VCOM Psychiatry Online
Case O
“Doc, I want that new drug…, you know…”

Martha Wunsch, MD
Chief Complaint

• Jeff is a 43 year old man who comes to your office for help with his addiction to pain pills. He is interested in “that new drug...I can’t pronounce it...suboxycotin or something or other.”

• His wife your name on the internet found
Look over these links before completing this case:

• [http://buprenorphine.samhsa.gov/about.html](http://buprenorphine.samhsa.gov/about.html)
  – Review this patient oriented information from Reckitt Benkeiser.
  – Click on button for health care provider section
Review the **Clinical Opioid Withdrawal Score Tool**
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

| Patient’s Name: _____________________ | Date and Time _____ / _____ / _____:
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Total Score _________

The total score is the sum of all 11 items

Initials of person completing Assessment: ______________

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
Question:
How did this patient find your name as a provider?

• He located you on the SAMHSA web site physician locator
  – The Substance Abuse Mental Health Services Administration (SAMHSA) certifies physicians to prescribe buprenorphine after they have completed a specific training course. This enables the physician to provide effective treatment for addiction from his/her office, as they treat any chronic disease.
  – The training is 8 hours long and is presented by several medical organizations (American Academy of Osteopathic Addiction Medicine, American Academy of Addiction Psychiatry, American Society of Addiction Medicine).
  – After completion of the course, “buprenorphine certified” licensed physicians have the option of listing their practices on a website locator, this making it possible for patients to access this modality of care. This is where the patient found you…
You begin to read about opiate addiction and its treatment..

• What is this medication he is talking about?

• Answer: Suboxone™ or Subutex ™

• What is the drug class of this medication?

• Answer: Suboxone ™ contains Buprenorphine as an active ingredient and naloxone, both of which are opioids. Subutex ™ contains only Buprenorphine.
• Does Suboxone™ contain an agonist, partial agonist, or antagonist? Does this affect its safety profile?
  • Answer: Buprenorphine is a partial agonist and as such has a ceiling effect. It is safer than a full agonist such as morphine as far as overdose potential but still has interactions at the CYP450 enzyme system with other medications, specifically benzodiazepines. Naloxone is an antagonist.
• What are the indications for use of this medication?
  • As a partial agonist, Suboxone™ and Subutex™ buprenorphine blocks the craving for the illicit use of opiates in the opioid abusing/dependent patient. Buprenorphine can be prescribed for time limited medically supervised withdrawal, but is more effective for long term medically assisted treatment of opioid dependence. This must be paired with substance abuse treatment such as counseling, group therapy, and attention to other medical and psychiatric diagnoses. Subutex™ is used primarily for medically assisted treatment of opioid dependence in pregnancy since naloxone is thought to be teratogenic in pregnancy.
• How is this medication prescribed and what are the dosage forms?
  • It is formulated in two forms: Buprenorphine and naloxone (Suboxone™) and Buprenorphine alone (Subutex™). It is given sublingually and can be prescribed in the physician’s office after the physician completes an 8-hour training course in Office-Based Opioid Treatment. It is available in a 2 mg buprenorphine/.5 mg naloxone and 8 mg buprenorphine/2 mg naloxone dosage forms.

• Why is naloxone in one of the preparations? Does it also treat addiction to opioids?
  • Answer: Naloxone is added to decrease diversion of the medication. When injected, this component of the Suboxone™ will cause severe withdrawal in the opioid intoxicated individual. Of course, the buprenorphine will also cause withdrawal when injected in the opioid intoxicated person, but by adding the naloxone the effect is much more intense. When taken orally, naloxone is digested by the gut and is not active as an antagonist. Therefore, the active ingredient is buprenorphine, not naloxone.

• Does it block the analgesic and euphoric effects of other opioids?
  • Yes.
What are the other treatment options for this patient if he wishes medication assisted treatment for opioid addiction/dependence?

- Naltrexone, or Revia™, which is an antagonist and methadone, which is an agonist.

Why not treat this patient with methadone in your office for his addiction?

- Methadone MUST be prescribed at a licensed opioid treatment program and cannot be prescribed by an individual provider outside such a program, even if he/she is certified in addiction medicine. There are multiple federal and state guidelines which govern the prescription of methadone for addiction. In fact, methadone may be prescribed in the office only for the treatment of PAIN. The Harrison Act, passed in 1914, has prohibited the treatment of patients for addiction with an opioid or opiate unless the patient is enrolled in a bonafide opiate treatment program. The Drug Abuse Treatment Act, passed in 2000, allows treatment with only buprenorphine in the office setting. It is an effective, safe medication which must be paired with other modalities of treatment such as substance abuse counseling and 12 step programs.
Now you feel better prepared to address this patient. What do you do next?

