Addiction Therapy May Expand to Primary Care

Treatment advances can broaden access to care and improve compliance in heroin and opioid addicts.

BY SHARON WORCESTER

The recent headway of two treatments for addiction to heroin and other opiates represents a major advancement and has the potential to put opioid addiction therapy within the purview of primary care providers, according to several experts.

The approval in October of a new indication for an injectable, extended-release formulation of the opioid receptor antagonist naltrexone, marketed as Vivitrol (Alkermes Inc.), now allows for its use as a treatment for preventing relapses in people who have undergone opioid detoxification. Moreover, an implantable form of the opiate agonist buprenorphine, that delivers a continuous dose of medication for up to 6 months, showed promise in a recently published phase III study.

Both advances have the potential for broadening access to care and improving treatment compliance, according to Dr. Nora D. Volkow, a psychiatrist and the director of the National Institute on Drug Abuse (NIDA).

Ultimately, the treatment options could help improve outcomes for the more than 800,000 people in the United States who are believed to be addicted to heroin, and the 1.85 million who abuse or are dependent on opioid pain relievers, such as Oxycontin and Vicodin, Dr. Volkow said in an interview.

Dr. Volkow said that she envisions an expanded role not just for psychiatrists and addiction medicine specialists, who have traditionally managed opioid-dependent patients, but also for primary care doctors and infectious disease specialists who could provide integrated care for heroin-addicted HIV patients.

Physicians Can Improve Tx Access

Access to care for all people with opioid dependence would be improved if more physicians adopt these new treatment options. Compliance also would improve, largely because both treatments involve extended dosing, Dr. Volkow pointed out.

Older treatment options such as methadone and daily sublingual buprenorphine can be effective, particularly when combined with counseling. However, they require more frequent dosing, a daunting hurdle for patients whose ability to be compliant is easily derailed by the forces of craving and the risk of relapse.

Furthermore, diversion is an issue with sublingual buprenorphine. And many treatment centers reject the idea of using opiates, even synthetic ones, to treat opioid addiction.

Vivitrol, which was approved in 2006 for the treatment of alcohol dependence, is the first non-narcotic, nonaddictive extended-release medication approved to treat opioid dependence. In a 6-month study of 250 patients, monthly intramuscular injection with the drug proved significantly more effective than placebo for preventing relapses: 36% of treated patients, compared with 23% of those on placebo, used no opioids between the 5th week and the end of the study, according to a statement released by the Food and Drug Administration following its approval of this new indication.

Importantly, all patients in the trial were completing or had recently completed detoxification and were no longer physically dependent on opioids at baseline.

Despite concerns that patients would not return for repeat injections, Dr. Volkow said she was particularly encouraged to learn that patients did return routinely in the Russian studies on which the new Vivitrol approval was based. "Patients were very compliant, which was not necessarily predictable," she said. "That made me very excited about this particular medication."

COURTESY NATIONAL INSTITUTE ON DRUG ABUSE (NIDA)

Patients were "very compliant. ... That made me very excited about this particular medication," Dr. Nora D. Volkow said.

NIDA is funding a study to replicate and expand upon the Russian studies, to verify that U.S. patients would respond similarly. Investigators also plan to compare outcomes associated with Vivitrol vs. buprenorphine, she said.

In a phase III, randomized controlled study of 108 opioid addicts, implantable buprenorphine was associated with a 6-month significant reduction in drug use among 40% of patients, compared with 20% of those taking placebo.

About 60% of the treated participants completed the study without experiencing withdrawal symptoms or cravings that compelled them to drop out. By comparison, studies of the daily sublingual dose of buprenorphine currently available for use showed a median adherence of only 40 days in clinical settings, and retention rates in 6-month clinical trials were only 35%-38% (JAMA 2010;14:1576-83).

Dr. Volkow said that she hopes implantable buprenorphine will soon become part of the arsenal of weapons against the crippling effects of opioid addiction.

But will more primary care physicians and other specialists start to provide addiction care?

