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The Rise and Risks of Methadone Prescriptions

RISE IN RISKS OF METHADONE PRESCRIPTIONS.

A drug that first gained prominence as the treatment for heroin addiction, methadone is now more commonly prescribed by medical practitioners for range of severe pain. Why we have seen this rise in methadone use, are we as prescribers doing everything we can to understand the risks of methadone and to ensure that our patients are aware of the dangers as well.

You are listening to ReachMD, The Channel for Medical Professionals. Welcome to the Clinician's Roundtable, I am your host, Dr. Mark Nolan Hill, Professor of Surgery and Practicing General Surgeon and our guest is Dr. Howard Heit, a nationally recognized Chronic Pain And Addiction Specialist practicing in Northern Virgin and an Assistant Clinical Professor at the Georgetown University School of Medicine.

DR. MARK NOLAN HILL:

Welcome. Dr. Heit.

DR. HOWARD HEIT:

Thank you very much for having me on your program, Dr. Hill.

DR. MARK NOLAN HILL:

Dr. Heit, methadone is now the fastest growing cause of the narcotic deaths in the United States. Could you explain?

DR. HOWARD HEIT:

Well, I think there are couple of reasons for this, is that methadone previously was used mainly for treating the disease of addiction, and I am certified in that particular area of medicine, but also methadone is being used increasingly more for pain management and the reason it is being used more and more for pain management is that it is an excellent medication, it is the cheap, but it is un-forgetting medicine if used not knowledgeably or prescribed with the knowledge of pharmacokinetics and pharmacodynamics of the particular medicine.

DR. MARK NOLAN HILL:

If you would review for a second, why and how it is used in heroin addiction?

DR. HOWARD HEIT:

Well, we have above a million people who have addiction to heroin and only 250,000 slots of opioid treatment centers. And what methadone does, it goes to the new receptor site, the same receptor site that heroin goes to and essentially extinguishes the cravings for methadone and this has been used since the mid 60s for the treatment of the disease of addiction. It was pioneered by a wonderful physician, Marie Nicewander and her husband, Vincentdall who started the first Methadone Clinic in New York City. It is very successful in regards to treating the disease of addiction, especially heroin addiction or any prescription opioid addition.

DR. MARK NOLAN HILL:

And how would we get to using it for patients with pain?

DR. HOWARD HEIT:

We got to use it with people who have pain;

1. Because it is an excellent analgesic needing a pain relieving qualities.

2. In this day and age where brand medicines, cost a lot of money, it is essentially cheap as far as a pharmacologic product because it has been around so long and is available in a generic form and is very cost efficient to use.

DR. MARK NOLAN HILL:

Although, it is the fastest growing cause of narcotic deaths in United States.

DR. HOWARD HEIT:

Well, again, what I have a problem with, is a tail wagging the dog or the dog wagging the tail.

DR. MARK NOLAN HILL:

What you means sir?

DR. HOWARD HEIT:

Well, what we mean is that what we get publicity about the downside of opioid pain management whether it would be methadone or controlled use of oxycodone products or other products that gets the headline, but the headlines never come out of <_____> gets her life back with appropriate rational pharmacotherapy with methadone, when someone returns to work and is able to support his or her

family with appropriate pain management with methadone. We never hear about the good stories. We always hear about the bad stories in the media or the press.

DR. MARK NOLAN HILL:

Why is that?

DR. HOWARD HEIT:

When we say it is not about the money, it is always about the money. Good news does not sell and bad new sell.

DR. MARK NOLAN HILL:

Well, should primary care physician start using methadone instead of OxyContin or should they go to someone like yourself or pain specialist. Who should prescribe this?

