WISAM Newsletter: Teleconference Minutes

May 26, 2016

Moderator: Aleksandra Zgierska (WISAM President; Madison)

Present: Joe Blustein (Madison), Matthew Felgus (Madison), Subhadeep Barman (currently still in Maine), Arthur Altbuch (Janesville), Mary Anne Kowol (Milwaukee), John Ewing (Madison), Bill Gaertner (Milwaukee), Nameeta Dookeran (Oconomowoc)

The teleconference started by discussing existing available resources to enhance clinical care related to addiction medicine; here are several mentioned:

FREE Provider's Clinical Support System (PCSS) for Medication-Assisted Treatments (PCSS-MAT: http://pcssmat.org) and Opioid Prescribing (PCSS-O: http://pcss-o.org): excellent free resource, funded by a grant from SAMHSA; it offers free webinars available "real-time" or via the archived library. One can sign up for regular news emails from them.

FREE David Mee-Lee's monthly Tips and Topics, sent via email (one needs to sign-up to it), it is an excellent resource:

dmeelee@changecompanies.net
http://www.changecompanies.net

FREE Join Together Daily News is a news service from the Partnership for Drug-Free Kids that provides daily or breaking news on the top substance abuse and addiction news that impacts our work, life and community. It also provides original reporting and/or commentary features published every Wednesday by influential thought leaders in the addiction field or staff.

http://www.drugfree.org/join-together/

PAID The Carlat Report: Addiction Medicine (however, it appears to be a paid resource, ~$109/year); a link to the copy of the recent report is attached so that you can get a flavor of what it is: http://carlataddictiontreatment.com/sites/default/files/CATR_May2016.pdf

Dr. Felgus led a conversation about non-benzodiazepine approaches to the treatment of anxiety, a mental health disorder that commonly co-occurs with addiction and is challenging to treat. Patients sometimes may report that they are "in withdrawal" (even after they have been on a stable dose of methadone or suboxone); it is tempting (and easy) for clinicians to increase the dose of opioid maintenance medication under the circumstances but it may not be the right

approach (if this is not a withdrawal), because it often can be anxiety. Withdrawal is not likely in a patient who has been on a stable dose of MAT and who has not had additional new medical problems, such as medication changes, or conditions (new disease; pregnancy) that could have change the metabolism of opioids.

The teleconference participants observed that, in their experience, some opioids can be activating and, when causing activation, these sensations may be confused by the patient with anxiety.

The question was also raised whether opioids themselves, especially long-term, can cause or worsen anxiety (same may apply to depression), it many of the clinicians on the call agreed that this seems to be their observation.

When anxiety is reported, it is common in primary care and in psychiatry that benzodiazepines are prescribed, even for those on MAT. It is important to educate the prescribers who do that, to reach out to them, contact them to explain the issue, so that they do not co-prescribe.

What can we then prescribe for anxiety instead of benzos?

SSRIs are the typical option outside of addiction; but it seems that their efficacy - in our pooled experience - is not great in this population.

SNRIs are also a possibility.

Bupropion, although it is the safest non-stimulant that can be used as the first line for ADHD, it is not effective (and not approved) for the treatment of anxiety.

Gabapentin and clonidine: We all agreed that gabapentin is very useful. It has certain risks, including abuse, but it has fewer risks than benzos, and the benefits outweigh the risks. It can be started at lower doses (eg, 100mg at nighttime only), but it is often started as 300 mg TID, with dose titration to at least 600 mg TID, up to 1200 mg TID. It is common to combine gabapentin with clonidine for anxiety (or withdrawal), with dosing starting as 0.1 mg /day (start at night) if concerns about low BP or tachycardia, otherwise starting as BID and quickly increasing to TID if tolerated. If gabapentin or clonidine are started as a single daily dose, it should be best done in the evening as these medications are sedating. If the patient reports grogginess the next morning, s/he can try taking the medication 2-3 hours before sleep time. Gabapentin can be used in pregnant women. If the patient is reluctant to start clonidine, e.g., due to its association in the patient's mind with the treatment of withdrawal ("it didn't work for me that time"), one can use Prazosin or doxazosin instead of clonidine. Evidence is limited in this area but preliminary research supports the use of clonidine-like medications for relapse prevention and anxiety. Growing evidence also supports the use of gabapentin for almost everything (this is Dr. Zgierska's personal comment ☺), including as the first line for mild to moderate alcohol/sedative withdrawal.

Propranolol can be very helpful with situational anxiety, e.g., flight anxiety, anxiety during MRI scan, stage anxiety.

Buspirone can be helpful as adjunct to other medications, but typically, in order to be effective, the dose needs to be 60 mg/day (start 10mg TID, titrate up to 20-30mg TID); higher doses can be activating and have side effects; it seems to be more effective in benzo naïve patients.

Hydroxyzine is used by some clinicians; some patients respond well, some don't; now there is the warning for this medication for QTc prolongation.

Quetiapine can also be helpful, but the doses are usually not higher that 100 mg/day to limit the risk of metabolic syndrome. It is typically started at 12.5 mg dose; many patients don't tolerate this medication though.

