WISAM's teleconference Oct 22, 2015

Moderator: Aleksandra Zgierska, MD, PhD (WISAM's President)

Present:

Miranda Behnke, MSW (Marinnette)

Arthur Altbush, MD (Janesville, Mercy System)

Keith Elkins, MD (XX)

Bob Lea, MD (Chipewa Falls)

David Galbis-Reid (XX)

Matthew Felgus, MD (Madison)

Nameeta Dookeran, MD (Oconomowac)

Aleksandra Zgierska, MD (Madison)

Agenda / Minutes:

1. Updates from the 2015 and plans for the 2016 WISAM's Annual Conference (Aleksandra Zgierska)

ThE 2015 conference was a success, it exceeded our expectations in the number of interested individuals and activities. For the next year we are planning to have a larger venue and 2 to 3 day conference. We are hoping to have Thursday and Friday devoted to workshops and lectures, and on Saturday to possibly have a Suboxone training/certification course targeting primary care clinicians. The attendees feedback was positive, with a lot of useful comments. One of the comments compared this year's conference to a 'call for collaboration,' while the next year's conference could be viewed as 'a call for action.' We like this approach and are thinking likewise, considering multiple breakthrough sessions/workshops, element people to share experience about practical aspect for addiction related care, as well as to form regionally oriented groups brainstorming solutions and collaboration within the micro regions. Dr Elkins suggested engaging other statewide organizations such as Wisconsin medical Society to these efforts, he will initiate the contact with the WMS to facilitate synergistic efforts promoting improve treatment axes and outcomes for addictive disorders in Wisconsin.

If the call members and with some participants have suggestions for the topics/workshops for the upcoming conference, and for potential speakers from Wisconsin or beyond, so suggestions would be appreciated, can be forwarded to the societies president and executive director.

We are planning to have the next years conference either in very late September or early October in Madison Wisconsin, however the following year, 2017, it can be held outside of Madison, suggestions are welcome.

2. Opioid and benzodiazepine taper

Dr. Dean Whiteway was unable to be present but sent in advance a link to an useful resource on benzodiazepines (from their metabolism, through details of tapering), available free of charge online: xx

Dr. Lea initiated the discussion stating that his preference is for fast opioid taper, often taking only three days or so, even when coming off high opioid doses. He applies a fast taper to benzodiazepines as well. To reduce the risks of benzodiazepine taper and in general to alleviate withdrawal symptoms, he uses phenobarbital orally, often with a loading dose of 60 mg times two, followed by 30 mg doses, several per day, for several days. The individual dosing depends on the patients individual circumstances. This is supplemented with other anti-withdrawal medications, including clonidine for opioid withdrawal, or gabapentin. He says he's had good success with this method, but also mentions it's predominantly used by him in the inpatient settings. In general, he mentioned he favors tapering off Suboxone, especially for younger patients as opposed to continue them on a stable dose of long term Suboxone. In his experience, Suboxone has not been successful or benign for many patients as a long-term therapy. He's had much more success and good experience with Vivitrol, which he views as particularly useful/indicated for younger patients, where long-term agonist maintenance should be viewed as the last resort. In his experience, in addition, patients requiring higher doses of Suboxone often engage in Suboxone in diversion, using some of the dose for themselves and selling the rest.

Other clinicians have described a different experience with Suboxone. Many had positive experiences, and had patients maintained on Suboxone long term. They mentioned tapering down or off Suboxone (when the patient is stable and doing well) with the patient's agreement, in the way that has been negotiated with the patient. They also emphasized positive experience with injectable naltrexone, as well as difficulties with initiating individuals with opioid addiction on this medication, due to the need to wait for 7-14 days after the last opioid dose, before one can initiate naltrexone. In general, there has been a consensus there are not enough clinicians managing opioid addiction using pharmacotherapy, in spite of the fact that naltrexone can be prescribed without a special certification/license by any clinician who holds prescribing privileges.

The issue of patients treated with high dose of Suboxone was also discussed. Drs Dookeran and Galbis-Reid shared their experiences with how ensuring the appropriate patient technique for taking the Suboxone film or tablet can improve Suboxone's efficacy. They counsel the patient about the appropriate technique and often observe the administration. They recommend for the patients to be in a supine position, with the chin tucked in so that the saliva pools under the tongue. The patient should not take anything by mouth or smoke for the 15 minutes prior to and 15 minutes after the application of sublingual Suboxone. The film or tablet should be held under the tongue for 15 minutes. It is important to make sure it is not glued to the teeth, as its absorption is then reduced. Ensuring appropriate medication administration technique can help the patient reduce symptoms that otherwise might suggest the need for a dose increase.

3. what was the last question / topic..?

Finally in the last minutes of the teleconference we discussed the management of alcohol withdrawal. Dr. Zgierska mentioned she sees in both the inpatient and outpatient settings an increased use of gabapentin for the treatment of alcohol withdrawal. This has been corroborated by others. Dr. Galbis-Reig says that in the inpatient settings he routinely uses 300 mg of gabapentin four times per day on schedule, in addition to benzodiazepines as-needed. In his observation, the addition of gabapentin

greatly reduces the need for benzodiazepines, with equally good outcomes. Dr. Zgierska brought up that this is consistent with the article published in Alcoholism: Clinical and Experimental Research, 2009, 33 (9):1582-1588, by Myrick Hugh et al. (add the pubmed link here to the abstract), describing results of an RCT of gabapentin, administered in three different dose regimens versus lorazepam. The patients in the gabapentin arms received one of the three different doses of gabapentin: 600, 900, or 1200 mg per day, compared to lorazepam 6 mg per day. These were the initial doses, tapered down to a slightly lower dose over four days (Gabapentin from 900->600mg; and from 1200->900mg; lorazepam from 6 to 4 mg). Treatment using the initial dose of 600 mg of gabapentin was stopped prematurely as two patients had seizure and one had syncope. The two higher-dose gabapentin arms successfully completed the study. The 1200 mg/day gabapentin arm outperformed the 900 mg/day gabapentin and 6 mg/day lorazepam arms.

The teleconference adjourned at 8:02 PM, with a reminder that it will resume in January 2016, due to the holidays on the fourth Thursday in November and December.