Treatment Options in Opioid Dependence - Frankly Speaking EP 47

Transcript Details

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Dr. Frank Domino:

Stephen is a 26-year-old painter who has been abusing prescription opioids. He first started taking them following a work accident where he fell off a ladder and was prescribed oral opioids. He lost his job and is now living at home with his mother. He was recently hospitalized for depression and opioid dependence, and recently completed a detox program. He comes in to see you to learn what his options are for avoiding relapse, because he does not want to. His mother will kick him out of the house if he starts using again.

Hi, this is Frank Domino, professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School. Joining me today is Alan Ehrlich, associate professor in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, and executive editor at DynaMed. Hi, Alan.

Dr. Alan Ehrlich:

Hi, Frank.

Dr. Domino:

So Stephen has quite the issues. It sounds wonderful that he's gone through detox. What are his options to help prevent relapse for his opioid abuse?

Dr. Ehrlich:

Well, the American Society of Addiction Medicine recommend maintenance therapy with some type of medication, and the most commonly used medications would be methadone or buprenorphine, along with naloxone. Naltrexone is another alternative, and that can be given either orally or as a once a month injectable. And there's some new evidence out comparing the naltrexone to buprenorphine.

Dr. Domino:

Wow! So this sounds like an agent that can be given once a month, has no real potential for abuse or diversion and is at least as efficacious as what we currently have, if not maybe even a little better. Are there any downsides to this new medication?

Dr. Ehrlich:

Well, there are a couple. I just wanna highlight one of the things you said, the downsides to the buprenorphine or the methadone is you can have dependence on those. Buprenorphine is a partial agonist of opioids and methadone is an opioid agonist. Naltrexone is an opioid antagonist and so one of the downsides is increased withdrawal symptoms, and there were more adverse events reported in the naltrexone group. The patients have to be completely off of opioids before starting the naltrexone, and that's one of the limitations.

In this study, the patient went through seven days of detox, and a lot of patients aren't going to be off opioids that long before you need to start giving them some type of maintenance therapy, or else you're at risk of them relapsing. That's one of the limitations. Another limitation is you can't use it in pregnant women. Naltrexone is FDA pregnancy class C, and there just isn't much data in pregnant women. There's some data in animal studies that is of concern. And so this would be something that you wouldn't wanna be using in that situation.

Dr. Domino:

What agents are safe and effective in pregnancy?

Dr. Ehrlich:

It's hard to say safe and effective, but I think the general sense is to use some type of opioid agonist and not try and detox and withdraw women during the pregnancy.

Dr. Domino:

During pregnancy and then deal with that postpartum for both the child and the mother. Well, it sounds like a very positive outlook. Are there any other downsides to this injectable opioid antagonist?

Dr. Ehrlich:

First of all, one of the things is that not everybody likes getting injections, some people prefer taking pills. Cost is another factor. The injectable naltrexone is fairly expensive, and often people who are going through treatment for opioid dependence don't have great health insurance, may not have coverage for these types of things. So those are areas of concern. Like many things in medicine, and clearly given the choices here and the upsides and downsides to all of them, this is an area where there needs to be shared decision-making.

Now, many family physicians are not in the business of directly treating patients for opioid dependence. They may be referring them, they may be seeing their patients when they're being treated with these other agents, and so I think it's something that we need to be informed about, even if you're not one of the people who's directly prescribing them. There are going to be additional concerns in terms of interactions with other medications and things like that.

Dr. Domino:

I know with, certainly with methadone and buprenorphine, special requirements are put forward that providers need to be trained in their use before they can prescribe them, or at least I believe that's the case. Is there any data that shows if I'm a primary care provider in a rural setting and I don't have great access to opioid treatment centers, do I need any special training with this medication? Or is this just something I can administer on a monthly basis without any additional education?

Dr. Ehrlich:

I don't believe that there are any additional training requirements for this, again because there's no potential for abuse.

Dr. Domino:

Great. Well, this sounds like a very interesting new development. Until we get some of the details worked out concerning its costs, it's as efficacious as what we currently have and seems to have a certain degree of fewer risks. Would you agree?

Dr. Ehrlich:

Yeah, I agree. One other thing, there are always going to be more areas of uncertainty, and one I wanted to highlight is the difference between patients who have addiction to heroin and addiction to prescription opiates. And we know from data that methadone seems to be better in patients with addiction to heroin compared to the buprenorphine. Whether there are going to be similar distinctions that naltrexone long-acting injectable works better in subpopulations and is less effective in some other populations, I think that still remains to be seen. This is a new tool, it's already been shown in other studies that it is more effective than placebo, but in terms of how it compares to other choices and in what populations, which choice is best, I think more data is needed.

Dr. Domino:

Alan, thanks so much for bringing this to our attention. I can easily see within the next few years all of us will need to be highly invested in managing the opioid crisis, and this will be be one more tool in our toolbox. Thanks, again.

Dr. Ehrlich:

Thanks, Frank.

Dr. Domino:

Practice pointer. A new agent is as effective as our current treatment methods for the treatment of opioid dependence, injectable naltrexone. Join us next time when we'll be discussing the best evidence on diagnosis and management for acute sinusitis.