Rachel Shuster:	Hi Dana, John, and Robert! Hope you are all doing well! :)
Dana Murphy-Parker:	Hi Rachel, Good to see you!
Sandra Cagle:	Thank you
Kathryn Gadd:	Thank you for sharing the slides!
Mary Espinosa:	Watching in Laplace LA as a group in our lunch break at a OTP clinic. Good Afternoon everyone
Elena:	It would be easier to see in Presentation Mode
Bhavna Bali:	Can we enlarge the slides to presentation mode, its hard to see, thanks!
Joseph De Santi:	I agree. Can someone tell the presentor?
Jennifer Shuler:	He can't see that screen
Jennifer Shuler:	yay!
Shaun GS Murphy:	then just click the space bar to move to the next slide
Parmis Rad:	Very informative presentation. Will we receive a copy of the slides
Gabi Teed:	can you explain blind dosing/
Gloria Lewis-Bailey:	Gloria Lewis-Bailey RN MS CARN
Emily McCall:	Calling this replacement treatment is rather stigmatizing
Lisa Webb:	Hello from Cypress, Texas, Lisa Webb, LCDC, Baylor College of Medicine. lisa.webb@bcm.edu
Ellie Grossman:	agree with Emily McCall. This is medication.
Rachel Shuster:	I agree, Emily. It is really difficult for individuals to change the language used to describe people who use drugs, people in recovery, treatment, and substances themselves. This is something I am very passionate about, and I hope that we can get to a point where this language isn't used. Until then, clinicians and professionals should live the example. I appreciate your advocacy on this!
Shaun GS Murphy:	at some point in the presentation (likely best at the end, could you talk about the efficacy of Suboxone vs methadone as an MAT. thank you!
Rachel Shuster:	Wow! I didn't know that!
Terrance Rhodes:	It's amazing the responses I get from patients who didn't know about methadone. They are thankful for these programs and feel liberated from the bondage of opioid use disorder.
Heather Regelbrugge:	I would love to and think that it would be very helpful if we could talk about why methadone and not suboxone. I think that if could discuss this we might better be able to understand the research behind this presentation.
Heather Regelbrugge:	Do we not think that the freedom from opioids would be the same and/or better using suboxone?
Tiffani Wells:	Vivitrol is one of the medications that is offered to people who are incarcerted and being released soon.
Anne Lee:	^^^Agree with Heather^^^Overdose on Buprenorphine is much less likely
Tiffani Wells:	incarcerated*
Terrance Rhodes:	I believe that one of the prison's in Georgia have a RSAT where they are testing vivitrol. It's a all female facility.
Heather Regelbrugge:	Yes agreed and do these clinics who provide the methadone, give out Narcan to reverse overdose?
Elaine Haegele:	Why is the 1 year of physiological dependence required? Who decided on that time frame and how?
Julie Truitt:	The ability to have choice based on what works for the individual should be the goal. In other forms of treatment there is choice- blood pressure, gout, diabetes....
Terrance Rhodes:	That's because suboxone has naltrexone.
June Caldwell:	Exactly

Rachel Shuster:	One benefit of methadone over buprenorphine is that methadone is a full agonist whereas buprenorphine is a partial agonist. Methadone may be a better choice for individuals who are diagnosed with OUD a well as needing management of pain. Additionally, it is an individualized decision for each patient. Patients are the experts of their own bodies - we have to listen to understand
Ellie Grossman:	suboxone does NOT have naltrexone in it. It has naloxone in it, just as a safety mechanism in case of illicit injection. when taken sublingual, the pt doesn't get any naloxone.
Betty Humphreys:	suboxone has naloxone not naltrexone
June Caldwell:	Buprenorphine and naltrexone = Suboxone
Terrance Rhodes:	Yes. Our clinic gives out Narcan.
Emily McCall:	We should advocate for access to all paths to recovery. Multiple pathways is the way to go while recognizing what the evidence supports.
Julie Truitt:	To "punish" a group of people because of what might happen to someone is not a good practice
Heather Regelbrugge:	I completely agree that choice gives control back to our clients. I am just trying to understand.
June Caldwell:	Correction: Buprenorphine and naloxone = Suboxone
Rachel Shuster:	Correct, Ellie and Betty. Suboxone and Zubsolv are brand-name formulations of buprenorphine/naloxone (not naltrexone which is Revia/Vivitrol)
Terrance Rhodes:	Sorry. My apolgies
Rachel Shuster:	Absolutely, Heather! :)
David Atchley:	The patients I treat who were using heroin or fentanyl IV don't seem to recieve sufficient relief from their withdrawal symptoms from buprenorphine/Suboxone. They may try it but almost always wind up switching to methadone.
Maureen Mead:	NAS shorter with Buprenorphine question methadone "GOLD STANDARD"
Anne Lee:	^^^Buprenorphine prevents Overdose because its binding coefficient is much stronger and it reaches a plateau at higher doses, it will not cause greater and greater respiratory depression with higher doses. Its because it is a Partial Agonist ****
Gabi Teed:	agreed Maureen, I was going to make that point
Emily McCall:	Comparative effectiveness of treatment: Wakeman SE, Larochelle MR, Ameli O, et al. Comparative Effectiveness of Different Treatment Pathways for Opioid Use Disorder. JAMA Netw Open. 2020;3(2):e1920622. doi:10.1001/jamanetworkopen.2019.20622
SUSAN MARTIN:	Suboxone is what is first line treatment in ED's after an opioid overdose and safer and can be continued as a maintenance medication by your Primary Care.
