Paradise Gained *or Paradise Lost*: How Can We Help Challenging Patients?

2020 New York Society of Addiction Medicine (NYSAM)

Public Policy Day 2/7/2020

Panel Discussion -- Moderator:

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MEDICINE *of* THE HIGHEST ORDER

UNIVERSITY *of* ROCHESTER MEDICAL CENTER

Disclosure

No disclosure or conflicts related to this presentation

Case 1

29 year-old M with extensive history of opioid, cocaine and other substance use has been attending an outpatient chemical dependency treatment program but struggling to stabilize. If he gets more than a few days (or even at times one days worth) of a buprenorphine Rx he frequently trades/sells for cocaine or opiates.

His UDS are typically positive for cocaine, fentanyl and its metabolites, occasionally opiates as well, THC, intermittent benzodiazepines (clonazepam).

He's had several ED visits for overdose (mixed stimulant/opiate) including one which resulted in ICU admit preceding this treatment episode.

He is married (separated), has 6 month-old child. Parents won't let him stay at home anymore (too much has been stolen/pawned).

Case 1

Patient charged $ 15,000.00 on his parent's credit card as cash advances (after stealing/pawning numerous other things from their house) that they finally reported to the police and he was arrested (pending disposition of charges).

PMH: ED/hospital visits for OD, intoxication, one episode of cellulitis. IVDU last 2-3 years, crack cocaine 2-3 years. Intermittent heavy alcohol use.

PCP –no PCP

Meds: on/off buprenorphine/naloxone and topiramate* (off label cocaine craving).

QUESTION: So… what are your thoughts for this patient?

Case 1 Discussion

Some additional information:

- Patient has been willing to come in for brief prescriptions and will do observed doses a few days a week.
- Intermittent attendance at a 'stabilization' group. About 50% attendance at individual counseling sessions (many phone calls to the counselor) when is in emergency situation –usually no money or looking for options outside of a shelter).
- Patient has connected with a peer counselor (very well established sober > 5 years very knowledgeable about treatment/support options)

Case 1 continued

Patient disappears from the clinic for a few days (after seeing MAT provider and getting Rx for 3 days to do obs doses).

On the weekend (5 days later) he is found by a volunteer group ("Hope dealers") that walks around set area of known with street level drug use and abandoned 'drug houses' picking up syringes and offering food, clothing items, etc. to people who are using drugs. Several in group are 'peers' that have been trained and work for area agencies and can facilitate rapid access into detox or treatment.

He agrees to go to an area detox after being found on the floor of an abandoned house in opioid w/d and post 'crack' binge.

At the detox the patient is placed on an 'opiate' protocol. He agrees to go directly inpatient and then to a halfway house "bed-to-bed-to-bed".

Case 1

He'd undergone induction with bup/naloxone 2/0.5 mg SL 10 hours after arrival and then was placed on 4/1 mg SL BID then 8/2 mg SL BID)

Protocol: 5 mg PO diazepam PO BID PRN x 3 days (unless placed on bup maint), clonidine 0.1 mg PO QID PRN x 3 days and hydroxyzine 50 mg PO QID PRN x 3 days.

5:30 PM on day 10 staff find a note on his bed, "*I'll be back had to take care of something.*" He is not found anywhere in the building. After 10:30 PM he returns knocking on front door asking to be let back in…

"*I had to go take care of my watch I pawned it and it was up for sale today. It was engraved…*" He doesn't appear intoxicated.

Case 1

Policy is to not readmit someone who leaves AMA without formal screen/assessment and review *and his bed was turned over*.

He is given bus tickets to local shelter (bed confirmed) and told to return in the AM for reassessment.

He is given an extra dose of Suboxone® prior to leaving (directly obs).

Patient doesn't return that day but does so 2 days later. Had used once (fentanyl/cocaine).

In the meantime…. Any other thoughts?

Case 1

Sublocade® had been ordered from his outpatient program and had finally arrived (the day after he'd left the detox a note).

