19 - Methadone

Methadone

504 The Maudsley® Prescribing Guidelines in Psychiatry CHAPTER 4 In rare cases, patients may be allergic to methadone or buprenorphine or to some of the constituents within the formulations. Methadone Initiation in all settings ■ ■Do not prescribe/dispense to a patient who is clinically intoxicated with opioids or other drugs (including alcohol). ■ ■Only prescribe as a 1mg/mL solution. ■ ■Do not prescribe tablets as these can be crushed and injected. ■ ■Describe supervision accurately, for example ‘directly supervised consumption’ or ‘take away three times per week’. Importance of context to methadone titration schedules Methadone is associated with an increased risk of death during titration, because: ■ ■It is a full agonist. ■ ■Assessing dose equivalence with street heroin is difficult. ■ ■There is wide inter-individual pharmacokinetic variation. ■ ■Repeated dosing is associated with substantial accumulation with steady state only reached after about five doses of methadone.33,34 Thus for safety reasons, methadone titration schedules are usually conservative. However, ensuring safe methadone titration is context--dependent, in that the consequences of uncontrolled opioid withdrawal and consequent disengagement need to be considered. Methadone in general hospital settings Fear of inadequate treatment of opioid withdrawal during general hospital admissions has led to people with opioid dependence not seeking help for their physical health problems or seeking help only when desperate.10 There is an elevated (fourfold) risk of drug-related death associated with hospital discharge and even more so for discharge against medical advice (almost eightfold increase).3 The general hospital is also a setting where more doses can be administered within 24 hours (e.g. 4–6 hourly), where respiration and oxygen saturations can be monitored with a greater frequency than in other contexts and more sophisticated respiratory support and sustained naloxone reversal can be provided. All these factors may allow a more aggressive methadone protocol (Table 4.12), with the caveat that a slower protocol may be necessary for those with head injuries, acute respiratory compromise, hepatic or renal failure, or co-prescription of other sedating drugs (e.g. medicated detoxification from alcohol using benzodiazepines). Methadone in psychiatric hospital settings Psychiatric hospital settings are different from general hospital settings in that familiarity with opioids and naloxone is lower, intensive physical health monitoring is less feasible and other sedating medications (antipsychotics, benzodiazepines) are routinely

Addictions and substance misuse CHAPTER 4 given alongside methadone. This does not mean that methadone should be withheld – the risk of drug-related death following psychiatric hospital discharge is too great. All efforts should be directed at (re-)establishing methadone treatment and avoiding loss of tolerance to opioids. Generally, methadone titration in the psychiatric setting is more cautious (Table 4.12). Cautions with methadone Intoxication Methadone should not be given to any patient showing signs of intoxication due to alcohol or other CNS depressant drugs (e.g.

benzodiazepines)35,36 as the risk of fatal overdose is greatly enhanced when concurrent methadone is taken.37,38 Concurrent alcohol and both prescribed and illicit drug consumption must be borne in mind when considering subsequent prescribing of methadone. This is because of the increased risk of overdose associated with simultaneous use of several respiratory depressants.39 Severe hepatic/renal dysfunction Metabolism and elimination of methadone may be affected in advanced liver disease.40 The dose or dosing interval should be adjusted accordingly against clinical presentation. Because of extended plasma half-life, the interval between assessments during initial dosing may need to be extended. Around 20% of methadone is eliminated via the renal route. Renal disease does not affect methadone elimination as in such conditions it is excreted exclusively via the biliary route. However, patients with advanced renal disease are more sensitive to sedation caused by methadone. Thus, for those with glomerular filtration rate (GFR) <15mL/min or creatinine >700 mmol/L, a reduction of 50% in methadone dose should be considered.41 Table 4.12 Methadone titration where extent of prior use is unknown or unconfirmed. Setting Procedure General hospital Initial dose of 10–20mg with further doses of 5–10mg every 6 hours if withdrawal persists (according to COWS or OOWS), up to 40mg in 24 hours. In the second 24 hours, the total dose used in the first 24 hours should be given as a split dose. Increase by 10mg every 2 days, monitoring withdrawal, sedation and respiratory depression. Maximum increase from day 1 dose over 1 week is 30mg. Consider split dosing. Psychiatric hospital Initial dose of 10–20mg on day 1. Increase by 10mg every 2 days, monitoring withdrawal, sedation and respiratory depression. Maximum increase from day 1 dose over 1 week is 30mg. Consider split dosing. Community drug service Initially, 10–30mg on day 1. Increase by 10mg every couple of days, monitoring withdrawal, sedation and respiratory depression. Maximum increase from day 1 dose over 1 week is 30mg. Important: All patients starting a methadone treatment programme must be informed of the risks of toxicity and overdose, and the necessity for safe storage of any take-home medication.8 Safe storage is vital, particularly if there are children in the household, as tragic deaths have occurred when children have ingested methadone. Prescribers should consider risks to children in all assessments and treatment plans of drug-using patients.

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