

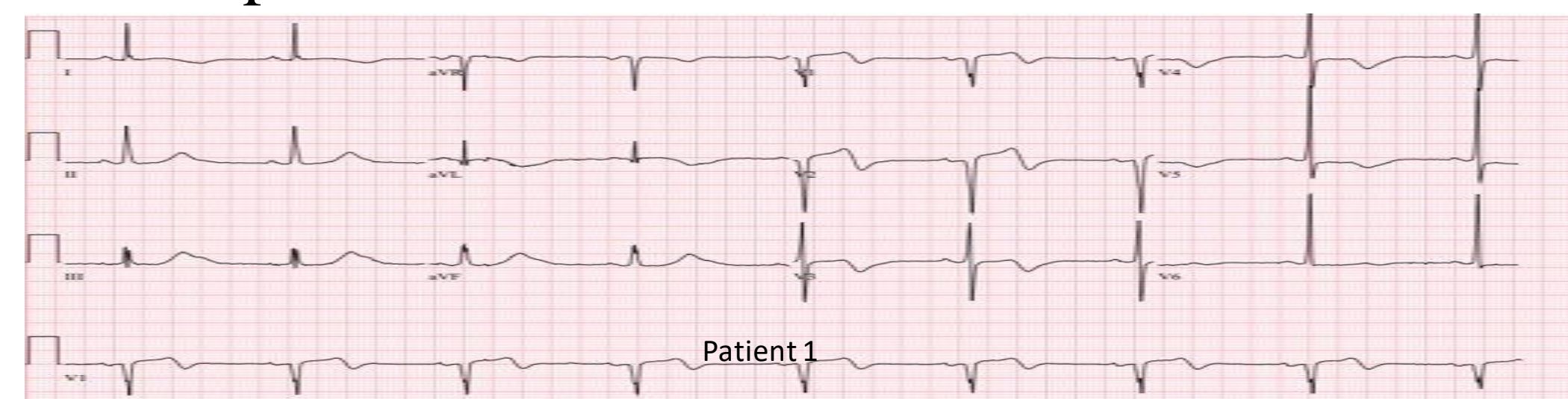
Time-limited transition from methadone to buprenorphine in the acute care setting:



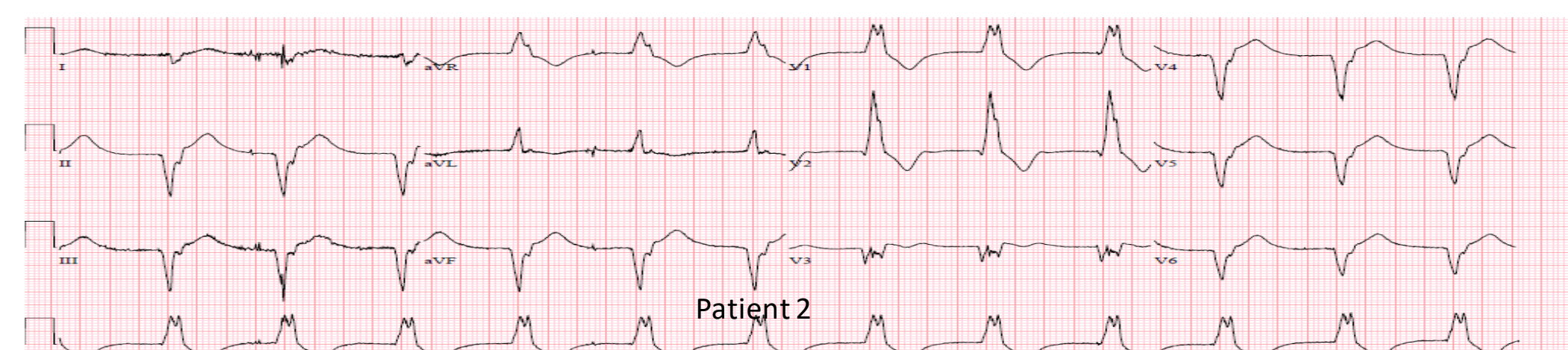
A safe and effective strategy Umer Farooq, Joy Chang, Annabelle Belcher

