Patient Evaluation

Taking the History

- Attitude of the interviewer should be:
  - Non-judgmental, curious, respectful
  - To facilitate effective treatment:
  - Acknowledge some information is difficult to talk about
  - Assure the patient that you are asking because of concern for his/her health
  - Try to avoid using labels or diagnoses

Taking the History

- Pay attention to the manner in which the patient responds
- Acknowledge discomfort
- Be persistent
- Always follow-up on “qualified answers”
- Assure confidentiality (as long as no one is at risk of being harmed)

Taking the History

- History of drug use:
  - Start with first substance used
  - Ask about all substances (licit and illicit)
  - Determine changes in use over time (frequency, amount, route)
  - Assess recent use (past several weeks)
  - Opioid dependence may be addiction to heroin or to prescription opioids; ask about history of both

Taking the History

- Prescription opioids:
  - Compulsive use of prescription pain medications
    - Unauthorized increases in dose
    - Using drug for other than pain relief: anxiety, stress, insomnia, to get “high”
  - Doctor shopping
  - Forging prescriptions
  - Frequent visits to the emergency department seeking opioid medications
  - Obtaining medication from family, friends, buying on the street; selling drugs
  - Use of alcohol or other illicit drugs

Taking the History

- Tolerance, intoxication, withdrawal:
  - Explain what is meant by tolerance
  - Determine the patient's tolerance and withdrawal history
  - Ask about complications associated with intoxication and withdrawal

Taking the History

- Relapse/attempts to abstain:
  - Determine if the patient has tried to abstain, and what happened
  - Longest period of abstinence
  - Identify triggers to relapse

Taking the History

- Consequences of use:
  - Determine current and past levels of functioning
  - Identify consequences
    - Medical
    - Family
    - Employment
    - Legal
    - Psychiatric
    - Other

Taking the History

- **Craving and control:**
  - Ask about craving and/or a compulsive need to use
  - Determine if patient sees loss of control over use
- **Treatment Episodes**
  - Response to treatment
  - Length of abstinence

Taking the History

- Medical history:
  - Past and/or present:
    - Significant medical illnesses
    - Hospitalizations/Operations
    - Accidents/injuries
  - Drug allergies
  - Current medications; evaluate for abuse of prescription opioids

Taking the History

- Psychiatric history
  - Symptoms/mental illnesses
  - Type of treatment(s)
  - Medication treatment

Taking the History

- Family history:
  - Substance use disorders
  - Other psychiatric conditions
  - Other medical disorders

Taking the History

- Personal (or social) history:
  - Birth and early development
  - Education
  - Employment and occupations
  - Marital status and children
  - Living situation
  - Legal status

Evaluating the Patient

- Physical examination:

  Look for evidence of addiction
  - Needle marks
  - Sclerosed veins (track marks)
  - Cellulitis/Abscess
  - Evidence of hepatitis or HIV

DSM-IV Criteria for Opioid Dependence

- A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:
- 1. Tolerance, as defined by either of the following:
  - a) a need for markedly increased amounts of the substance to achieve intoxication or the desired effect, or
  - b) markedly diminished effect with continued use of the same amount of the substance
- 2. Withdrawal, as manifested by either of the following:
  - a) the characteristic withdrawal syndrome for the substance, or
  - b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms

DSM-IV Criteria for Opioid Dependence

- 3. The substance is often taken in larger amounts or over a longer period than was intended
- 4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
- 5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects

DSM-IV Criteria for Opioid Dependence

- 6. Important social, occupational, or recreational activities are given up or reduced because of substance use

- 7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance

- Consider use of DSM-IV checklist to make diagnosis (see Clinical Tools CDROM for this course)

Characteristics of Addiction (Dependence)

- Control (loss of)
- Compulsion to use
- Consequences (continued use despite negative consequences – family, occupational/educational, legal, psychological, medical)
- Craving

Assess for Other Substance Use

- Alcohol
- Sedative-hypnotics (especially benzodiazepines)
- Cocaine
- Methamphetamine
- Cannabis
- PCP
- Nicotine
- “Club Drugs” (Ecstasy, Ketamine, GHB)
- Non-controlled (clonidine, phenergan, antihistamines, etc.)

