Session 4

Michael McCormick: What can we (ASAM) do to get Kratom deemed as an illegal and dangerous drug and therefore out of convenient stores?

- Adam Lake: still can buy pounds of dried poppy heads online too
- Jamie Redwing: I have seen several KRATOM patients admitted just for that alone
- Dr. Polydorou: Thank you for raising. ASAM member advocacy is certainly a component. The DEA has been regularly updating the substances on their control substance schedules as well. Particularly due to the growing prevalence of synthetic compounds.

Anyse Storey: I have a patient on Tianeptine 1500 mcg/day. Anyone with experience and/or recommendations for tapering ?

- Dr. Polydorou: Reports of utilizing buprenorphine has been published and clinically used.
- Dr. Polydorou: "Would also be mindful of the non-opioid effects and potential withdrawal from tianeptine as well."

Adam Lake: just to clarify, the harrison act only applies to opioids, not other substance use disorders, right? I mean, we were all just talking about using benzo tapers and barbiturates for related use disorders.

- Dr. Polydorou: Harrison's related to opioid, and cocaine derived products as well.

Juliette Perzhinsky: Is there any data about the safety of mid-level providers treating OUD independently (in IPA states)?

- Dr. Polydorou: Not familiar with negative trends being identified as a result of the CARA act expansion.

Lynn Maupin: Will kratom show on a UDS as an opioid

- Adam Lake: no, not chemically similar enough to morphine to be picked up
- Dr. Polydorou: “Generally it would not. However best to review your specific test's DRI (drug reactivity index) to ensure which opioids and opioid related compounds are detected at appropriate thresholds."

Leslie Hayes: Do exogenous opioids activate the delta receptor at all? I definitely see patients using opioids for an anxiolytic effect.

- Dr. Polydorou: There is an effort to study the treatment potential for anxiety as well as opioid related disorders by utilizing delta receptors.
- Leslie Hayes: Thank you!

Leslie Hayes: A friend was at a conference about fifteen years ago where they mentioned that patients with fatal overdose were far more likely to have clonidine on board. The thinking was that it blocks compensatory tachycardia and hypertension that usually mitigate respiratory depression. I haven't seen anything specific on that since. Any thoughts?

Ali Damji: Is buprenorphine preferred for pregnant women given the risk of precipitated withdrawal and causing preterm labour?

- Leslie Hayes: There have been studies that suggest that buprenorphine-naloxone is safe during pregnancy, and there are several centers using only the combo product. That said, the official recommendation is still to use the monoproduct.
- Sree Atluru: Good article from Henree Jones PhD regarding systematic review on bup vs bup-naloxone: https://www.ajogmfm.org/article/S2589-9333(20)30123-3/fulltext

Juliette Perzhinsky: I've noticed a different situation when initiating bup/nx on older adults with OUD and pain, they tend to not get analgesic benefit. Any recs for treatment in this delicate age group (after non-pharma and conservative tx's have been exhausted)?

Greg Gramelspacher: Would you agree that methadone should be more available for treatment of OUD outside a OTP? As is done in some counties of Europe?

- Adam Lake: And canada

Greg Gramelspacher: Comment of use of methadone to treat patients who have both chronic pain AND OUD.

- Juliette Perzhinsky: But restricted to the auspices of an OTP, correct?
- Dr. Polydorou: "Utilizing methadone for pain in those patients separately in an OTP already on methadone can be considered by clinicians familiar with its use. Methadone dosing amount and frequency are different for pain and OUD and therefore require close consideration."
- Dr. Polydorou: An OTP would not be dosing methadone for pain management.
- Juliette Perzhinsky: "Can you clarify this? If a patient has OUD and is on methadone thru an OTP and also has chronic pain, who can legally prescribe the methadone if it is for both OUD and pain?"

Sree Atluru: I help for pregnant people with SUD: OUD with induction on buprenorphine has been challenging in the high rates of fentanyl present(I've had a few preg folx go into precip withdrawal because of undisclosed fentanyl use) any thoughts or suggestions on how to safely transition them? we are trying to do more outpatient inductions to help ease hospital space

- Karl Wittnebel: Microdose ramp if you have time with them; Takes 7 days. They stay on the Fentanyl during that time, which increases compliance substantially. Search "Bernese method".

Sunil Khushalani: I thought Induction as term has been retired

Erin: Big difficulties getting on bup from those with fentanyl despite it being short acting --even waiting until very high COWS and well over 24 hours. Thoughts/suggestions.

- Karl Wittnebel: Microdose ramp. "Bernese method". Changes everything.
- Karl Wittnebel: https://onlinelibrary.wiley.com/doi/full/10.1111/ajad.13135?casa_token=-rvVDeUhPjYAAAAA%3AlkxMbhXTkRMrB_sAsTo3pWJLBg8ryep3ZwZmOUmFOq768uldpJZn6_0hpUQLiaA7jTax0P1rb7lDaN4

- Adam Lake: Hämmig R, Kemter A, Strasser J, et al. Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method. Subst Abuse Rehabil. 2016;7:99-105. Published 2016 Jul 20. doi:10.2147/SAR.S109919
- Erin: Yeah but I am outpatientn and I haven't seen as many outpatient options for microdosing. I will check the literature. Thanks
- Adam Lake: I'll use this in patients who aren't able to tolerate the short term abstinence for a classic bup start.
- Karl Wittnebel: I do it exclusively in outpatients. Suboxone 2mg films and have them cut the film
- to suit.
- Erin: awesome thanks. I have been having them cut down to 1 mg as well.

