

Experts Still Railing Against Buprenorphine Limits

American Society of Addiction Medicine says law makes no sense and 'constitutes rationing of care.'

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN DIEGO — Despite the recent potential easing of the federal limit on the number of opiate-addicted patients a physician can treat, substance abuse experts continue to see a pressing need for more buprenorphine slots.

At a recent meeting of the American Society of Addiction Medicine, those experts complained that there were still more potential patients than they can legally treat. These experts are lobbying government officials for a further easing of the limit.

A bill recently introduced into the U.S. Senate by Sen. Arlen Specter (R-Pa.) would in essence relax the limits further. The revision would allow those who have had their buprenorphine waiver for 1 year to apply for more patients.

The Drug Addiction Treatment Act of 2000 created the office buprenorphine prescribing program. Initially, the 30-patient limit established by the act was interpreted to mean 30 patients could be treated per site. However, in August 2005, that provision was amended to mean 30 patients could be treated per physician, regardless of the number of physicians with a waiver who were based at a particular site.

Those attending the meeting cheered and applauded when Mark L. Kraus, cochair of the society's public policy committee, said in a statement from the society that the law "makes absolutely no sense" and "constitutes rationing of care."

"No other FDA-approved medication has an arbitrary limit as to the number of patients a physician is allowed to treat," Dr. Kraus said. "If government's major purpose is to prevent diversion, rationing of care is not reasonably related to that goal."

Currently, there are about 7,000 physicians who have received the training and a waiver for office treatment of addiction with buprenorphine.

No one ventures to estimate the number of potential opiate-addicted individuals who are prevented from getting treatment because of the 30-patient limit. However, it has been reported that clinics in some cities have hundreds on their waiting lists.

And some physicians are known to be openly flouting the limit and exceeding it, with one physician in Massachusetts treating some 600 patients, government officials said at the meeting.

On the other hand, only 20% of 1,059 waived physicians reported being at the 30-patient limit in a 2005 survey, said Ar-

lene Stanton, Ph.D., of the Center for Substance Abuse Treatment, of the Substance Abuse and Mental Health Services Administration (SAMHSA).

The caveat to interpreting that number, however, is that only 67% of the waived physicians reported having prescribed buprenorphine and, of those who had prescribed it, 38% used it only to detoxify patients, not for maintenance.

Regarding safety and effectiveness, the buprenorphine program appears to be going well, according to Dr. Stanton's report. In a survey of about 400 patients, 59% were free of all illicit drug use; 81% were free of all opioid use. At the same time, the Drug Abuse Warning Network recorded only 108 emergency department visits related to buprenorphine use in 2004.

By March 2005, 104,640 patients had been inducted onto buprenorphine, with about 65,000 of those patients on maintenance treatment.

Diversion of buprenorphine may be occurring, but it is not considered a problem by federal authorities, said Denise Curry, deputy director of the Office of Diversion Control at the Drug Enforcement Agency (DEA), who spoke at the meeting.

Ms. Curry said there are reports that Suboxone is available on the streets and that it goes for about \$45 a dose in Virginia, but the agency has not found any evidence of abuse and has no confirmed cases of diversion.

The DEA is much more concerned with

other problems, particularly methamphetamine, Ms. Curry said.

"We have bigger fish to fry," she said.

The other, equally important, solution to the lack of availability of buprenorphine for all those who need it is to encourage more physicians to get a waiver, said Dr. H. Westley Clark, the director of SAMHSA's Center for Substance Abuse Treatment.

There are about 500,000 ambulatory-care physicians in this country, but only 7,000 have a waiver. Getting a waiver takes only 8 hours of training, and most states require physicians to have 25 hours of continuing medical education a year, he said.

"We need to convince our colleagues in primary care that they, too, have a responsibility in this," he said. "We have a large number of physicians who are not willing to deal with this."

But while increasing the number of prescribers might be a solution in the cities, it may not be in rural areas, according to one person at the meeting who got up to speak.

Rural America has a big problem with illicit opioid use in general and OxyContin in particular. But most primary care physicians in rural areas are too busy already to take on treating substance abusers, said Dr. James W. Berry of Bangor, Maine.