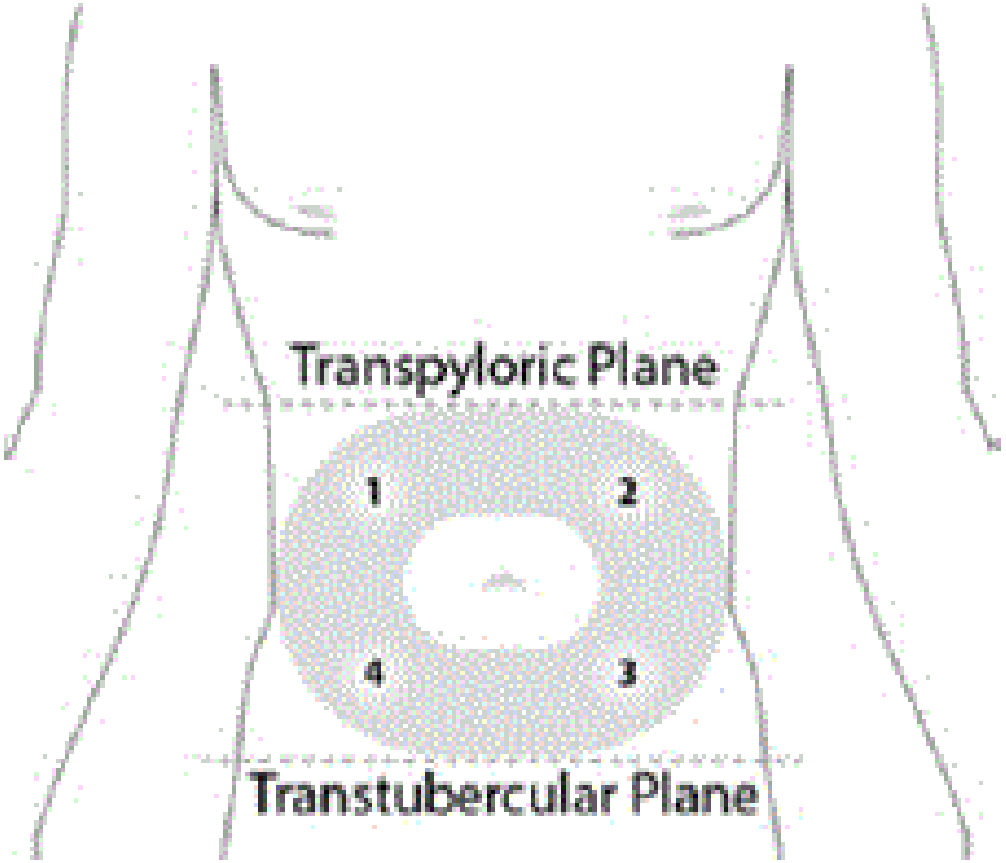
As soon as he returned transportation to the outpatient program was arranged by peers from the detox to have the shot administered.

One day of bup admin in detox (re induction 2/0.5 mg then 4 x 2/0.5 mg)

Patient tolerated the shot fine.

