Complex Cases in Buprenorphine Treatment, Part 2

Module 9

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Disclosure

MI-CCSI, or the presenter, does not have any financial interest, relationships, or other potential conflicts, with respect to the material which will be covered in this presentation.

Patient-Centered Treatment for Substance Use Disorder in Primary Care

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Clinical

Module	Title
1	Navigating Buprenorphine Prescribing for the Primary Care Physician
3	Buprenorphine Medical Management: Monitoring the Patient
5	Challenging Clinical Scenarios in MOUD: Early Refills and Lost or Stolen Medication
7	Complex Cases in Buprenorphine Treatment, Part 1
9	Complex Cases in Buprenorphine Treatment, Part 2
11	Pain and Addiction

Operational

Module	Title
2	Substance Use Disorder and Patient Identification
4	OBAT Eligibility, Intake and Assessment
6	Patient Support for Induction and Maintenance
8	Operationalizing Team Meetings, Systematic Case Review, & Documentation
10	Team Roles and Responsibilities
12	Supporting the Patient Beyond Buprenorphine

Action Period Assignment

From Module # 7

- **Do you currently counsel your MMOUD patients on alcohol use prior to prescribing buprenorphine? If so, what do you advise your patients?**
- **A patient on buprenorphine with no history of AUD, psychiatric illness, or other SUD diagnoses asks you if he can "have drink of wine with my dinner a couple times a month." What is your advice and why?**
- **You inform a patient that his urine testing will include EtG and EtS, and he responds to you: "I don't consent to that. I don't drink and I'm not paying for a test that is completely unnecessary." What is your reply and why?**

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OBJECTIVE

At the conclusion of this presentation, the participant will be able to:

- **Apply concepts learned to individual cases.**

AGENDA

1	Case Study – The Case of Cindy
2	Case Study – The Case of Becky

Today's Cases

- Real examples: histories and outcomes are presented just as they happened.
- Unexpected outcomes, as a training tool, are essential to review.
- Some of the treatment interventions implemented were done based on clinical intuition, rather than derived from the medical literature or published guidelines.

The Case of Cindy

The Case of Cindy

- 33-year-old pregnant Caucasian female at 12 weeks, presents to a collaborative care OB/Addiction clinic with a history of heroin addiction and significant anxiety symptoms.
- She reports using IV heroin for 2.5 years but has sustained sobriety from the drug for approximately 7 years.
- Briefly participated in a methadone maintenance program for 9 months.
- Was on prescribed buprenorphine for approximately 3 years but self-discontinued this medication 1 year ago.
- Currently not on MAT and is not requesting buprenorphine.

What are the next steps?

The Case of Cindy

Initial Visit

- At first visit, the patient reports taking buprenorphine from an “old prescription” and is using ¼ of an 8 mg tablet “every few days” and feels that she can discontinue this medication at any time.
- Current prescribed medications:
  - Xanax 1 mg twice daily
  - Zoloft 100 mg daily
  - Gabapentin 300 mg 3x daily
  - Seroquel 100 mg at bedtime
- Psychiatric history: Diagnoses of MDD, OCD, and GAD. She reports ”anxiety” as her primary concern.

The Case of Cindy

- Psychiatric history (cont'd): 2 inpatient psychiatric hospital stays 3 years ago, one of which was following a suicide attempt.
  - Patient attempted to jump off a bridge but was intervened upon.
- The hospital stays and the suicide attempt were triggered by her newborn baby being "taken away" due to her substance use difficulties.
- Patient is not under the care of a psychiatrist and is not currently engaged in psychotherapy.

Questions:

- Does anything particularly concern you at this point?
- Is there any part of the above history that you would like to expand on?

The Case of Cindy

Substance Use History

- Used IV heroin for 2.5 years, before participating in a long-term residential treatment program, during which, she was placed on methadone.
- Was on methadone for 9 months.
- After stopping methadone, patient was placed on buprenorphine which she continued for 3 years, before self-discontinuing this medication within the last year.
- Reports occasionally using more then the prescribed Xanax.
- No history of any other substance use related difficulties.
- She attends AA/NA meetings 2-3 times per week.

