

Results of the Prescribing Methadone Survey

Conducted between June – August 2008

Fellowships Surveyed:

Australasian Chapter of Addiction Medicine, Royal Australasian College of Physicians (AChAM)

Australasian Chapter of Palliative Medicine, Royal Australasian College of Physicians (AChPM)

Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (FPM – ANZCA)

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Original Report Date: 12 September 2008

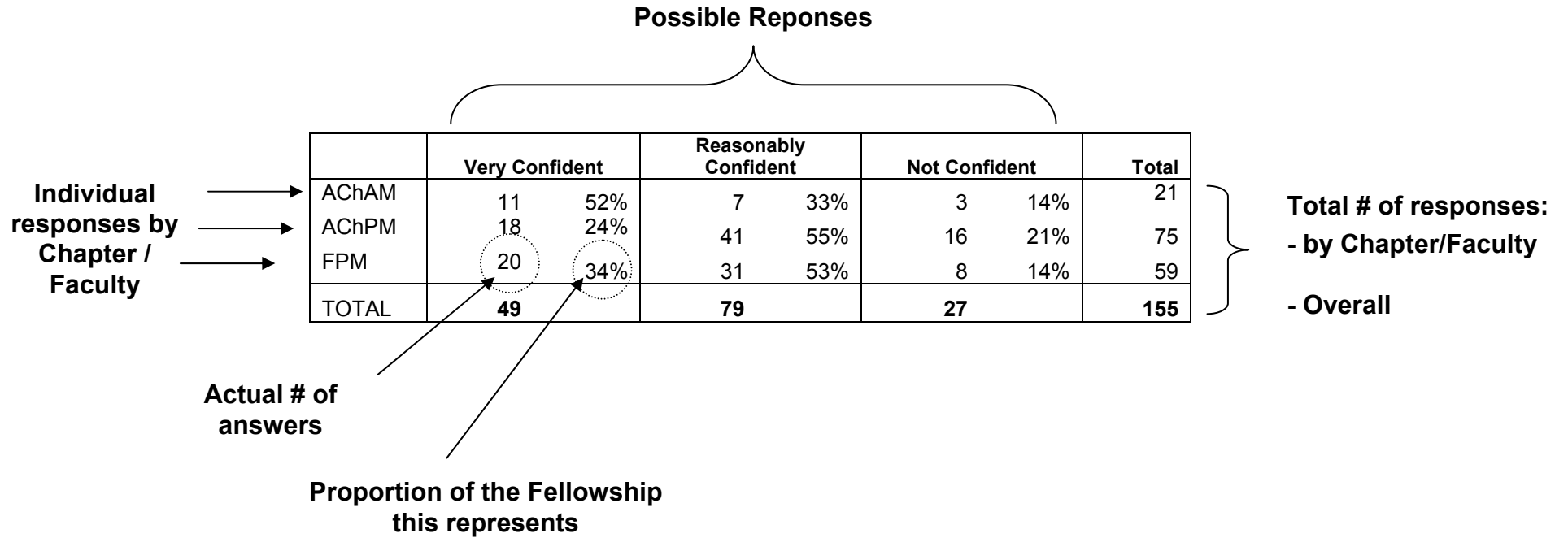
Amendment Date: 22 September 2008

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APPENDIX A – Survey Results

Results Table Guide



NB: The results have not been sanitised to eliminate duplicate answers or skipped questions.
Refer to the Appendix A for the summary of results and deviations.

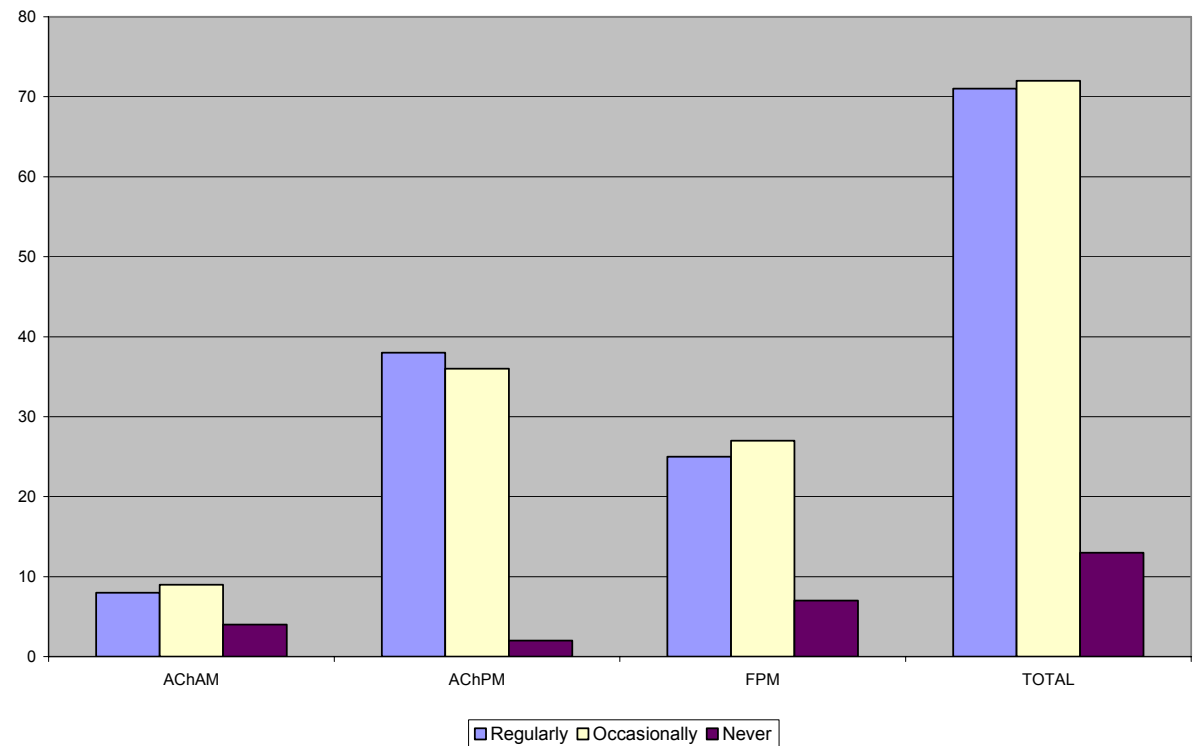
Q1. Do you ever use Methadone for the treatment of chronic pain or cancer pain in your patient population?

Results:

	Regularly		Occasionally		Never		Total
AChAM	8	38%	9	43%	4	19%	21
AChPM	38	50%	36	47%	2	3%	76
FPM	25	42%	27	46%	7	12%	59
TOTAL	71		72		13		156

Key Points:

- On average 43% of all respondents use Methadone regularly in their practice for the treatment of chronic pain or cancer pain in their patient population.
- Palliative Medicine Specialists are the most regular prescribers specifically for the treatment of chronic pain or cancer pain in their patient population.
- Addiction Specialists are the least likely to use Methadone for this reason.
- 89% respondents use Methadone at least occasionally for the treatment of chronic or cancer pain.



