

**Your letter head**  
**Give this to patients to have with them when**  
**They see a physician or dentist**

Dear Doctor:

The bearer of this letter is a patient in a methadone maintenance treatment program. Methadone patients frequently need treatment for other medical, surgical, and dental conditions. At times the health professional is not familiar with addictive disease and the various forms of treatment, including maintenance pharmacotherapy using methadone or LAAM. The reaction to being informed about the addictive disease/methadone treatment often includes fear, anger, prejudice, disgust, and other negative subjective responses, none of which contribute to the objective delivery of quality health care. Many patients are very reluctant to provide information to the other health professional about their addiction and treatment with methadone or LAAM because of previous unpleasant experiences. The most common reaction is based on fear and disgust which is inversely proportional to the professional's level of familiarity with addiction medicine and patients with addictive diseases. The purpose of this brief letter is to touch on the most common problems encountered and to offer any assistance I might be able to provide.

It is widely accepted that addictions are diseases and that their treatment is a legitimate part of medical practice. Addictive disease can be characterized as a chronic, relapsing, progressive, probably incurable, and often fatal (if untreated) disorder. The principle diagnostic features are obsession, compulsion, and *continued use despite adverse consequences* (loss of control).

Methadone has been used in the treatment of opioid dependence for over 30 years. It has been found to be both effective and safe in long term administration. An adequate individualized daily dose of methadone eliminates drug craving, prevents the onset of withdrawal, blocks (through opiate cross-tolerance) the effects typical of other opiates, such as heroin or morphine. Efficacy of treatment is based on elimination of or reductions in illicit/inappropriate drug use, elimination or marked reduction in illegal activities, improved employment, pro-social behavior and improved general health. Such treatment has been shown to be effective in reduction of the spread of HIV and other infections. Dramatic reductions in mortality rates are seen in methadone maintained patients in comparison to untreated addicted populations.

The methadone maintained patient develops **complete tolerance to the analgesic, sedative, and euphoric** effects of the maintenance dose of methadone. Tolerance **does not** develop to the effects of *reducing drug hunger and preventing the onset of withdrawal syndrome*. Methadone has a half-life in excess of 24 hours which makes single daily dosing possible. Methadone has a relatively flat blood plasma level curve that will prevent the onset of abstinence syndrome for over 24 hours *without* causing any sedation, euphoria or impairment of function.

Along with discrimination, and related to the same stigma, the failure to provide adequate treatment of pain methadone maintained patients is a common and very serious problem.. Since the patient is fully tolerant to the maintenance dose of methadone **No analgesia is realized from the regular daily dose of methadone**. Relief of pain depends on maintaining the established tolerance level with methadone and then providing additional analgesia. Studies have shown that exposure to adequate doses of narcotics for the relief of acute severe pain does not compromise treatment of the addiction.

Non-narcotic analgesics should be used when pain is not severe. In the event of more severe pain the use of opioid agonist drugs is quite appropriate. The dose of opioid agonist drugs, such as morphine, is usually increased to compensate for the opioid cross tolerance established by the methadone. Also, the duration of analgesia may be less than usual. Doses must be individually titrated to ensure adequate analgesia. Best results are obtained with a scheduled

dosing as opposed to PRN. Morphine may be required q 2-3 hours at whatever dose that provides relief.

There is no justification for subjecting a maintenance patient to unnecessary pain and suffering because of their disease or its treatment. Adequate treatment of pain will ensure a more pleasant hospital stay as well as enhance healing and recuperation.

**Opioid partial agonist and agonist/antagonist drugs such as Buprenex, Talwin, Stadol, and Nubaine should never be used in the methadone tolerant individual.** Severe opiate withdrawal syndrome can be precipitated by drugs of this type.

Both propoxyphene and meperidine are known to produce CNS excitatory metabolites. Due to the cross tolerance the higher doses required to achieve analgesia can increase the risk of seizures. For this reason propoxyphene and meperidine should be avoided in the maintenance patient.

The administration of opioid agonist drugs should be closely supervised in terms of quantities and duration. Prescribing for self-administration by the patient should be carefully monitored. If it is necessary to prescribe for self administration, caution should be exercised in the amounts prescribed and refills carefully supervised.

Similar precautions are indicated in the prescribing of sedative/hypnotic and CNS stimulant drugs. The abuse potential of *ALL* benzodiazepines is quite high.

At times the attending physician is tempted to treat the opioid dependence itself. This is usually attempted by tapering the methadone dose to zero. If successful, the graded reduction may result in a reduction or elimination of the physical dependence but has no effect on the disease itself. Even after the methadone is discontinued significant signs and symptoms of abstinence may persist for several weeks and even months. The relapse rate associated with detoxification alone approaches 100%. A relapse to street/illicit drugs increases risk of overdose, hepatitis, AIDS, and a host of other biomedical, psycho-social, legal, and other complications.

Under some circumstances some form of intervention can be accomplished during a hospital stay for other conditions when desired by the patient and in consultation with the methadone program physician. Such a process should involve experienced addiction professionals with a strong emphasis on continuity of care upon discharge.

If you have any questions or concerns about our mutual patient in relation to methadone or drug dependency please call me. I would be delighted to hear from you.

Sincerely,

Your name and special instructions