DR. HOWARD HEIT:

Well, I think very strongly whenever a physician or healthcare provider prescribes a medicine, he or she should know the pharmacodynamics of the medicine and the pharmakinetics of the medicine. What is pharmakinetics? Well, that have to do with drug absorption, distribution, binding, excretion, but the easy way to remember pharmacokinetics is what the body does to the drug. He/she should also know the pharmacodynamics of the drug. The mechanism of which the drugs produce the effect and again the easy way to remember that is what the drug does to the body. So, if you are going to use any medication and I do not care whether you are using it for pain management or a drug for pulmonary disease, you have to be familiar with the pharmakinetics and pharmacodynamics of that drug or you should not prescribe it.

DR. MARK NOLAN HILL:

Well then how is methadone different than the OxyContin in terms of the pharmacokinetics and the dynamics?

DR. HOWARD HEIT:

Well, there is a big difference. Big difference. Methadone is a more complex medication pharmacokinetically and pharmacodynamically. It has a bearable half life meaning that, I know if I have used I controlled the oxycodone product then I am going to get a steady state blood level in 36 hours, but the path life of methadone has a marked individual variation anywhere from 14 to 40 hours.

DR. MARK NOLAN HILL:

Why?

DR. HOWARD HEIT:

That is just the way it works. I cannot tell you that, but it also works on other receptor sites. It is an antagonist on what we call the MNV receptor site and that may have to do with tolerance of the medications and if we have looked at all the deaths secondary to methadone, they usually occur in the first 2 to 3 weeks whether that methadone was used on the street illicitly prescribed a in opioid treatment center for the treatment of addiction or used in pain management.

DR. MARK NOLAN HILL:

And your thoughts about that.

DR. HOWARD HEIT:

It has occurred for 3 reasons. The initial dose was too high. It was titrated up too quickly or there was a drug-drug interaction that changed the blood level of the drug.

DR. MARK NOLAN HILL:

But how do you know, how to start and when to start and what to give exactly.

DR. HOWARD HEIT:

The key is to go very slow and go conservatively. You got to think about it logically. You could always add to the medication if you need more analgesia, but the patient could always call you and say doc the dose isn't strong enough. I am still having my pain #7 while you are trying to get it down to #4 or 5, so I could always add if necessary, but it is very hard for me to get it out of your body when you are having respiratory depression and not breathing and fall on the floor, it is very difficult to reach for the phone and call your doctor under those circumstances, so the key is always is always to be very conservative in your dosing and titrate to affect.

DR. MARK NOLAN HILL:

And what about interactions with other drugs that are commonly used?

DR. HOWARD HEIT:

You have to know this because one of the things that is very unique about methadone is its metabolism to the liver and it goes to what we called cytochrome 450 enzyme system and there are medications that will cause induction of that system meaning you will spree the metabolism up through that system, such as antiseizure medicine, such as Dilantin, Tegretol, certain hypoglycemic agents such as insulin, phenobarbital, and then contrary you have medicines that will cause an inhibition of the cytochrome 450 system, such as cimetidine, antifungal agent, certain antidepressants, even grapefruit juice, and so it is incumbent on the healthcare provider who prescribes methadone to know all the medicines that the patient is on or the medicine the patient is going off because that could affect the blood level of methadone and affect the patient in an adverse way.

DR. MARK NOLAN HILL:

With all this potential risks involved and multiple factors you mentioned, is it worth in terms of the efficacy and benefits of methadone.

DR. HOWARD HEIT:

Like with any other medicine, if used properly what I call along with good rational pharmacotherapy, I believed very strongly its benefit outweigh its risks, but the keys to know about methadone, it does not have a sense of humor, if used inappropriately.

DR. MARK NOLAN HILL:

If you have just joined us, you are listening to the Clinician's Roundtable on ReachMD. I am your host, Dr. Mark Nolan Hill and our guest is Dr. Howard Heit, a nationally recognized Chronic Pain And Addiction Specialists practicing in Northern Virgin and an Assistant Clinical Professor at the Georgetown University School of Medicine. We are discussing the rise in risks of methadone prescriptions.

Dr. Heit, going back to the question that I have previously asked you considering all of these factors, well then who really should be prescribing this medication?

