OAT, OUD, OMT, OAD … And that's just the beginning of the problem. Making sense of Opioid Use Disorder with the PEER Guidelines

Tina Korownyk, Jessica Kirkwood

Faculty/Presenter Disclosures

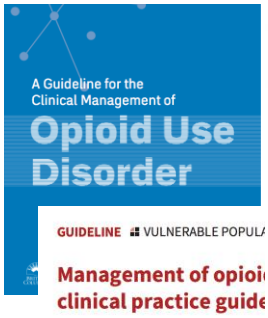
- **Faculty: Tina Korownyk: University of Alberta & Academic Relationship Plan**
- **Relationships with financial sponsors:**
  - **Grants/Research Support:** Alberta College of Family Physicians; Toward Optimized Practice, CIHR, PRIHS
  - **Speakers Bureau/Honoraria:** Alberta College of Family Physicians;
  - **Consulting Fees:** N/A
  - **Patents**: N/A
  - **Other:** N/A

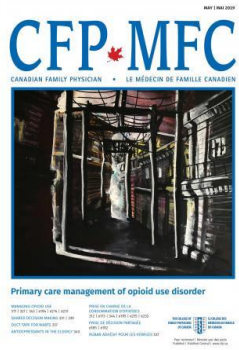
- **Faculty: Jessica Kirkwood: Clinical Lecturer UofA, Boyle McCauley Health Centre**
- **Relationships with financial sponsors:**
  - **Grants/Research Support: N/A**
  - **Speakers Bureau/Honoraria:** Alberta College of Family Physicians;
  - **Consulting Fees:** N/A
  - **Patents**: N/A
  - **Other:** N/A

Learning Objectives

At the end of this session, participants will be able to:

- Understand the best available evidence on OUD management in primary care.
- Describe methods used to identify patients with OUD.
- Compare and contrast available treatments for OUD.





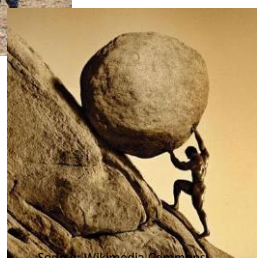
TOP QUESTIONS

- ***Where should OUD be managed?***
- ***How is OUD best diagnosed?***
- ***What is the efficacy and safety of pharmacotherapy for OUD including:***
  - ***Buprenorphine-naloxone***
  - ***Methadone***
  - ***Naltrexone***
  - ***Cannabinoids***
- ***What is the evidence for prescribing practices including***
  - ***contracts, urine drug screens and witnessed ingestion***
- ***What is the evidence for the tapering of opioids or OAT?***
- ***Do psychosocial interventions improve outcomes for patients already on pharmacotherapy?***
- ***Does residential treatment improve outcomes?***
- ***How do we manage comorbidities in patients on pharmacotherapy for OUD (acute and chronic pain, ADHD, anxiety and insomnia)***

17 SYSTEMATIC REVIEWS

Ambitious

Just Dumb



Opioid Use Disorder Guideline Process

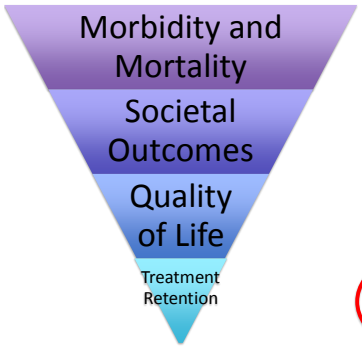
OUD Committee
3 generalist GPs (TK, DK, EO)
2 inner-city GPs (JM, TM)
1 addiction & pain GP (NW)
1 psychiatrist (WL)
1 nurse practitioner (RQ)
1 pharmacist (TN),
1 social worker (KR)
1 community support worker (CB)
1 person with lived experience
2 non voting pharmacist project managers (BT,AJL)

Evidence Review Committee
4 GPs (MA, MK, TK, SG)
5 Pharmacists (AL, JT, BT, ND, RT)
1 nurse (DP)
2 medical students (CF, PY)

