Panel 1

Judith Prophete: I am confused about the use of peak and trough, one the methadone clinics in my area will not increase beyond 150 mg unless there is a peak and trough when clinically the client is not over sedated not comfortable at peak and is in withdrawal. CLARIFICATION PLEASE WHEN TO USE PEAK/TROUGH

- Dr. Polydorou: There has been very limited clinical consistency and utility from methadone peak and trough over the past 20 years. Could potentially be helpful when an OTP is considering twice daily methadone dosing, yet not at the exclusion of the clinical presentation. Additionally, some states do require such levels be drawn for specific reasons, such as prior to approval of methadone twice daily dosing.

Houd Alshanqiti: Can keppra be addictive ?

Marcia Glass: In the alcohol lecture, there was a chart that listed number of days drinking in last month but the averages were 7 - 9, which seems low, and they were listed as drinks not days. Just wondering if there is clarification for that chart. Thanks!

Houd Alshanqiti: Can you tell us about smoking buscopan ?

Kori Singleton: I am seeking clarification regarding prescribing methadone for Dm of dependence in post-acute care setting (ie skilled nursing, nursing home, hospice). I was told DATA waiver covers this but I'm sure it does not. Perhaps this considers "hospitalized"?

- Dr. Polydorou: A DATA waiver is not applicable to methadone, only buprenorphine. Methadone for OUD is coordinated with an OTP.

Clare White: What do you think about mirtazapine for patients with methadone use disorder + OUD, already treated with buprenorphine/naloxone?

Teresa Ainsworth: I saw a reference in "Essentials" about using increased methadone for co-occurring cocaine abuse. Can you speak to the mechanism ?

- Dr. Polydorou: "Methadone has non-opioid receptor effects such as on NMDA"