# TREATMENT CHOICES IN OPIOID ADDICTION

More than 50,000 people die of opioid overdoses every year and this number becomes obsolete with each passing day. More people are killed by opioids than traffic accidents or guns.

All of us know someone with the disease of opioid addiction and everyday we either personally deal with the devastation that opioids cause, or read or hear about it. Opioids are taking lives the way that the AIDS epidemic did when it was at its peak in the 1980s and early 1990s. We were able to control the AIDS epidemic and if the government, the health care system, law enforcement and actually each and every one of us decides that we are going to defeat this epidemic, we will.

## First things first: it's a chronic disease

A lot of people think that opioid addiction is a weakness, a personal failure or a character flaw. Society and people like to feel stronger by making others feel weak. But we know from medical research that opioid use disorder is a chronic disease, much like diabetes, high blood pressure and asthma. And like these diseases it has no cure, the same relapse rates, and, if you want to follow it, excellent and successful treatment.

If you take diabetes as an example you know that some people have a "touch of sugar" and others are insulin dependent diabetics. In mild diabetes, some patients only need to watch their diet and exercise regularly, others take pills to lower their blood sugar, and some have to inject high doses of insulin every day.

So everyone who is prescribed or tries an opioid doesn't get addicted. We have receptors in our brains called mu receptors, which opioids latch onto and we experience an opioid high. Everyone's brain is different and many factors like our genes, the age at which drugs are tried, the dose used, the potency of the drug, whether it is eaten or injected, our social and family condition, our psychiatric issues all control the mu receptor and whether we don't get a high, get a bit of a high or a very intense one.

Before determining the right treatment for opioid use disorder it is vital to understand that this is a chronic disease. If you don't understand and accept this, treatment is probably not going to work for you.

## There ain't no motivation pill

For any treatment to be successful the patient has to be motivated. Families, courts, jobs or a society pushing a person to get sober doesn't work. The motivation has to come from within the person. I like to tell patients that I don't have the motivation pill, and if I did, my face would be on the cover of Time magazine!

Patients who have been through treatment multiple times know that that the times it worked, they had been motivated themselves. The times it didn't they were either half-hearted or had been pushed by other people or factors.

As physicians we try to give the best treatment we can for the patient, but we are not always able to judge the strength of a patients motivation and dedication toward recovery. It is very easy to see through the patient who is half hearted and trying to dupe the system. Because of the large number of people that need treatment, we have no patience, or room, for people that are either not ready for recovery, or are trying to use the system, or both. We want to save the life of someone who really wants sobriety, not play games with patients.

**Counseling is essential/Customizing treatment to each patient**

With every kind of treatment, patients are more successful with sobriety when they go through group and individual counseling. These sessions help the patient understand what started their addiction, what their relapse triggers are, what to do in case of a crisis, the importance of sober support and getting back to school or work.

How often a patient should get counseling has not been scientifically established; all we know is that counseling helps a lot with recovery. We assess each patient and try to determine how severe their addiction is, as well as their family and social situation, and come up with an individualized service plan to best help the patient.

Some patients do well with once a week group therapy, while others have to start with three to five times a week counseling sessions. Yet others need to be in an inpatient facility or in residential treatment. It is important to customize or tailor the treatment to each patient instead of adopting a one-size-fits-all approach.

**Treatment choices**

1. Abstinence-based treatment
2. Methadone maintenance
3. Buprenorphine-naloxone: Suboxone, Zubsolv, Bunavail
4. Naltrexone pill
5. Naltrexone injection: Vivitrol

**Abstinence-based treatment: you're kinda on your own**

The phrase "cold-turkey" comes from opioid withdrawal because when opioids are stopped suddenly the person feels cold, has goose bumps, sweating, nausea, vomiting, diarrhea, insomnia, anxiety, irritability and muscle and bone pain. While the patient may feel that they are going to die; opioid withdrawal does not kill and usually after two to five days, the severe withdrawal symptoms go away and the patient may just be left with some cravings.

In the old days, all we could do was help patients through the withdrawal with medications like Zofran for nausea/vomiting, Imodium for diarrhea, Motrin for pain, Flexeril for muscle pain and

clonidine for cravings. And we counseled patients and hoped for the best. This form of treatment doesn't work well for all patients, in fact only a minority maintains sobriety with this and relapse rates are high.

It remains a choice for those patients who don't want any medication-assisted treatment and there are patients that maintain long-term sobriety with this and counseling.