A. Take a complete medical, social, psychiatric and substance abuse history.

B. Ascertain if the patient diagnostically is appropriate for addiction treatment has adequate social support for treatment as an outpatient.

C. Evaluate his risk for HIV and Hepatitis B & C.

D. All of the above
Sorry, this is an incorrect answer
Correct!

All of the actions discussed in the previous question are appropriate and indeed necessary steps to take BEFORE considering outpatient treatment of a addiction patient with bupremorphine.
History

• His last use of opiates was this morning and he expects a prescription today.
• He becomes belligerent when you explain that you will need to see him today and then bring him back for another appointment to begin prescribing him Suboxone™.
• At this point he gets up to leave the office….swearing at you….yells at the receptionist as he slams the door and leaves the office.
• His wife gets up to go after him, begging him to stay and listen.
• You inform her that he will need to reschedule given his hesitancy and behavior, but give her the information about Suboxone™ and office protocol for beginning the medication.
“Doctor, you have a call from the ER”

You ask the patient and his wife to wait a moment while you take this call.
It’s your colleague, Dr. Reskew, in the ER who has a release from Jeff to speak with you.

She referred the patient to you and is calling because this patient rarely gives a thorough history.

• Patient is seen frequently in ER looking for pain medications for his “back problem”.
  – He has been asked to leave the ER multiple times because of violent outburst when refused prescriptions.
  – His wife has been in the ER after episodes of domestic violence stating her husband “has an anger problem”.
  – He has been in jail multiple times
  – Remarkably, he has no medical problems including HIV or Hepatitis.
  – He has a long psychiatric treatment history beginning in childhood.
Past Psychiatric History

• ER doc says she has referred him to Narcotics Anonymous but he says “it’s not for me sitting around with a bunch of whining addicts....”

• No known history of depression but is often very irritable in the ER.

• He was hospitalized in a state juvenile psychiatric facility at age 16 years, then spent time in juvenile detention, after taking a gun to school and starting a fight. He ran away from his mother and foster care multiple times. He robbed from his aunt and uncle. He broke into and destroyed part of his grandmother’s home.

• As an adult, his legal history includes breaking and entering charges, robbing a convenience store at gunpoint, and sexual assault.
What was his most likely diagnosis as a youngster?

a. Attention Deficit Disorder with Hyperactivity
b. Severe depression with “acting out behavior”
c. Bipolar Disease
d. Conduct Disorder
Sorry, this is an incorrect answer
Correct!

Let’s review the criteria for the diagnosis of Conduct Disorder and the criteria that this patient has met!
Conduct Disorder

A. A repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months:

Aggression to people and animals
(1) often bullies, threatens, or intimidates others
(2) often initiates physical fights
(3) has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
(4) has been physically cruel to people
(5) has been physically cruel to animals
(6) has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
(7) has forced someone into sexual activity

See More...
Conduct Disorder

Destruction of property
(8) has deliberately engaged in fire setting with the intention of causing serious damage

(9) has deliberately destroyed others' property (other than by fire setting)

Deceitfulness or theft
(10) has broken into someone else's house, building, or car

(11) often lies to obtain goods or favors or to avoid obligations (i.e., "cons" others)

(12) has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)
Conduct Disorder

**Serious violations of rules**

(13) often stays out at night despite parental prohibitions, beginning before age 13 years

(14) has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)

(15) is often truant from school, beginning before age 13 years old.

**B.** The disturbance in behavior causes clinically significant impairment in social, academic, or occupational functioning.

**C.** If the individual is age 18 years or older, criteria are not met for [Antisocial Personality](#)
More information from the hospital…

- He has attempted to “con” some of the new doctors out of pain medication. He used an alias one time so they wouldn’t have access to his old chart, but a clerk recognized him.
- Has been sent to collections by hospital multiple times for failure to pay bill.
- Medications
  None
The wife gives more history during remaining appointment time.

- **Family History**
  - Both of his parents were heavily involved with illegal drugs and alcoholic. He was placed in foster care at age 4 years-10 years. Mom stopped drinking and tried to raise him from age 10 years but he spent much of his adolescence in either juvenile treatment of a psychiatric facility.
  - His father died of overdose last year, probably pain pills

- **Social History**
  - They are married and have a child, but have never been able to live together due to domestic violence.
  - She has filed for divorce, but is still willing to “help him get off drugs” for the child’s sake.
  - Legal: Incarcerated for armed robbery before they were married.
  - Education/Employment: Never finished high school. Intermittent employment in construction, but always fights with his coworkers and gets fired eventually.
1 week later...