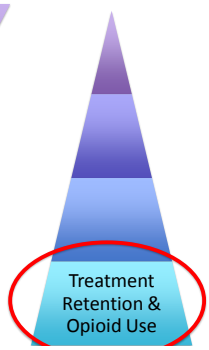
External Peer Review
60 Peer Reviewers

Final Guideline

Outcomes we Care About



What we Found



Additional Limitations

- Inconsistent termin
  - eg "heroin abuse", "
  - ORT, OST, OAT, OMT
  - "Usual care"
- Small studies, very high drop-out rates
- Multiple outcomes assessed, only positive findings reported
  - ie urine drug screens at 1,2,4,8,12,16,32 weeks…

"Fourteen male patients were enrolled… Only males were selected because the rate of opioid abuse is thought to be negligible among females."
Indian J Psychol Med 2017;39:445-9

Where is OUD best managed?

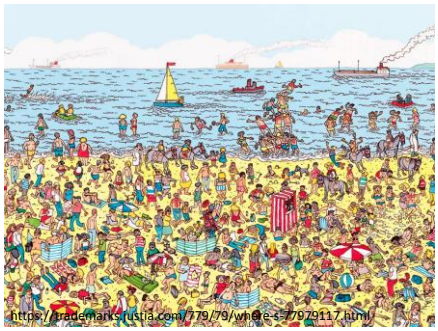
OAT in primary care vs specialty care (3 RCTs, mean 42 wks)
- Retention in treatment (3 RCTs, 287 patients):
  - 86% vs 67% specialty care; **NNT=6**
- Street opioid abstinence (3 RCTs, 313 patients):
  - 53% vs 35% specialty care; **NNT=6**
- Patient satisfaction (1 RCT, 46 patients):
  - Patients **"very satisfied"** more often in primary care **(77% vs 38%)**
- All trials included some element of additional training, consultant availability and team support

OAT vs Waitlist
- Retention in treatment (3 RCTs, 458 patients)
  - 68% vs 22%; **NNT = 3**

OAT versus Waitlist

https://imgflip.com/memegenerator/Oprah-You-Get-A

Identifying the OUD patient in your chronic pain population



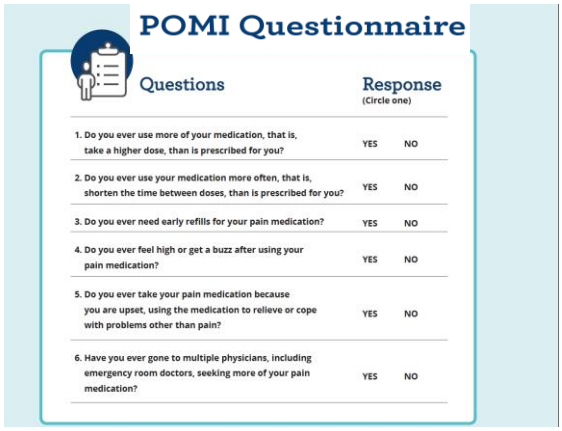
https://trademarks.justia.com/779/79/where-s-7979117.html

How do I Diagnose OUD?

Searching for tools to help identify OUD:

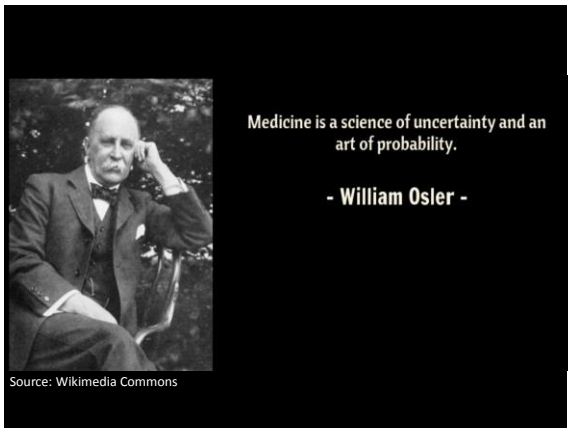
- Found 14 systematic reviews with 6-50 studies
  - 16 different tools studied.
  - 23 different diagnostic criteria used for comparison.