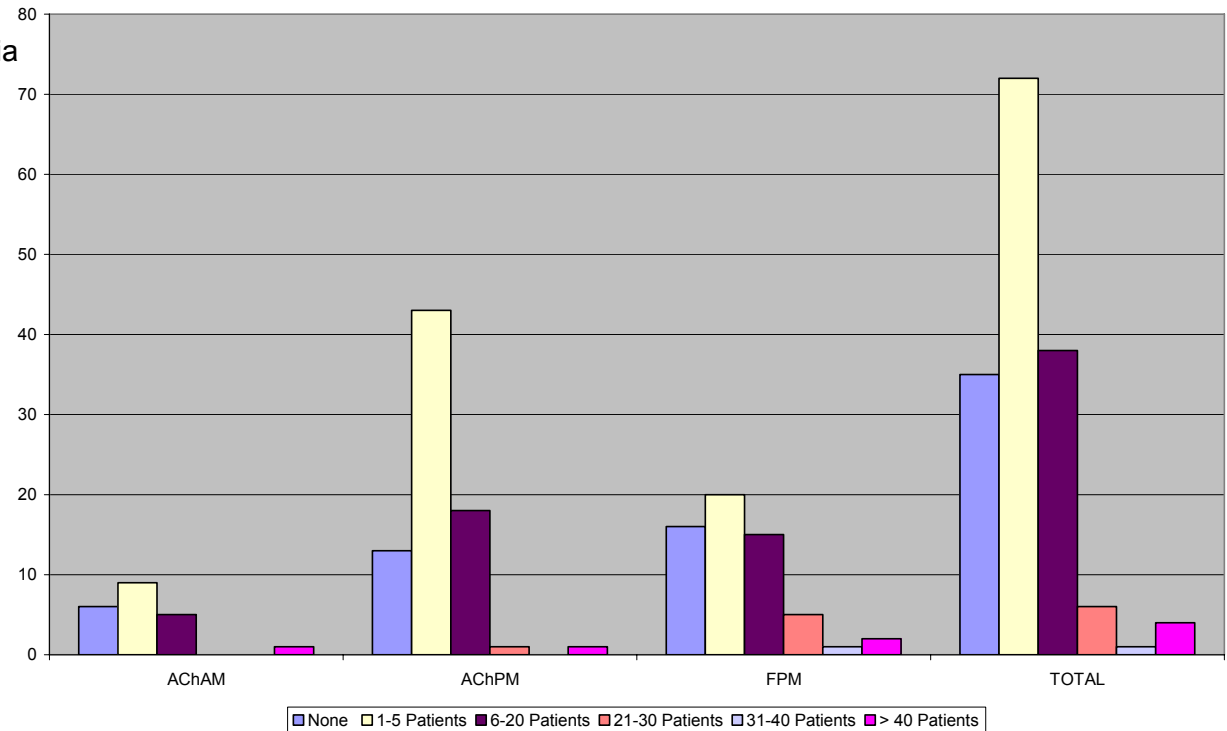
Q2. Approximately how many patients would you currently be prescribing methadone for analgesia?

Results:

	None		1-5 Patients		6-20 Patients		21-30 Patients		31-40 Patients		> 40 Patients		Total
AChAM	6	30%	9	45.0%	5	25.0%	0		0		1	5.0%	20
AChPM	13	18%	43	58.1%	18	24.3%	1	1.4%	0		1	1.4%	74
FPM	16	31%	20	39.2%	15	29.4%	5	9.8%	1	2.0%	2	3.9%	51
TOTAL	35		72		38		6		1		4		145

Key Points:

- The largest proportion of respondents is currently prescribing methadone for analgesia for between 1-5 patients.
- A third of AChAM and FPM Fellows, and a fifth of AChPM are currently not treating any patients methadone for analgesia.
- On average 26% of all respondents are currently treating between 6-20 patients.



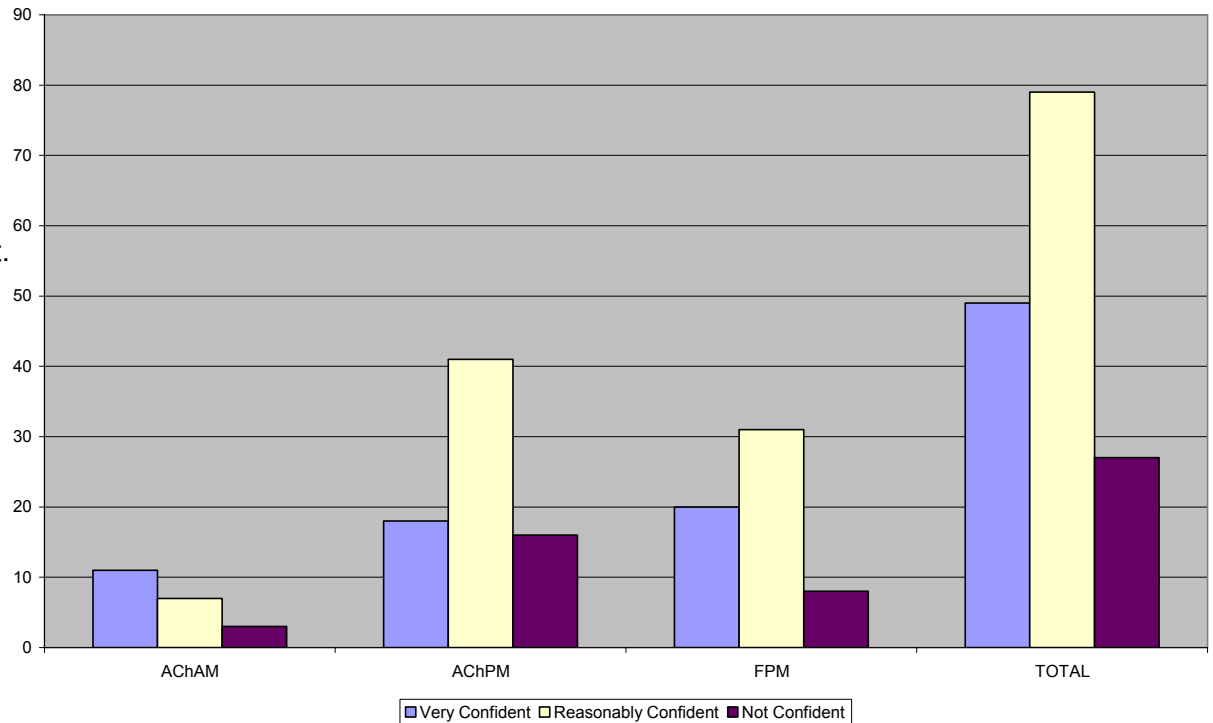
Q3. How confident are you in prescribing methadone in opioid naive patients?

Results:

	Very Confident		Reasonably Confident		Not Confident			Total
AChAM	11	52%	7	33%	3	14%		21
AChPM	18	24%	41	55%	16	21%		75
FPM	20	34%	31	53%	8	14%		59
TOTAL	49		79		27			155

Key Points:

- Half of AChAM Fellows are very confident with prescribing methadone.
- Half of AChPM and FPM Fellows are reasonably confident with prescribing methadone.
- A fifth or less of respondents are not confident.