The Case of Cindy

Social History

- Lives with her mother.
- Never married.
- Gave birth 3 years ago, but states her baby was ”taken away” by CPS. This was an emotionally traumatic experience.
- Not currently employed but trained as a medical assistant.
- Currently on probation for disorderly conduct and jostling.
- No history of other psychological trauma, including any physical, sexual, or emotional mistreatment.
- Father has a significant history of drug and alcohol addiction but is in recovery and is very supportive to the patient.

The Case of Cindy

First Follow-up Visit

- Urine drug screen: only prescription medications present: alprazolam, gabapentin, sertraline, and quetiapine.
- MAPS report: regular prescriptions for alprazolam. No concerning activity.

Questions – Your initial assessment is complete:

- What is your recommended treatment plan?
- What, if anything, are you most concerned about?
- What else would you like to know?

The Case of Cindy

Initial Plan

- Recommend detoxification off Xanax, due to its high reinforcement potential, history of misuse, and her SUD history.
  - Detoxification was recommended with clonazepam, due to it's long-acting nature.
  - Patient still had one month supply, so no new Rx was provided.
- Continue all other prescribed medications.
- Encouraged continued participation in NA/AA.
- Recommended out-patient treatment services – County access number provided.
- Follow with regular urine drug screens and MAPS reports.
- Follow-up in 2 weeks.

Would you do anything differently?

The Case of Cindy

2nd Follow-up Visit

- Patient reported continued intermittent use of non-prescribed buprenorphine, which she reports was from an old prescription.
- She also reports continued use of Xanax and is using more than the prescribed amount on days that are more “stressful.”
- Clinicians considered Rx for buprenorphine, but concern arose regarding patient’s concurrent use of Xanax and likely illicitly acquired buprenorphine.
- UDS: No unexpected results.
- Inpatient treatment suggested, but patient declined.

What are your thoughts?

The Case of Cindy

3rd Follow-up Visit

- Patient reports buying Ativan and Suboxone off the street.
- She reports using buprenorphine and benzodiazepines to help mitigate anxiety.
- UDS and MAPS report: unremarkable.
- Clinicians again consider prescribing buprenorphine but are concerned about patient's non-prescribed use of buprenorphine and BZDs.
- Inpatient treatment was again recommended, and patient was provided with resources, but she declined.
- Follow-up scheduled in 2 weeks.

