OTAC Case-based Webinars

Sedating Substances and OAT

Tuesday 28 March 2023, 6-7pm

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THE UNIVERSITY OF SYDNEY

We acknowledge the traditional custodians of country on the lands on which we meet and recognise their continuing connection to land, waters and culture

We pay our respects to their Elders past, present and emerging

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Aims & format of case-based webinars:

- **Overall aim:** To provide a comfortable, beneficial & continuing learning environment for OAT Prescribers in NSW
- **Format:** Online (via Zoom) clinical case-based discussion and the provision of webinar learning resources
- Webinars run 6-7pm monthly (February to November)
- Learning resources & certificate of participation that can be used for CPD will be emailed to all participants at the end of each webinar
- Information about upcoming and previous webinars, including recordings, slides & resources, will be available on the OTAC website: www.otac.org.au/webinars
- Webinars will involve experienced facilitators from around NSW

Have case patient case you would like to present, or suggested webinar clinical topic?

Email: daniel.winter@sydney.edu.au

Some housekeeping…

- Keep on ‘mute’ unless speaking or asking questions. Put video on (if possible).
- To prepare for the case discussion have a pen & paper or an online ‘notepad’ so you can quickly jot down points to discuss.
- Ask questions via chat or raise your hand in Zoom for the facilitator invite you to speak. When you first speak, please introduce yourself.
- The webinar will be recorded for OTAC prescribers who can’t attend so be careful not to reveal any identifying information about clinical cases or other confidential information.
- Always be considerate and polite to your online colleagues.
- Please declare to the organiser if you think you may any conflict of interest prohibiting your attendance at the webinars.

Case discussions - preparation

- We allow about 10-15 mins per case

  including your thinking time, jotting down notes, discussion & completing online 'before and after discussion' polls such as:

  "Case X: Would you prescribe takeaways? Yes or No"

NOW:

1. Have your pen/paper or electronic notepad ready.
2. Be prepared to complete the before and after 'pop-up' poll.
3. For each case think: **What case details are important? What else would you like to know? What would you say to the patient?**

Sedating Substances and OAT

In this Case-Based Webinar we will review 3 cases considering a range of potentially sedating substances concurrently used by patients on OAT.

Online ‘polls’ before and after each case aim to encourage discussion and guide learnings.

Case scenario 1

Mr DN a 33 yrs male, released from gaol 1 month ago, is currently on 130 mg methadone and has had three pregabalin and clonazepam overdoses in the last week (BIBA to ED but DAMA).

Overdoses were in the context of longstanding pregabalin and benzodiazepine misuse.

Case scenario 1 – Poll I [Before]

Mr DN a 33 yrs male, released from gaol 1 month ago, is currently on 130 mg methadone and has had three pregabalin and clonazepam overdoses in the last week (BIBA to ED but DAMA).

Overdoses were in the context of longstanding pregabalin and benzodiazepine misuse.

[Online poll – BEFORE case discussion]

Would you continue to prescribe methadone for this patient?

Yes/No

Case scenario 1. Discussion

Mr DN a 33 yrs male, released from gaol 1 month ago, is currently on 130 mg methadone and has had three pregabalin and clonazepam overdoses in the last week (BIBA to ED but DAMA). Overdoses were in the context of longstanding pregabalin and benzodiazepine misuse.

Discussion points:

- **Would you continue methadone for this patient?**
- **What are the risks with ongoing methadone for this patient?**
- **How would you initially approach this patient about your concerns?**
- **What alternative treatment options would you discuss with this patient?**

Case scenario 1. Poll I [After]

Mr DN a 33 yrs male, released from gaol 1 month ago, is currently on 130 mg Methadone and has had three pregabalin and clonazepam overdoses in the last week (presented to ED but DAMA). Overdoses were in the context of longstanding Pregabalin and benzodiazepine misuse.

[Online poll – AFTER case discussion]

Would you continue to prescribe methadone for this patient?

Yes/No

Case scenario 1. Poll II* [Before]

Mr DN has agreed to an OAT medication transfer from methadone to depot buprenorphine (Buvidal®).

