Transfer from high dose methadone to buprenorphine on a specialist in-patient unit – a case series

Dr Rebecca Lawrence, Ritson Clinic, Royal Edinburgh Hospital, Edinburgh EH10 5HF November 2013 rebecca.lawrence@nhslothian.scot.nhs.uk

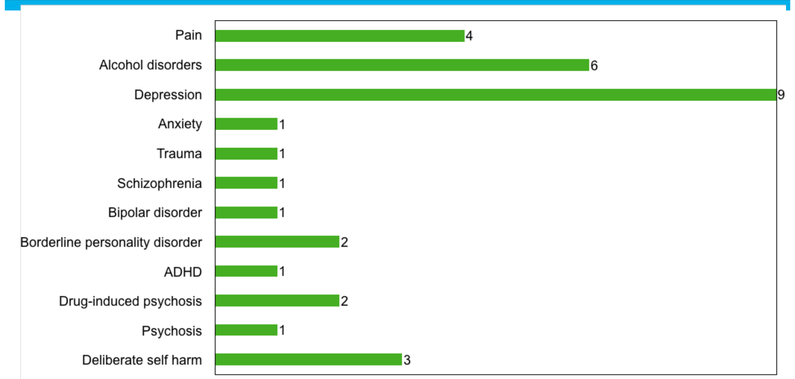
Background

Buprenorphine is the only licensed alternative to methadone in the UK for opioid replacement therapy. It carries less risk of respiratory depression and is safer in overdose. As it is a partial agonist, the withdrawal syndrome is often milder. Some patients are intolerant of methadone, find it stigmatising, or may be required to change due to drug interactions or prolonged QTc interval. Most current guidance advises a reduction in methadone to 30mg before transfer due to the risk of precipitated withdrawal, running a high risk of destabilisation.

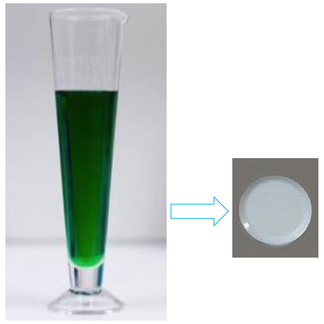
Methods

Patients on methadone doses up to 120mg / day were admitted to the Ritson Clinic (specialist in-patient addictions unit) through their community addiction key workers. All gave written consent to be included in a prospective case series. Information recorded included diagnoses, comorbidity, use of alcohol and other drugs, length of time from stopping methadone to starting buprenorphine, COWS scores, dose of buprenorphine on discharge, total lofexidine required for symptomatic relief of withdrawals during the process, length of stay and perceived outcomes (patients and staff). Patients were encouraged to stop methadone just prior to admission, and were started on buprenorphine 4mg when showing clear opiate withdrawals signs (COWS ~ 15). One or two further 4mg doses were given on Day 1 depending on withdrawals, and patients were then titrated by up to 8mg daily until comfortable.

Recorded psychiatric comorbidities (past & present)



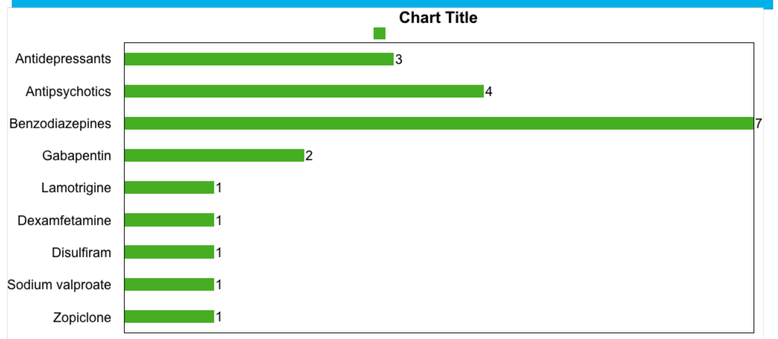
Results



15 patients were admitted from May 2012 to April 2013 and all successfully transferred to buprenorphine. Average time from stopping methadone to starting buprenorphine was 61.5 hours and average length of stay was 6.5 days.