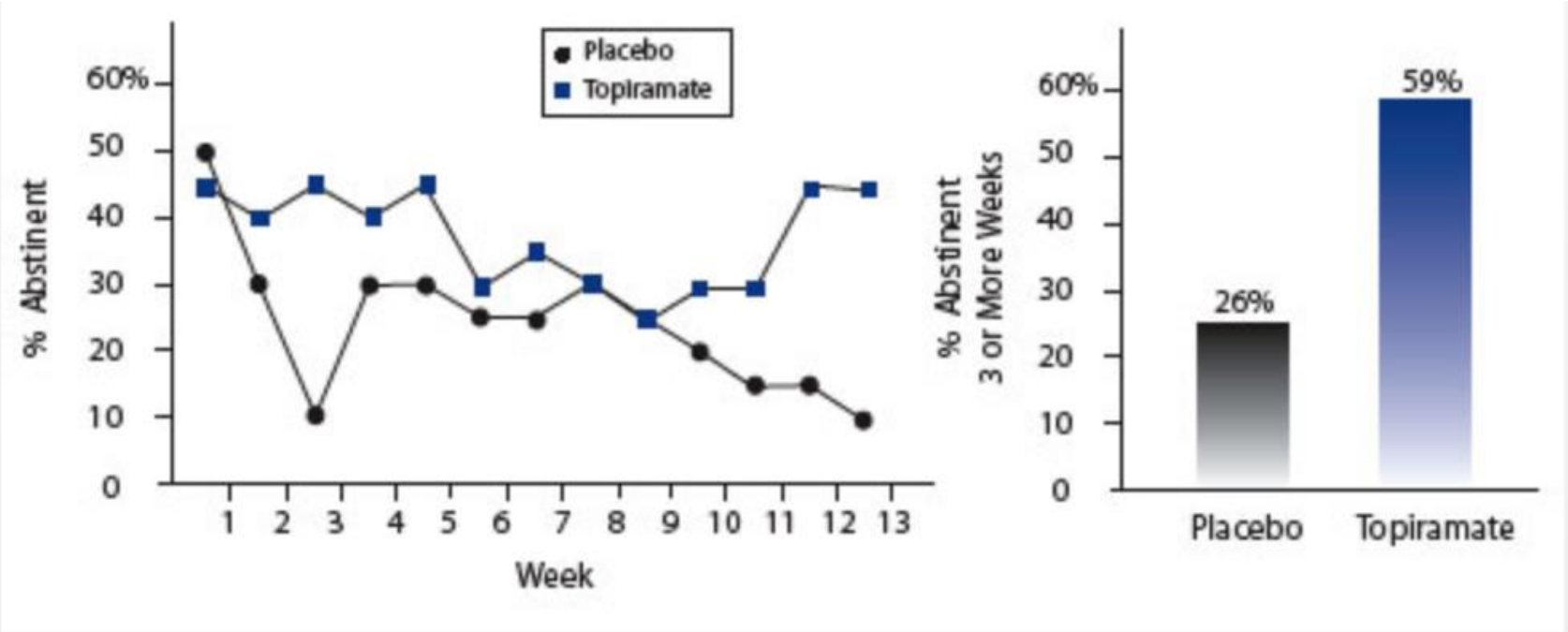
Sent back to detox and awaiting inpatient placement with plans to continue with the shot 4 weeks later.

Sublocade®



SC admin in abdomen

Topiramate and cocaine (50 mg PO BID → 100 mg PO BID)



Topiramate Helps Outpatients Abstain From Cocaine In almost every week of the study, more patients were abstinent in the topiramate group than in the placebo group. Of the 40 participants in the study, more patients taking topiramate achieved 3 or more continuous weeks of abstinence from

Case 2

A 37 year-old Puerto Rican gentleman presents for evening clinic in an outpatient treatment program. He is on monthly visits for medication for his opioid use disorder and takes 2 and ½ of the 8/2 mg buprenorphine/naloxone films.

He's been at the program 3 months started in group (phase I) and counseling although 3 weeks in reported getting work in a factory and his attendance has been very low since. He's seen his counselor once since last visit. He was changed to evening groups but has missed ¾ of them, "I'm tired after work."

He has history of > 10 years IVDU heroin and cocaine. Previous treatment (approx. 8 times). One year in OTP on methadone but stopped due to time constraint.

Case 2

The patient lives with his sig other and her children. He has 3 other children that live with their mother. No current alcohol use. He smokes 1.5 PPD cigarettes.

Tonight in the clinic he is tired. Denies use. "but I need a higher dose of the 'Subs'. Vague about how he's taking the current dose (was written for one 8 in AM and at HS and the half as needed during the day).

"No use I'm good just tired from work."

