IOTOD

improving outcomes
in the treatment
of opioid dependence

Session 5

Complex cases: panel discussion

Chaired by Professor Graham Foster

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Patient A

Patient A

Patient

- 32-year-old female, opioid dependent > 5 years
- Comorbidities: juvenile arthritis

Medication(s)

- For the last 6 months: 'long-acting' oxycodone hydrochloride 160mg BD, 'short-acting' oxycodone hydrochloride 190mg daily, pregabalin 300mg BD
- This regime was chosen by the pain clinic following referral

Patient A

Challenge

- Patient appears to be going backwards – still in treatment but compliance is poor
- Ongoing drug dependence despite a 20% dose reduction (in oxycodone)
- Currently requesting an extra / top-up dosage of long- and short-acting oxycodone hydrochloride, plus pregabalin on a weekly basis
- Pregabalin is on maximum dose
- Biological and immunosuppressive agents for arthritis are not suitable due to low immunity

Question

- What else could be done to help this patient?

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Patient B

Patient B

Patient

- 53-year-old male, opioid dependent for > 10 years
- Suffers from degenerative disc disease
- Prescribed morphine for pain by previous doctors

Medication(s)

- Morphine 90 mg BD:
  - It took 10 weeks from initial consultation to decrease dose from 100mg BD to 90mg BD
  - Gabapentin also tried

Patient B

Challenge

- Patient complained of back and neck pain in recent consultation
- Patient is unwilling to further reduce opioid dose but rather wants to increase back up to 100mg BD
- Has been cautioned of high-dose opiate risks

Question

- How this patient could be managed more effectively?

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Patient C

Patient C

Patient

- 52-year-old male
- Before treatment was heroin dependent for > 10 years
- Worsening anxiety disorder, COPD (diagnosed 1-year ago), previous nicotine dependence (quit 2 years ago)

Medications

- Has been on OST for past 8 years. Currently on methadone 60mg daily
- Also taking a bronchodilator for COPD

Patient C

Challenges

- Good compliance while on treatment but has destabilized whenever attempts to reduce methadone dose
- COPD has been worsening over last few months
- Suggested switching to buprenorphine to help respiratory impact but patient is very reluctant to switch as he had a friend who "didn't like it"

Questions

- What would be the next best step? Switch to buprenorphine or attempt to reduce the methadone dose again even though this has destabilised patient in the past? How can we manage his anxiety disorder?

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Patient D

Patient D

Patient

- 24-year-old male, opioid dependent for three years
- Before treatment was using heroin, cocaine and ketamine
- Alcohol and nicotine dependent
- Suffers with depression

Medication

- For past 6 months: Methadone 75 mg
- Currently on methadone 75mg
- Refused all offers of psychosocial support

Patient D

Challenges

- Compliance is very poor – has had numerous relapses
- Patient's partner recently diagnosed with HCV
- In general, patient is distrusting of health services and reluctant to engage – is unwilling to undergo HCV testing and states "I don't want to have loads of hospital visits and tests"
- Unlikely to go for liver scans

Questions

- What is the best approach for HCV testing / treatment that should be proposed? Should tests for any other health complications be considered?
- What else can be done to manage this patient more effectively and how should this be communicated?

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Patient E

Patient E

Patient

- 30-year-old female, opioid dependent for at least 5 years
- History of heroin, fentanyl and benzodiazepine use
- Antisocial personality disorder with depression

Medication

- Currently on methadone 70mg daily
- Has been in OST for around 1 year

Patient E

Challenge

- Compliance is extremely poor and has been an ongoing issue with this patient
- Has had numerous relapses and suspected intermittent benzodiazepine use
- Regularly misses appointments; complains of "hassle to attend"
- Suspected pregnancy – "cannot remember last period, thinks maybe 2 months ago"

Questions

- What would the best treatment approach be for this patient? Are there any new treatments that might be more effective for this patient?

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Patient F

Patient F

Patient

- 33-year-old male, opioid dependent for 8 years
- Was previously taking heroin
- Former alcoholic but sober for past 5 years. No other known comorbidities

Medication

- Currently on buprenorphine/ naloxone 12mg
- Stable for past 4 years
- One unsuccessful attempt at detox

Patient F

Challenges

- Patient has been very stable and doing well on buprenorphine/naloxone
- At our last consultation, expressed a wish to detoxify again; is concerned about instability / relapse but adamant that wants to try

Questions

- Is detoxification right for this patient? What would the best approach be and how do I ensure correct support in place?
- Should patient destabilize, what else might be offered?

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Patient G

Patient G

Patient

- 37-year-old male, opioid dependent for > 20 years
- Previously used heroin

Medications

- Methadone 90mg + diazepam 30mg
- 'Long-acting' morphine 10mg BD + tramadol 100mg QDS (for last 4 years since pancreatitis diagnosed)

Patient G

Challenges

- I met patient 2.5 years ago; he appeared to be in opioid withdrawal
- Patient anxious about medication reductions but has managed to reduce tramadol to 50mg x 19 per week
- Experienced heroin overdose in past year and also developed groin abscess
- Patient eventually attended pain clinic but refused to engage with CBT and nurse specialist. Has missed gastroenterology and pain clinic referrals in past
- Patient says no one can reduce his medication without his consent
- Patient does have naloxone training and kit

Questions

- What else can be done?
- How should we manage the multiple opioid prescriptions?

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Patient H

Patient H

Patient

- 42-year-old female, opioid dependent > 3 years

Medications

- For last 3 years:
  - 30/500 mg codeine/ paracetamol x 2 QDS
  - 50–100 mg tramadol QDS
- Prescribed initially for back pain by GP

Patient H

Challenges

- Usually arrives two days early for weekly prescription – gets agitated/ confrontational if not dispensed
- Patient reports previous physiotherapy and pain clinics did not help. According to notes does not appear to be in pain but was prescribed more analgesia
- As a locum GP, I was uncomfortable prescribing a repeat when asked. Patient has not had a medication review for > 6 months, so I suggested appointment with regular GP

Questions

- How would you proceed in this scenario?