DR. HOWARD HEIT:

I think Mark that anybody who is doing pain management should be familiar with at least a few opioid medications that are what we called 24-7 medications, mainly that they have long half lives. We have to realize that such as control this oxycodone or fentanyl patches or morphine in certain delivery systems or just immediate release opioid in clever delivery system while methadone is the only medication approved by the FDA that is truly a long-acting opioid intrinsically. It is not in a clever delivery system. The key in the proper use of methadone is education, not regulation of the medication.

DR. MARK NOLAN HILL:

What are the patients saying in terms of their pain relief?

DR. HOWARD HEIT:

The pain relief is done correctly, they think it is a miracle medication.

DR. MARK NOLAN HILL:

Tell us about the contract that you entered into with the mutual obligation with your patient.

DR. HOWARD HEIT:

Well, Mark, I would like to use the word rather than contract, I like to use the word agreement.

DR. MARK NOLAN HILL:

Why is that so?

DR. HOWARD HEIT:

Because I am not entering into a legal agreement with the patient, a legal contract. I am entering into agreement. That agreement states the responsibility that I have and the responsibility that the patient has in receiving a control substance. It states before I write the first prescription for that patient, the mutual responsibilities of each party essentially what I will do for you and what you will do for me based on mutual trusts and responsibility. It sets up the rules of the game before I write the first prescription.

DR. MARK NOLAN HILL:

And how do you do that?

DR. HOWARD HEIT:

Well, I have a written agreement that I have used over the years, and I have the patient read it and if they agree with it or have any questions about it because it also gives informed consent of explaining the difference between addiction, physical dependence, and tolerance, which I think is very important for the patient to know. I gave a copy to the patient. I also gave the patient an extra copy to take to the pharmacist because I want the pharmacist to know who is prescribing these scheduled two medications. In case if there are any questions they could always call me. There is written agreement is a sense of form of informed consent and a sense of what we would do for each other because we have to remember the prescribing of a controlled substance especially in opioid is a privilege not a write and the receiving of it is a privilege of right. The pharmacist is dispensing it is a privileged not a right.

DR. MARK NOLAN HILL:

Dr. Heit, not to be too simplistic, but how you do keep from being duped I have been in practice for 26 years and the patient I never would have guessed, would be dishonest to me, have duped me going to different pharmacies, telling me things, and how do you really know when the patient enters into this agreement with you that there are going to be straight and honest.

DR. HOWARD HEIT:

Mark, are you familiar with the term pseudoaddiction?

DR. MARK NOLAN HILL:

No, sir.

DR. HOWARD HEIT:

Pseudoaddiction is a term in which a patient has been inappropriately or untreated for pain and that patient will do aberrant behavior in order to get good pain management. But when that patient receives rational pharmacotherapy and complimentary therapy in order to treat your pain, all aberrant behavior stops. While addiction is a primary chronic neurobiological disease that is marked by a fair control of her drug use and compulsive use, continue to use despite harm and cravings. So what you do when you first see a patient. You set up the appropriate boundaries with that patient based on history and physical and then if the patient stays within that boundaries, then pseudoaddiction is a diagnosis made retrospectively, which the behavior normalizes. Somebody with the disease of addiction, the behavior deteriorates despite your best effort. So, if you set up appropriate boundaries before you write the first prescription of the mutual responsibility of each, the patient who is trying to drug seek rather than pain relief seeking will declare themselves. So, I believe everybody who comes into my practice, truly has pain until they declare themselves one way or the other.

DR. MARK NOLAN HILL:

I want to thank our guest Dr. Howard Heit. We have been discussing the rise and risks of methadone prescriptions.

I am Dr. Mark Nolan Hill and you have been listening to the Clinician's Roundtable on ReachMD, The Channel for Medical Professional. Be sure to visit our web site at reachmd.com featuring on-demand podcast of our entire library. For comments and questions, please call us toll-free at 888MDXM157 and thank you for listening.