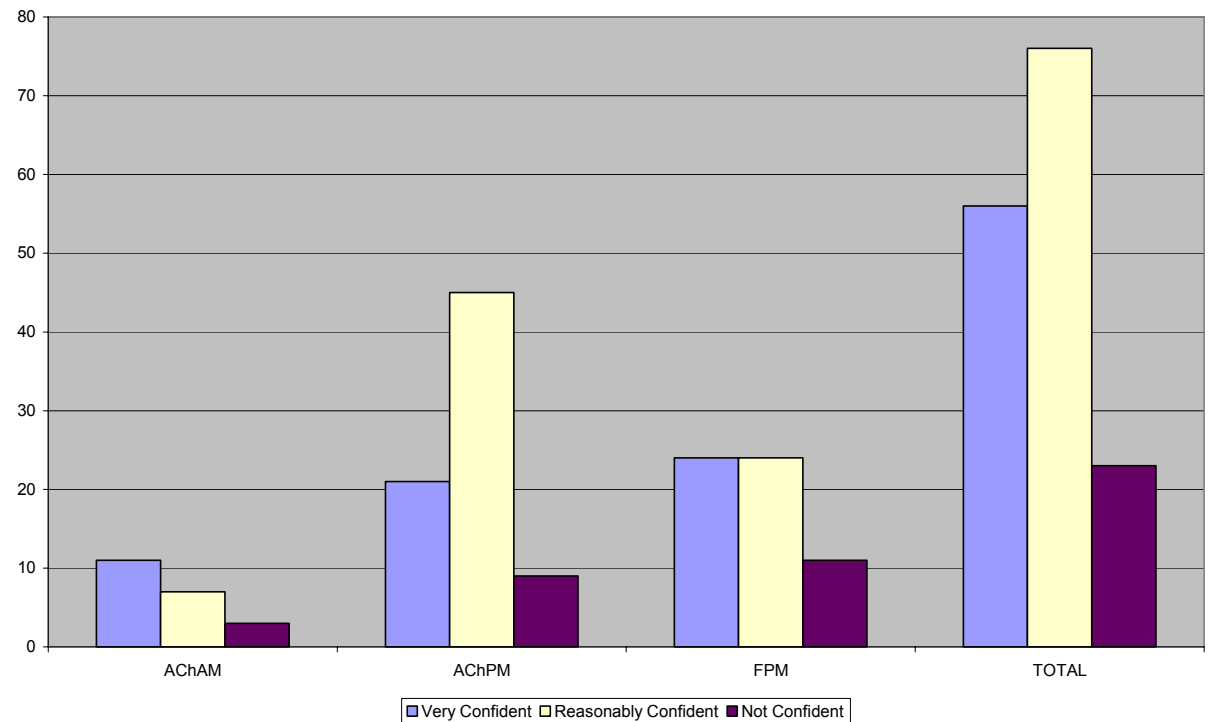
Q4. How confident are you in prescribing methadone in opioid experienced patients (eg when toxicity has developed on previous opioid)?

Results:

	Very Confident		Reasonably Confident		Not Confident		Total
AChAM	11	52%	7	33%	3	14%	21
AChPM	21	28%	45	60%	9	12%	75
FPM	24	41%	24	41%	11	19%	59
TOTAL	56		76		23		155

Key Points:

- All three Fellowships are reasonably to very confident in prescribing methadone to opioid experienced patients.
- AChAM Fellows are most confident.
- FPM Fellows are least confident.



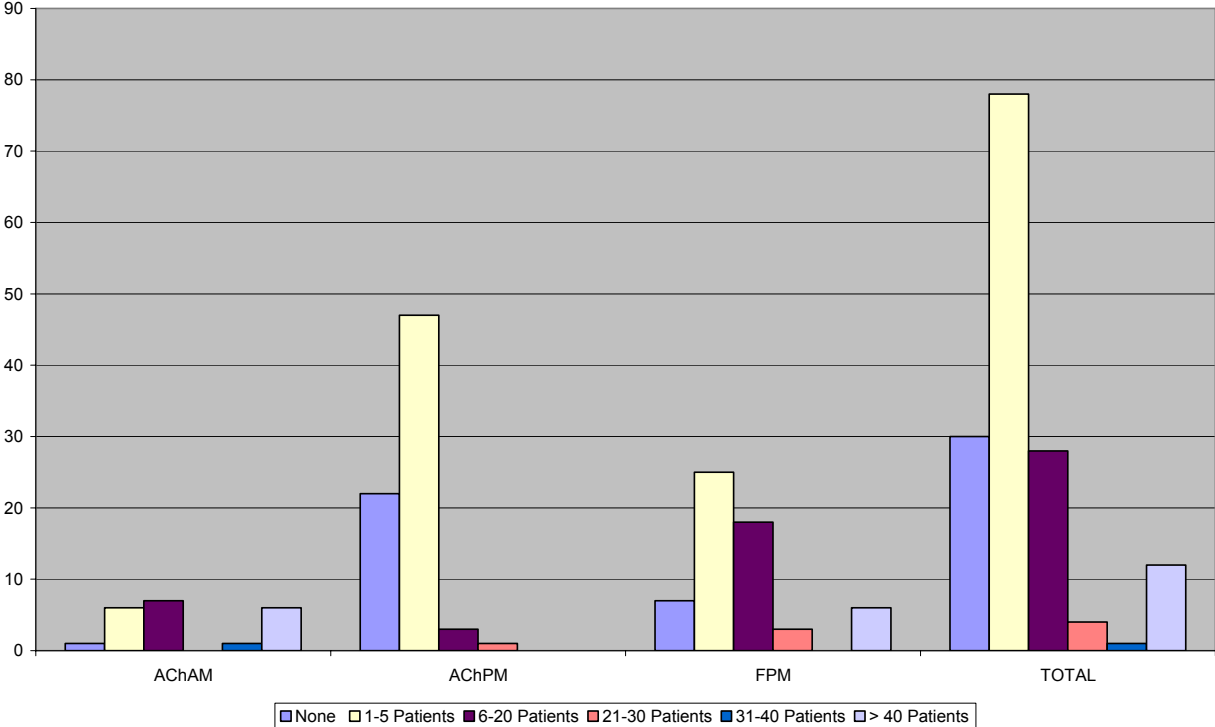
Q5. Approximately how many patients do you see annually with moderate to severe pain who are on a methadone maintenance program for opioid addiction?

Results:

	None		1-5 Patients		6-20 Patients		21-30 Patients		31-40 Patients		> 40 Patients		Total
AChAM	1	5%	6	29%	7	33%		0%	1	5%	6	29%	21
AChPM	22	29%	47	63%	3	4%	1	1%		0%		0%	73
FPM	7	12%	25	42%	18	31%	3	5%	0	0%	6	10%	59
TOTAL	30		78		28		4		1		12		153

Key Points:

- The AChAM Fellowship understandably sees a much higher volume of patients with moderate to severe pain who are on a methadone maintenance program.
- The AChPM and FPM Fellowship still sees annually in the range of 1-20 patients.
- A small proportion of the FPM Fellowship sees a very highly volume of patients.



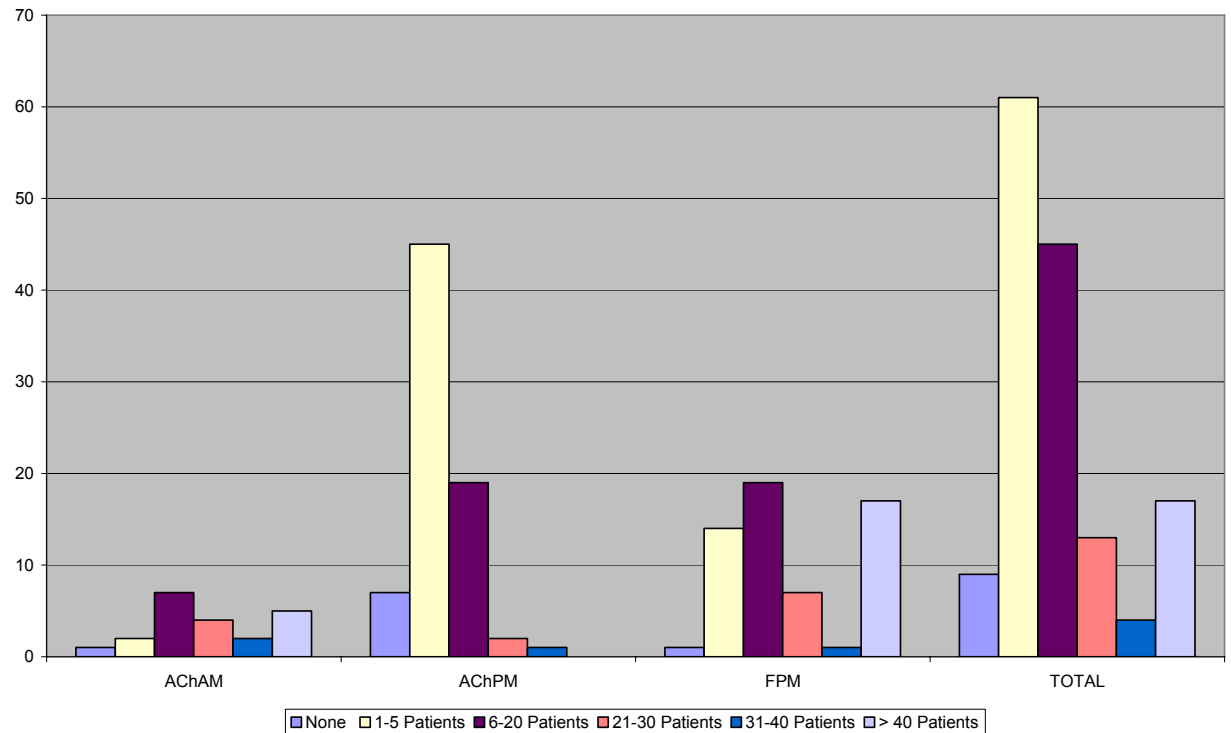
Q6. Approximately how many patients do you see annually with moderate to severe pain that have a past history of drug addiction?