Jere Brewer:	Are you going to address Opioid Induced Endocrinopathy?
Rachel Shuster:	David -- I have found that sometimes dosing is insufficient. With fentanyl and fentanyl analogues, sometimes individuals need more than just 16 mg/day
Emily McCall:	I truly don't mean to be critical, but we should not be using stigmatizing language such as abuse
Terrance Rhodes:	Agreed. I thought the correct language was " Use Disorder."
maclennm:	what do you ean that there is no blocking dose for fentabyl?
Rachel Shuster:	I agree, Emily. A great alternative for "abuse" is "misuse" or "non-medical use"
Heather Regelbrugge:	The stigma is so harmful to our clients.
Rachel Shuster:	Terrance - I like that too. The only caveat is that not all substance use qualifies as diagnosable SUD. So, I try to either use "substance misuse" when talking broadly and "substance use disorder" when speaking specifically of the diagnosis

Terrance Rhodes:	That's interesting Rachel.
Patrick Anderson:	I don't understand why this had to turn into a methadone vs suboxone debate. This presentation is just about methadone then and now. Not methadone compared to other treatment modalities.
Emily McCall:	NIDA has a wonderful resource for words matter
Rachel Shuster:	Maclenm - unsure if your question is towards me. There is a "blocking dose" for fentanyl. Because it's stronger, sometimes individuals need more than 16 mg/day. Sometimes prescribers are uncomfortable with this because they have learned that 16 mg should saturate the receptors. Higher doses are safe when used in appropriate populations. It can help to do a COWS after observed dosing of 16 mg
Terrance Rhodes:	I've had to explain to some of my patient's who are struggling with high risk situations that most of the pills on the street are laced with fentanyl.
Raine Agner:	YES SIR - THE REGULATIONS MUST CHANGE !!
David Atchley:	I have seen this with doses going up to 32 mg per day.
Denee Foster:	32mg? WOW!
Subu dubey:	HI Dr John will we ever see MTD in our private offices for treatment for MOUD
SUSAN MARTIN:	Many federal agencies need to change their names from "abuse" to "use"
Lisa Webb:	Very informative! Thanks John!
Subu dubey:	yes
Irene Satake:	yes
Rachel Shuster:	I agree, Susan! They should lead by example!
Kimberly Myers:	we can hear
maclennm:	sp just answer a question as we can hear you.
Urmilgupta:	Informative indeed!
Tracy Szirony:	Suggestions for changing from buprenorphine to methadone?
June Caldwell:	In my pharmacy I had male patients who would claim an allergy to naloxone so they could obtain Subutex (plain buprenorphine) instead of Suboxone (buprenorphine and naloxone). Subutex was usually ordered for female patients who might become pregnant (naloxone crosses the placenta).
Rachel Shuster:	I think that going from buprenorphine to methadone can be rather seamless. It is transitioning from methadone to buprenorphine (and buprenorphine to naltrexone) that can be difficult
Maureen Shogan:	Buprenorphine crosses the placenta as well
David Atchley:	To change from buprenorphine to methadone, wait 24 hours from last dose and then start methadone.
Glenn Field:	We actually went farther - - we did "hiddn detox", by lowering meth by 2.5 mg for 10-14 days, then lowering it agin if patient didn't complain. Hardly ever worked
Casey Ploof:	Tracy- Transitioning from partial to full opioid agonist is relatively easy. Most recommend holding partial for one day (if even that), then beginning methadone at lower dose with goal of titrating up.
Andy Lemons:	Can skin test for naloxone “allergy “ if need be
Arielle Gerard:	Some patients report headaches with the naloxone.
Casey Ploof:	they can be instructed to spit out saliva for side effects, such as headache
Dr Juma:	How many your patients who are at 120mg usually use 80mg and sell the rest?
kaye meier:	are you aware of any clinics that use medical technology to alleviate withdrawal symptoms so that individuals can go into MAT programs without the fear of withdrawal symptoms? Thanks!
Shaun GS Murphy:	thank you for addressing that. we offer both services. and we hear various things on both.

Arielle Gerard:	Also need to be down to methadone 30mg before you switch to buprenorphine.
Dr Juma:	Do you use Buvidal? Long acting Buprenorphine?
maclennm:	what is the usual dose of sbx you ar tlkaing about? what about sublicade?
Jill Lopez:	What is recommended for pregnant women?
Sandra Cagle:	Do you need to do routine EKG monitoring on the larger doses of methadone due to prolonged QTc interval?
Gabi Teed:	suboxone or Subutex is recommended in pregnancy
Jill Lopez:	Thank you
Arielle Gerard:	Pregnant women can use methadone or bupe (ideally Subutex without naloxone). Both evidence-based & safe as long as there's no substance mixing.