Detecting Substance Use

- Laboratory methods:
  - Blood
  - Liver function test abnormalities
  - Elevated mean corpuscular volume on CBC
  - Urine testing for presence of drugs of abuse

Importance of Psychiatric Assessment

- Psychiatric considerations (may be relative contraindications)
  - Psychosis (if not well-controlled on medication)
  - Suicidal
  - Homicidal
  - Cognitive impairment or dementia

Comorbid Psychiatric Disorders

- Distinguish between substance-induced disorders versus independent psychiatric disorders:
  - Substance-induced: Disorders related to the use of psychoactive substance; typically resolve with sustained abstinence
  - Independent: Disorders which present during times of abstinence; symptoms not related to use of psychoactive substance

Substance-Induced Disorders

- Symptoms occur only when actively abusing drugs
- Symptoms are related to intoxication, withdrawal, or other aspects of active use
- Onset and/or offset of symptoms are preceded by increases or decreases in substance use
- Goal:
  - sustained abstinence
  - re-evaluation

Independent Disorders

- Symptoms occur when not using or abusing psychoactive substances, or with steady use without change in amount or type
- Family history may point to independent disorder if present in first degree relatives
- Goal: cessation of substance use, and treatment of psychiatric symptoms

Depressive and Anxiety Symptoms

- Common for opioid dependent patients to report depressive and anxiety symptoms at treatment entry
- Symptoms often resolve within few days (i.e., substance-induced)

Treatment of Co-Occurring Psychiatric Disorders

- Patients with opioid dependence and independent depressive and anxiety disorders:
  - Will respond to medication treatments for depressive and anxiety disorder(s) at similar rates to those without opioid disorders

Treatment of Co-Occurring Psychiatric Disorders

- Avoid use of benzodiazepines
  - Risk of abuse
  - Interactions with buprenorphine
  - First line treatments are serotonin reuptake inhibitors and psychotherapy (e.g.: cognitive behavioral therapy) for depression or anxiety disorders

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- Does the patient have a diagnosis of opioid dependence?
- Is the patient interested in office-based buprenorphine treatment?
- Is the patient aware of the other treatment options?
- Does the patient understand the risks and benefits of buprenorphine treatment; that it will address some aspects of the substance use (e.g.: withdrawal suppression and blockade) but not all aspects (e.g.: triggers and cravings that may be elicited by events and circumstances in the environment)?

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- Is the patient expected to be reasonably compliant? Are there indicators from his/her life that suggest s/he is reliable, such as steady employment, following through in taking medications for other medical conditions, or showing up on time for office appointments?

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- Is the patient expected to follow safety procedures?
- Is the patient psychiatrically stable?
- Are there resources available in the office to provide appropriate treatment? On-call coverage? Are there treatment programs available that will accept referral for more intensive levels of service if needed?
- Is the patient taking other medications that may interact with buprenorphine, such as naltrexone, benzodiazepines, or other sedative-hypnotics?

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- HIV: Buprenorphine might be easier to use than methadone in patients needing antiretroviral treatment; drug-drug interactions with antiretrovirals to date have not been of clinical importance (unlike for methadone)
  - Possible exceptions: atazanavir watch for sedation/cognitive impairment, rifampin: opiate withdrawal

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Co-occurring Conditions

- Hepatitis and impaired hepatic function: Unless the patient has acute hepatitis, pharmacotherapy with methadone or buprenorphine is not contraindicated on the basis of mildly elevated liver enzymes
  - Moderately elevated levels (>=3times the upper limit of normal) should be monitored
  - Active hepatitis: should be appropriately evaluated and treated
  - As should persistently moderate or markedly elevated liver function tests

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Co-occurring Conditions

- Seizures: Use buprenorphine cautiously in patients being treated for seizure disorders. When used concurrently with barbiturates or other anti-seizure medications, such as phenytoin, the metabolism of each drug may be compromised.

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Co-occurring Conditions

- Pregnancy: Methadone is currently the standard of care for opioid-dependent pregnant women in the United States, however newer studies show buprenorphine to be similar to methadone in terms of efficacy and may be associated with less frequent Neonatal Abstinence Syndrome and milder abstinence symptoms should they occur in neonates.