His UDS results return…

Last month's UDS results (also neg bup)

Component	Result	Flag	Range	Units	Reported	Location
AMPHETAMINES W/ CONFIRM	Negative		300	ng/mL	2020-01-18 12:23	F
BARBITURATES W/ CONFIRM	Negative		200	ng/mL	2020-01-18 12:23	F
BENZODIAZEPINES W/CONF	Negative		50	ng/mL	2020-01-18 12:23	F
THC W/ CONFIRM	Negative		20	ng/mL	2020-01-18 12:23	F
COCAINE W/ CONFIRM	Negative		150	ng/mL	2020-01-18 12:23	F
METHADONE W/ CONFIRM	Negative		150	ng/mL	2020-01-18 12:23	F
OPIATES W/ CONFIRM	Negative		100	ng/mL	2020-01-18 12:23	F
OXYCODONE W/ CONFIRM	Negative		100	ng/mL	2020-01-18 12:23	F
PHENCYCLIDINE W/ CONF	Negative		25	ng/mL	2020-01-18 12:23	F
NITRITE	19.4		<200	mcg/mL	2020-01-18 12:23	F
PH	3.8	A	4.50 - 9.00		2020-01-18 12:23	F
Low pH						
CREATININE	2.1		>20.00	mg/dL	2020-01-18 12:23	F
SPECIFIC GRAVITY	1.0239		1.0010 - 1.020		2020-01-18 12:23	F
SPECIMEN VALIDITY	see below				2020-01-18 12:23	F
Invalid - The specimen does not meet the requirements for normal urine.						

Case 2 –prior month UDS (norbup-cr 462 ng/mg cr)

CUSTOM TOX PROFILE HD

ORDERING PROVIDER: TIMOTHY WIEGAND
STATUS: FINAL

COLLECTED: 2019-12-17 19:00
RECEIVED: 2019-12-18 14:27

Component	Result	Flag	Range	Units	Reported	Location
AMPHETAMINES W/ CONFIRM	Negative		300	ng/mL	2019-12-20 14:32	F
BARBITURATES W/ CONFIRM	Negative		200	ng/mL	2019-12-20 14:32	F
BENZODIAZEPINES W/CONF	Negative		50	ng/mL	2019-12-20 14:32	F
THC W/ CONFIRM	Negative		20	ng/mL	2019-12-20 14:32	F
COCAINE W/ CONFIRM	Negative		150	ng/mL	2019-12-20 14:32	F
METHADONE W/ CONFIRM	Negative		150	ng/mL	2019-12-20 14:32	F
OPIATES W/ CONFIRM	Negative		100	ng/mL	2019-12-20 14:32	F
OXYCODONE W/ CONFIRM	Negative		100	ng/mL	2019-12-20 14:32	F
PHENCYCLIDINE W/ CONF	Negative		25	ng/mL	2019-12-20 14:32	F
NITRITE	17.2		<200	mcg/mL	2019-12-20 14:32	F
PH	6.3		4.50 - 9.00		2019-12-20 14:32	F
CREATININE	14.3	A	>20.00	mg/dL	2019-12-20 14:32	F
Dilute						
SPECIFIC GRAVITY	1.0028		1.0010 - 1.020		2019-12-20 14:32	F
SPECIMEN VALIDITY	see below				2019-12-20 14:32	F
Dilute - The specimen is dilute.						

Case 2

How would you approach this patient?

How are you using or applying drug testing (UDS or other types e.g. saliva/oral fluid) with your patients who have opioid use disorder?

Discussion…

Case 2

The results for the past few months are reviewed with the patient contrasting normal results (initially) with the recent.

He is asked to do another observed and he agrees (but is clearly anxious).

He is able to provide a small amount of urine which when a dip is done returns negative for bup and pos for fentanyl, cocaine, opiates and THC.

After results he reports he used, “4 days ago” and he was taking, “extra Suboxone’s so I ran out.”

What are the options tonight?

Case 2

The patient becomes very emotional asking for, "4-5 days of them please!"

Offered to have a re induction the following day at 11:00 (or if working after work) but he repeatedly requests, "just 4-5 days of them tonight that's all I'm asking for!"

The patient is not showing any withdrawal. If the apt was during the day he would be offered an obs induction then (or if not able to do as this patient would offer same following AM).

Discuss your strategies of working with a patient found to be diverting his Rx?

What resources do you have/use to support?

Case 2 –examples used in program

Flexible re induction offered for patients.

Peer counselor support to connect and help re engage.

Stabilization program (5 days a week) that can be coupled with obs dosing/short Rx regimens.

Sublocade® offered to many

Off-label medication use for cocaine craving.