Jill Lopez:	thank you
Terrance Rhodes:	Some doctors prefer to prescribe 8mg of suboxone during induction phase.
Arielle Gerard:	Methadone safe & recommended in pregnancy as needed. Breastfeeding ok.
Maureen Shogan:	May breast feed on either buprenorphine or methadone
Laura Levine:	There are also some micro dosing induction protocols to start bup in patients on methadone
Constance Flynn:	The switch can be challenging from Methadone to Suboxone but it is possible. Lower dose to at least 30mg if possible and then wait until they score > 10 on COWS. If precipitated withdrawal occurs with first Suboxone dose, just give more.
David Atchley:	precipitated withdrawal is not from the naloxone. it is from the buprenorphine
Maureen Shogan:	Rooming in with mom for 96 hours cuts down on need for baby medication and reduces LOS
maclennm:	naloxone in SBX HAS NO EFFECT!!! It is not bioavailable. You are talking about the agaonist/antagonist nature of buprenorphrine.
Parmis Rad:	What is the dose at which EKG is run?
Parmis Rad:	And do you do EKG in house or refer out?
Arielle Gerard:	I like baseline EKG for all but some limit them to family hx long QT syndrome or 'high dose'. But even a small dose can be 'high' for some.
Elaine Haegele:	Why a whole year to establish physical dependence though? People can develop physical dependence in less than a year… How common is it for programs to have this regulation? Can providers or clinics request exceptions for patients with less than a year of physiological dependence?
David Atchley:	Research says that there is no utility in doing methadone peak and troughs unless you are concerned that the patient is a rapid metabolizer.
June Caldwell:	Methadone pharmacokinetics are interesting. Methadone may persist in the liver and other tissues; slow release form tissues may prolong the pharmacological effect despite low serum concentrations.
Susan Tatum:	Could you please say more about the fact that you are seeing methadone work better for individuals using fentanyl, benzos, (and there was a third you mentioned) than Suboxone? Seems a little counter intuitive given the dangers of methadone if individuals continue to take with fentanyl or Benzos. Thank you
Arielle Gerard:	Fentanyl increases tolerance. Bupe can't cover cover who have high tolerance, only methadone can. Love bupe but methadone fills gaps that it can't.
Arielle Gerard:	cover patients*
kaye meier:	Fantastic presentation - THANK YOU!!!
Shannen Lyons:	Agreed Arielle- Also Both methadone and Suboxone are high risk when using benzos. in general
Emily McCall:	Methadone and benzos are a super dangerous combo. The respiratory depression risk is higher than suboxone
kaye meier:	Agree Emily - patients need to be monitored for OIRD.
Arielle Gerard:	Agreed. Need to talk more about dangers of mixed use with patients esp. with how many ppl are using benzos.

Parmis Rad:	How is alcohol use handled?
Dr Juma:	How many of your patients use on top?
Arielle Gerard:	In my experience, similar to re: counseling on resp. Depression.
Arielle Gerard:	To Benzos*
June Caldwell:	How about marijuana use?
David Atchley:	John, At your facility do you increase patient's doses until they are withdrawal-free for a full 24 hours?
Allison Koetter:	I missed what he said about benzos- does he impose a limit of their methadone dose if they are positive for benzos?
Arielle Gerard:	Cannabis has no evidence for increasing resp. depression.
stephanie corrente:	you mentioned the over representation of Caucasian in those receiving treatment. Are you tracking disparities in other populations as well? For ex. indigenous populations
Raine Agner:	What do you mean AMPHETAMINES take it out of your system? Take Methadone out?
David Atchley:	Amphetamines increased patient's metabolic rate, causing their methadone to wear off faster
Jill Lopez:	Thank you for such great information! Good to learn about our pregnant population
Tracy Szirony:	Any concerns with gabapentin ???
Emily McCall:	For procedural pain, there's no difference in using Subutex vs suboxone. There is for methadone vs suboxone
David Atchley:	For 24 hours
Arielle Gerard:	No evidence for gabapentin causing resp. depression in my experience.
Irvin Williams:	As historical reference, Cincinnati had 21 day methadone detox clinics as far back as 1973, in the community and at the VA.
Gabi Teed:	lots of conflicting information ….
Elaine Haegele:	What about dose increases to address craving? Not in withdrawal, but persistent craving
Andy Lemons:	Good study from Canada showed significant higher rates of opiate associated death when combined with Gabapentin... so yes!, it's a concern
Faisal Mohsin:	Do you do methadone peak and trough levels in patients who are not stabilizing on it?
Emily McCall:	Clean is also a stigmatizing word
Loree Elahee-Lee:	what are your concerns about Rx marijuana?
David Atchley:	Gabapentin CAN cause respiratory depression. Look up information from the FDA.
Irene Satake:	Yes
Tatsiana Boutenko:	why do you switch from suboxone to subutex before surgery?
kaye meier:	Do you mean physiologically monitored, to prevent OIRD from leading to overdose?
Ellie Grossman:	iyou don't switch to subutex before surgery. just keep the usual maintenance med onboard peri-op.