[Online poll – BEFORE further case discussion]

How would you approach transferring Mr DN from methadone to Buvidal®?

[Select the option most appropriate for your setting]

A. **Cease methadone and after 24 hrs if opioid withdrawal is moderate to severe (e.g. COWS) commence transfer with buprenorphine SL initially**

B. **Start buprenorphine SL the next day along with the same dose of methadone as part of an outpatient microdosing transfer to Buvidal®.**

C. **Reduce methadone to 80 mg and discuss with patient about an inpatient switch to Buvidal®**

D. **Reduce methadone to 80 mg and start an outpatient microdosing transfer to Buvidal®**

E. **Something else?**

Case scenario 1. Further Discussion:
How would you approach transferring Mr DN (a high-risk patient) from methadone to Buvidal®?

Discuss proposed options:

A. **Cease methadone and after 24 hrs if opioid withdrawal is moderate to severe (e.g. COWS) commence transfer with buprenorphine SL initially.**

B. **Start buprenorphine SL the next day along with the same dose of methadone as part of an outpatient microdosing transfer to Buvidal®.**

C. **Reduce methadone to 80 mg and discuss with patient about an inpatient switch to Buvidal®**

D. **Reduce methadone to 80 mg and start an outpatient microdosing transfer to Buvidal®**

E. **Something else?**

Situations that influence treatment planning

Polydrug use

Polydrug use is common among people who are opioid dependent. Of particular concern is use of alcohol, benzodiazepines or other sedatives in conjunction with opioids because of an increased risk of overdose, particularly during methadone induction and during withdrawal attempts. (See polydrug use and risk). Amphetamine or other stimulant use may result in mental state changes and should be monitored.

Risks related to polydrug use should be assessed prior to and during treatment for opioid dependence. Referral to specialist services is indicated for patients with substance misuse of, or dependence to, multiple drugs or alcohol, but polydrug use should not be a reason to withhold OAT (C).

Transferring the patient from Methadone to Buvidal®

f. Induction from other opioids: prescription opioids and methadone

Patients should be initiated onto at least 7 days of SL BPN treatment prior to initiating depot BPN treatment. Longer periods of SL BPN treatment may be required if the patient reports adverse events, drug-drug interactions or if finding it difficult to stabilise on a dose of BPN – for example following a transfer from methadone (which can take 1-2 weeks to stabilise). Guidance on initiating SL BPN treatment from other opioids (including prescription opioids and methadone) can be found in National Guidelines for Medication Assisted Treatment of Opioid Dependence (2) (Section A.4).

Table 25. Strategies for managing benzodiazepine misuse in OAT patients

Strategy	Action
Patient education regarding the potential adverse consequences of benzodiazepine use	This should target potential 'immediate' effects of benzodiazepine co-intoxication (e.g. impairment of memory, cognition and judgement, and how this can in turn lead to high risk behaviours and harms such as needle sharing, unsafe sex, violence, crime and driving offences), as well as longer-term disturbances in sleep and mood. Also, risk of seizure with sudden supply disruption for benzodiazepine-dependent patients.
Regular monitoring and review	
Dosing schedule	Ensure supervised dispensing of OAT and limit access to takeaway doses.
Dosage	Ensure an adequate OAT dose to prevent opioid withdrawal symptoms Consider reducing high methadone doses (e.g. >150 mg) as a means of reducing overdose risk in patients with frequent intoxicated presentations.
Medicine choice	Assess OAT medicine – buprenorphine in combination with benzodiazepines may carry less risk of respiratory depression than full opioid agonists[6,7] and buprenorphine may be a safer OAT agent than methadone in patients with a history of benzodiazepine-related overdose.