Flexible group/counseling programs (e.g. individual sessions instead of group).

Case 2

Patient did not return for re induction.

Contact notes indicate he'd not been working in the factory (unclear if lost job or other).

In process of trying to re engage.

Case 3

A 34 year-old M with long history of stimulant and opioid dep is seen in an outpatient MAT clinic. He is taking Suboxone® 8/2 mg SL TID, amphetamine ER 20 mg two tabs/day and amphetamine IR 10 mg two tabs daily as well as gabapentin 1200 mg PO TID. He is also on insulin for DM

PMH: DM, "neuropathy" and ADHD

In the fall he has several screens with neg amphetamine and very low norbup-cr levels (100's – 200's) he has cocaine use (intermittent) and becomes homeless, enters a short detox then a halfway house and with obs doses levels he is at 600-800s norbup-cr.

In review he has had only about half of his screens pos for amphetamines. Most pos gabapentin and fluctuating bup levels.

Case 3

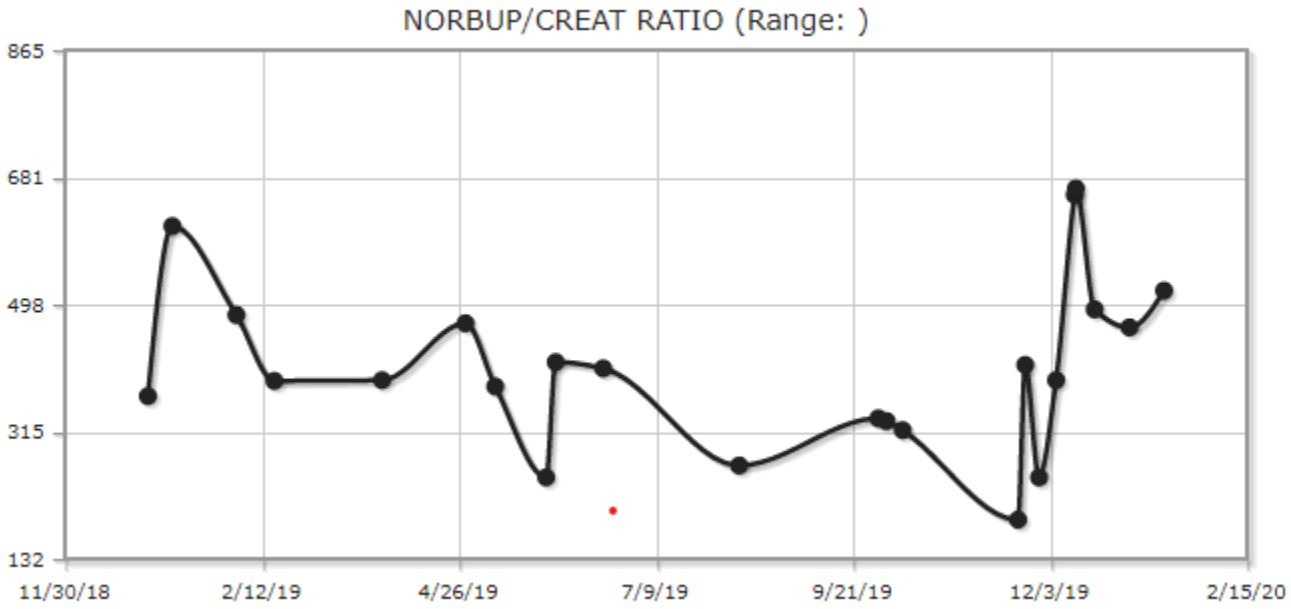
While in the halfway house the patient is taking the buprenorphine (which had been reduced to 16 mg/day after missing counts and refusing obs dosing prior to entry into HWH) the gabapentin and amphetamine.

About 2 weeks into halfway house his PCP abruptly stops prescribing the stimulants and gabapentin as they had finally read notes that had been sent (with consent) from the treatment program about his progress.

He presents to the prescriber in distress that he is in "withdrawal from my amphetamines and gabapentins."

