Review

# The Methadone Patient:
## Pain, Addiction and Acute Management

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This article aims to acquiant the primary care provider or specialist, with the use of methadone for pain, for addiction, or in the patient where both conditions exist. Some basic guidelines for acute management of the patient on methadone, regardless of the reason, are provided.

This article is not intended to provide instruction on the prescribing of methadone; rather, it is intended to allow the treating physician to better understand the presenting patient's context and how to deal with it in a way that is safe, compassionate and realistic.



### Methadone

Methadone was developed for the treatment of pain, but is best known for its use in the treatment of opioid dependence disorder, or addiction. Today, it is an increasingly popular drug in three areas:

1. Addictions treatment (methadone maintenance treatment [MMT])
2. Palliative care
3. Chronic non-malignant pain (CNMP)

Almost inevitably, a physician will encounter patients who are being prescribed methadone, these patients may have a history of addiction or substance misuse, or of chronic pain, or both. It can be a real challenge to sort out the factors involved, let alone deal with all the aspects of acute care.

Methadone has relatively low psychoactivity. This means that there is little euphoria or high to be had from it. For MMT, this means that there is little positive reinforcement to "chase a high." It also means that it is a good choice for potent opioid analgesia, with few euphoric side-effects for those who find those side-effects unpleasant. Additionally, methadone significantly blocks the euphoric effects of other opioids, but not the analgesic effects. It is thus good for both addiction treatment and for pain, as it reduces the positive euphoric re-inforcement of the use of other opioids, but allows the use of other opioids for additional analgesia.

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## The goals of treatment

### MMT

The goal of MMT is to control symptoms and to help to improve function. Symptoms to be controlled are those of withdrawal and cravings for opioid use. Improved function comes in the social and psychological areas. Reduction or elimination of the use of other opioids and other recreational substances, such as cocaine, are important components of treatment. For some, eventual cessation of all drug use is attainable. For others, permanent MMT is required to maintain a healthier and more productive lifestyle.

### Methadone use in pain

The goal of methadone use in pain treatment is to control pain symptoms and to improve physical and psychological function.

## Differentiating addiction treatment from pain treatment

The following are some simple indicators (though not 100% reliable) to differentiate between addiction treatment and pain treatment:

### Addiction, or MMT

1. Methadone q.d., diluted in a crystalline juice, with consumption observed by a pharmacist or MMT program staff member, is the standard for addiction treatment
2. Very stable and reliable patients may have infrequent observed consumption, or may be prescribed an encapsulated formulation
3. The typical range of dosing for addiction treatment is between 60 mg to 200 mg q.d. Lower and higher doses are not rare

## Sidebar

### The Dos of dealing with the acutely-presenting methadone patient

Patients on methadone will present with the same problems as any other patient. Providing appropriate care is made easier by adopting a realistic approach.

#### Sine qua non

You cannot prescribe methadone for methadone maintenance treatment, palliative pain, or for chronic non-malignant pain without a specific exemption. This exemption—or permission to prescribe—is granted by the federal government (which controls methadone in Canada), but is usually administered by the provincial licensing body, or College of Physicians and Surgeons. If you do not have the appropriate exemption, you must consult with someone who does.

#### The Dos

##### Do communicate

Regardless of what actions you choose, a phone call is the best method to help sort out the situation and a note or a letter to the methadone prescriber will improve patient care.

##### Do provide appropriate treatment

Non-opioid analgesics are effective for acute pain. Additional opioid pain control may be appropriate, in doses not exceeding double what would normally be given.

##### Do follow the lead

If the patient with a broken arm in the ED is getting observed methadone q.d., indicate that your prescription for acetaminophen plus codeine is to be dispensed in daily allotments.

##### Do support the patient

The patient on methadone, regardless of the reason, is working with a physician to improve his/her quality of life. Be supportive, understanding and realistic.

*For the Don'ts, look to page 89.*

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## Sidebar continued...

*The Don'ts of dealing with the acutely-presenting methadone patient*

*The Don'ts*

Don't stop

Whenever possible—and safe—continue methadone dosing as usual.

Don't change

Do not change the methadone dose without first consulting with the original prescriber.

Don't add

Do not add non-emergent medications without consultation with the original prescriber. Always consider possible interactions.

Don't do anything

If the appropriate treatment of the presenting condition is not urgent or straightforward and you are unable to contact the methadone prescriber, do nothing. Withdrawal or increased pain is not fatal.

## *Pain*

1. Methadone t.i.d. or q.i.d. is the typical regimen for the treatment of pain
2. The majority of formulations for pain treatment are tablets or encapsulated formulations. Some patients receive and prefer dosages mixed in juice
3. Observed doses are rare in the treatment of CNMP
4. Typical total daily doses range from 20 mg to 300 mg. Extremely high doses are not uncommon
5. The patient using methadone t.i.d., in tablet or capsule form, who demonstrates improved pain control and improved function without medication control problems has a straightforward chronic pain condition. A substance-use risk assessment should still be done, but these patients must be treated in the same fashion as anyone with chronic pain receiving opioid analgesics

Sometimes, though, the patient with both CNMP and a history of addiction will receive methadone q.d., b.i.d. or more frequently in a day. A rule of thumb is that the more frequent the dosing, the better the patient's control of the medication and therefore more emphasis can be put on the diagnosis of CNMP.

Ultimately, it does not matter what the underlying conditions are, as long as symptom control and improved function are evident and the benefits of the use of methadone outweigh the risks. Dx