Resource:

SL BPN and Depot BPN (Buvidal®) doses (weekly & monthly)

SL BPN daily dose and recommended corresponding doses of Buvidal® Weekly and Buvidal® Monthly

Dose of daily SL BPN	Dose of Buvidal® Weekly	Dose of Buvidal® Monthly
2-6 mg	8 mg	-
8-10 mg	16 mg	64 mg
12-16 mg	24 mg	96 mg
18-24 mg	32 mg	128 mg
26-32 mg	-	160 mg

Based on: Buvidal® - Australian Product Info p3 capbuvim40421[1]

Case scenario 1. Poll II* [After]

Mr DN has agreed to an OAT medication transfer from methadone to depot buprenorphine (Buvidal®).

[Online poll – BEFORE further case discussion]

How would you approach transferring Mr DN from methadone to Buvidal®?

[Select the option most appropriate for your setting]

A. **Cease methadone and after 24 hrs if opioid withdrawal is moderate to severe (e.g. COWS) commence transfer with buprenorphine SL initially.**

B. **Start buprenorphine SL the next day along with the same dose of methadone as part of an outpatient microdosing transfer to Buvidal®.**

C. **Reduce methadone to 80 mg and discuss with patient about an inpatient switch to Buvidal®**

D. **Reduce methadone to 80 mg and start an outpatient microdosing transfer to Buvidal®**

E. **Something else?**

Case scenario 2

Ms WN is a 40 years female with previous trauma and alprazolam dependence. She is currently prescribed diazepam 5 mg TDS by her GP with no aberrancy. She presents with an acute exacerbation of her chronic back pain (since a heavy lifting injury 10 years ago causing L5/S1 nerve root impingement and disc prolapse). After the injury she became dependent on prescribed opioids leading to commencement of Buvidal® 16 mg weekly which manages her opioid dependence and has improved her back pain and general wellbeing.

Case scenario 2 – Poll I [Before]

Ms WN is a 40 years female with previous trauma and alprazolam dependence. She is currently prescribed diazepam 5 mg TDS by her GP with no aberrancy. She presents with an acute exacerbation of her chronic back pain (since a heavy lifting injury 10 years ago causing L5/S1 nerve root impingement and disc prolapse). After the injury she became dependent on prescribed opioids leading to commencement of Buvidal® 16 mg weekly which manages her opioid dependence and has improved her back pain and general wellbeing.

[Online poll – BEFORE case discussion]

How would you manage her current 'acute on chronic' pain?

A. Prescribe Panadeine Forte® and pregabalin

B. Prescribe oxycodone

C. Refer her to neurosurgery for surgical repair of her disc prolapse

D. Refer her to rheumatology outpatients for physiotherapy and an L5/S1 nerve root injection as an outpatient

E. Something else?

Case scenario 2. Discussion:
How would you manage her ‘acute on chronic’ pain?

A. Prescribe Panadeine Forte® and pregabalin
B. Prescribe oxycodone
C. Refer her to neurosurgery for surgical repair of her disc prolapse
D. Refer her to rheumatology outpatients for physiotherapy and an L5/S1 nerve root injection as an outpatient
E. Something else?

Chronic pain syndromes and pharmaceutical opioid dependence

In the past two decades, non-medical use of pharmaceutical opioids, including over-the-counter preparations, has increased. The boundary between chronic pain and addiction management is complex, with a continuum of presentations between some people using pharmaceutical opioids rather than heroin for non-medical reasons, and others commencing opioid use for management of chronic pain and then progressing to opioid dependence.

While both methadone and buprenorphine can be used effectively in treating patients with chronic pain and opioid dependence, a comprehensive treatment plan that addresses pain management is required. The evidence regarding long term use of prescription opioids for chronic non-malignant pain is limited. Specialist advice or referral is recommended for people with chronic pain and opioid dependence because of the potential complexity of managing both conditions (C).

Chronic pain

Chronic pain in patients receiving OAT should be managed as for any other patient with psychosocial and non-opioid pharmacological approaches emphasised. However, there are some notable differences (C):

- Tolerance means that normal doses of opioids are likely to be less effective.
- When prescribing, be aware of the potential for aberrant behaviours and use appropriate strategies (monitoring and interval dispensing).
- Avoid use of other psychoactive medicines for which there is no evidence of effectiveness in pain relief (e.G. Benzodiazepines, antipsychotics).
- Exercise caution with the use of gabapentinoids as these medicines may be used non-medically, can produce intoxication, a delirium and a withdrawal syndrome.