The Case of Cindy

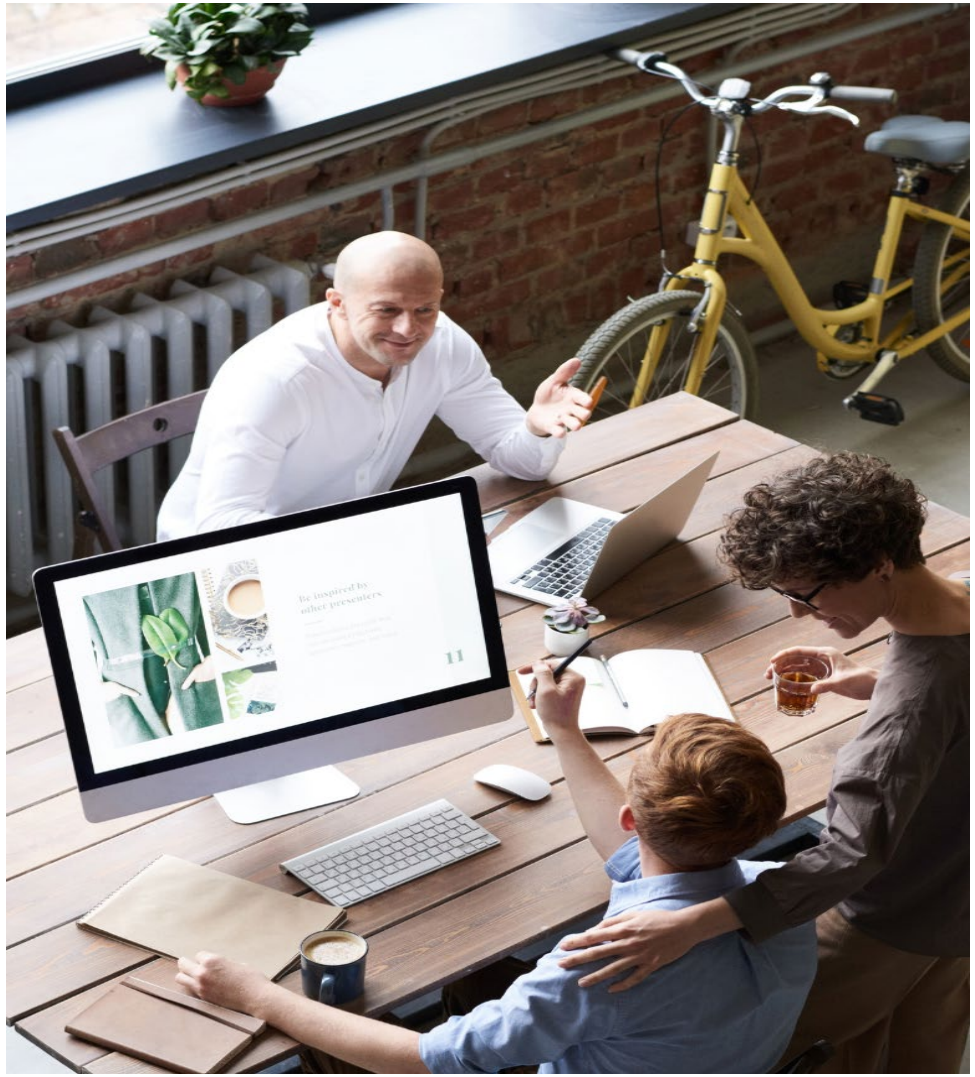
4th Follow-up Visit

- Patient declined to participate in inpatient treatment.
- She reports discontinuing her use of non-prescribed buprenorphine and has not used the drug in 5 days.
- She reports experiencing significant opioid withdrawal and described “feeling terrible.”
- Continues to use Xanax (provider has issued another Rx) and has been taking 3-4 mg daily over the last two weeks.
- She will run out of her Rx early and reports her provider will not issue another Rx.
- She asks for assistance with BZD withdrawal.

What would you do?

The Case of Cindy

Treatment Plan



- Patient was placed on clonazepam to wean off benzodiazepines.
- Longer acting BZDs make the tapering process easier for the patient.
- Initial dose of clonazepam 1 mg 2x daily, with a plan to decrease by 10-20% every 2-4 weeks.
- She continues to decline inpatient services.
- Continue to follow urine drug screens.
- She is now seeing a counselor every 1-2 weeks.
- Encouraged continued participation in NA/AA.

The Case of Cindy

5th Follow-up Visit

- Patient now at 21 weeks (over 2 months since first visit).
- She has tolerated clonazepam (2 mg daily) well.
- Reports continued use of non-prescribed buprenorphine and is using a “sliver” of an 8 mg tablet. She last used this drug 4 days ago and reports mild-moderate symptoms of opioid withdrawal.
- UDS shows buprenorphine but is otherwise unremarkable.
- Recommendations to patient:
  - Methadone maintenance – patient adamantly declined.

Why was methadone recommended? Do you agree?

The Case of Cindy

What about buprenorphine?

Why not prescribe buprenorphine?

- Clinician's mindset at that time.
  - Misuse of benzodiazepines.
  - Obtaining buprenorphine and BZDs from street.
  - Concern for diversion and escalation of substance misuse.
  - Methadone maintenance and/or inpatient treatment were deemed as best treatment option.

The Case of Cindy

6th Follow-up Visit

- Patient at 24 weeks
- Doing well on clonazepam 1 mg 2x daily – she is not ready to taper.
- Reports last use of buprenorphine was 2 weeks ago.
  - She continues to report significant withdrawal symptoms and generally reports not to be feeling well, due to buprenorphine discontinuation.
- UDS shows buprenorphine and clonazepam.
  - Patient reported last use of buprenorphine was 2 weeks – UDS should not show drug.
- Patient denied use of buprenorphine, despite UDS results.

The Case of Cindy

Subsequent Visits

- Patient was compliant will all f/u visits and UDSs.
- Decision was made to maintain the patient on clonazepam and NOT to taper.
- She continued to test positive for buprenorphine, but would only admit to intermittent use, and acknowledged purchasing this off the street.
- All urine drug screens were unremarkable, other than consistently showing buprenorphine.
- Patient's anxiety significantly increased as her due date approached, due to fears of potential CPS involvement, given her prior history.