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Co-occurring Conditions

- Pregnancy: If patient refuses methadone and wishes to stay on buprenorphine
  - document informed consent for ongoing treatment with buprenorphine
  - switch to equivalent dose of buprenorphine mono-product

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Co-occurring Conditions

- If methadone is selected, start day following last dose of buprenorphine/naloxone. Administer split dose (e.g.: 30 mg on day 1 in two divided doses and increase as clinically indicated).

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Pain

- Buprenorphine is an effective parenteral analgesic, but its duration of analgesia is relatively short
- Buprenorphine's analgesic potency is approximately 30x that of morphine
- A bell-shaped dose response curve has been reported for buprenorphine's analgesic effects
- Sublingual formulation not developed for analgesic use

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Pain

- Acute Pain in Buprenorphine Maintained Patients
  - Try non-opioid analgesics (ketorolac, NSAIDs, or Cox-II inhibitors, acetominophen) initially
  - If these are insufficient, make sure some form of opioid maintenance medication is continued

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Pain

- The patient's acute pain is unlikely to be treated by their once daily maintenance dose of buprenorphine – other management of pain will be required
- If opioid analgesics required, consider switching off buprenorphine (e.g., to methadone)

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment:Acute Pain

- Alternately, could try to obtain analgesic effect with an increased dose of buprenorphine – that is, small supplemental doses of sublingual buprenorphine periodically throughout the day in addition to their once daily dose of maintenance buprenorphine,

  i.e.: split doses of buprenorphine; 25% increase in dose—depending on the level of pain/discomfort

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Acute Pain

- Additional strategies to consider:
  - Titrate down buprenorphine dose and transfer patient to full opioid agonist temporarily (e.g.: methadone), then return to buprenorphine
  - Use of regional anesthesia such as epidural blockade

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Acute Pain

- Use of other methods of pain control such as TENS (Transcutaneous Electrical Nerve Stimulator), Nerve Block, Steroid injection, etc.
- Consult Pain Specialist for help with alternative methods of pain control

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment: Chronic Pain

- In general, when treating a patient with chronic pain:
  - Consider consulting a pain medicine specialist
  - Consider multidisciplinary team approach
  - Try non-opioids and adjuvant analgesics
  - Begin with non-pharmacologic therapies

Appropriateness for Office-based Buprenorphine Treatment: Chronic Pain

- If chronic opioid analgesics are required for pain control:
  - Buprenorphine may make it difficult to get anagesia from full mu agonists
  - Buprenorphine maintenance may need to be discontinued

Appropriateness for Office-based Buprenorphine Treatment: Chronic Pain

- Patient's opioid dependence may be better treated with methadone maintenance (avoids complications of possible precipitated withdrawal by buprenorphine or difficulty obtaining effective analgesia)

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- Use of alcohol, sedative-hypnotics, and stimulants:
- The abuse of sedative-hypnotics (benzodiazepines, barbiturates, and others) may be a relative contraindication for treatment.
- Injected buprenorphine and benzodiazepines have resulted in deaths.

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- Essential to assess for use, intoxication, and withdrawal from sedative-hypnotics. If a patient is at risk for withdrawal seizures from alcohol or sedative-hypnotic use, buprenorphine will not control seizures.

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- Since alcohol is a sedative-hypnotic, patients should be cautioned to avoid alcohol while taking buprenorphine.
- Persons with active or current alcohol dependence are not good candidates for office-based buprenorphine treatment.

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- Other drugs: Buprenorphine is a treatment for opioid dependence, not other drug use disorders. Does not impact cocaine/amphetamine use, cannabis use, alcohol use.
- Abuse of or dependence on other drugs (such as stimulants or sedatives) is common among opioid-addicted persons and may interfere with overall treatment adherence.

Factors to Consider in Determining If a Patient Is Appropriate for Office-based Buprenorphine Treatment

- Patients should be encouraged to abstain from the use of all non-prescribed drugs while receiving buprenorphine treatment.
- Use of other drugs *is not* an absolute contraindication to buprenorphine treatment.
- Persons with multiple addictions may need to be referred for additional or more intensive treatment.

Summary

- Important to take a complete history
  - Necessary to make correct diagnoses
  - For treatment planning
- Recognition of co-occurring disorders important to provide most effective treatment