Complex Cases in Buprenorphine Treatment

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Action Period Assignments from - 2/12/21

- Do you currently counsel your MAT patients on alcohol use prior to prescribing buprenorphine? If so, what do you advise your patients?

- A patient on buprenorphine with no history of AUD, psychiatric illness, or other SUD diagnoses asks you if he can “have drink of wine with my dinner a couple times a month.” What is your advice and why.

- You inform a patient that his urine testing will include EtG and EtS, and he responds to you: ”I don’t consent to that. I don’t drink and I’m not paying for a test that is completely unnecessary.” What is your reply and why.

Today's Cases

- Real examples: histories and outcomes are presented just as they happened.
- Unexpected outcomes, as a training tool, are essential to review.
- Some of the treatment interventions implemented were done based on clinical intuition, rather than derived from the medical literature or published guidelines.
- Please participate in case discussions and share your opinions!

Case of Cindy

- 33-year-old pregnant Caucasian female at 12 weeks, presents to a collaborative care OB/Addiction clinic with a history of heroin addiction and significant anxiety symptoms.
- She reports using IV heroin for 2.5 year but has reports sustained sobriety from the drug for approximately 7 years.
- Briefly participated in a methadone maintenance program for 9 months.
- Was on prescribed buprenorphine for approximately 3 years but self-discontinued this medication 1 year ago.
- Currently not on MAT and is not requesting buprenorphine.

Case of Citdy – First visit

- At first visit, the patient reports taking buprenorphine from an "old prescription" and is using ¼ of an 8 mg tablet "every few days" and feels that she can discontinue this medication at any time.
- Current prescribed medications:
  - Xanax 1 mg twice daily
  - Zoloft 100 mg daily
  - Gabapentin 300 mg 3x daily.
  - Seroquel 100 mg at bedtime.
- Psychiatric history: Diagnoses of MDD, OCD, and GAD. She reports "anxiety" as her primary concern.

Case of Cindy

- Psychiatric history (cont’d): 2 inpatient psychiatric hospital stays 3 years ago, one of which was following a suicide attempt.
  - Patient attempted to jump off a bridge but was intervened upon.
- The hospital stays and the suicide attempt were triggered by her newborn baby being ”taken away” due to her substance use difficulties.
- Patient is not under the care of a psychiatrist and is not currently engaged in psychotherapy.
- **Questions:**
  - Does anything particularly concern you at this point?
  - Is there any part of the above history that you would like to expand on?

Case of Cindy – Substance use History

- Used IV heroin for 2.5 years, before participating in a long-term residential treatment program, during which, she was placed on methadone
- Was on methadone for 9 months.
- After stopping methadone, patient was placed on buprenorphine which she continued for 3 years, before self-discontinuing this medication within the last year.
- Reports occasionally using more then the prescribed Xanax.
- No history of any other substance use related difficulties.
- She attends AA/NA meetings 2-3 times per week.

Case of Cindy – Social History

- Lives with her mother
- Never married
- Gave birth 3 years ago, but states her baby was "taken away" by CPS. This was an emotionally traumatic experience.
- Not currently employed but trained as a medical assistant.
- Currently on probation for disorderly conduct and jostling.
- No history of other psychological trauma, including any physical, sexual, or emotional mistreatment.
- Father has a significant history of drug and alcohol addiction but is in recovery and is very supportive to the patient.

Case of Cindy – First visit

- Urine drug screen: only prescription medications present: alprazolam, gabapentin, sertraline, and quetiapine.
- MAPS report: regular prescriptions for alprazolam. No concerning activity.

- **Questions – Your initial assessment is complete:**
  - **What is your recommended treatment plan?**
  - **What, if anything, are you most concerned about?**
  - **What else would you like to know?**

Case of Cindy – Initial Plan

- Recommend detoxification off Xanax, due to its high reinforcement potential, history of misuse, and her SUD history.
  - Detoxification was recommended with clonazepam, due to it's long-acting nature.
  - Patient still had one month supply, so no new Rx was provided.
- Continue all other prescribed medications.
- Encouraged continued participation in NA/AA.
- Recommended out-patient treatment services – County access number provided.
- Follow with regular urine drug screens and MAPS reports.
- Follow-up in 2 weeks.

Would you do anything differently?

Case of Cindy – 2nd Follow-up

- Patient reported continued intermittent use of non-prescribed buprenorphine, which she reports was from an old prescription.
- She also reports continued use of Xanax and is using more than the prescribed amount on days that are more "stressful."
- Clinicians considered Rx for buprenorphine, but concern arose regarding patient's concurrent use of Xanax and likely illicitly acquired buprenorphine.
- UDS: No unexpected results
- Inpatient treatment suggested, but patient declined.

What are your thoughts?

