

# Pharmacotherapy Newsletter

## Pharmacotherapy (methadone, buprenorphine and naltrexone) patients and pain management in the emergency department

People who have substance use disorders are at increased risk of accidents/injuries and similarly are more likely to have additional problems during the acute treatment/management and recovery phase after such accidents/injuries. It has been estimated that approximately one in six patients attending a public hospital emergency department meets the criteria for a Substance Use Disorder.

### Tolerance

Many, if not most, chronic substance abusing people will develop significant degrees of tolerance to a variety of centrally acting drugs: in particular, the hypnotosedatives (e.g. benzodiazepines, anaesthetic agents) and opioid analgesics. The latter patients especially pose problems when they attend with painful injuries and require specific treatment, including analgesia.

Patients who are on opioid maintenance pharmacotherapy (methadone or buprenorphine) will always have higher tolerance to opioid analgesics in the setting of acute pain because their “normal homeostatic” daily dose of methadone or buprenorphine does not provide analgesic effect when it is being used to maintain the state of medically stabilized opioid physiological dependence. This sort of treatment generally reduces the risk of relapse to illicit heroin injecting, removes the daily risk of withdrawal symptoms (as occurs with heroin addiction) and reduces mortality from heroin overdoses.

### Higher doses needed for analgesia

When such a pharmacotherapy patient attends an emergency department (ED), with acute pain, requiring opioid analgesia, additional “higher than usual” doses are recommended. If subsequently admitted to hospital, these patients will require their normal “homeostatic” methadone or buprenorphine dose to be maintained (i.e. a normal daily physiological requirement) and the additional opioid, plus any other analgesic treatment to be provided. The latter can be weaned slowly as the patient improves and the pain subsides.

Welcome to the May 2006 Pharmacotherapy Newsletter in which we are featuring pain management for pharmacotherapy clients.

Your feedback and contributions are always welcome, particularly any good news stories about clients and services.

We look forward to developing a forum for the exchange of opinions and information.

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## Supervised dosing on discharge

However, if the patient is able to be discharged from the ED after receiving acute pain management, some extra analgesic cover may be necessary for a few days following, which may pose a risk regarding the safe/appropriate use of that medication after dispensing. In these circumstances, it is usual to dispense such drugs of dependence in a daily supervised manner, in conjunction with their methadone or buprenorphine. This would be arranged through their usual pharmacy and ideally, after contacting and speaking with their normal treating doctor/pharmacotherapy provider. Alternatively, after-hours consultation with the Drug and Alcohol Clinical Advisory Service (DACAS) can provide clinical advice about managing pain under these circumstances.

## Chronic pain and pharmacotherapy

Another situation is when a patient who has a chronic pain problem is attending a methadone or buprenorphine maintenance program (i.e. where a part of their pain management might involve the use of methadone or buprenorphine). Here, the daily opioid pharmacotherapy is providing both analgesic effect and the maintenance of opioid physiological dependence. The same can be said for patients attending specialist pain clinics and who are on long-acting opioids such as MS Contin, Kapanol, Oxycontin, etc.

When such patients attend with an acute exacerbation of a chronic pain problem and are on daily opioid pharmacotherapy, the same general approach applies. They are usually given additional opioids (i.e. assuming other approaches have not been adequate) in higher than what would be considered usual doses for non-opioid dependent patients.

On some occasions, it may be possible to manage the acute exacerbation of chronic pain by temporarily increasing the methadone or buprenorphine.

In these cases, communication with the pharmacotherapy prescribing doctor and the dispensing pharmacy is essential.

Recent research has identified that many, chronically opioid-maintained individuals, have some degree of hyperalgesia, rendering them more vulnerable to nociception and possibly to increased risk of developing chronic pain. This is an additional reason why these patients need special consideration when assessing their pain and response to pharmacological treatment.