**Methadone maintenance: the original treatment**

Methadone is a long-acting opioid and in the 1970s methadone clinics started in cities across the United States. The government tightly regulates methadone clinics because methadone is a very powerful, long acting and dangerous opioid and can kill easily. In a methadone clinic a physician evaluates the patient, and calculates their methadone dose, mainly based on their opioid use. The patient drinks liquid methadone in the presence of a nurse and has to come every day to take the liquid methadone.

Advantages of methadone maintenance:

1. Potent opioid; takes away all opioid withdrawal symptoms and cravings.
2. Proven to reduce opioid overdose death rates.
3. Very close monitoring of patient, so is good for complicated patients who have used high dose opioids for a long time with little sobriety.

Disadvantages of methadone maintenance:

1. Daily visits to clinic.
2. Difficult to hold down a job or go to school.
3. Unfortunately very high methadone doses are typically used. Some patients are therefore high on methadone.
4. Difficult to wean off as withdrawal from methadone is particularly severe.

**Buprenorphine-naloxone: Suboxone, Zubsolv, Bunavail**

(For ease of understanding I will be using Suboxone to represent buprenorphine-naloxone)

Active ingredient is buprenorphine and not naloxone:

A lot of people think that Suboxone works because it has the opioid blocker, naloxone, in it. This is not true. Suboxone, Zubsolv and Bunavail's active ingredient is buprenorphine, which is an opioid. Buprenorphine is not a powerful opioid and has just enough of an effect on the mu receptor to treat withdrawal symptoms and take the craving for opioids away.

When Suboxone is used under the tongue, the buprenorphine is absorbed and becomes active. The naloxone does not work when it is taken under the tongue. Naloxone only becomes active when it is injected and if Suboxone is liquefied and injected the naloxone in the Suboxone places a patient in immediate and severe withdrawal. *So the reason that naloxone is placed in Suboxone is to prevent patients from liquefying Suboxone and injecting it.*

A great medication:
Buprenorphine-naloxone is a great medication and has been successful in turning millions of lives around. Eight to sixteen milligrams per day is a common dose. The lowest dose should be used which keeps the patient's withdrawal symptoms away, especially the cravings. At sixteen milligrams the mu receptors are saturated and when a higher dose is given it is only the bad side effects that the patient notices, not necessarily an improvement in cravings or withdrawal symptoms.

Stages of treatment:

1. Induction
2. Stabilization
3. Maintenance
4. Weaning

*Induction:* This is the first stage. The patient is requested to present in opioid withdrawal so the Suboxone can be started immediately. The lowest possible dose of Suboxone that will take care of withdrawal is given to the patient and they are rechecked in two to three days. If the urine drug screen in the next visit is negative, and a dose increase is requested, we do raise the dose.

*Stabilization*: in the next few visits we focus on stabilizing the Suboxone dose. Sometimes the dose is too much and the patient feels that they are nodding during the day, and thus the dose is reduced. Others feel that the dose is insufficient. If the urine drug screen is negative and the patient is compliant with counseling, the Suboxone dose is increased.

*Maintenance*:
This is the phase when the patient is comfortable with their dose and typically is the longest of all the phases of buprenorphine treatment.

*Weaning*:
Depending on the dose of Suboxone that the patient is on, it can take one to four months for a patient to be weaned off Suboxone completely. The dose of Suboxone is lowered very gradually and the patient advised that they will feel opioid withdrawal symptoms for two to five days, and after that, they are pretty much fine. Essentially all patients realize that they had been unnecessarily nervous about dose reduction, and indeed they felt a little achy and have a bit of insomnia for a couple days, but that after that they were fine.

Duration of treatment:
This is different for different people and we try to customize the treatment to each patient. Some patients are on Suboxone for a few months, some for a few years and others indefinitely. Just like they had with their choice of opioid, patients get very attached to Suboxone and some become very resistant to dose reduction. Patients want to reduce their doses by one-quarter films and I reassure them that, just the way they had gotten attached to their drug, they have

now latched on to Suboxone and we reduce the dose by half a film, or four milligrams, every two to four weeks (when the patient is on eight to sixteen milligrams of Suboxone).

Side effects:
Suboxone can cause drowsiness, constipation, weight gain and leg swelling. And of course dependence as it is an opioid.

How long Suboxone?
Research does not guide us regarding the duration of treatment with Suboxone. To best treat patients I have divided patients into three categories with regard to duration of Suboxone use:

1. Short term treatment
2. Medium term treatment
3. Long-term or indefinite treatment

*Short-term treatment*:
The patient is on Suboxone for a few weeks and is rapidly weaned to zero and placed on naltrexone.