- Only 2 compared to the "gold standard" DSM
  - **COMM** – 40 pt scale with 17 questions
    - Positive LR 3.35 **(Small help ruling in)**
    - Negative LR 0.30 **(Small-moderate help ruling out)**
  - **POMI** – 6 question checklist
    - Positive LR 10.3 **(Large help ruling in)**
    - Negative LR 0.20 **(Moderate help ruling out)**
    - POMI completed in patients using prescription opioids

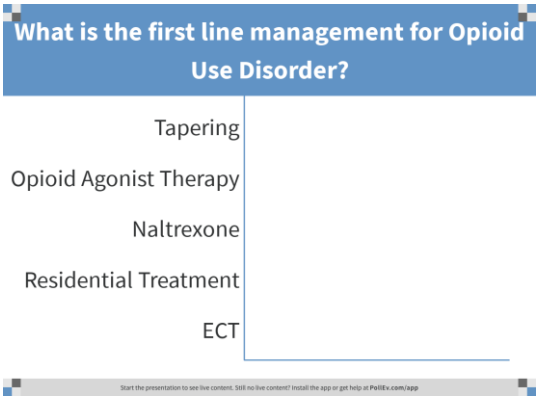


POMI Questionnaire

Questions	Response (Circle one)	
1. Do you ever use more of your medication, that is, take a higher dose, than is prescribed for you?	YES	NO
2. Do you ever use your medication more often, that is, shorten the time between doses, than is prescribed for you?	YES	NO
3. Do you ever need early refills for your pain medication?	YES	NO
4. Do you ever feel high or get a buzz after using your pain medication?	YES	NO
5. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?	YES	NO
6. Have you ever gone to multiple physicians, including emergency room doctors, seeking more of your pain medication?	YES	NO

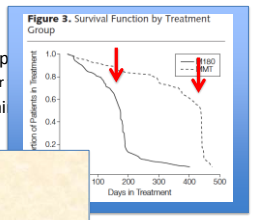


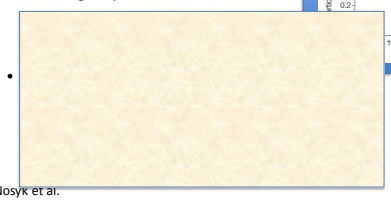
Source: Wikimedia Commons



To Taper or Not to Taper?

- **Tapering to discontinue prescribed opioids:** No RCTs
- **Switch to OAT and Taper: 3** RCTs
  - 1 aimed for 60 pain pts, stopp
    - all randomized to taper quit or
  - 6/57 (11%) of taper pts remai group
-



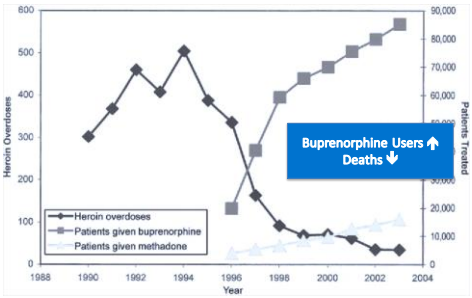


Nosyk et al.

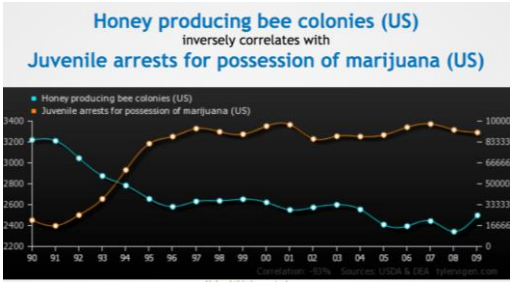
Opioid Agonist Therapy for OUD

Treatment Retention	RCTs	Follow Up	Tx	Control	NNT	Quality of Evidence
Buprenorphine versus **placebo**	9 RCTS 2528 pts	30d-52 wks	65%	40%	4	Moderate
Methadone versus **no Methadone**	6 RCTs 1114pts	45d-2 yrs	73%	22%	2	Moderate
Methadone vs Buprenorphine	24 RCTs 3828 pts	2-52 wks	60%	45%	7	Moderate
Abstinence						
Buprenorphine versus **placebo**	3 RCTs 206 patients	-	60%	39%	5	Moderate
Methadone versus **no Methadone**	4 RCTs 753 pts	-	47%	22%	4	Moderate
Meth vs Bup	6 RCTs 566 pts	-	30%	28%	NSS	Moderate

