INPATIENT PRACTICE

Suboxone for Opiate Withdrawal in the Hospital

BY WILLIAM B. HUNTER, M.D.

Suboxone, a combination of buprenorphine and naloxone, originally was developed for outpatient psychiatric practice. However, the hospital setting just might be ideal for treating inpatients who have opiate addiction with Suboxone.

This month, Dr. William B. Hunter, who is an inpatient psychiatrist with expertise that includes several years as medical director of Turquoise Lodge, a substance abuse treatment program in Albuquerque administered by New Mexico's health department, examines conditions under which Suboxone might be used to help the psychiatric inpatient.

CLINICAL PSYCHIATRY NEWS: How is Suboxone administered by physicians with office-based practices?

Dr. Hunter: In a nutshell, a patient addicted to heroin, for example, can come to the physician's office in a state of withdrawal (4-8 hours after the last dose of heroin). Suboxone-induced withdrawal can then begin. During those hours, the patient becomes stable on a dose of Suboxone and is discharged from the office to return for follow-up the next day.

CPN: Why are patients with heroin addiction such a challenge to treat?

Dr. Hunter: In general, heroin addiction is not a nice, clean-cut sort of illness. "Feeding" the illness, so to speak, is illegal in every sense of the word. By definition of addiction, the heroin addict's primary focus of energy is obtaining drugs. The illegal nature of opiates combines with the compulsion of addictive illness. The result more often than not is craftiness combined with a degree of poverty and impaired health. Certainly from the hospital perspective, the healthy, motivated, and gainfully employed opiate addict is a rarity.

CPN: Is it typical for heroin addiction patients to be admitted to an inpatient psychiatry unit?

Dr. Hunter: I wouldn't say this is typical. Patients may be admitted to a unit devoted to drug detoxification or to a psychiatric unit. Admission to the latter generally signifies a concurrent psychiatric disorder. Traditionally, an opiate detoxification on either type of unit ideally is managed with a methadone taper. (Units without federal licensure for methadone have been limited to nonnarcotic withdrawal treatments. Although moderately effective, such programs tend to have a high percentage of patients leaving against medical advice fairly early in their treatment.)

CPN: Do issues of facility licensure for use of a substance such as Suboxone come into play?

Dr. Hunter: Because the prescription of Suboxone is through physicians who have received specialized training for buprenorphine treatment of addicts, there is no issue of facility licensure. Any psychiatric or inpatient substance abuse treatment center with a licensed pharmacy and a properly trained physician can use Suboxone for opiate withdrawal treatment. This capability makes safe, effective treatment of opiate dependency much more available nationwide. I suspect that within a few years, if not already, such addiction treatment will be readily available on medical or surgical units for properly identified patients who are suffering from opiate addiction.

> **Because the prescription of Suboxone is through physicians with specialized training for buprenorphine treatment, there is no issue of facility licensure.**

CPN: I understand that there are a couple of caveats to keep in mind when treating patients with Suboxone. What are they, and why do they exist?

Dr. Hunter: These caveats arise from the fact that Suboxone is both an opiate agonist and an antagonist. First, the patient must be demonstrating symptoms of opiate withdrawal. The intensity of withdrawal can be evaluated by an experienced clinician or by use of the Clinical Institute Narcotic Assessment (CINA) scale. Frequently, the latter will be used in the hospital by nursing personnel and then be supplemented through clinical evaluation.

Second, methadone-treated patients should not undergo induction with Suboxone unless a stable daily dose of 30-35 mg/day has been verified through a methadone clinic. If the patient is not in a program and has urine positive for methadone, that patient is not a candidate for Suboxone-induced opiate withdrawal.

CPN: But wouldn't an inpatient be less likely to test positive for methadone?

Dr. Hunter: Yes, generally an inpatient demonstrates clear symptoms of opiate withdrawal 4-8 hours after the most recent use. A longer period of time before withdrawal symptoms develop will occur with some of the synthetic opiates, and where methadone detoxification is intended (at a maintenance dose of 30 mg/day of methadone), the time before significant withdrawal symptoms may be as long as 24-36 hours.