Sunil Khushalani: Could you please talk about right way to use microdosing

- Dr. Polydorou: Micro-dosing discussion can be considered during our later panel talk.

Ivy Lee: How do you manage suboxone in someone who is to have surgery or has a trauma possibly requiring narcotics for pain management? Have heard both sides- some say stop suboxone and others say continue with increased narcotics for pain.

- Dr. Polydorou: "Much to consider. Briefly would be consider maintaining but increasing dose and frequency of buprenorphine in cases of expected moderate escalation of pain when opioid pain control would otherwise be indicated

Kimberly D. Blake: Having trouble with induction more recently, with all the fentanyl. Having better success with mono tabs in precipitating withdrawal. Any thoughts?

- Adam Lake: I had been thinking that the newer generic bup/nx products seem to have lower bioavailability (based on patient reports), so the old mono product maybe has a higher effective dose? I've definitely had more success going much higher on the initial induction than my pre fentanyl bup starts.
- Dr. Polydorou: The combo formulation remains recommended.

Luther Philaya: Spring conference talked about macro-dosing. We use it with very good results.

Luther Philaya: An interesting article this week about initiation of buprenorphine in ER's. https://urldefense.com/v3/__https://www.lac.org/news/new-report-from-the-legal-action-center-finds-that-denying-necessary-care-for-substance-use-disorders-in-emergency-departments-can-violate-federal-law__;!!KXH1hvEXyw!KWcoh-mEMQL8eKEkedavgZ5gjq-vIOddgdH1yc0jZfdgBBuT-IpKqd1cKmzHwfDQw6sw$

Leslie Hayes: https://urldefense.com/v3/__https://www.lac.org/news/new-report-from-the-legal-action-center-finds-that-denying-necessary-care-for-substance-use-disorders-in-emergency-departments-can-violate-federal-law__;!!KXH1hvEXyw!KWcoh-mEMQL8eKEkedavgZ5gjq-vIOddgdH1yc0jZfdgBBuT-IpKqd1cKmzHwfDQw6sw$

- Leslie Hayes: I guess I can't include links. It was at Legal Action Center. Headline read New Report from the Legal Action Center Finds that Denying Necessary Care for Substance Use Disorders in Emergency Departments Can Violate Federal Law

- Leslie Hayes: why do we need to wait for 7 days before starting sublocade?

Hashem Dadoush: Based on the early studies and FDA initial approval information. Current research looking at it as an option for early induction.

- Dr. Polydorou: In previous lecture, he strongly recommended checks LFTs on a regular basis? Why is there such a significant difference of opinion when it comes to hacking LFTs when pt is on naltrexone?

Erin: I am gonna guess because he was giving the alcohol lecture and that group is starting out wiht inherent liver disease whereas I think this presenter is emphasizing that the drug itself is not necessarily hepatotoxic this group without other reasons to suspect liver disease likely doesn't need the same liver monitoring

- Dr. Polydorou: Yes, the general consideration of the different clinical risks around liver disease related to AUD and OUD, and therefore frequency of LFTs.

Maria Robles: What is the data behind not using naltrexone in patients with cirrhosis?

Harpreet Grewal: Is long-acting Naltrexon injection a concern if the patient needs a urgent surgery?

- Adam Lake: This is always my fear in patients on XR-NTX
- Dr. Polydorou: The effects of naltrexone-xr is generally limited to about 6 weeks. Can consider overlapping with a short period of oral naltrexone.

Mark Chambers: I noticed how short the half-life of naloxone is, only 4hr. In my clinic, we check for the presence of naloxone on send-out drug screens(as well as buprinorphine and norbuprinorphine)to assess compliance with therapy. Should we be concerned if naloxone is absent on the send-outs or is it possible it will not show up due to its short half-life?

Yngvild Olsen: Just want to make the point that people can be abstinent when taking an opioid agonist

Hashem Dadoush: why do we need to wait for 7 days before starting injectable Bupernorphine

Jamie Redwing: we have had such trouble w/ our FENTANYL IV-using pts that we changed our guidelines for early detox from an initial high dose of 25 or 30mg methadone all the way up to 50 or 60mg followed by a LONG taper - up to 14 days for pts committed to long-term treatment. Our AMA rate crashed, pts were much less ill. We also began using microdosing in order to perform a more rapid transition to either buprenorphine/naloxone or vivitrol.....scary at first but these were highly selected pts based on clinical presentation

Kori Singleton: I've been told since I am data waiver Ed, I can order methadone in the Skilled nursing facility or other post_acute care setting, nursing home as well. I do not believe, could u come t?

Norma Naghaviani: For Dr. Polydorou: experience/opinion re: microinduction for methadone to BN treatment for OUD?