"It's going to be very interesting to watch," said Dr. Peter D. Friedmann, professor of medicine and community health at Brown University, Providence, R.I.

"Traditionally, primary care doctors have not been very proactive in taking on the care of these patients," he said.

However, he suggested that opioid dependence could be the new depression. That is, until the advent of relatively safe and easy-to-use depression medications in the early 1980s, the care of depressed patients was not seen as the purview of primary care doctors, but now they are routinely treating depression in their practices.

Will Opioid Dependence Become The New Depression?

It remains unclear whether that will be the case now, however, given that Vivitrol has been available for years for the treatment of alcohol abuse and primary care doctors have not exactly "flocked to take that on," he said.

These are complicated patients who at times are difficult to manage, and there is still a lot of stigma and unease among doctors about how to care for them, he explained.

"It's clearly a positive for the field. It's going to improve things, but is it going to be a panacea? I doubt it," he said, adding: "I'm cautiously optimistic."

Dr. Thomas Kosten, former director of the U.S. National Buprenorphine Implementation Program and currently a professor in the psychiatry and neuroscience departments at Baylor College of Medicine, Houston, also expressed cautious optimism about expanded access to care for opioid-dependent patients.

"I can't imagine psychiatrists performing the minor surgical procedure involved with buprenorphine implants, but it is certainly within the purview of many internists and general practitioners," he said, noting that in many cases in primary care, the machinery is already set up for providing such office procedures, and – in the case of Vivitrol – for providing injections.

"In fact, they would be more comfortable and better equipped to do this," said Dr. Kosten, who also is research director of the Veterans Health Administration's National Substance Use Disorders Quality Enhancement Research Initiative, based in Houston.

A challenge might be in ensuring that patients receive counseling as needed, but research is increasingly indicating that patients can do well on medications alone if they remain compliant, so concern may be moot, he added.

Another deterrent for many providers has been the requirement of government-sponsored training and oversight of physicians who wish to prescribe buprenorphine.

Dr. H. Berryman Edwards, a psychiatrist in private practice in Bellevue, Wash., and an outspoken critic of the U.S. Drug Enforcement Administration's "disruptive" approach to the oversight of physicians who do prescribe buprenorphine, agreed that psychiatrists aren't likely to use the implantable formulation.

But he acknowledged that for primary care doctors and others who embrace this new formulation, it eliminates many of the concerns about diversion and compliance that have deterred physicians from using the treatment in the past.

It will take a certain level of commitment from those who have a desire to use these treatments in the primary care office setting, said Dr. Andrew J. Saxon, a professor of psychiatry and behavioral sciences at the University of Washington, Seattle, and one of the site investigators for the implantable buprenorphine study.

While most primary care doctors probably won't have an interest, those who are willing to learn the implantation procedure – which can be a bit time consuming – and who undergo the required training, will certainly be able to provide this treatment in the office setting.

In some cases, it may be that the implants are done elsewhere but patients are followed by their primary care physician, he said.

Vivitrol's Primary Care Promise

Vivitrol, on the other hand, could quite easily be provided in the primary care setting. He described Vivitrol as "a pharmacological treatment that is almost perfection," largely because of the requirement that patients be off opioids before they can receive it.

Vivitrol is safe, he said, with one exception: Patients receiving it will have a decreased tolerance for opioids, and may be at an increased risk of overdose.

The overdose risk must be closely monitored, but overall, the treatment has the potential to be a tremendous advantage, Dr. Saxon said.

Dr. Volkow and Dr. Edwards reported having no conflicts of interest. Dr. Friedmann has studied Vivitrol and has received in-kind donations of the medication for his research. He is on the speakers bureau for Reckitt Benckiser Pharmaceuticals, the maker of the sublingual formulation of buprenorphine. Dr. Kosten has served as a consultant to Reckitt Benckiser and to Alkermes. He has served on the data safety monitoring board for Titan Pharmaceuticals, which makes the implantable buprenorphine. Dr. Saxon has served as a consultant to Reckitt Benckiser, and was a site investigator for the Titan-sponsored buprenorphine implant study. ■