The Case of Cindy

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The Case of Cindy

Final Outcome

- Patient was scheduled for induction of labor and described anxiety to OB NP as “through the roof” at her last visit.
- At 39 weeks, and 3 days after her last appointment, Cindy found on her bed unresponsive with a syringe by her side.
- She was taken to local hospital where she and her unborn child were pronounced dead.
- Cause of death was a heroin overdose.
- She was 33 years old.
- Our entire clinic, MD, NP, RN, MSW, MA, and even front desk staff attended the funeral.

The Case of Cindy

Retrospective

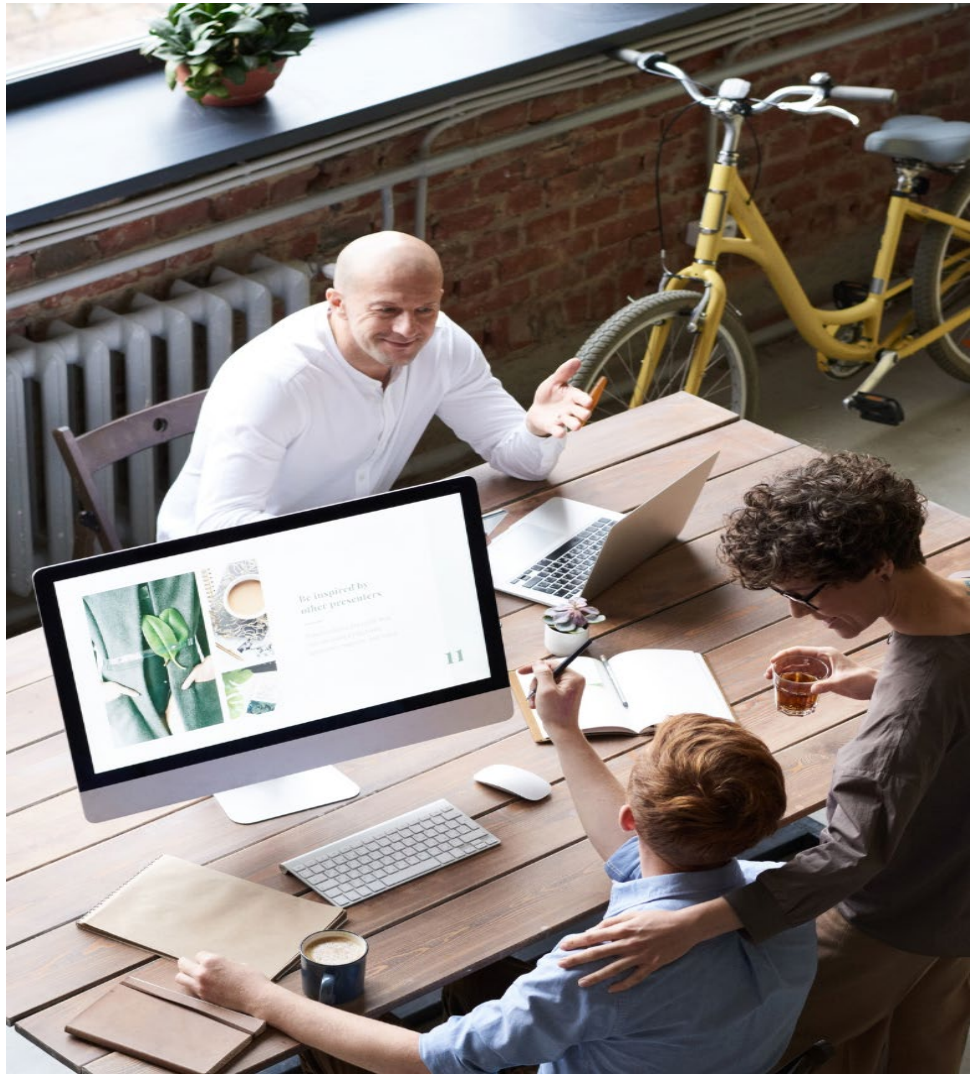
- Was this an unintentional OD or a suicide?
  - We will never know.
- We didn't expect this....
  - Urine drug screens NEVER showed heroin or any other opioid other than buprenorphine.
  - No evidence of heroin use throughout her entire pregnancy.
  - Patient was compliant: never missed an appointment or UDS.