Your staff inform you that Jeff has called for an appointment...

✓ What are important keys to managing this patient effectively?
✓ What does the patient need to do prior to beginning treatment with Suboxone™?
Discuss the “rules of the road” for treatment,

- Outline the treatment plan carefully to the patient and his support system, including consequences for specific behaviors.
  - Inform the patient that verbal abuse of your staff will not be tolerated, broken appointments will not be rescheduled, and financial obligations must be honored to continue treatment.
- Engage the family member in managing his medication to decrease the chance of diversion.
- Avoid confrontation, instead relying on clear boundaries in the relationship.
- Request Jeff complete an intake with the substance abuse treatment program prior to initiation of prescription of medication.
- Require release to speak with treatment team members prior to beginning prescription of medication.
- Require that he attend substance abuse counseling, focusing on individual counseling since he will probably disrupt group dynamics, in order to receive weekly prescriptions from you.
- Inform the patient that weekly pill counts and urine drug screens will be part of the treatment plan.
The patient has completed a substance abuse intake at the local public treatment program, has attended two sessions already..

And the counselor has called to let you know the patient is engaged in treatment but anxious to begin medication.
Two weeks later…
the patient returns again for an appointment

- You carefully outline the plan to him and ask if he would like to pursue treatment.
  - Today will complete the medical intake
  - He will need to return for “induction” on buprenorphine after wife fills prescription.
  - He will be expected to attend treatment at the local substance abuse program and comply with their recommendations as part of your treatment plan.

- He thinks you are being unreasonable, but with urging from his wife, signs an agreement to undergo treatment with you.
Question:

The patient will need to have symptoms of withdrawal at initiation of treatment. Why?
Answer: Because buprenorphine is a **PARTIAL** agonist, if the patient is intoxicated at first dose he will develop severe withdrawal. This is because of the difference in efficacy of a full mu agonist and a partial mu agonist.
More History from the patient’s wife…

Substance Abuse History

- **Tobacco**: Does not smoke but chews very occasionally. Began at age 15 years. Last chew at least 2 months ago.
- **Marijuana**: Tried once at age 12 years but does not like the effect. Makes him choke.
- **Cocaine**: Tried at age 14 years and has snorted occasionally. Last use 1 year ago.
- **Methamphetamine**: Denies
- **Heroin**: Uses when he is out of town on a construction job and cannot get access to pain pills. Prefers his oxycodone to heroin, which he injects
Substance Abuse History

• **Alcohol**: Describes himself as a social drinker.
  – Began drinking in high school, age 14 years. Drank on weekends with friends.
  – Currently drinks “a beer” after work with friends but hasn’t gotten drunk since age 21 years.
  – Doesn’t think it’s a problem
What questions do you ask him about his alcohol consumption?

- How many drinks a week? (7-10)
- What does he consider “a drink”? (8 ounce glass of beer)
- Does he ever drink more than 3-5 drinks at a sitting? (No)

Wife concurs with all of these answers, noting that he did drink too much until 4 years ago—about the time he began abusing a lot of pain pills. It was a factor in the domestic violence.
Is his drinking a problem?

• No, in general his consumption of alcohol is of minimum risk to a male under age 65 years. However, given the interaction with buprenorphine you will ask him to abstain from using alcohol, except for “ceremonial use” such as a toast at a wedding, communion wine.

• He agrees to this limit.
Substance Abuse History

• Prescription Drugs
  – Was prescribed hydrocodone after an accident on the job 5 years ago.
  – Escalated use and doctor refused to refill the prescription and he was still in pain.
  – Began buying on the street from construction buddies. Began to enjoy the high.
  – Admits to some “drug dealing”
    • “It was easy for me to get and I passed it around at work sites. It was good money”.
Prescription Opiate Abuse

- Oxycodone: Used up to 360-400 mg/day, snorting. If used extended release formula, would crush and inject.
- Hydrocodone: Used only if oxycodone not available.
- Dilaudid: Denies
- Fentanyl: Has injected patches, but difficult to procure.
- Methadone: Has heard it could kill him, so avoids.
Substance abuse history

• Benzodiazepines
  – Uses lorazepam and clonazepam--if he cannot get access to pain pills--to treat the withdrawal

• Hallucinogens: Tried LSD once as teen.

• His wife adds that he is spending less and less time with their child, and doesn’t show up when he says he will. This is a change in his behavior.
  – When he comes to the home high or in withdrawal, she will not let him see their child. This has been happening more.