## Concomitant treatment with naltrexone

A small percentage of former heroin addicts are undertaking treatment with an opioid antagonist, naltrexone, which can be taken orally or sometimes administered as an implant (lasting three to four months on average). A depot naltrexone preparation is already marketed in the United States and possibly will soon be available in Australia; this has a duration of action of about one month. Hence, patients maintained on this long-acting opioid antagonist treatment may also pose difficulties in the setting of acute pain management, particularly if opioids are considered necessary.

Patients are usually well informed about these predicaments and of the need to notify any treating doctor in the setting of acute pain.

## Naltrexone patients presenting in unconscious state

If a patient presents in an unconscious state, the fact that they may have an implant or be on this medication is sometimes impossible to determine. The relevant information may only be acquired later when family or friends are able to provide such a history, or contact with the patient's treating doctor/drug counselling agency is made. Sometimes this information may not be discovered until the patient has regained consciousness. Although not formally evaluated, anecdotal reports suggest that some of these patients may require increased doses of anaesthetic agents.

Implants, and similarly, depot preparations, are unable to be removed surgically, even though this approach has been tried. The recommended management of patients who are on naltrexone treatment is high dose opioid agonist therapy that is titrated to "exceed" the naltrexone antagonism and provide analgesic efficacy. This must be extremely closely monitored due to uncertainties about the patient's level of opioid tolerance (opioid receptor numbers and sensitivities change in response to chronic antagonist therapy).

Patients on prescribed naltrexone tablets will often carry an alert card, identifying them as being under naltrexone therapy, their treating doctor and date of commencement of therapy. Inpatient treatment of these patients should always be managed in liaison with an acute pain service.

It should also be pointed out that in patients taking the naltrexone tablets, the effect of this medication will wane over 24–48 hours and therefore their sensitivity to opioids could be expected to dramatically increase over that period of time. This emphasises the need for close clinical monitoring.

## Acute pain

Acute pain management problems in pharmacotherapy patients are fortunately not common but when they do occur, they often create a lot of distress for the patient and the treating medical team. Many teaching hospitals now have an acute pain service and additionally, Addiction Medicine consultants are available to assist emergency department staff in managing these often challenging situations. DACAS is a twenty-four hour service that provides consultation in regard to these matters for any health professional (telephone: 9416 3611 or 1800 812 804).

**Dr Michael McDonough**  
**Chronic Pain and**  
**Drug Dependency Clinic**  
**Western Hospital**

## New Pharmacies

During the past twelve months many pharmacies have joined the group participating in the Victorian Pharmacotherapy Program. They are:

Priceline Pharmacy,  
1010 Sturt Street, Ballarat

Priceline Pharmacy,  
138 Main Street, Croydon

Greenvale Pharmacy,  
Milleara Road, Greenvale

Tran Tran Pharmacy,  
166 Victoria Street, Richmond

Watsonia Full Life Pharmacy,  
11 Watsonia Road, Watsonia

Soulsby & Struth Pharmacy,  
Liebig Street, Warrnambool

Orrong Pharmacy,  
704 High Street, East Prahara

Terry White Pharmacy,  
Southland

John O'Meara Pharmacy,  
1/202 Blackburn Road, Syndal

Frankston Amcal Pharmacy,  
Bayside Shopping Centre, Frankston

Minh Ha Pharmacy,  
Station Place, Werribee

Junction Pharmacy,  
Pascoe Vale Road, Moonee Ponds

Westgarth Pharmacy,  
High Street, Westgarth

Viewbank Pharmacy,  
Lower Plenty Road, Viewbank

Priceline Pharmacy,  
Ocean Grove

UFS Dispensary,  
Ballan

Terry White Pharmacy,  
Louisa Street, Coburg

Toni Riley Pharmacy Eaglehawk,  
30 High Street, Eaglehawk

## Suboxone

As of 1 April 2006, Suboxone (buprenorphine hydrochloride and naloxone) will be available on the Pharmaceutical Benefits Scheme under the same arrangements as methadone and Subutex. This follows the official registration of Suboxone by the Therapeutic Goods Administration on 27 July 2005.