Warning signs:

- History of IV heroin use.
- History of 2 inpatient psychiatric hospital stays associated with last pregnancy.
- History of an aborted suicide attempt following last delivery.
- Significant escalation in anxiety when told of induction of labor.

The Case of Cindy

My thoughts . . .



- Hindsight is always 20/20….
- What we could have done differently:
- Prescribe buprenorphine despite our concerns and be liberal with dosage to ensure patient comfort.
- Do not switch to clonazepam
- Continue use of Xanax, along with prescribed buprenorphine under close medical supervision.
- Provide 7-14 days prescriptions of Xanax and buprenorphine to limit potential for overuse.

What do you think?

The Case of Becky

The Case of Becky

- 33-year-old pregnant female at 29 weeks presents with a 6-year history of heroin and methamphetamine use.
- She was recently treated in a long-term care facility and was placed on Subutex (buprenorphine) 8 mg 3x daily. She was discharged from residential treatment 10 days prior to presentation.
- Patient reports that only days after discharge, she began using heroin and methamphetamine again, in addition to the prescribed buprenorphine.
- UDS shows morphine, methamphetamine, THC, and buprenorphine.

The Case of Becky

- Psychiatric history: patient reports:
  - History of ”manic depression.”
  - Multiple inpatient psychiatric hospitalizations, due to drug overdose. Patient reports that overdoses were due to addiction and were not suicide attempts.
  - Denies any history of suicide attempts.
  - History of multiple psychiatric medication trials, but reports doing best on Lithium.
- She reports feeling significantly depressed with mood swings. No SI.
- Mental status exam does not reveal any signs of mania, hypomania, or psychosis.