Results:

	None		1-5 Patients		6-20 Patients		21-30 Patients		31-40 Patients		> 40 Patients		Total
AChAM	1	5%	2	10%	7	33%	4	19%	2	10%	5	24%	21
AChPM	7	9%	45	60%	19	25%	2	3%	1	1%		0%	74
FPM	1	2%	14	24%	19	32%	7	12%	1	2%	17	29%	59
TOTAL	9		61		45		13		4		17		154

Key Points:

- Across the board, a third of respondents indicated that they see in the range of 6-20 patients a year with moderate to severe pain that have a past history of drug addiction.
- The FPM Fellows had almost a third of their Fellowship seeing more than 40 patients annually.
- Almost half of the AChPM Fellowship see in the range of 1-5 patients per year.
- A quarter of the AChAM Fellowship see above 40 patients per year.



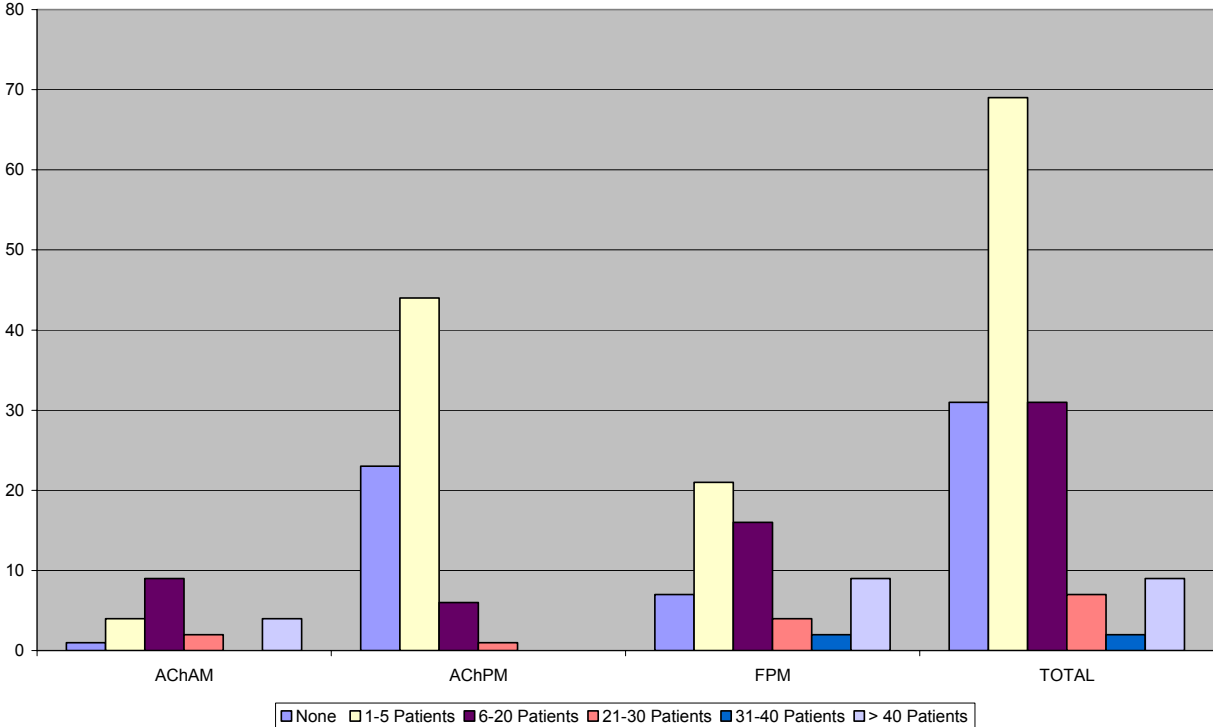
Q7. Approximately how many patients do you see annually with moderate to severe pain, currently using illicit drugs in whom methadone might be an appropriate option?

Results:

	None		1-5 Patients		6-20 Patients		21-30 Patients		31-40 Patients		> 40 Patients		Total
AChAM	1	5%	4	19%	9	43%	2	10%		0%	4	19%	20
AChPM	23	31%	44	59%	6	8%	1	1%		0%		0%	74
FPM	7	12%	21	36%	16	27%	4	7%	2	3%	9	15%	59
TOTAL	31		69		31		7		2		9		153

Key Points:

- 15-20% of FPM and AChAM see more than 40 patients with moderate to severe pain that would be prospective methadone candidates.
- 70% of AChPM Fellows annually see 1-20 patients with whom methadone might be an appropriate option while most of the remaining third see none.



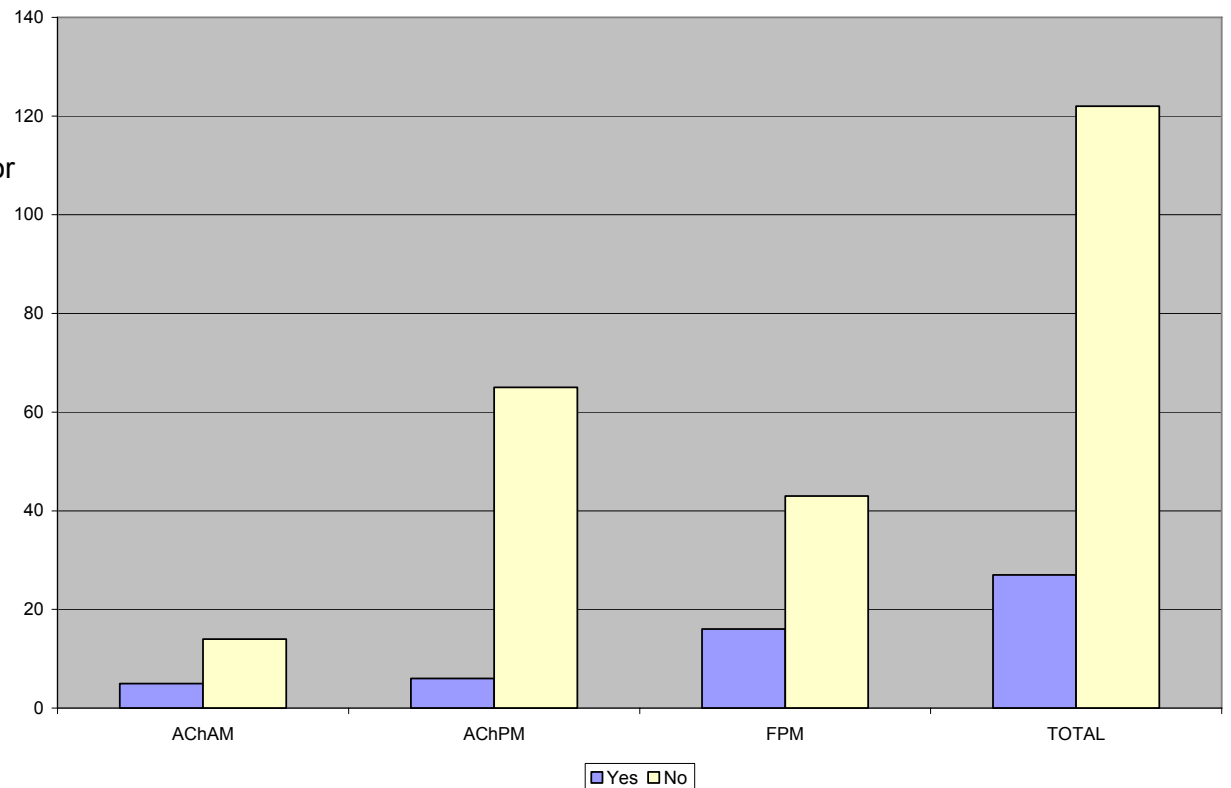
Q8. Do you believe there is sufficient literature available on the use of methadone in patients with chronic pain or cancer pain who are either drug dependent or who have not been illicit drug users in the past?