Reckitt Benckiser has secured distribution of Suboxone and stock is now available.

## The new pharmacotherapy policy

The arrival of Suboxone has prompted the first major review of Victoria's pharmacotherapy policy for some years. A number of important changes will be introduced when the revised policy takes effect.

### Clinical guidelines

The new policy formally adopts the "National Clinical Guidelines And Procedures For The Use Of Methadone In The Maintenance Treatment Of Opioid Dependence (2003)" and "National Clinical Guidelines And Procedures For The Use Of Buprenorphine In The Treatment Of Heroin Dependence (2006)".

The new Victorian policy concentrates on practices that should be adopted to provide legal, safe and effective pharmacotherapy services.

### Take-away doses

The major changes relate to the authorisation of take-away doses by prescribers. The policy, for the first time, provides extensive advice to practitioners about assessment of stability in treatment, and links stability to defined levels of supervision of doses. A pro-forma tool is provided to assist prescribers complete and document

stability assessments. The assessment tool clearly links the outcome to a particular level of supervision for each client, and can be used to manage client expectations about take-away doses.

Prescribers will be fully accountable for ensuring they authorise take-away doses only within the advice in the policy. If practising within the policy, the prescriber will no longer need to notify the Drugs and Poisons Regulatory Regulation Group (DPRG) when take-away doses are authorised. There are no provisions for seeking approval for take-away doses outside the policy.

## Minimising illicit dose diversion

Diversion of prescribed doses of pharmacotherapies for illicit or unsanctioned use is a threat to the health and safety of patients and third parties, and to the integrity of the pharmacotherapy system itself. Providers of pharmacotherapy services have an obligation to implement anti-diversion strategies to minimise diversion. The policy advises a number of such strategies and practices that should be adopted.

## Timing

It is expected that the new policy will be released in early June. A copy will be sent to all approved prescribers and dosing points, and will be posted on the DPU website <http://www.health.vic.gov.au/dpu/pharm.htm>

**Until the policy is released, the existing policy remains current.**

## Safe Management of Methadone Transfers between Pharmacies

Because methadone is potentially very toxic if not used correctly, safe practice is critical to preventing things going seriously, even fatally, wrong when prescribing or dispensing methadone. This is outlined in the Victorian guidelines.

For several years we have known about the risks associated with beginning treatment with methadone, during the first two weeks of treatment.

Recent incidents have identified risks associated with transfer of patients between pharmacies, and the need for meticulous checking of methadone dosing history before prescribing or providing doses of methadone for transferring clients.

A number of countermeasures are recommended in the Victorian guidelines.

Recommendations include:

- Prescribers should ensure that patients have been dosing regularly, and have not lost opioid tolerance through interrupted or irregular dosing, before repeating prescriptions.
- Pharmacists should contact the prescriber if the patient attends irregularly for methadone doses.
- Pharmacists beginning or resuming dosing should contact the previous purported dosing point to confirm the dose and precise date on which the last dose was given.

- If the pharmacist finds that there has not been continuous dosing or there are irregularities in frequency of dosing or actual dose, he or she should contact the prescriber for direction.

If the dosing history suggests a risk that opioid tolerance has been lost, follow the Starting Methadone Law: Start low and go slow.

## Reminders

Pharmacists must not dispense pharmacotherapies after a prescription has expired. Consistent and prominent methods noting prescription expiry dates should be used.

Pharmacists may use telephone directions from the prescriber in an emergency but the directions should be confirmed by fax, and followed by the original prescription.

Prescribers must certify client photographs prior to dosing by the pharmacist.

## DPU has moved to 50 Lonsdale Street, Melbourne

However, the 1300 numbers for fax and telephone remain unchanged.

**Phone: 1300 364 545**  
**Fax: 1300 360 830**