Methods

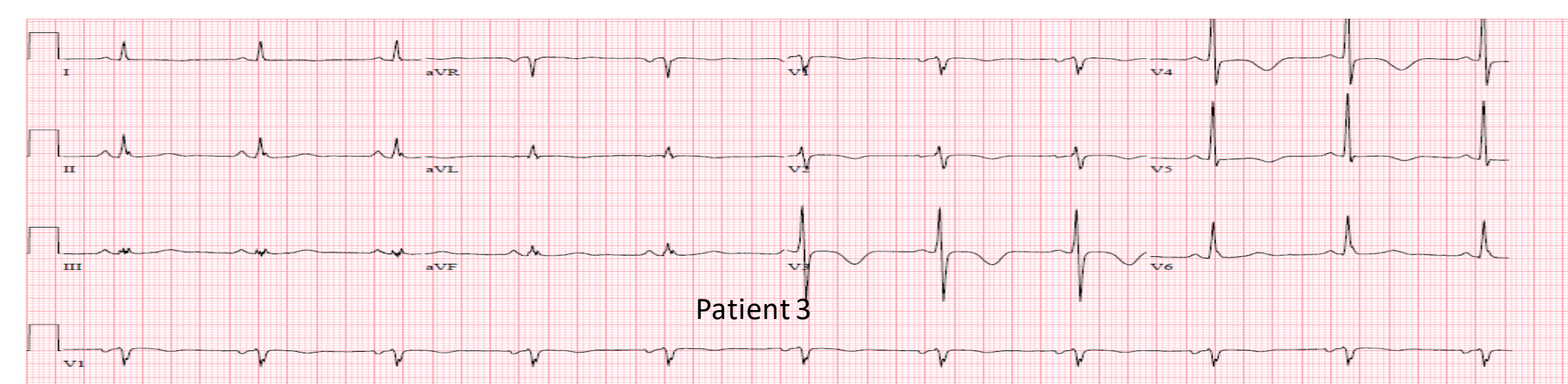
1. Our patients were being treated with methadone for opioid use disorder at doses of 85 mg, 110 mg and 125 mg.
2. All three patients had developed cardiac complications including prolonged QTc intervals either at the time of presentation or early in the admission.
3. Patient one presented with Non-ST Elevation Myocardial Infarction and patient two and three had ventricular fibrillation leading to cardiac arrest out of the hospital.



4. To minimize withdrawal, full opioid agonist therapy in the form of oral and intravenous hydromorphone was initiated as soon as the decision was made to switch to buprenorphine.



5. Low doses of IV buprenorphine (0.15 mg followed by 0.3 and 0.6 mg every 6 hours were ordered before transitioning to oral buprenorphine/naloxone.



6. Patient one and two received a total of 2.1 mg of IV buprenorphine but patient 3 only received 1.35 mg of IV buprenorphine before their first oral buprenorphine doses.
7. Opioid agonist therapy was discontinued without complications once patients were transitioned to oral buprenorphine/naloxone.

Introduction

The transition of patients from methadone to buprenorphine over a short period time has historically posed significant challenges. Methadone has a longer half-life and is structurally very different from buprenorphine, and no established standards exist to guide best practices for successful transitioning strategies. Thus, dosing protocols vary greatly across different treatment institutions. The most successful outcomes have been reported for patients maintained on lower doses of methadone. Little has been reported, however, for patients who are maintained on high (and more clinically relevant) doses of methadone. We report a case series of patients admitted to the University of Maryland Medical Center who were previously maintained on relatively higher doses of methadone for opioid use disorder and were successfully transitioned to buprenorphine for cardiac indications in a safe and effective manner.

Abstract with health equity and references:
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Results

Patient 1:	Day	Full agonist therapy	Intravenous Buprenorphine	Oral Buprenorphine/Naloxone
	1	Hydromorphone 69 mg	0.30 mg	N/A
	2	Hydromorphone 68 mg	1.80 mg	N/A
	3	Hydromorphone 44 mg	N/A	8/2 mg QID

Patient 2:	Day	Full agonist therapy	Intravenous Buprenorphine	Oral Buprenorphine/Naloxone
	1	Hydromorphone 49 mg	0.30 mg	N/A
	2	Hydromorphone 38 mg	1.80 mg	N/A
	3	Hydromorphone 24 mg	N/A	2/0.5 mg QID

Patient 3:	Day	Full agonist therapy	Intravenous Buprenorphine	Oral Buprenorphine/Naloxone
	1	Hydromorphone 29 mg	0.15 mg	N/A
	2	Hydromorphone 23 mg	1.20 mg	N/A
	3	Hydromorphone 18 mg	N/A	2/0.5 mg QID

1. Patients continued to receive medical and interventional treatments for the cardiac pathology that brought them into the hospital during and beyond this period.
2. No further elevations in QTc intervals were noted during their hospitalization. Buprenorphine/naloxone doses varied at discharge from 8 mg to 16 mg and arrangements were made for outpatient follow-up.

Conclusion

1. Patients who are no longer safe candidates for methadone therapy due to severe, life-threatening cardiac sequelae are now able to transition to buprenorphine during the acute care hospitalization and discharge on therapeutic dosages without impacting length of stay or compromising patient comfort.
2. Although challenging, buprenorphine/naloxone can be a realistic option for patients whenever medically indicated or desired by the patients, irrespective of how much or when their last dose methadone was.
3. There was no need for symptomatic assessment of opioid withdrawal by Clinical Opiate Withdrawal Scale.
4. If successful, such a method can also help minimize length of stays.