Reduction in overdose mortality with expanded access to OAT (France)



Carrieri et al., 2006



Correlation: -0.933389

http://tylervigen.com/view_correlation?id=1582

So…what about Mortality?

- Rarely reported in RCTs – only 10 pharmacotherapy trials included data on deaths
  - Trials comparing buprenorphine, methadone or naltrexone to placebo or no intervention
- Deaths occurred in 6/10 trials
  - 13/472 deaths in control group
  - 4/463 deaths on pharmacotherapy

Reduced Mortality with OAT?

Copyright Unknown

Bottom Line: Exploratory analysis suggests that OAT may reduce mortality in patients with OUD.

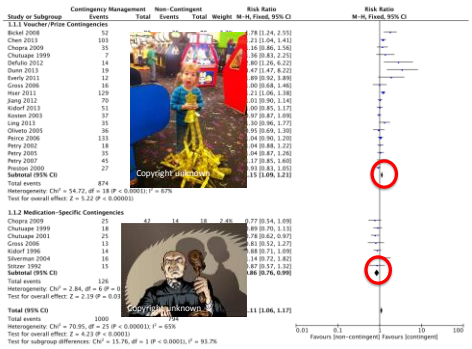
Opioid Antagonist - Naltrexone

- Naltrexone (oral + injectable) compared to placebo or usual care
  - improves treatment retention
    - 33% versus 25%, NNT=13, 8 RCTs
  - Decreases re-incarceration
    - 24% versus 33%, NNT=12, 4 RCTs
- Compared to buprenorphine
  - Oral naltrexone worse for treatment retention
    - 2% versus 32%, NNH = 4, 1 RCT
  - Injectable no significant difference in retention
  - requires 7-10 day opioid free period
    - In most studies patients had undergone detoxification (ie incarcerated patients)
  - Injectable formulation not currently available in Canada.

Which of the following has evidence for improved outcomes?

- Contracts/Treatment Agreements
- Routine urine drug testing
- Positive Contingency Management
- Negative Contingency Management
- All of the above

Contingency Management



Psychosocial Interventions for Patients on OAT

Intervention versus Control	Morbidity and Mortality[1]	Societal Outcomes[2]	Quality of Life and Symptoms[3]	Opioid Use and Treatment Retention[4]
Counseling versus minimal to no counselling	-	-	-	75% vs 61%, NNT = 8
Extended Counseling versus Brief Counselling	-	-	-	No difference
Motivational Interviewing versus Usual Care	-	-	No Difference (QoL)	Motivational Interviewing better
Cognitive Behavioral Therapy versus Usual Care	-	-	-	No difference
Contingency Management versus Usual Care	-	-	-	75% vs 66% NNT = 11 68% vs 77% NNH =11
Technology-Based [10] Psychosocial Interventions versus Usual Care	-	-	-	No Difference

And now our recommendations

Insufficient Evidence

- There is insufficient evidence to create a recommendation for or against the use of residential treatment for patients with OUD
- There is insufficient evidence to create recommendations for the following co-morbidities:
  chronic pain
  acute pain
  Insomnia
  anxiety
  ADHD

Weak Recommendations

- Clinicians could **consider the use of a simple tool such as the POMI** if assistance is needed identifying chronic pain patients who may have OUD
- Clinicians could **consider take-home doses** (i.e. 2 to 7 days) as an option when need and stability indicate
- Clinicians could **consider urine drug testing** as part of the management of patients with OUD
- Clinicians could **consider treatment agreements** (i.e. contracts) in the management of OUD for some patients