Results:

	Yes		No		Total
AChAM	5	24%	14	67%	19
AChPM	6	8%	65	87%	71
FPM	16	27%	43	73%	59
TOTAL	27		122		149

Key Points:

- The overwhelming majority, on average 76%, of all respondents felt that there was insufficient literature on the use of methadone in patients with chronic pain or cancer pain who are either drug dependent or who have not been illicit drug users in the past.



Please note: There is an error in the wording of Question 8 in the questionnaire, thus caution must be used when interpreting these results. It should read "...or who **have** been illicit drug users in the past."

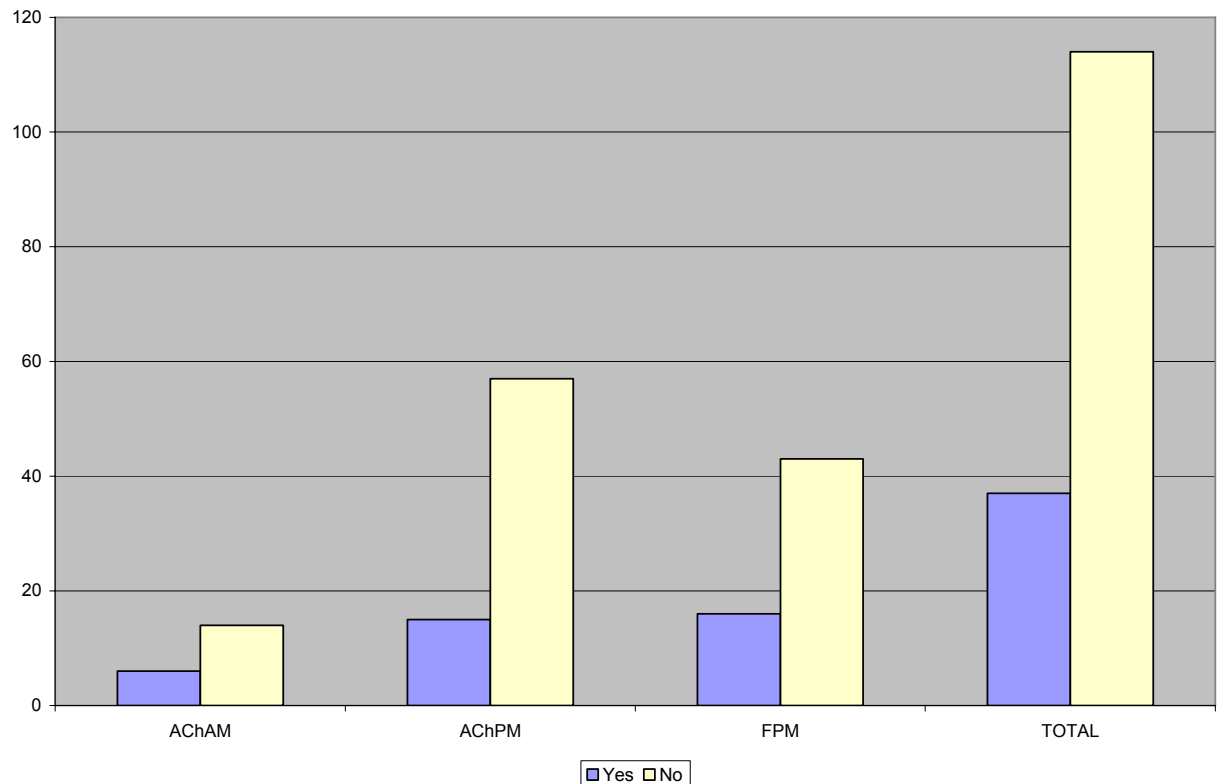
Q9. Do you believe that current literature and current information packages available to you are relevant and adequate for your current clinical practice?

Results:

	Yes		No			Total
AChAM	6	29%	14	67%		20
AChPM	15	20%	57	76%		72
FPM	16	27%	43	73%		59
TOTAL	37		114			151

Key Points:

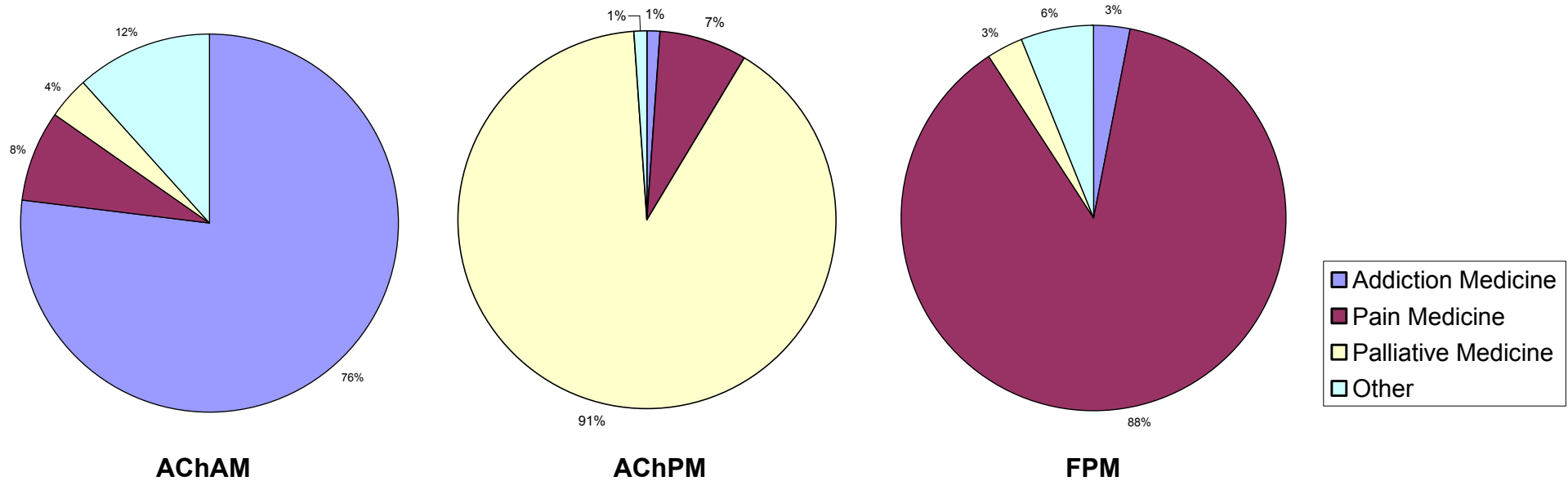
- Slightly fewer but still a large majority (72%) of respondents felt that there was adequate current literature and information packages available for their clinical practice.



Q10. What is your area of Specialist practice?

Results:

	Addiction Medicine	Pain Medicine	Palliative Medicine	Other
AChAM	20	2	1	3
AChPM	1	6	73	1
FPM	2	57	2	4
TOTAL	23	65	76	8



Key Points:

- 'Other' areas of practice were General Practice, Psychiatry, Anaesthesia, ICU and Rehabilitation.