He would have been out of the gabapentin that day (he found out when he called to get renewal on his Rx) and the ER amphetamines the day prior, the IR not for two weeks…

Case 3


NORBUP/CREAT RATIO (Range:)
865
681
498
315
132
11/30/18
2/12/19
4/26/19
7/9/19
9/21/19
12/3/19
2/15/20

Amphetamine screens

Component	Result	Flag	Range	Units	Reported
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2020-01-15 08:50
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2020-01-02 11:10
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-12-20 09:42
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-12-13 09:41
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-12-12 22:57
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-12-06 00:11
AMPHETAMINES W/ CONFIRM	Negative		300	ng/mL	2019-11-29 15:15
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-11-24 11:31
AMPHETAMINES W/ CONFIRM	Negative		300	ng/mL	2019-11-21 18:39
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-10-24 08:11
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-10-20 10:53
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-10-09 16:54
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-10-03 15:45
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-09-30 14:27
AMPHETAMINES W/ CONFIRM	Negative		300	ng/mL	2019-08-09 14:44
AMPHETAMINES W/ CONFIRM	Negative		300	ng/mL	2019-06-19 18:08
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-06-02 00:46
AMPHETAMINES W/ CONFIRM	Negative		300	ng/mL	2019-05-29 10:15
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-05-10 09:33
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-04-29 07:11
AMPHETAMINES W/ CONFIRM	Negative		300	ng/mL	2019-03-29 02:18
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-02-16 18:44
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-02-02 14:22
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2019-01-09 16:06
AMPHETAMINES W/ CONFIRM	See Below		300	ng/mL	2018-12-31 12:55

Discussion

Questions/comments?

How do you support patients with concerning Rx medication use?

If patient has non-medical use/abuse of stimulants or sedatives that are prescribed by another provider what are your strategies?

Do you offer to take over prescribing?

Would you switch to alternative forms (e.g. lysdexamfetamine from IR amphetamine) or taper if signs misuse (e.g. gabapentin)?

Case

The gabapentin is prescribed at 900 mg PO TID –patient tolerates this fine. Appreciative.

Not prescribed the stimulant. After review/discussion he had clearly only been taking part of the time.

After complaints he is in stimulant withdrawal for several days/week he concedes he is doing fine. "I feel better without it to tell the truth."

Two months in he's on the Suboxone® 8/2 mg SL two and ½ daily, the gabapentin 900 mg PO TID and coming to program/appears to be doing well.

Case 4

A 32 year-old F with history of gastric bypass surgery has been, "calling all over to get an apt I just have to stop doing this you guys were the only one that could get me in on the same day!"

Reports illicit buprenorphine/naloxone use for years, "3 of the 8's a day." She has been working, has 2 kids at home, mother at home, work stressful, "I'm spending too much on the Suboxone's."

She has a PCP she sees for "carpal tunnel," anxiety and ADHD.

Meds: something for anxiety (clonazepam 0.5 mg PO TID), Vyvanse® and omeprazole

Reports history of Rx opioid use after surgery and then overtook, lost Rx's and someone offered buprenorphine which she's taken, "for 1-2 years."

Case 4

The patient provides a UDS with dip pos buprenorphine and amphetamine (which is when she'd disclosed the Vyvanse® use) no other +.

An Rx for 8/2 mg SL BID is given for 3 days –she has f/u to complete intake the next day and she agrees to come in to do obs dose.

The next visit she is given a weeks worth of buprenorphine/naloxone (Friday) but is put on as a 'walk in' the next Tuesday as she is, "almost out of them I had to take a few extra." Describes mostly pain as reason why taking extra. No craving reported. Counseled on use of apap and to f/u with PCP about NSAID. Agrees to take as Rx'd.

f/u approx.. for two weeks (though has missed several groups).

Rx increased to 2.5 of the films/day after another episode of overtaking. Working on stopping the clonazepam (reported only intermittent use)

Case 4

The patient fills another clonazepam Rx but it's neg in her urine. She reports it was, "accident just with my other Rx's I'm not taking it."

Signed consent for her provider to discuss medication regimen.

After started on 2.5 films SL daily she presents in a panic just after 2 weeks in to a 28 day Rx.