Case	Dose of methadone on admission (1mg/1ml)	Alcohol / illicit drugs	Length of stay (days)	Time from stopping methadone to 1st dose buprenorphine	COWS score prior to 1st dose	Dose on discharge	Lofexidine received	Outcome (patient)	Outcome (staff)
1	***65ml***	***Heroin 1 week ago; cannabis 3-4 weeks ago; occasional speed***	***4***	***48 hours***	***17***	***14mg***	***1.2mg***	***Good***	***Good***
2	70ml (last had 35ml)	Cannabis	3	76 hours	16	12mg	0.4mg	Good	Good
3	***50ml***	***Amphetamine; cannabis***	***9***	***48 hours***	***9***	***16mg***	***0.4mg***	***Good***	***Good***
4	70ml	70ml methadone every 2 days; diazepam 2 x / month; occasional cannabis	7	120 hours	15	16mg	None	Good	Good
5	***120ml***	***Diazepam; methadone (?up to 100ml)***	***7***	***72 hours***	***12 (17 after 1st dose - ?precipitated withdrawal***	***24mg***	***2.4mg***	***Good***	***Good***
6	45ml	None	6 days	32 hours	15	20mg	5mg	Reasonable	Reasonable
7	***70ml***	***None***	***10 days***	***56 hours***	***13***	***24mg***	***2.8mg***	***Good***	***Good***
8	70ml	Heroin (2 weeks prior); diazepam & "tablets"	8 days	121 hours	5	18mg	None	Good	Good
9	***50ml***	***3 litres cider / day – also detoxed from alcohol; none (positive screen for benzodiazepines couple weeks prior to admission)***	***8 days***	***51 hours***	***17***	***14mg***	***0.4mg***	***Good***	***Good***
10	45ml	Intermittent diazepam & cannabis	4 days	54 hours	17	20mg	0.2mg	Better than expected	Good
11	***115ml (last had 85ml)***	***None***	***10 days***	***56 hours***	***14***	***16mg***	***0.6mg***	***Very pleased***	***Good***
12	100ml	Diazepam, heroin until 2 days prior to admission	7 days	48 hours	12	20mg	1.0mg	Good	Good
13	***65ml (last had 30ml)***	***Occasional cannabis, alcohol, gabapentin & trazodone***	***2 days***	***19 hours***	***10***	***20mg***	***2.0mg***	***Better (early discharge due to personal circumstances)***	***Good***
14	60ml	Heroin 1 week prior; cannabis	8 days	84 hours	20	20mg	2.0mg	Finding things difficult	Fair as regards withdrawals
15	***80ml***	***Cannabis***	***4 days***	***38 hours***	***10***	***20mg***	***0.4mg***	***Good***	***Good***

Other psychotropic medication prescribed



Discussion and conclusions

These complex, and not always stable, patients all transferred from doses of between 45 and 120mg methadone. None were considered by staff to have precipitated withdrawal, and most perceived good outcomes and tolerated the process well. Most required high levels of support while waiting to go into opiate withdrawal and would have found this difficult in the community. Timings and final doses were highly variable, and not possible to predict. Clinical assessment of withdrawal was more helpful than COWS scores, and the author would suggest cautiously proceeding with initial buprenorphine dose (2-4mg) after 48 hours established abstinence from opiates in all patients. After the first dose, some clinicians titrate patients very rapidly to achieve stabilisation as quickly as possible; we proceeded more cautiously (maximum 8mg daily) to avoid higher than required ultimate dosing, which was possible with the increased support in this setting.

This series may help to inform further guidance in high dose transfers, depending on resources. Complex patients benefited from the high level of support available in an in-patient unit, but stable patients without comorbidities may well be transferred successfully in an out- or, preferably, day patient setting.

Bibliography

2007. *Drug misuse and dependence: UK guidelines on clinical management*

NICE (2007c), *Methadone and buprenorphine for the management of opioid dependence: NICE technology appraisal guidance 114.*