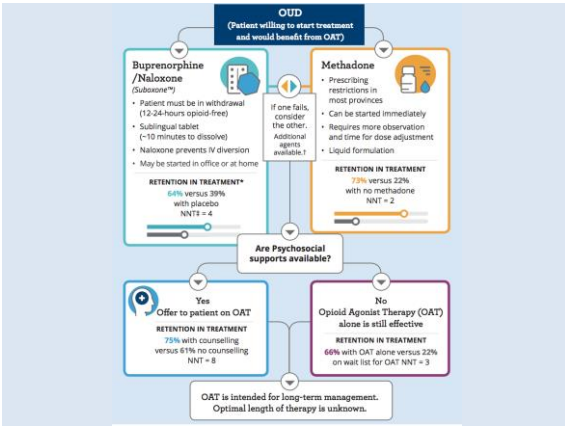
Strong Recommendations

- We recommend that management of OUD be **performed in primary care** as part of the continuum of care
- We recommend clinicians **discuss use of buprenorphine-naloxone or methadone** with their patients
- We recommend against initiation of OAT with the intention to discontinue in the short-term. **OAT is intended as long-term** management.
- We recommend the **addition of counselling** to pharmacotherapy where available
- We recommend **against punitive measures** involving opioid agonist treatment (i.e. reduction in dose or loss of carries), unless safety is a concern

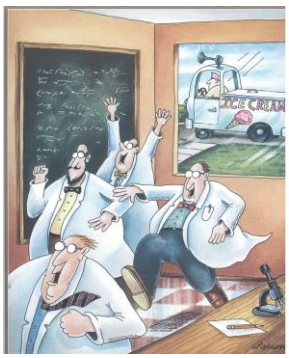
Table 3. Practice Pearls*

Opioid Agonist Therapy (OAT)
○ Promote harm reduction, such as ensuring patients have a naloxone kit.
○ Patients must have a lock box for take-home doses or "carries" of OAT.
○ Despite most references stating the maximum dose of buprenorphine-naloxone (Suboxone®) is 24mg/day, the dose can be increased up to 32 mg/day in select cases.
○ If unsure about going up on OAT dose due to sedation concerns, ask patients to dose in the morning and re-book appointment 3-4 hours post-dose to ensure they are not over-sedated.
○ Titrate dose of OAT based on withdrawal symptoms. Ask about the TIME of day that withdrawal symptoms are the worst. True withdrawal symptoms are worst right before the next dose is due.
○ Side effects of OAT are similar to those seen with opioids including constipation, amenorrhea in females and low testosterone in males. ○ Methadone can cause sweating which can also be a withdrawal symptom.
○ For chronic pain patients, first stabilize the opioid use disorder before managing pain. ○ Pain outcomes may improve as OUD stabilizes.
○ OAT can still be used in the context of polysubstance use disorder (ie. OUD + stimulant use disorder).
○ If employed in safety sensitive jobs, check employer standards for urine drug testing and pharmacotherapeutic management.
○ If a urine drug test is negative for methadone or buprenorphine/naloxone (or their metabolites) in a patient on OAT, consider the possibility of diversion.
Withdrawal Symptoms
○ Untreated, withdrawal symptoms may last for weeks. With treatment (ie. buprenorphine), they will usually settle within 3-5 days depending on titration.
○ Familiarize yourself with opiate withdrawal signs/symptoms- does the physical exam correlate with the patient's subjective report of symptoms?
○ Craving is a withdrawal symptom.
Access Additional Resources
○ Access community pharmacists to gather information on patients you are concerned about. How do they look when they come in? Are they sedated/intoxicated?
○ Consider mentorship networks, if available, to help manage co-morbidities (eg. pain) or to discuss alternative management for patients with suboptimal response to OAT, etc.

*Pearls are based on the opinions of the guideline committee and current trends in practice.



Thank You



Questions from the Audience

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