"My counselor sent me down. I don't know what happened I thought it was to take 2.5 of them twice a day so that's what I was doing and I just realized I only have a few films left but my apt isn't for another 2 weeks!"

Emotional but asking for another Rx.

UDS show bup metabolite levels that are 800's – 1000's and only pos amphetamines.

Case 4 –ISTOP reviewed and also shows…

Rx Written	Rx Dispensed	Drug	Quantity	Days Supply
)1/28/2020	01/28/2020	zolpidem tartrate 10 mg tablet	30	30
)1/07/2020	01/20/2020	vyvanse 70 mg capsule	30	30
)1/20/2020	01/20/2020	eszopiclone 2 mg tablet	30	30
2/17/2019	12/21/2019	vyvanse 70 mg capsule	30	30
2/03/2019	12/08/2019	clonazepam 0.5 mg tablet	120	30
1/26/2019	11/26/2019	vyvanse 70 mg capsule	30	30
0/29/2019	11/07/2019	clonazepam 0.5 mg tablet	120	30
0/29/2019	10/29/2019	vyvanse 70 mg capsule	30	30
0/15/2019	10/15/2019	vyvanse 60 mg capsule	30	30
0/09/2019	10/10/2019	vyvanse 60 mg capsule	3	3
0/09/2019	10/10/2019	clonazepam 0.5 mg tablet	120	30
0/07/2019	10/07/2019	hydrocodone-chlorphen er susp	25ml	5
)9/11/2019	09/11/2019	vyvanse 60 mg capsule	30	30
)9/11/2019	09/11/2019	clonazepam 0.5 mg tablet	120	30
)8/21/2019	08/21/2019	clonazepam 0.5 mg tablet	90	30
)8/06/2019	08/15/2019	vyvanse 70 mg capsule	30	30
)8/06/2019	08/15/2019	clonazepam 0.5 mg tablet	30	30
)8/01/2019	08/01/2019	temazepam 15 mg capsule	30	30
)7/16/2019	07/16/2019	vyvanse 70 mg capsule	30	30
)7/16/2019	07/16/2019	clonazepam 0.5 mg tablet	90	30

Case 4

She has 2-3 of the 8/2 mg films left now.

She picked up first zolpidem, "it didn't work," then eszopiclone. None of which were disclosed.

What are your thoughts?

What type of program is best for this patient (about 50% of visits made, many quite late).

Also reports upcoming surgery for "carpal tunnel" in about 10 days…

Case 4

Patient instructed to take one 8/2 mg daily.

On the 2nd day 12/3 mg daily Rx'd for the remainder of the two weeks.

Surgery moved to after the 2 weeks complete and she's restarted on short Rx's of 8/2 mg SL BID (split perioperatively –pending discussion with pre op team).

Reached out to her prescriber of stimulants and sedatives.

Asked peer to contact.

Encouraged area exercise/recovery program "Rocovery Fitness"

Ongoing…

Case 5 the final case

A 42 year-old M with long history of struggling with substance use disorder. Heavy opiate/fentanyl and cocaine (both IV and smoked)

> 25 separate detox admits at local facility.

Prior OTP methadone for 1.5 years ("too much going every day")

Numerous outpatient programs but for last 8 months has attended a local 'harm reduction' program that provides MAT, a PCP, HCV treatment and can continue MAT without outpatient treatment if patient not interested in outpatient treatment.

Some family in area (though mostly estranged) housing precarious.

About 75% of time detox → inpatient → shelter or brief halfway house and out for past year.

Case 5

The last 4 detox visits show he's linked to an outpatient from detox or inpatient has 1-2 visits for 7 days of 8/2 mg BID which is increased to 8/2 mg SL TID on 2nd visit. 2 of the 2nd visits for 14 days (42 films) and one for 84 films (28 days) each time (5 days, then 7 days, and 2 days) after picking up the Rx he is back in the detox.

UDS in detox show neg bup in all but the first and cocaine, fentanyl/opiates, BZD (thought to be from detox).

Refusing Sublocade® and also refusing returning to the OTP.

What are your thoughts?

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