“Really doc, the pain pills are all I’ve been using pretty much. I don’t even get a good buzz from them anymore. You know, some of my sources have dried up since they are putting some of the docs out of business. I’ve tried to cut myself down, but I get so sick…”
Question

Is this patient too “high risk” for you to prescribe buprenorphine?
No. However, you will limit prescriptions to weekly amounts at first and communicate closely with the substance abuse treatment program. Also, will perform weekly pill counts AND occasionally call him in for a pill count between visits.
Opiate Withdrawal

What are the signs and symptoms of opiate withdrawal and how are these measured?
Answer: The clinical opiate withdrawal scale (COWS) is a validated instrument which quantified the level of withdrawal a patient is experiencing.
# Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient’s signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

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<td>1 nasal stuffiness or unusually moist eyes</td>
<td></td>
</tr>
<tr>
<td>2 nose running or tearing</td>
<td></td>
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<tr>
<td>4 nose constantly running or tears streaming down cheeks</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Score: _______</th>
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</table>

The total score is the sum of all 11 items

Initials of person completing Assessment: ______________

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal
Does this patient meet the criteria for opiate dependence or abuse and why?

*Let’s review*....
DSM-IV Drug Dependence

Meets 3 criteria for over 1 year

- Tolerance (increased drug use to achieve same effect)
- Opiate withdrawal signs or symptoms
- Using more drug more than intended
- Unsuccessful attempts to cut down on use
- Excessive time related to drug use (obtaining, hangover)
- Impaired social or work activities due to drug use
- Use despite physical or psychological consequences
DSM-IV Drug Abuse

1 or more criteria for over 1 year

- Role Impairment (e.g. failed work or home obligations)
- Hazardous use (e.g. Driving while intoxicated)
- Legal problems related to drug use.
- Social or interpersonal problems due to drug use.
Further History

• HIV, Hepatitis B and C negative several years ago
• Denies other medical problems except for chronic lower back pain
  – Never completed evaluation by pain physicians as asked by family practitioner
• Denies surgical procedures
• Never hospitalized although treated in ER for traumatic injuries, including multiple motor vehicle accidents
Social History

• Living with brother, who is actively abusing drugs.
• Currently unemployed after argument with co-workers, but is willing to talk with social services about possibilities.
• Has no friends other than drug using colleagues.
• He states that selling diverted pain pills is good money. “Hey-everyone has to make a living, doc.”
• Is interested in placement in a “half-way house” unless his wife will let him move home.
Physical Examination

- VS: HR 130, BP 170/1055, RR 16, T= 99.5
- Appearance: Agitated, sweating profusely. Complaining of abdominal cramping and severe joint aches. Yawns several times during examination and blows nose. Reports he is having difficulty sitting still.
- Skin: Prominent piloerection over arms, multiple well healed track marks on right hand, antecubital fossa.
- HEENT: Pupils 5-6 mm, Fundi visible and normal without papilledema. Profuse tearing during exam. Clear nasal discharge, Neck supple, no masses, no bruits
PE

- Lungs: Clear to auscultation
- CV: Tachycardia, RR without murmur, rub, gallop
- Abdomen: Liver at right costal margin. Spleen not palpable. Hyperactive bowel sounds
- GU: Normal male, testes descended bilaterally
- Musculoskeletal: Normal range of motion, normal mass.

Patient leaves room to use the bathroom. Returns after vomiting.
PE

• Neurological Exam:
  – Gait normal
  – Reflexes increased bilaterally,
  – CN 2-12 intact
  – Strength normal in spite of cramping of muscles
  – Visible tremor of tongue
  – You ask him to put out his hands to “stop a train” and note visible tremor of hands.
Mental Status Exam

• Appearance: Alert, appears anxious. Fidgets throughout exam
• Attitude toward examiner: Somewhat hostile, but cooperative with encouragement
• Mood: Patient notes that he has been fine, unless he cannot get access to his “oxys” and then he knows he gets irritated easily
• Affect: Angry, sad.
• Speech: Normal rate and quality, although answers are brief
• Thought Process and content:
  – Content is appropriate.
  – Fund of knowledge is good for educational level.
• Perception
  – Patient denies hallucinations or illusions.
Currently, what psychiatric diagnosis does this patient meet criteria for?

- a. Major Depressive Disorder
- b. Borderline Personality Disorder
- c. Narcissistic Personality Disorder
- d. Antisocial Personality Disorder
- e. It is difficult to diagnosis this patient with a personality disorder until he has been free of illicit substances, and participating in substance abuse treatment, for at least 30 days
Sorry, this is an incorrect answer
Correct!