*Medium-term treatment*:
This treatment is for one to two years and ideally I prefer the dose of Suboxone to be eight milligrams or below.

*Long-term or indefinite treatment*:
I reserve this for patients who have concurrent psychiatric illnesses, such as not well- controlled bipolar disease or schizophrenia. If treatment is going to be indefinite, I prefer the dose to be eight milligrams or less.

We try to use the lowest Suboxone dose possible, as patients themselves realize they do not need more than eight milligrams and some then decide to sell or share it.

"Switched one addiction with another"
People unfamiliar with current research, those stuck in the abstinence-based model and fans of the 12-step program, claim that treatment with Suboxone is switching heroin for Suboxone, an illegal drug with a legal one. This is entirely untrue. And a typical attempt to make oneself look good and the opioid addicted patient feel bad. We have research that shows that Suboxone has a healing effect on the brain and is an excellent bridge from opioid addiction to a life of sobriety.

**Naltrexone pill and injection (Vivitrol)**
Naltrexone is a long-acting opioid antagonist and it was initially FDA approved in 2006 for the treatment of alcohol use disorder. In 2010 it was approved for opioid use disorder. Unlike

Suboxone, naltrexone does not have an opioid in it and can be prescribed by any physician. To prescribe Suboxone a physician has to be specially trained in prescribing it.

Suboxone and methadone have a lot of research data proving their great outcomes in maintaining sobriety, and reduction in opioid overdoses. Studies show that naltrexone works well in patients who are very committed toward their sobriety. In maintaining sobriety and preventing opioid overdoses, Suboxone and methadone are far superior to naltrexone.

Some patients don't want to be on an opioid like Suboxone and this is understandable. But it is important to remember that comparing Suboxone to the naltrexone pill or the shot, Vivitrol, is like comparing apples to oranges.

Certain professions like pilots or truck driving do not allow Suboxone and in that situation naltrexone is a good choice.

Naltrexone cannot be given when an opioid is present in the system, as it will immediately put the patient in severe withdrawal. Naltrexone is started either at the start of addiction treatment or after Suboxone has been weaned down to zero.

*Naltreone pill*:
The naltrexone pill is prescribed at 50mg daily and is inexpensive and approved by essentially all insurance companies.

*Naltrexone injection/Vivitrol*:
Vivitrol is a monthly injection and lately has been heavily promoted by its manufacturer Alkermes and its use is skyrocketing across the United States. It costs about $1200 per injection and 380 milligrams is injected once a month intramuscularly. Several court systems across the country are also concentrating on Vivitrol. It is important to understand that both the naltrexone pill and the Vivitrol injection work, the only difference being that the pill can be stopped by the patient but once the Vivitrol is injected it obviously cannot be removed, and its effects last one month. And even though use of an opioid while on Vivitrol will place the patient in withdrawal, patients have been known to relapse while on Vivtrol.

The intense marketing of Vivitrol has led to its indiscriminate prescribing by physicians and its recommendation by the justice system and this is placing a terrible burden on our health care system. ***Vivitrol is not a cure-all and the naltrexone pill is just as good as the injection.***

*Side effects of naltrexone*:
The main side effects of naltrexone, both oral and injection, are fatigue, headache and nausea.

**So what should you do?**
I'll list out some options of what you can do when you enter a program:

Option 1:

- If the patient has not used opioids for seven days and the urine drug screen is negative the naltrexone pill can be started.
- If opioids are present in the urine, a return appointment can be made after three days and naltrexone can be started then.
- Naltrexone pill can be continued indefinitely.
- If taking the pill everyday is a problem and the insurance company covers Vivitrol, it can be tried.

Option 2:
- Start on Suboxone.
- In return visits try to stay on the lowest dose of Suboxone that takes care of opioid withdrawal and cravings.
- After four to six months of treatment, start weaning process to zero.
- After Suboxone has not been taken for one week and the urine drug screen is negative for it, naltrexone can be started.

Option 3:
- Start on Suboxone
- Have regular discussions with your doctor about the duration of treatment and if it is mutually decided that you need to stay on Suboxone indefinitely, make sure you are on the lowest dose that would control opioid cravings.

Option 4:
- Go through opioid withdrawal and go with abstinence-based therapy. Meaning no Suboxone and no naltrexone.
- I am not in favor of this option as the patient is unprotected in dealing with a disease and because oral naltrexone is cheap and effective in the motivated patient.

The lives of millions of opioid addicted patients have been transformed after their entry into programs that treat opioid use disorder. And being the instrument of such a massive change in people's lives has been, by far, the most humbling and gratifying experience in my life.