposed to be super short acting right? And it's it's supposed to theoretically be heroin we think is a six to 12 hours time and fentanyl theoretically should be in the same time. Why does it seem that sometimes patients they haven't used fentanyl for quite a long time, but then they still may precipitate that's that was one of the cases that I talked about. The other one was a methadone where we thought we waited long enough and we didn't.

Carolyn 42:12
Yeah, your fentanyl is very short acting. So it seems like paradoxical, right? Like how could I be precipitating withdrawn with this short acting opioid. But the key property to remember is that it's very lipophilic. So individuals who have a lot of fentanyl use, it's actually getting stored and their and their adipocytes. And over time, it's actually slowly expanding back out into the plasma. So even though it has like a short plasma life, it actually sort of mimics some of the properties of these long acting opioids. So I've definitely precipitated withdrawal in patients who have had fentanyl exposure, and it's been making my buprenorphine inductions much more complicated. Yeah, so I like to present a menu of options to patients. And there is I can cite this paper, there's a paper about this revised buprenorphine protocol, we actually give smaller and more frequent doses. So your way to number one, a cow score is greater than 13. So you give it a little bit more time for that fentanyl to sort of try and leak out of those adipocyte cells. And then you give two milligrams more frequently, every 60 to 90 minutes, probably up till you know eight to 16 milligrams on the first day, possibly even higher, depending on their their withdrawal scores. And, and that will, hopefully help minimize the chance of precipitated withdrawal.

Paul 43:28

What's this setting like for this initiation? And sort of what is the follow up look like is it seems that seems very labor intensive, and requires a fair amount of supervision. And I where I feel like the typical office based initiation, you just don't see that, I guess, at least in my limited experience.

Carolyn 43:45
When I do it in the office, I try and make it as simple as possible. If I know patients, some of my patients just now and the urine reflects that, like they're spent in all, I'll say, Wait 48 hours from your last opioid use that will roughly get most patients to cows of 13. And then I'm giving them four milligram foams and telling them to cut and then take them every hour or hour and a half, up till 16 milligrams on the first day or one, whatever they stop, you know, feeling like they're in withdrawal. And I'll just call them in a couple days.

Matt 44:16
And then a precipitate. Do you have any instructions? What to do? They just still just keep going with every hour and a half, two hours.

Carolyn 44:24
That's what I encourage them to do. I think it really depends on the level of severity. Yeah, I found that using this method, and most of my patients are saying, Oh, I feel like I get a little bit of withdrawal. It is not untolerable so I make sure they have all the adjuncts, clonidine, etc, to help get them through that. Yeah. And then the patients who really can't tolerate it, you know, sometimes they come back and we talk about micro dosing. We talk about methadone, we present sort of a menu of options, right?

Matt 44:52
So methadone patients have to go to a clinic. There's some stigma associated with that. Some patients want that some patients not the stigma, they want methadone, some patients don't. And I think with the with the micro dosing, the film's come in this these foil packs, so you can cut it while it's still in the pack. And I actually talked to one and this is total expert opinion, one doc from a methadone clinic and they told me they cut an eight milligram strip into eight strips. So essentially one milligram and they're micro dosing with one milligram strips instead of two. And Dr. Weimer, who's been on our show talking about Addiction Medicine has a protocol for buprenorphine, micro dosing that we can link to as well. So, like we said, going from 100, down to 50 miles an hour, but you're doing it by gradually putting your foot on the brake rather than just slamming it all at once. I think we actually need to start to wrap up. I know we were hoping to go through some other stuff, but there's just so much to talk about. We have so many shows on Addiction Medicine, people should definitely check out the full episodes. This is just a more of a refresher, chance for us to talk about it. Is there anything any big things, Carolyn, that you think we're missing from this one?

Carolyn 46:09
I think that's it. You know, treating patients with substance use disorders is very rewarding. So I encourage everybody to give it a try. Get your X waiver if you haven't until we know whatever

the fate of that may maybe try starting medications for alcohol use disorder. It's really a rewarding your patients need you so give it a go.

Matt 46:31
And I know we said we were going to talk about benzo use disorder. That was Episode 2224. We talked about it with Dr. Weimer so people can check that out. We spent a little bit of time talking about benzo tapers, but for chronic benzos they got to be very slow just like with chronic chronic opioids. That's that's what I'll say about it. And Paul, did you have a parting comment?

Paul 46:52
Yeah, we didn't get to it. But I just a quick reminder that perioperative management on patients who are on buprenorphine or actually anything for opioid use disorder, just talk to the patients and and also like talk, talk to the surgeon and have some sort of plan around the time of the operation. It's a nice reminder is that you don't necessarily have to stop the group morphine and you can sort of work around that. But that's I mean, that's we did a whole episode about that. So refer to that, but just don't forget to talk to the patients during times when you might actually need to change their medications around a little bit.

Matt 47:17
Yes, absolutely. Absolutely. Okay. Well, Paul, I think we should get to the outro

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