The Case of Becky

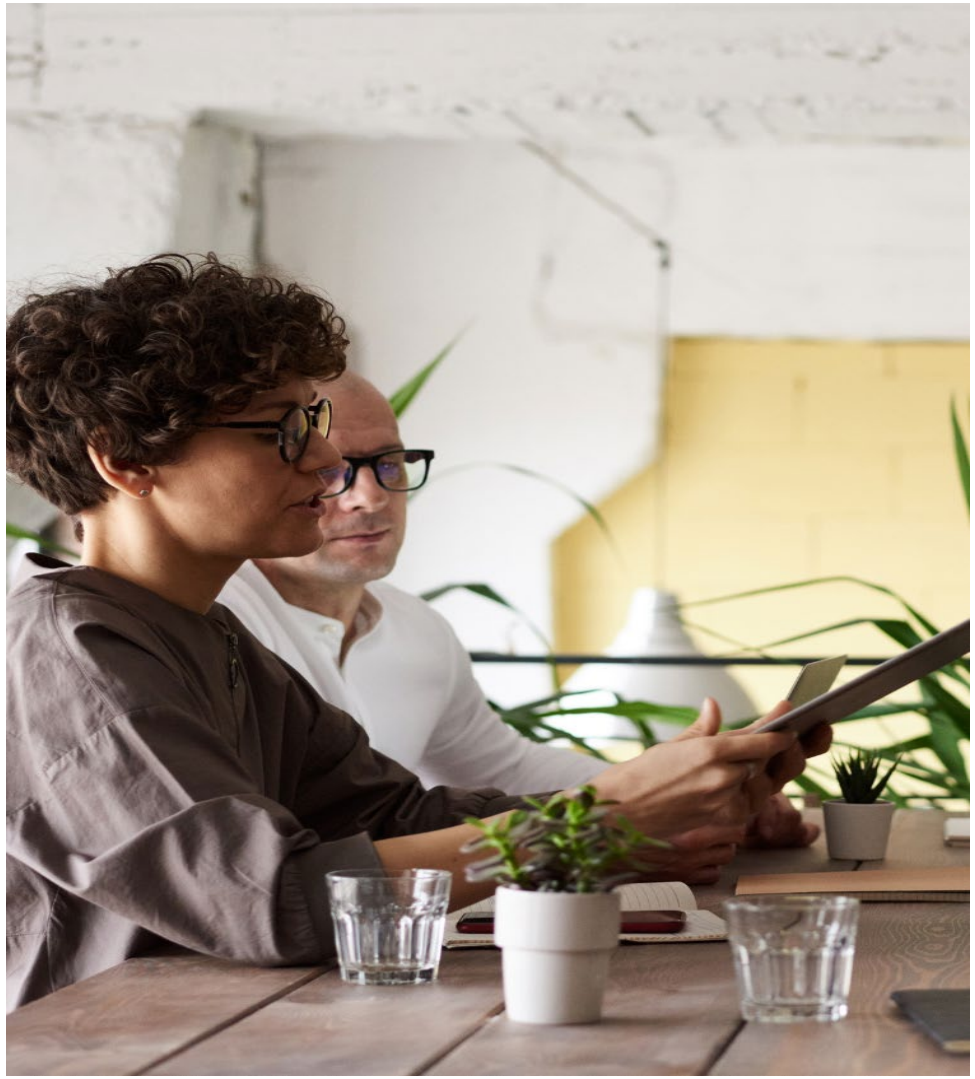
Social History

- Unstable housing, but lives with FOB, who is abusive.
- Was previously living in hotels.
- Has two children who live with her parents.
- Currently facing significant legal charges and possible prison time, due to drug-related offense.
- Has no reliable support (possibly grandmother).

What is your treatment plan for Becky?

The Case of Becky

Treatment Plan



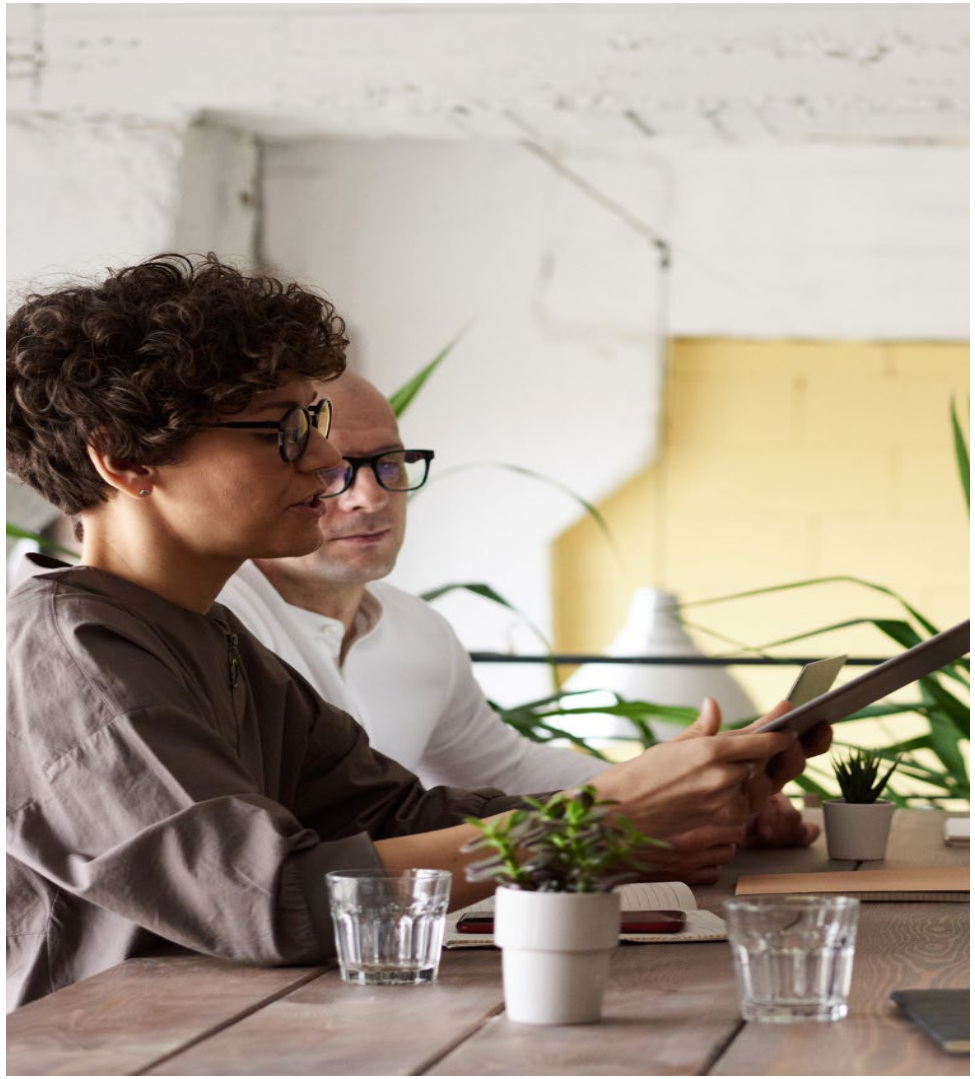
- Methadone maintenance was recommended, but patient adamantly declined.
- Inpatient treatment was also suggested, but patient declined.
- Rx Lithium 300 mg 2x daily, based on patient's psychiatric history, mental status exam findings, and report of therapeutic efficacy.
- Agreed to provide 7-day supply of buprenorphine with RV in one week.
  - Patient educated on precipitated withdrawal and informed on how to preform a home induction.