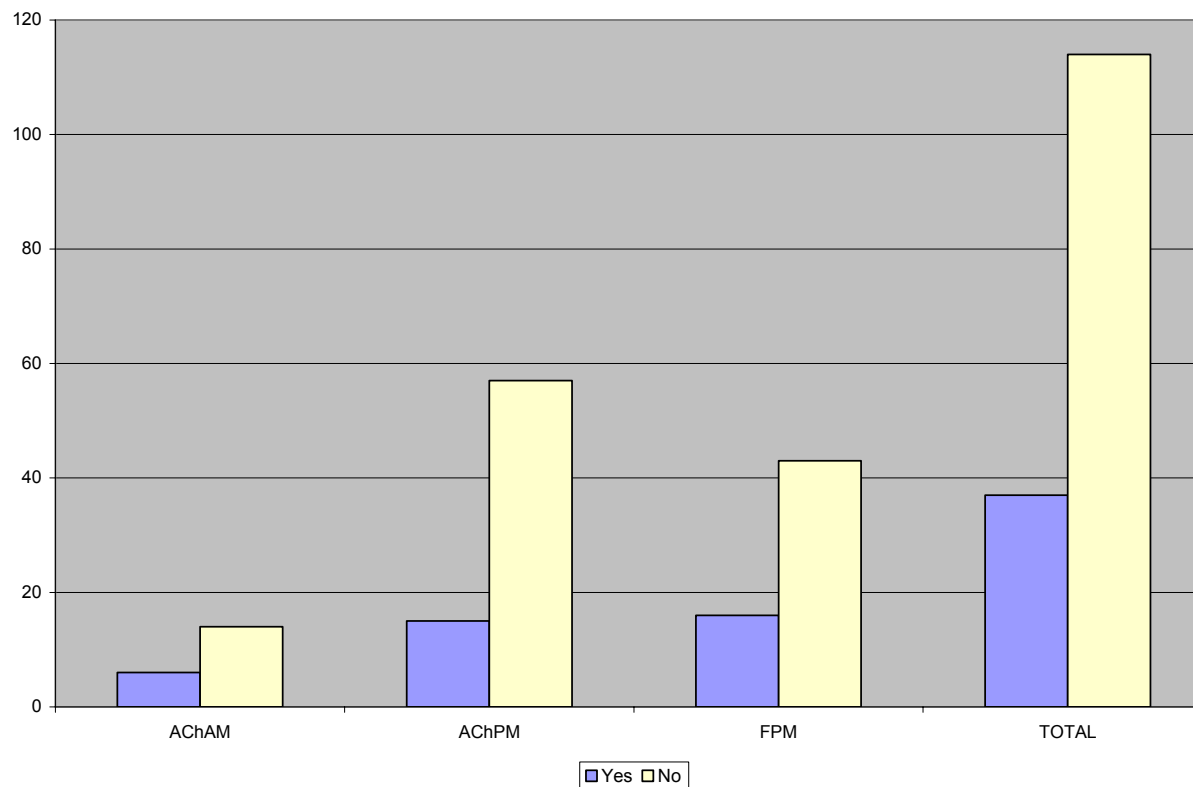
Q11. Would you be interested in attending an education programme through the RACP on this topic?

Results:

	Yes	No	Possibly	Total
AChAM	15	-	6	21
AChPM	54	4	17	75
FPM	35	3	21	59
TOTAL	104	7	44	155

Key Points:

- Out of 155 Fellows surveyed in all three Fellowships, 148 or 95% are potentially interested in an education program through the RACP in Methadone prescribing.



Q12. If such a workshop were to be held, what topics would you particularly like to be covered?

Responses from the Australasian Chapter of Addiction Medicine Fellowship:

- Management of pain for the opioid dependent.
- Management of the patient's psyche on the change-over: how to address the confrontation of addiction element to analgesia seeking.
- Pain management in clients on methadone and opioids.
- Methadone hyperalgesia and toxicity. Non opioid approaches.
- Assessing and managing high risk; role of buprenorphine in pain management.
- Consequences of under-treated pain.
- Applicability and success rates of pain management treatment to those with CNMP and addiction; is this different from others with CNMP, if so, why and what are the implications?
- Development of Guidelines for assessment of patients with chronic non-malignant pain before commencement on any opioid analgesia.
- Guidelines on approach to management of those on opioid substitution treatment who present with CNMP.
- The absolute necessity of multidisciplinary (chronic pain & dependence/addiction expertise) assessment and management for most if not all chronic pain patients.
- Role/availability of non-opioid treatments.
- Buprenorphine.
- MMT reductions in CNMP; pain exacerbations in MMT; opioid hyperalgesia .
- Chronic Pain Assessment and Best Practice Management.
- Opioid rotation, use of buprenorphine for pain.
- Pain management.
- Opioids and Pain Management.
- The role of therapeutic blood monitoring in pain and dependence management.
- Tx options for opiate induced hyperalgesia.

Responses from the Australasian Chapter of Palliative Medicine Fellowship

- Consensus on using methadone to treat cancer pain
- Opioid:methadone conversions
- Use of methadone with other opioids
- Breakthrough dosing
- Opioid conversion to and from methadone
- Safe guidelines for instituting methadone
- Initiating methadone treatment and dose escalation
- ECG or not.
- Parenteral methadone
- Bd vs tds vs daily dosing regimens
- Use of methadone in patients who are or have been drug dependent.
- Pain relief: acute/chronic/palliative in drug dependent patients
- Methadone effects on QT interval and implications for palliative patients.

- Use of methadone in illicit drug users.
- Use of other opioids in illicit drug users
- Tips on prescribing methadone - how to start in opioid naive and opioid tolerant patients.
- Interface between pain and opioid dependence.
- Conversion from existing opioids to methadone
- Use of methadone in PCA devices
- Use of methadone for pain in the patient on maintenance methadone.
- All the topics above
- Methadone toxicity
- Overview of evidence for methadone efficacy in various pain subtypes.
- Safe opioid conversion protocols, evaluating risk-benefits of methadone.
- Rotating from methadone to other opioid for uncontrolled pain/rotating from other opioid to methadone.
- Role of 'add on methadone', ie, adding methadone and titrating as a second opioid rather than replacing the existing opioid in uncontrolled pain.
- Current research re role in neuropathic pain (my understanding of most recent cochrane review is that there is no evidence that it is better than other opioids for this).
- Conversion regimens between methadone and other opioids.
- Adjuvant use of methadone vs use as first line opioid.
- Indications and switching from other opioids to methadone and vice versa.
- Indications for use and its role in the armamentarium for chronic pain;
- Latest thinking on how to start and how to titrate.
- Use of methadone and second opioid concurrently. Finding an appropriate opioid in setting of opioid induced hyperanalgesia potentiated or induced by methadone.
- Practise use of methadone in chronic pain.
- Dose titration, pharmacokinetics, opioid rotation, specific clinical scenarios for use.
- Guidelines
- Pain control in patients on methadone, pain control in IVU - current and previous.
- Use of methadone in palliative care, particularly previously drug dependent patients.
- Opioid conversion to methadone
- Commencing methadone in opioid-naive patients/use of methadone with another opioid.
- Pain management in someone on maintenance methadone.
- Dose conversion from other opioids, prn methadone, methadone titration methods including self-titration protocols, methadone PCA (Cherny has used this),
- Use of parenteral methadone, evidence base for use in neuropathic pain.
- Benefit over other opiates, how to convert to methadone, role of methadone in addition to other opiates, pain management in those on methadone maintenance.
- Use as 'breakthrough'
- Use in renal impairment
- Comparative opioid pharmacokinetics overview
- Methadone dosing regimens for palliative care.
- Protocols for starting methadone in opioid naive and non-naive cancer patients.
- Pharmacology of methadone, conversion methods from one opiate to methadone and reverse as there is currently such a wide diversity of practice.
- Indications for use - either to change from other opioid or as initial opioid.
- Methods of conversion from and to other opioid.