Case scenario 2 – Poll I [After]

Ms WN is a 40 years female with previous trauma and alprazolam dependence. She is currently prescribed diazepam 5 mg TDS by her GP with no aberrancy. She presents with an acute exacerbation of her chronic back pain (since a heavy lifting injury 10 years ago causing L5/S1 nerve root impingement and disc prolapse). After the injury she became dependent on prescribed opioids leading to commencement of Buvidal® 16 mg weekly which manages her opioid dependence and has improved her back pain and general wellbeing.

[Online poll – AFTER case discussion]

How would you manage her current 'acute on chronic' pain?

A. Prescribe Panadeine Forte® and pregabalin

B. Prescribe oxycodone

C. Refer her to neurosurgery for surgical repair of her disc prolapse

D. Refer her to rheumatology outpatients for physiotherapy and an L5/S1 nerve root injection as an outpatient

E. Something else?

Case scenario 3

Mr LM is a 30 years male with a history of schizoaffective disorder on olanzapine 10 mg daily. He has a history of benzodiazepine misuse and anxiety and takes 10 mg diazepam daily prescribed by his GP with no aberrancy. He is on methadone 100 mg daily for opioid dependence and has takeaways on weekends. He has never presented to his dosing pharmacy intoxicated. He is about to start University classes twice a week and wants to start counselling and obtain more takeaways.

Case scenario 3 – Poll I [Before]

Mr LM is a 30 years male with a history of schizoaffective disorder on olanzapine 10 mg daily. He has a history of benzodiazepine misuse and anxiety and takes 10 mg diazepam daily prescribed by his GP with no aberrancy. He is on Methadone 100 mg daily for opioid dependence and has takeaways on weekends. He has never presented to his dosing pharmacy intoxicated. He is about to start university classes twice a week and wants to start counselling and obtain more takeaways.

[Online poll – BEFORE case discussion]

What would you do about his takeaways?

A. Cease his Takeaways because he is still taking diazepam, and resume takeaways when it is evident that he has engaged well with counselling

B. Change his script so that he can receive his takeaways during the week, go to university and start counselling

C. Reduce his takeaways because he is still taking diazepam

D. Reduce his methadone dose because he is still taking diazepam

E. Something else?

Table 15. Case flagging in OAT

	High treatment needs	Moderate treatment needs	Low treatment needs
Adherence to treatment conditions	Frequent high-risk presentations (e.g. intoxicated, missed doses) Poor treatment engagement (e.g. missed appointments) Complex OAT transfers	No (or infrequent) high-risk presentations Generally adherent with treatment conditions (e.g. dosing, appointments)	No high-risk presentations (e.g. intoxicated presentations, missed doses) Adherent with treatment
Substance use	High-risk or harmful polydrug use (e.g. misuse of, or dependence on alcohol, benzodiazepines, other opioids, psychostimulants)	Polydrug use identified but not high-risk (i.e. no intoxicated presentations or overdoses)	No significant use of alcohol or other substances
Mental and physical health conditions and cognitive impairment	Serious mental (including significant risk of harm to self or others), physical health or cognitive impairment issues that require specialist input, intensive care coordination and regular monitoring May include patients recently discharged from hospital	Issues generally stable, or being addressed in treatment care plan May include patients recently discharged from hospital	Generally stable
Pregnant	Pregnancy with significant perinatal risk factors	Pregnant without other significant perinatal risk factors	Not pregnant
Social circumstances	Significant issues (e.g. homelessness, domestic violence, child protection) May include patients recently released from custody	Stable but still need some assistance No significant child protection or domestic violence concerns May include patients recently released from custody	No significant concerns