Case of Cindy – 3rd Follow-up

- Patient reports buying Ativan and Suboxone off the street.
- She reports using buprenorphine and benzodiazepines to help mitigate anxiety.
- UDS and MAPS report: unremarkable
- Clinicians again consider prescribing buprenorphine but are concerned about patient's non-prescribed use of buprenorphine and BZDs.
- Inpatient treatment was again recommended, and patient was provided with resources, but she declined.
- Follow-up scheduled in 2 weeks.

Case of Cindy - 4th follow-up

- Patient declined to participate in inpatient treatment.
- She reports discontinuing her use of non-prescribed buprenorphine and has not used the drug in 5 days.
- She reports experiencing significant opioid withdrawal and described “feeling terrible.”
- Continues to use Xanax (provider has issued another Rx) and has been taking 3-4 mg daily over the last two weeks.
  - She will run out of her Rx early and reports her provider will not issue another Rx.
  - She is asks for assistance with BZD withdrawal.
  - **What would you do?**

Case of Cindy – Treatment plan

- Patient was placed on clonazepam to wean off benzodiazepines.
  - Longer acting BZDs make the tapering process easier for the patient.
  - Initial dose of clonazepam 1 mg 2x daily, with a plan to decrease by 10-20% every 2-4 weeks.
- She continues to decline inpatient services.
- Continue to follow urine drug screens
- She is now seeing a counselor every 1-2 weeks.
- Encouraged continued participation in NA/AA

Case of Cindy – 5th Follow-up visit

- Patient now at 21 weeks (over 2 months since first visit).
- She has tolerated clonazepam (2 mg daily) well.
- Reports continued use of non-prescribed buprenorphine and is using a "sliver" of an 8 mg tablet. She last used this drug 4 days ago and reports mild-moderate symptoms of opioid withdrawal.
- UDS shows buprenorphine but is otherwise unremarkable.
- Recommendations to patient:
  - Methadone maintenance – patient adamantly declined.
  - **Why was methadone recommended?**
  - **Do you agree?**

Case of Cindy – What about buprenorphine?

- **Why not prescribe buprenorphine?**
- Clinician's mindset at that time.
  - Misuse of benzodiazepines
  - Obtaining buprenorphine and BZDs from street
  - Concern for diversion and escalation of substance misuse.
  - Methadone maintenance and/or inpatient treatment were deemed as best treatment option.

Case of Cindy – 6th Follow-up visit

- Patient at 24 weeks
- Doing well on clonazepam 1 mg 2x daily – she is not ready to taper.
- Reports last use of buprenorphine was 2 weeks ago.
  - She continues to report significant withdrawal symptoms and generally reports not to be feeling well, due to buprenorphine discontinuation.
- UDS shows buprenorphine and clonazepam.
  - **Patient reported last use of buprenorphine was 2 weeks – UDS should not show drug.**
- Patient denied use of buprenorphine, despite UDS results.

Case of Cindy – Subsequent visits

- Patient was compliant will all f/u visits and UDSs.
- Decision was made to maintain the patient on clonazepam and NOT to taper.
- She continued to test positive for buprenorphine, but would only admit to intermittent use, and acknowledged purchasing this off the street.
- All urine drug screens were unremarkable, other than consistently showing buprenorphine.
- Patient's anxiety significant increased as her due date approached, due to fears of potential CPS involvement, given her prior history.

Case of Cindy – Final outcome

- Patient was scheduled for induction of labor and described anxiety to OB NP as "through the roof" at her last visit.
- At 39 weeks, and 3 days after her last appointment, Laura found on her bed unresponsive with a syringe by her side.
- She was taken to local hospital where she and her unborn child were pronounced dead.
- Cause of death was a heroin overdose.
- She was 33 years old.
- Our entire clinic, MD, NP, RN, MSW, MA, and even front desk staff attended the funeral.

Case of Cindy – Retrospective

- Was this an unintentional OD or a suicide?
  - We will never know.
- We didn't expect this....
  - Urine drug screens NEVER showed heroin or any other opioid other than buprenorphine.
  - No evidence of heroin use throughout her entire pregnancy.
  - Patient was compliant: never missed an appointment or UDS.
- Warning signs:
  - History of IV heroin use.
  - History of 2 inpatient psychiatric hospital stays associated with last pregnancy.
  - History of an aborted suicide attempt following last delivery.
  - Significant escalation in anxiety when told of induction of labor.

Case of Cindy – My thoughts….

- Hindsight is always 20/20….
- What we could have done differently:
  - Prescribe buprenorphine despite our concerns and be liberal with dosage to ensure patient comfort.
  - Do not switch to clonazepam
  - Continue use of Xanax, along with prescribed buprenorphine under close medical supervision.
  - Provide 7-14 days prescriptions of Xanax and buprenorphine to limit potential for overuse.

What do you think?