- Cardiac effects. Use as a prn medication.
- Initial titration regimens. Breakthrough analgesia when established on methadone.
- Update on titration to methadone from other opioid,
- Management of cancer pain in patients on maintenance methadone,
- Use of methadone in patients addicted to opioid following extensive non-cancer treatments, eg, GVHD.
- Conversion to methadone from other opioids.
- Indications, dose range, how to withdraw opioids, use of non-opioid drugs and non-drug strategies.
- Indications and methods of commencing methadone when opioid toxicity and/or non-effectiveness of the patient's regular opioid is an issue in the palliative care setting.
- Prescribing more than a single opioid.
- Choice and dosing of breakthrough medication
- Conversion back from methadone to alternative opioid
- Oral to subcut conversion ratio.
- Hyperanalgesia risks and methadone
- Differences (if any) in prescribing for the purpose of methadone maintenance treatment vs prescribing in the setting of palliative care. In particular the rationale for single daily dosing versus divided dosing in the different patient groups would be interesting to better understand.
- Treatment of cancer pain in drug addicted patients.
- Opioid rotation to methadone. There is a need for an agreed-upon policy.
- Pain control in patients on methadone, pain control in IVDU - current and previous.
- Use of methadone as analgesic in cancer patients on methadone maintenance program. Opioid switching to methadone. Breakthrough medications for patients on regular methadone.
- Role for low dose methadone in combination with other opioids
- Review of the basic science of methadone and its receptor activity
- Methadone-o-phobia and how to overcome it.
- Conversion of other opioids to methadone. Using methadone in combination with other opioids. Adjusting maintenance methadone in setting of onset of pain/cancer pain.
- Rotation, recommended conversion ratios, toxicity.
- Methadone in impending organ failure.

Responses from the Faculty of Pain Medicine Fellowship:

- Conversion to Methadone from other opioids
- Pharmacokinetic discussion, opioid rotation, side effects, long QT etc
- How to prescribe, how much to prescribe, when to prescribe, opioid conversion with morphine
- Australian epidemiological information would be helpful
- Safety
- Initiating treatment, opioid conversion, treating acute pain in those with addictive disorders
- Regulatory issues relating to methadone prescribing
- Pharmacology opioid pharmacology comparisons, half-life implications, nmdaantagonism realities with meth, monitoring usage.
- Dealing with the bad name Methadone has
- Changing to Methadone in an outpatient setting
- Practical management with methadone. Risks

- Happy with the relative lack of opioid effectiveness in CNMP, don't need to do that again, but using methadone in opioid naïve malignant pain, and renal failure, and managing methadone programme patients with chronic or malignant pain would be useful .
- Containment; contracts; psychiatric disease in addiction medicine.
- Opioids, chronic pain, addiction
- Chronic non-cancer pain
- I regularly have excellent results using methadone at very low doses eg <5 mg per day in the elderly, children and in pregnancy. There is very little literature to back up my practice and the support of the college would be appreciated.
- How to improve liaison of addiction medicine and pain medicine in the management of patients
- Detox and suboxone
- Regulatory aspects need to be covered in detail.
- Patients with addiction and pain issues
- I have pain fellowship but am not working in chronic pain currently. I have involvement with acute pain and palliative care at the major tertiary hospital I work at. I therefore have not answered the questionnaire. I have done a workshop on line which I think was through the Addiction Medicine Chapter so I would like to see what sort of workshop you are proposing.
- I am therefore interested in a workshop but with the caveats above.
- Treatment of addiction in pain patients.
- Persuading patient to change to methadone
- -information on success of methadone program and its outcome measures information on addiction services in Victoria,
- Long term plans for funding of these services
- Is there a long term plan for those patients who are on methadone and continue to abuse other opioids
- The overlap between addiction and pain medicine, lessons learned in addiction medicine than would be helpful in pain medicine and vice versa
- Pharmacokinetics, monitoring compliance, other medication use
- An emphasis on the problems and challenges of methadone. This includes the highly variable half life and the difficulty in weaning methadone after long term exposure. Like all opioids, care should be exercised in avoiding rapid escalation and the development of opioid induced hyperalgesia. It should also be emphasized that the evidence for an NMDA receptor blockade effect of methadone is weak - at best.
- Monitoring compliance / diversion
- Methods of assessing prescribing compliance. Guidelines for conversion to methadone in opioid tolerant patients. Guidelines on the level of restriction to apply (dispensing intervals, urine testing etc). This information is obviously available, however it is still worthwhile to engage in discussions to improve decision making in difficult cases.
- Therapeutic Opioid Dependence- Management. Management of chronic pain with opioid medication.
- Patient selection for methadone prescription
- Commencing or converting to methadone in outpatients
- Is the NMDA effect a myth? How best to manage tolerance? How best to manage hyperalgesia?
- A broad range of topics including initiating prescriptions in opioid dependent patients - both for chronic/cancer pain and for patients with a combination of aberrant drug seeking behaviour and chronic/cancer pain
- Dosage regimes, particularly when changing from other forms of opioid medication. Safety issues.
- Intravenous methadone in the acute setting possibly. Perhaps informing colleagues on the potential for QT prolongation and dysrhythmia on high dose methadone when they prescribe for noncancer patients. Perhaps reinforcing the multimodal approach to analgesia so that ridiculous doses aren't prescribed. Ensuring the understanding by colleagues that tolerance in the setting of opioids is likely to be associated with significant opioid induced hyperalgesia.

- Before any discussion of methadone use is undertaken there has to be education among the whole of the medical profession particularly gps on the use and misuse of opioids in chronic pain. The specific issues I would like covered are the cardiac effects and side effects of methadone and a little on the unique pharmacology of the drug
- Assessing for diversion. Opioid conversion guidelines.
- I would be very interested in such a workshop and am addressing some of the issues at the Faculty spring course at Ayers Rock in a workshop
- Processes to satisfy legislation; processes to limit inappropriate use e.g collection of drug from pharmacy. Testing for illicit use ; what addiction services are available in the community and how does one link with them.
- Induction; swapping opioids
- Practical uses, pitfalls, kinetics, alternatives.

Additional comments

Responses from the Australasian Chapter of Addiction Medicine Fellowship:

- Will it be in different states to avoid travel?
- Prof. Stephan Shug from Perth is a very good speaker.
- I think there is generally poor understanding among GPs and specialist medical practitioners regarding the management of co-occurring addiction and chronic non-malignant pain, including clinical risk assessment and its management, picking up on all the signs of addictions and putting it all together to arrive at an appropriate clinical pathway, a duty to first do no harm in one's clinical decision-making and prescribing (including the avoidance of iatrogenic dependence and understanding that safe and evidence-informed prescribing must always take precedence over varying interpretations of clinical justice, patient choice or preference and access), the clinical pharmacology of opioid and benzodiazepine medications and clinical safety and clinical effectiveness ramifications, safe and evidence-informed prescribing practices, detecting and managing the range of subterfuges and/or aggression among patients seeking psychoactive medications, the role of buprenorphine in cases of high clinical risk, the receptor science underpinning an interaction between a full and partial opioid receptor agonist in various clinical contexts and titration of. Dose. In short, it is my observation that as a profession, and in general, the medical profession perform very poorly in these and related areas. The concerns I am expressing here relate almost entirely to patients with chronic non-malignant pain rather than malignant pain, though I have managed several patients with a terminal illness whose high risk behaviour placed themselves and others at such immediate and significant risk that we had no option other than to continue with strict clinical boundary setting including a requirement of continued daily supervised dosing.
- Frequently those treating opioid dependence ignore the issue of CNMP and those treating CNMP ignore the issue of addiction; both situations are to the detriment of our patients and frequently to society at large. Patients with both opioid dependence and CNMP are very difficult to assess and treat, but also have the most need of appropriate treatment. Marijke Boers and I made a brief presentation about this for the recent Auckland APSAD conference.
- Tasmania has rapidly increasing numbers of GP patients getting opiates for chronic pain with totally inadequate Pain Clinic facilities for assessment and management and generally inadequate resources to deal with them. I consider methadone an excellent and under-used opiate analgesic but close supervision of use is essential.
- I am a psychiatrist and see patients with chronic pain syndromes.
- There is increasing evidence that pain management can be improved with monitoring of the levels of various opioids in the blood. I have extensive practical experience in the area. I manage over 50 Opioid Substitution patients on methadone and buprenorphine as well as 150 chaotic pain and dependence patients, who are managed on most available opioid-like analgesics. I have some experience in Palliative Care Medicine as I worked as a consultant to the Daw Park Hospice. Dr Dilip Kapur uses double blind infusions to assess pain response and regularly uses opioid levels to assess pain response.