However, given the history of a conduct disorder prior to age 15 years, past history of behaviors obtained from his wife, history of incarceration, and some of his statements during the exam, one can be reasonably correct that his diagnosis is Antisocial Personality Disorder and proceed with treatment based on that assumption.
What are the criteria for Antisocial Personality Disorder (ASPD)? Which does he meet?

- **Diagnostic Criteria**
- There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following:
  - failure to conform to social norms with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest
  - deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
  - impulsivity or failure to plan ahead
  - irritability and aggressiveness, as indicated by repeated physical fights or assaults
  - reckless disregard for safety of self or others
  - consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations
  - lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another
- The individual is at least age 18 years.
- There is evidence of **Conduct Disorder** with onset before age 15 years.
- The occurrence of antisocial behavior is not exclusively during the course of Schizophrenia or a Manic Episode.
Addiction and Personality Disorders Pearls…

• Management of a patient with dual diagnosis of personality disorder and addiction requires the involvement of a treatment team.

• Although his behavior is still consistent with his diagnosis of Antisocial personality disorder, he is easier to manage while not actively abusing opioids.
What labs will you order on this patient and why?
✓ **Urine Drug Screen:** To ascertain for presence of opiates, also determine what other illicit drugs he is currently abusing.

  ✓ **Answer:** + for morphine, oxycodone, benzodiazepine.

✓ **LFTs:** Patient has a history of alcohol abuse, also is at risk for hepatitis B and C.

  ✓ **WNL**

✓ **HIV and Hepatitis B panel:** History of IV drug use, unsure of risk for sexual exposure
What symptoms/signs does this patient have of opiate withdrawal?
## Score on COWS

<p>| | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Resting Pulse Rate</td>
<td>HR&gt;120=4</td>
</tr>
<tr>
<td>Sweating</td>
<td>Profusely=3</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Reports=1</td>
</tr>
<tr>
<td>Pupils</td>
<td>Larger than room size=1</td>
</tr>
<tr>
<td>Bone and Joint Aches</td>
<td>Reports severe and diffuse=2</td>
</tr>
<tr>
<td>Runny nose or tearing</td>
<td>Present=2</td>
</tr>
</tbody>
</table>
### COWS Score

<table>
<thead>
<tr>
<th>GI Upset</th>
<th>Vomiting=3</th>
</tr>
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<tbody>
<tr>
<td>Tremor</td>
<td>Slight Tremor=2</td>
</tr>
<tr>
<td>Irritability/Anxiety</td>
<td>Patient obviously irritable and anxious=3</td>
</tr>
<tr>
<td>Piloerrection</td>
<td>Felt and seen=3</td>
</tr>
<tr>
<td>Yawning</td>
<td>Yawning once or twice=2</td>
</tr>
<tr>
<td><strong>Total Score</strong></td>
<td>26 (Severe Withdrawal)</td>
</tr>
</tbody>
</table>
List the Psychiatric Diagnosis by Axis
• **Axis I:** Opiate Dependence, Benzodiazepine Abuse, Poly Drug Abuse

• **Axis II:** Antisocial personality disorder, conduct disorder as child.

• **Axis III:** Opiate Withdrawal, severe

• **Axis IV:** Employment problems, legal problems, divorce, relationship problems.

• **Axis V:** 55
The rest of the story…

• The patient returns later that day after his wife has the prescription for Suboxone™ filled.
• He is given a 4 mg dose of Suboxone™, which almost immediately alleviates his symptoms of withdrawal.
• He requires a total daily dose of 16 mg of Suboxone™.
• He is compliant with substance abuse treatment at the local agency.
Is this a treatment success? How would you measure?

- Urine Drug Screens: + for illicit opiates once, + for marijuana twice.
  - Do you refuse further prescription on this basis?
  - No, instead you communicate with the treatment team closely regarding these results.

- Pill Counts: Have been correct at each visit. Wife is monitoring his dosages and there is no concern about diversion

- ER visits: None

- Substance Abuse Treatment: Patient attends weekly individual sessions at Community Service Board
  - He has participated in some group sessions with other Suboxone™ patients at CSB
Treatment successes

• No new legal problems have developed
• Is compliant with visitation with child according to divorce agreement
  – Wife reports no domestic violence
  – He is required to have monitored visitation and has been cooperative
• Is currently working on a construction site with few incidents with co-workers
Summary

Jeff is a 43 year old male with opiate dependence, Antisocial Personality Disorder who sought your help and prescription of Suboxone™. He has been compliant with treatment for substance abuse at the local CSB. Urine Drug Screens have been negative and there is no evidence of diversion. He continues to struggle with relationship issues, but is able to visit with his child. He is employed.