Table 16. Matching treatment components according to treatment needs*

	High treatment needs	Moderate treatment needs	Low treatment needs
Treatment settings	Specialist OTP clinic or in shared care arrangement with primary care Specialist clinic dosing or use community pharmacy dosing cautiously	Specialist OTP, primary care or shared care arrangement Usually community pharmacy dosing	Primary care setting, or in shared care arrangement Usually community pharmacy dosing
Minimum clinical review frequency	Every month	Every 2 months	Every 3 months
Minimum medical review frequency	Every 2 months	Every 3 months	Every 6 months
Minimum comprehensive treatment review frequency	Every 3 months	Every 6 months	Every 6 months
Urine drug screening	As clinically indicated, and linked to clinical and medical review (e.g. every 1–2 months)	As clinically indicated, and linked to clinical and medical review (e.g. every 2–3 months)	As clinically indicated, and linked to clinical and medical review (e.g. every 3–6 months)
Supervised dosing conditions	Generally no takeaway or unsupervised dosing (special circumstances apply)	Generally limited takeaway doses available (e.g. 1–2 doses per week)	Generally greater number takeaways (e.g. 2–4 per week) or unsupervised dosing (buprenorphine-naloxone only)

*This is a guide. Treatments should be tailored to circumstances of the individual patient and service providers.

Case scenario 3 – Poll I [After]

Mr LM is a 30 years male with a history of schizoaffective disorder on olanzapine 10 mg daily. He has a history of benzodiazepine misuse and anxiety and takes 10 mg Diazepam daily prescribed by his GP with no aberrancy. He is on Methadone 100 mg daily for opioid dependence and has takeaways on weekends. He has never presented to his dosing pharmacy intoxicated. He is about to start university classes twice a week and wants to start counselling and obtain more takeaways.

[Online poll – AFTER case discussion]

What would you do about his takeaways?

A. Cease his Takeaways because he is still taking diazepam, and resume takeaways when it is evident that he has engaged well with counselling

B. Change his script so that he can receive his takeaways during the week, go to university and start counselling

C. Reduce his takeaways because he is still taking diazepam

D. Reduce his methadone dose because he is still taking diazepam

E. Something else?

In summary:

- We have discussed 3 cases considering a range of potentially sedating substances (including other opioids, benzodiazepines, pregabalin) concurrently used by patients prescribed OAT.

- We have also considered how to discuss and proceed with changing OAT (e.g. MMT to Buprenorphine) for patients at particular risk.

- As always OAT prescribers need to consider patient preferences, be guided by guidelines, understand the risks, benefits and processes involved in initiating and switching OAT, and knowing when to seek specialist advice is key.

Supports & Other Services:

- **SafeScript:** https://www.safescript.health.nsw.gov.au/health-practitioners

- **Contact your local AOD service**

- **Ring DASAS** (Drug & Alcohol Specialist Advisory Service)

  DASAS operates 24 hours a day, 7 days a week

  DASAS is funded by NSW Health and managed by St Vincent's Hospital Alcohol and Drug Service in Sydney

  How to contact DASAS?

  Within Sydney Metropolitan Area: (02) 8382-1006
  Regional, Rural & Remote NSW: 1800 023 687

  https://www.svhs.org.au/our-services/list-of-services/alcohol-drug-service/drug-alcohol-specialist-advisory-service

Thank you for your contribution

See you next time

OTAC Case-Based Webinar on Tuesday 16th May 2023

(No webinar in April due to Easter and other public holidays)

Upcoming topics

OAT in custodial settings & post-release, Chronic pain management, Mental health considerations, and more

Have any clinical questions, patient cases you would like to discuss,

or suggested OAT clinical topics?

Email: daniel.winter@sydney.edu.au

References:

1. Buvidal® - Australian Product Information Buvidal® Monthly p3 accessed at https://apps.medicines.org.au/files/capbuvim.pdf on 14 November 2022.
2. NSW Clinical Guidelines: Treatment of Opioid Dependence 2018. NSW Ministry of Health, Sydney Australia.
3. Lintzeris N, Dunlop A, Masters D (2019) Clinical guidelines for use of depot buprenorphine (Buvidal® and Sublocade®) in the treatment of opioid dependence. NSW Ministry of Health, Sydney Australia.