CPN: This sounds like a fairly short time range. But it probably feels like a long time for the patient.

Dr. Hunter: That's right. Also, it's important to remember that opiate addicts seem to have more trouble generally tolerating pain.

On the other hand, it is fairly easy to make the patient an ally in the induction. The opiate addict who has not experienced withdrawal symptoms is rare. Maintaining close medical observation with the promise of intervention as withdrawal symptoms become apparent allows a generally high level of collaboration with the patient.

CPN: At what dosages do you treat these patients? How would you titrate up?

Dr. Hunter: With clear symptoms of opiate withdrawal, I like to begin an induction that is at once both conservative and results in rapidly diminishing withdrawal symptoms. After a thorough explanation to the patient about allowing the Suboxone to dissolve under the tongue, I administer a test dose of 2 mg. If there are no adverse effects, I administer 4 mg sublingually after ½ hour. If there are no adverse effects after what is now a total of 6 mg, I administer 8 mg sublingually 1 hour after the second dose. Usually, the patient has felt considerable reduction of symptoms at the time of the 8-mg dose. After successful administration of the 8-mg dose, I begin a regimen of 8 mg sublingually three times daily.

CPN: At what point is a baseline for Suboxone administration established?

Dr. Hunter: This usually occurs after 24-48 hours. Also at this point, a withdrawal taper or maintenance dose regimen may be implemented. The hospital setting allows close monitoring for any adverse reactions. ■

DR. HUNTER *is an inpatient psychiatrist at Lutheran Medical Center, New York.*

Survey Addresses Location, Practice Patterns of Pain Specialists

BY ROXANNE NELSON
Contributing Writer

SAN ANTONIO — Lack of nearby pain practices helps explain why only about 5% of U.S. adults with chronic pain ever see a pain specialist, Brenda Breuer, Ph.D., said at the annual meeting of the American Pain Society.

The finding comes from a survey of 748 pain specialists who responded to a survey that was sent to about 2,500 pain specialists certified by the American Board of Medical Specialties or the American Board of Pain Medicine.

"We felt that if we identified any deficiencies, that would be a first step towards improvement," explained Dr. Breuer of the department of pain medicine and palliative care at Beth Israel Medical Center, New York.

The specialties, age, and geographic location of the physicians who responded to the survey were similar to those of the nonresponders. Most (74%) had primary training in anesthesiology, whereas others were trained in physiatry (15%), neurology (5%), psychiatry (3%), and other areas (11%).

Analysis of census data showed that individuals residing near pain practices were similar to the general U.S. population. Pain practices were underrepresented in rural areas, and people living near pain specialists tended to have higher incomes and higher education levels that the general population.

Academic physicians, who accounted for about one-third of the respondents, were more likely than others to have had their primary training in neurology, and were more likely to have completed a pain fellowship. They were also more likely to be associated with a facility involved in research, to hospitalize patients for aggressive treatment of severe pain, and to have interdisciplinary practices.

> **Although there are only six board-certified pain physicians per 100,000 adult chronic pain patients in the United States, it is as yet unclear whether there is a shortage.**

Respondents in practices that focus on a specific modality (29%) were more likely than others to have had their primary training in anesthesiology, and were significantly less likely to have interdisciplinary practices, to prescribe and maintain patients on controlled substances, to follow patients longitudinally, and to hospitalize for aggressive treatment of severe pain. They were also more likely than others to treat pain in only one part of the body, such as headaches.

Conversely, physicians in multimodality, comprehensive practices were more likely to use opioids and to collaborate with specialists. They were also likely to have an integrated practice, which included not only physicians of different specialties but also a psychologist, a physician assistant, and a social worker.

Board certification does not imply a uniform approach to chronic pain treatment. Nationally, there are only six board-certified pain physicians per 100,000 adult chronic pain patients, but it is as yet unclear whether there is a shortage, she said.

"Future surveys of pain patients are needed to complement physicians' surveys to assess the actual efficacy of pain management," Dr. Breuer said. ■

Pages 54a—54b