Case of Becky

- 33-year-old pregnant female at 29 weeks presents with a 6-year history of heroin and methamphetamine use.
- She was recently treated in a long-term care facility and was placed on Subutex (buprenorphine) 8 mg 3x daily. She was discharged from residential treatment 10 days prior to presentation.
- Patient reports that only days after discharge, she began using heroin and methamphetamine again, in addition to the prescribed buprenorphine.
- UDS shows morphine, methamphetamine, THC, and buprenorphine.

Case of Becky

- Psychiatric history: patient reports:
  - History o "manic depression."
  - Multiple inpatient psychiatric hospitalizations, due to drug overdose. Patient reports that overdoses were due to addiction and were not suicide attempts.
  - Denies any history of suicide attempts.
  - History of multiple psychiatric medication trials, but reports doing best on Lithium.
- She reports feeling significantly depressed with mood swings. No SI.
- Mental status exam does not reveal any signs of mania, hypomania, or psychosis.

Case of Becky – Social History

- Unstable housing, but lives with FOB, who is abusive.
- Was previously living in hotels.
- Has two children who live her parents.
- Currently facing significant legal charges and possible prison time, due to drug-related offense.
- Has no reliable support (possibly grandmother).

- **What is your treatment plan for Becky?**

Case of Becky – Treatment plan

- Methadone maintenance was recommended, but patient adamantly declined.
- Inpatient treatment was also suggested, but patient declined.
- Rx Lithium 300 mg 2x daily, based on patient's psychiatric history, mental status exam findings, and report of therapeutic efficacy.
- Agreed to provide 7-day supply of buprenorphine with RV in one week.
  - Patient educated on precipitated withdrawal and informed on how to preform a home induction.

Case of Becky – 2nd Follow-up visit

- Patient reported continued methamphetamine use (3x since last visit).
- Also reports use of a single dose of unprescribed Xanax and Seroquel.
- Denies any opioid use and is happy with buprenorphine.
- She reports to be considering adoption and has an interested party in mind (MSW met with patient in this regard).
- Patient provided 1 week Rx for buprenorphine.
- UDS obtained and results uploaded next day….

Case of Becky

- UDS from 2nd f/u visit:
  - Buprenorphine
  - Methamphetamine
  - Amphetamine
  - Fentanyl and norfentanyl
  - Tramadol

- **What would you do now?**

Case of Becky – Concerns arise

- Attempted to contact patient to discuss UDS – no answer
- Patient no-shows to f/u visit
  - MD and MSW make multiple attempts to call patient – no answer and no option to leave voice message.
  - Patient does not call to request buprenorphine Rx (she was only given one week supply).
- Patient no shows again one week later.
  - MD and MSW place calls – no answer
  - Grandmother contacted, who stated that she has not heard from patient in 2 weeks (her last appointment date).
- MSW suggests doing "wellness check."

Case of Becky – patient resurfaces

- Patient returns to clinic after a 5-week absence.
- Gestational age is now 37 weeks.
- She reports that she was in Saginaw, due to the ailing health of FOB's mother.
- States she has been out of buprenorphine and has been using heroin.
- Reports intermittent methamphetamine use.
- UDS positive for morphine and methamphetamine
- **What would you do?**

Case of Becky

- OB recommends admission for induction of labor (IOL) for baby's safety given deterioration of patient's status.
- Patient offered an admission for IOL, but declines.
- Admission to addiction treatment facility recommended with placement on methadone, but patient declined.
- Patient provided 7-day supply of buprenorphine to help mitigate risk of overdose and death.
  - Difficult decision
  - Discussed with all clinicians involved.
  - Concerns and reasons for prescribing reflected clearly in the medical record.
  - No additional updates currently – Becky is still pregnant

Case of Becky – Takeaway points

- Sometimes we engage in a harm reduction approach.
- Create an environment where the patient is willing to come back to you, regardless of the circumstance he/she has encountered.
- Reach out and ask for guidance, if the case is too complex. It ALWAYS helps to discuss a case with a colleague.
- TREAT THE PATIENT, NOT THE DRUG SCREEN RESULTS.
- Always document your reasoning, especially in cases of high-risk prescribing.
  - Acknowledge that this is a high-risk situation, but that you're engaging in this treatment to prevent a potential overdose and death and that you will appropriately monitor the patient.

Action Period Assignments

- We discussed today two high risk cases today with two very different treatment approaches. One involved prescribing buprenorphine in a high-risk situation, and other involved not providing buprenorphine under similar circumstances. Prior to this presentation, what was your opinion of providing buprenorphine in the context of active substance use, and did these cases change your viewpoint? Why or why not?
- Some clinics have very stern controlled substance agreements, which stipulate that ANY drug use outside of what is prescribed may result in dismissal from the clinic. While we have discussed the clear disadvantages to this approach, can you think of any advantages to taking this type stance?

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