

“Methadone Misunderstood”

The letter Sunday, December 6, 2009, titled “Methadone warnings might save lives”, was heartbreaking. The letter was from the parent of a teenager who died from apparent methadone medical mismanagement and was an attempt to clear up some misconceptions about methadone. I would like to respond to the request for a follow-up article because methadone is a medication that is riddled with misconceptions and stigma.

As stated in the letter, methadone is used both for pain management as well as the treatment of opiate addiction. Opiates are a class of drugs which includes medication such as oxycodone, morphine, hydrocodone, methadone and heroin. Addiction is a bio-psycho-social disease manifested by loss of control over drug use, use despite harm, and cravings. Addiction is not the same as “physical dependence.” Physical dependence occurs in any person who takes opiates consistently for more than a few weeks, and is manifested by a characteristic withdrawal syndrome when the medication is stopped abruptly. Someone can be addicted, but not have physical dependence and vice versa.

Methadone clinics (also known as Opiate Treatment Programs or OTPs) use methadone to treat opiate addiction. I understand that it seems counterintuitive to treat drug addiction with a drug. I thought the exact same thing before I started working at an OTP. As a physician specializing in both Addiction Medicine and Pain Management, I thought I would go in there and show them what recovery was really about. I assumed that the clinic patients were people in active addiction, who had found a legal way to get drugs. To my surprise, what I found were clients who were doing the hard work of recovery, just like the clients in “abstinence based recovery.” These clients who were in a “medication assisted” recovery process were not only abiding by all of the strict state and federal regulations that govern OTPs, but they were flourishing in recovery. These clients were attending individual therapy, group therapy and 12 step meetings in the community. Many were recovering in all aspects of their lives, and helping the new comer to achieve the same. Just as in “abstinence based recovery,” some clients in “medication assisted recovery” do not stabilize. Despite our best efforts, many people may continue to be active in their addictive process. It is frustrating for families, friends, and most of all for the client.

Methadone, when prescribed for pain management, is prescribed by physicians in their office. They do not operate under the strict regulations of an OTP. Methadone for relief of pain should be dosed about every eight hours. Methadone in an OTP, where it is used to relieve the signs and symptoms of withdrawal, only needs to be dosed once a day and this is usually done under direct observation at the clinic. Methadone is a very potent opioid analgesic (pain killer). It should only be used for pain in patients who have developed tolerance to opiates. It is very easy for an “opiate naive” patient, (a person without tolerance to opiates), to overdose on methadone. This is the result of respiratory depression which is dose dependent meaning that the higher the dose, the more likely it is for a person to stop breathing. Also, when methadone or any opiate is combined with other sedatives, such as Xanax, Valium, Klonopin or alcohol, there is an increased risk

for respiratory depression and death. Physicians prescribing methadone need to be aware of the potential lethal combination of opiates and benzodiazepines (Valium, Xanax, and Klonopin).

Another characteristic of methadone that makes it so dangerous when not prescribed or taken appropriately is its long duration of action (i.e., half life). Methadone levels build up in the blood for about five days even while taking the same dose due to its long half-life of 24 hours. This means a person may be prescribed ten milligrams, three times a day and feel fine the first day or two. As the blood level continues to get higher even while taking the same dose, the person may become overmedicated. In a worst case scenario, they may stop breathing and die from an accidental overdose. This is particularly easy to do if the patient is also taking benzodiazepines, barbiturates or alcohol.

Whether a physician is prescribing methadone in an OTP or in a pain management practice, it is imperative to “**start low and go slow.**” Patients need to be educated regarding the signs of opiate toxicity and they need to be monitored closely.

My hope is to diminish the stigmatization of methadone and of Opiate Treatment Programs. Medication Assisted Treatment is not the first choice when a person is initially attempting to recover from addiction. However, in many patients, their brains never stop craving long enough to fully engage in the recovery process. I have heard people say “Oh, he’s just not ready. He’ll stop when it’s bad enough.” That is simply not true. I do not know one patient in active addiction who truly wants to continue being a prisoner to this disease. They are hopeless and afraid, and often convinced that treatment does not work. The brains of patients who have abused drugs and alcohol often have been altered significantly. These patients need medication in order to engage in treatment and to stabilize. Some will be able to successfully undergo a medically supervised taper and some will need to be on medication long term.

Methadone is not an evil drug. Methadone is an effective medication for chronic pain. It is relatively inexpensive and it is safe when prescribed by a knowledgeable physician and taken as prescribed. Methadone, when coupled with psycho-social support, is also a highly effective medication for the treatment of opiate addiction. I know, because I see it working every day.

Stacy Seikel, MD
Medical Director
The Center For Drug-Free Living, Inc.

Pain & Addiction Specialist
Hanley Pain and Rehab