"As for psychiatrists, there aren't any," he added. ■

Buprenorphine Switch Improves Detox

BY TIMOTHY F. KIRN
Sacramento Bureau

SAN DIEGO — The switch from the use of intramuscular buprenorphine to sublingual buprenorphine probably has improved the completion rate of short-term, inpatient opiate detoxification, according to the experience at the Center for Chemical Dependence at Johns Hopkins Bayview Medical Center, Baltimore.

When that 26-bed detoxification unit switched to sublingual buprenorphine, the withdrawal-treatment completion rate went from 73% in the 3 months before the change to 86% in the 3 months after, said Dr. Janet Soeffing of the center at the annual conference of the American Society of Addiction Medicine.

In the 3 months before the switch, which occurred in November 2004, 483 patients were admitted for opiate withdrawal and treated with intramuscular buprenorphine. In the 3 months after, 473 patients were admitted and treated with the sublingual agent.

Among a control group of patients who entered the unit but did not receive treatment for opiate dependence, the rates of treatment completion were 89% in the 3 months before November 2004 and 83% after, a difference that was not statistically significant, Dr. Soeffing said.

The patients who did not

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complete treatment either left against medical advice or were dismissed by staff for breaking the rules of the unit.

The administration protocol for the intramuscular buprenorphine was a standard one in which patients received 0.3 mg twice daily for 3 days.

The protocol for the sublingual buprenorphine was based on a regimen developed in Australia (Drug Alcohol Depend. 2003;70:287-94); patients received 8 mg the first and second day, 6 mg the third day, and 2 mg

on the morning of discharge.

"There are some studies to suggest that the sublingual formulation of buprenorphine may be associated with a faster onset of action or even a greater bioavailability," said Dr. Soeffing, speculating on the possible reason why completion improved. "But these studies are hard to replicate."

The sublingual formulation was approved in this country in October 2002 and immediately began to replace intramuscular buprenorphine as the agent of choice for detoxifying, Dr. Soeffing said.

Withdrawal-treatment completion is extremely important because patients who fail to complete tend to drop out of the medical and dependence-recovery system altogether, Dr. Soeffing said.

Previous studies have shown that some of the factors associated with not completing withdrawal treatment include young age, a shorter duration of drug use, female sex, dual diagnosis, and the medication used for symptom control during withdrawal, she added. ■

Panic Attack/Alcohol Use Association Greater in Men

BY DAMIAN McNAMARA
Miami Bureau

MIAMI — Higher self-reported alcohol consumption among men with panic attacks carries important implications for patient screening, according to a poster presentation at the annual conference of the Anxiety Disorders Association of America.

"The take-home message for physicians is to look for comorbidity in men with panic attacks for alcohol use and other substances," Erin Marshall said in an interview.

Previous research indicated a relationship between panic attacks and drinking behaviors. "It could be a coping mechanism—people with panic attacks drink more than people without panic attacks," said Ms. Marshall, doctoral student in clinical psychology at the University of Vermont at Burlington.

To assess associations between panic attacks, alcohol consumption, and gender, Ms. Marshall and her colleagues studied 413 college students in Mexico City. One of the collaborators, Samuel J. Cardenas, Ph.D., of the Uni-

versidad Nacional Autonoma de Mexico, facilitated recruitment of participants.

A total of 61% of participants were female. Each student completed self-report measures about substance use patterns and panic attack history. "We found men with panic are drinking the most," Ms. Marshall said.

As predicted, individuals experiencing panic attacks were significantly more likely to drink alcohol (P less than .01), as were males (P less than .001). In addition, "the interaction of panic attacks and gender incrementally predicted levels of alcohol consumption (P less than .001), such that the association between panic attacks and alcohol consumption was stronger in men than women," the authors wrote.

"There was a nonsignificant difference in women between those with panic attacks and those with no panic," Ms. Marshall said.

The findings of this study are a starting point for future research. The present research only assessed alcohol consumption and, she added, it might be useful next to study people with alcohol abuse. ■