SUBOXONE & OPIOID USE DISORDER

Case Studies

FAMILY PRACTICE RENEWAL PROGRAM

Urine Drug Screens

CASE STUDY #4: MARY

Mary (35) comes for her refill of Suboxone. You give her an office urine test which is positive for Ritalin and Cocaine. You send off a confirmatory test (in Newfoundland/Labrador, this is often the UDS 42). It comes back positive for Ritalin, ritalinic acid, cocaine, and benzoylecgonine. There is also hydromorphone.

CHAT TASK: How do you explain the difference between the two tests? What do you do about her Suboxone?

UDS: Immunoassay vs Chromotography

Summary: Urine Drug Screening

	Immunoassay	Chromatography
Opioids	• Detection window 3-5 days • Can't distinguish different opioids. Misses synthetic opioids eg oxycodone, fentanyl, methadone. • A specific immunoassay is available for oxycodone	• Detection window 1-2 days • Identifies specific opioids, including synthetic opioids. • Codeine metabolized to morphine • Monoacetylmorphine (MAM) very specific for heroin use
Cocaine/BEG	• Detection window for BEG is 3-5 days • Very specific for cocaine use	• Detection window for cocaine 1-2 days • Very specific for cocaine use
Benzodiazepines	• Regular diazepam use detected for up to 30 days. • Lorazepam & other intermediate-acting benzos often missed • Clonazepam poorly detected at moderate doses	
Cannabis	• Regular daily use: Can detect up to 10-28 days	

Mary: UDS

- You have a frank and honest discussion with Mary. Your goal is to determine her use, needs, and other mitigating factors in her life (such as new stressors, comorbid anxiety, etcetera).
- You determine that she is still uncomfortable at her current dose but feared she would not receive carry doses if she asked for an increase. She also reports a roommate who is using cocaine and Ritalin, and this is proving to be difficult to avoid--she uses because it is available, not because of a craving. She does have a previous diagnosis of ADHD but does not take anything for this and feels she is able to manage overall.

CHAT TASK: How do you respond to this?

CARRY DOSES

CASE # 6: TOM

Tom is 2 months into his treatment with Suboxone. He is stable on a dose of 18 mg, after having an additional small increase during his induction. He has been offered a contract on an oil patch in Alberta and feels this job is “too good to pass up.” He is expected to work four weeks on, and two off. He is asking for carry doses.

What do you do now?

1. Decline carries
2. Check if the patient is stable
3. Give carries
4. Switch to Methadone
5. Switch to Sublocade
6. Ask for a copy of his employment contract and copy of his travel ticket
7. Do a UDS-42 and only give carries if it is negative for illicit drugs
8. Schedule another appointment

CARRY DOSES

Tom has been stable, with clean UDS since his start. He approached his pharmacy about carry doses, but they are concerned about going "too fast too soon." He is in a panic and comes to see you in clinic.

CHAT TASK: How do you respond?

CARRY DOSES

In Newfoundland and Labrador, there are no specific Suboxone guidelines. At present, most providers and pharmacies apply methadone guidelines to Suboxone therapy. These are sometimes viewed as being restrictive. There are other guidelines available that you can draw upon, including from British Columbia. In general, Suboxone is a safer alternative to treatment than almost any other modality.

Things you can look for in determining if a patient is a candidate for carry doses is clinical stability, including factors such as length of time being treated, comorbid drug use, comorbid psychiatric issues, legal issues, and housing stability. Patients whom you feel are stable are candidates for carry doses. ***You may provide carry doses as soon as stability is attained.***

RESISTANT PATIENTS

CASE # 7: Jim

- Jim, 42 year old male patient of yours
- Comes in with his wife, who is also a patient of the clinic, and he appears to have a sick, flu-like illness
- Wife tells you he has had a problem with opiates for the last few years but now things are getting “out of hand”
- They have 3 kids and mother has had to move in
- The patient says: “I NEEDS YOUR HELP BUDDY”

Resistant Patients: JIM

He says he wants to try to wean off the medications with your help and would like you to prescribe him the opiates. "I don't want no methadone or that other one, I hear all sorts of stories about them. You can abuse them too."

CHAT TASK: Where is this patient in terms of change? What do you say to him?

RESISTANT PATIENTS: Jim

The six stages of the model for change are:

- precontemplation
- contemplation
- determination
- action
- maintenance
- Termination

CHAT TASK: Where do we go next with Jim?

RESISTANT PATIENTS

- This illustrates a patient not yet interested in seeking treatment, but may want easy access to his drug of addiction from a stable or cheaper source (your narcotic pad!).
- In general, narcotic tapers rarely work when using an individual's drug of abuse.
- A focus on behavioural therapies or non-opioid therapies may be of use. This would include
  - Counselling (especially Cognitive Behavioural Therapy)
  - Smart Recovery/Narcotics Anonymous
  - Clonidine
  - Naltrexone