The Case of Becky

2nd Follow-up Visit

- Patient reported continued methamphetamine use (3x since last visit).
- Also reports use of a single dose of unprescribed Xanax and Seroquel.
- Denies any opioid use and is happy with buprenorphine.
- She reports to be considering adoption and has an interested party in mind (MSW met with patient in this regard).
- Patient provided 1 week Rx for buprenorphine.
- UDS obtained and results uploaded next day….

The Case of Becky



- UDS from 2nd f/u visit:
- Buprenorphine
- Methamphetamine
- Amphetamine
- Fentanyl and norfentanyl
- Tramadol

What would you do now?

The Case of Becky

Concerns Arise

- Attempted to contact patient to discuss UDS – no answer.
- Patient no-shows to f/u visit.
  - MD and MSW make multiple attempts to call patient – no answer and no option to leave voice message.
  - Patient does not call to request buprenorphine Rx (she was only given one week supply).
- Patient no shows again one week later.
  - MD and MSW place calls – no answer
  - Grandmother contacted, who stated that she has not heard from patient in 2 weeks (her last appointment date).
- MSW suggests doing “wellness check.”

The Case of Becky

Patient Resurfaces

- Patient returns to clinic after a 5-week absence.
- Gestational age is now 37 weeks.
- She reports that she was in Saginaw, due to the ailing health of FOB's mother.
- States she has been out of buprenorphine and has been using heroin.
- Reports intermittent methamphetamine use.
- UDS positive for morphine and methamphetamine

What would you do?

The Case of Becky

- OB recommends admission for induction of labor (IOL) for baby's safety given deterioration of patient's status.
- Patient offered an admission for IOL, but declines.
- Admission to addiction treatment facility recommended with placement on methadone, but patient declined.
- Patient provided 7-day supply of buprenorphine to help mitigate risk of overdose and death.
  - Difficult decision.
  - Discussed with all clinicians involved.
  - Concerns and reasons for prescribing reflected clearly in the medical record.
  - No additional updates currently – Becky is still pregnant

The Case of Becky

Takeaway Points

- Sometimes we engage in a harm reduction approach.
- Create an environment where the patient is willing to come back to you, regardless of the circumstance he/she has encountered.
- Reach out and ask for guidance, if the case is too complex. It ALWAYS helps to discuss a case with a colleague.
- **TREAT THE PATIENT, NOT THE DRUG SCREEN RESULTS.**
- Always document your reasoning, especially in cases of high-risk prescribing.
  - Acknowledge that this is a high-risk situation, but that you're engaging in this treatment to prevent a potential overdose and death and that you will appropriately monitor the patient.

Action Period Assignment

- We discussed two high-risk cases today with two very different treatment approaches. One involved prescribing buprenorphine in a high-risk situation, and the other involved not providing buprenorphine under similar circumstances.
    - Prior to this presentation, what was your opinion of providing buprenorphine in the context of active substance use, and did these cases change your viewpoint? Why or why not?
- Some clinics have very stern controlled substance agreements, which stipulate that ANY drug use outside of what is prescribed may result in dismissal from the clinic.
    - While we have discussed the clear disadvantages to this approach, can you think of any advantages to taking this type of stance?

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Thank You

Please email me at ejouney@med.umich.edu with any questions.