Responses from the Australasian Chapter of Palliative Medicine Fellowship:

- Conversion ratios always seem so confusing that I have no confidence in its use.
- Rarely use it, but my lack of knowledge contributes to me possibly not considering to use it. Is there any paediatric information on methadone?
- I'm concerned about introducing the problematic concept of 'addiction' into palliative medicine. Therefore don't favour this joint project.
- I see a lot of patients with ESRD and methadone is a sound option
- Need to develop an instruction sheet for E.D's for patients with dependency requiring analgesics
- Methadone is a unique pain killer with complicated pharmacology. It is important that palliative care specialists maintain skills and familiarity with prescribing it.
- Dose escalation in illicit drug users
- Harm minimization in illicit drug users who also need palliative care
- Could the session be placed on DVD. Can this session count for CPD?

- Can a web-based resource linked to CPD be made?
- Dr Barry Taylor is Director of CPD for the RACP and works at our hospice. He would be happy to help organise a workshop +? Make RACP resources available.
- Results recorded are from an audit conducted on these questions using drgs/database palliative care.
- A seminar of this nature and discussion would be very useful.
- This will be a really useful workshop especially if it could be a travelling one that can be brought to regional meetings - ie, 1-2 speakers only with portable slides -
- (see comments in accompanying email).
- Need opportunity to exchange ideas and stories.
- I think this would make an excellent workshop.
- Wrt. Q9: The difficulty with available literature is that there is such a range of conflicting approaches advised.
- Happy to help with this, as I feel as though I am very experienced in this field.
- As the literature on conversion and commencement regimens is so variable, my practice has varied over the years. My latest practice is currently guided by recommendations at ANZSPM Conference, in discussion lead by Kate Jackson from Monash. She presented a good paper. Andrew Skeels from Canberra has presented some good cases in past years; cautionary tales of narcotisation. Both would be good speakers to invite.
- It would be fantastic to bring together the methadone experience of those working in these different areas. Invite Geoff Gourlay too.
- Q.7 is a little difficult to answer as we often have no idea of what people are using illicitly. They may be abusing many drugs. It is often easier to get a past history than a current one.
- Q.8 - unable to answer as confusing - do you really mean 'who have NOT been illicit drug user' or do you mean 'who HAVE BEEN illicit drug users'? If it is the latter my answer is NO, if it is the former, I am unable to answer.
- A workshop in Qld. Would be good.
- Would need seminars in each state, also each state has different practices and different state rules, would be good to include gps at some stage if we can get some consensus at specialist level (which may be hard as the evidence on which to base a seminar will be very heavily opinion based). However I think its a good idea to at least start discussing this each amongst Palliative Medicine, Addiction Medicine and Pain Medicine at specialist level.
- I have worked with others who prescribe methadone more readily than I do, with several different theories on why they use it and in what doses. The different 'theories' contradict; i've seen all of them work in some and fail in many.
- Good for trainees.
- I think this would make an excellent workshop
- Would be very interested in this workshop, add me to list if there is one.

Responses from the Faculty of Pain Medicine Fellowship:

- Methadone in my opinion is a very good and useful drug and I would support increasing education
- The problem is not just with methadone, inappropriate or over the use of fentanyl patches and tramadol would fit into this education program as well.
- Would favour an online education module
- Saturday course would be ideal
- It is important that such a course be offered in each major city as we cannot all come to Sydney where the college of addiction medicine is located.
- I regularly have excellent results using methadone at very low doses eg <5 mg per day in the elderly, children and in pregnancy. There is very little literature to back up my practice and the support of the college would be appreciated.

- How and when to reduce methadone dose
- Practical handbook summary for guidelines are needed.
- Can you please do it as the faculty refresher day? I'm sure there are anaesthetists who are not in pain medicine who would be interested too.
- Many drug abusers who enter our service refuse methadone, even if recommended for pain relief, and subsequently do not remain under our care for long. Strategies for engaging these patients would be valuable
- Methadone tablets for licit drug abuse: Phodin A; Eur J Pain 2006: 10: 271
- The diversion of methadone with mortalities is the reason that I don't prescribe it more often. If requires a patient who is not going to divert or daily dispensing if a person has a history of illicit drug use. It doesn't help the prescriber if there is a possibility of diversion (but you aren't sure ie the majority of the time).
- Buprenorphine (Norspan) patches and prn sublingual maybe a safer option to explore. Literature is limited on the combination of other opioids with Norspan patches for chronic non-cancer pain and this is an important deficit. The available literature is based on high dose buprenorphine doses used in Addiction Medicine which may not reflect the wider possibilities in Pain Medicine. I am trialing Norspan patches with sl prn on Acute Pain Rounds, and Norspan patches with combination analgesics (if needed) in Outpatient settings. I think this approach is being developed in several centres around Australia.
- Spent 8 years running obstetric & gynae pelvic & palliative gynae at Nat Womens in Auckland. Lots of methadone program mums and we used methadone for osteoarthropathy of pregnancy when all else failed. Currently I am in ICU at North Shore Auckland so lots of addicts in trouble, and still in pain clinic at Auckland TARPS
- - I work in a Drug and Alcohol unit. My practice is almost exclusively in patients on methadone or buprenorphine maintenance. I think it would be very helpful for Pain Medicine trainees and clinicians to spend time in a Methadone unit.
- Strong support programme
- My experience with prescribing methadone is in the US in patients who were not addicted or who had a PHX of abuse for pain management when they could not tolerate other opioids or were escalating and already on high doses and tolerant. I do not have a license to prescribe it in Aust.
- When is Australia going to have access to the IV form?
- The concept of a workshop is excellent
- Q3 & 4 are unclear. I am confident that I know the current literature and have 25 years of methadone prescribing experience. Every patient, tolerant and naive, responds differently. I am not confident that I can predict responses to methadone
- For the course to have a significant impact it would need to be held in multiple cities to improve attendance.
- Are we discussing use of methadone tablets or syrup or both?
- Very challenging area.
- I look forward to a multi-disciplinary approach incorporating psychological assessment and management.
- The ideal time to hold a course would be FPM/ANZCA ASM
- Given the current extent of diversion of opioid pharmaceuticals into the drug abuse arena, what controls would be indicated and if methadone liquid were prescribed as pain treatment would the prescribing practitioner have the same responsibilities and liabilities regarding child safety as occurs in addiction medicine practice.
- We use methadone in the acute and subacute postoperative pain setting in selected patients, as well as some chronic pain patients. It has some benefit. In general I would prefer none of the chronic noncancer pain patients to be on opioids. I consider methadone to be the best of a crap bunch of drugs (ie opioids). I have been irritated by the dichotomy between methadone elixir for addiction medicine and tablets for pain therapy. This makes therapeutic options limited. The manufacturers should go back to providing tablets of other strengths eg 5 and 20 mg.
- Important topic with inadequate education to date
- I think it would be good to share and learn from other practitioners.