Pregabalin is approved in Europe for generalized anxiety disorders; although research evidence suggests it may be more potent than gabapentin but this has not been apparent in clinical practice. In addition, this medication is usually more expensive that gabapentin, may require prior authorization and it is a controlled substance, hence a paper prescription or a phone-in is required, as it can't be faxed to the pharmacy; altogether clinicians primarily use gabapentin. Pregabalin is reserved more for those who can't use gabapentin or 'failed' gabapentin and do not want to try it again, while we believe that this class of medications can be helpful.

Tiagabine (Gabitril) is another gabapentinoid that can be considered when other gaba-meds (pregabalin; gabapentin) fail or are too sedating; it has a different profile of side effects though than other gabapentinoids, hence caution is recommended: https://en.wikipedia.org/wiki/Tiagabine

Non-pharmacological approaches are very useful for the treatment of anxiety, we should strongly encourage patients to engage in these therapies, as they can safely provide life-long skills for coping with anxiety and other problems.

Cognitive Behavioral Therapy (CBT) works but only if the patient "does it," and incorporates the strategies into daily life.

Mindfulness and "body work" have a growing supportive evidence, but the principle is the same as for CBT: unless the patient really does it, it will not work… Insurance coverage is worse for these modalities than for CBT.

Brain spotting is a new modality, similar to EMDR (but not the same), developer David Grand, PhD: https://brainspotting.pro/page/what-brainspotting

Dr. Felgus noted that he had patients who experienced a dramatic improvement in symptoms after only 3 sessions; by comparison, he would have expected such magnitude of progress after 9-12 months of "talk therapy." Local resource: The Midwest Brainspotting Institute, https://midwestbrainspottinginstitute.org/ Coverage via insurance is possible if it is billed by the therapist as a therapy; but if the patient needs to pay out of pocket, the costs are $100/session or more. We will present more about this technique and other ones at our upcoming 2016 WISAM Annual Conference (see below).

Additional topic discussed: Probuphine, the first buprenorphine implant for the maintenance treatment of opioid dependence, was just approved by the FDA. Probuphine is designed to provide a constant, **low-level dose of buprenorphine** for six months in patients who are already stable on low-to-moderate doses of buprenorphine (up to 8mg/day), as part of a complete treatment program. Trainings are under way on how to implant it.

All H.O.P.E. bills (http://legis.wisconsin.gov/assembly/hope/legislation/), introduced by Rep. Nygren, have been signed into law but the execution of these laws have not been apparent yet.

The PDMP bill, which is of particular relevance to all opioid prescribers, may not be "required" to comply with until Apr 1, 2017 (http://docs.legis.wisconsin.gov/2015/related/acts/266.pdf).

Change in the dispenser's reporting to the PDMP: pharmacies now have to report within 24 hours of dispensing the medication (instead of the prior timeframe of up to 1 week):

"Require a pharmacy or a practitioner to generate a record documenting each dispensing of a monitored prescription drug […] and to submit the record to the board no later than 11:59 p.m. of the next business day after the monitored prescription drug is dispensed"

Clinicians have to check the PDMP and document it every time before issuing a prescription for controlled substances:

"SECTION 14. 961.385 (2) (cs) of the statutes is created to read: 961.385 (2) (cs)

1. Require a practitioner to review a patient's records under the program before the practitioner issues a prescription order for the patient.

2. The requirement under subd. 1. that a practitioner review a patient's records under the program before the practitioner issues a prescription order for the patient does not apply if any of the following is true:

a. The patient is receiving hospice care, as defined in s. 50.94 (1) (a).

b. The prescription order is for a number of doses that is intended to last the patient **3 days or less and is not subject to refill**.

c. The monitored prescription drug is lawfully administered to the patient [eg, in the ED].

d. Due to emergency, it is not possible for the practitioner to review the patient's records under the program before the practitioner issues a prescription order for the patient.

e. The practitioner is unable to review the patient's records under the program because the digital platform for the program is not operational or due to other technological failure if the practitioner reports that failure to the board."

April 1, 2017, except as follows: (1) REQUIREMENT TO REVIEW PATIENT RECORDS. The creation of section 961.385 (2) (cs) of the statutes takes effect on the 30th day after the date of publication in the Wisconsin Administrative Register of the notice under SECTION 17 (2g) of this act, or on April 1, 2017, whichever is later."

Teleconference adjourned at 8:00 PM.

The next WISAM Teleconference will take place on Thursday, June 23, 2016, 7-8 PM.

Please note: The monthly teleconferences will break for summer, with no teleconference in July or August. We will also not hold a teleconference in September as we will meet in-person at the WISAM Annual Conference. The next teleconference after June will then take place on October 27, 2016.

June: Teleconference on June 23, 2016, 7-8 PM

July: No Teleconference (summer break)

August: No Teleconference (summer break)

September: No Teleconference (in-person meeting at WISAM Annual Conference)

October: Teleconference on October 27, 7-8 PM

Please let Cindy Burzinski, WISAM's Executive Administrator, know if you have suggestions for topics to discuss at the upcoming teleconferences, or if there are any errors in the current document: Cindy.Burzinski@fammed.wisc.edu

SAVE THE DATE: The **WISAM 2016 Annual Conference** is scheduled for **Thursday, September 29 – Friday, September 30** at the Pyle Center in Madison, WI. More details to come once speakers/topics have been finalized. On **Saturday, October 1** post-conference, there will be a buprenorphine training for physicians at the Pyle Center.

Please remember to **renew your ASAM membership** or consider becoming a member. More details can be found at: http://www.asam.org/membership