

Open letter to physicians and other health care providers facing pain management during opioid agonist therapy with methadone

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Both maintenance treatment providers and consumers are aware of the all-too-frequent and unnecessary failure on the part of treating physicians and dentists to provide adequate treatment for pain in patients being treated with methadone. This may be a result of a lack of information, simple misunderstanding, or unfortunately, at times associated with prejudice toward patients with opioid dependence being treated with methadone.

This brief correspondence is to provide simple guidelines that are evidence-based and supported by years of clinical experience.

Patients being maintained with methadone require special considerations for acute pain management in surgical or trauma situations. Methadone Maintenance Treatment (MMT) patients are often denied any analgesia and serious under-treatment of pain is very common. MMT patients develop full tolerance to the analgesic effects of the medication (methadone). During MMT a cross-tolerance develops to all opioid agonist drugs accounting for the "blockade" effect. Early research demonstrated that stable MMT patients could not distinguish 20 mg IV morphine from IV saline. The usual maintenance dose does not provide any analgesia, and adequate analgesia will require higher doses of opioid agonists given with greater frequency than in a non-tolerant patient.

Methadone has a half-life of 24-36 hours but analgesic effects are from 4-6 hours, similar to morphine in both potency and duration (Goodman & Gilman). Morphine, dilaudid, codeine, etc. are appropriate for the treatment of acute pain in the MMT patient.

Mixed agonist/antagonists (Talwin, Stadol, Nubain) and partial agonists (buprenorphine) must not be used as they will precipitate opioid withdrawal. Meperidine and propoxyphene should be avoided due to risk of seizures at the higher doses required to produce analgesia in opioid tolerant patients.

Summary:

1. Continue maintenance treatment without interruption.
This provides a background in which other treatment may be effective.
2. Provide adequate individualized doses of opioid agonists which must be titrated to the desired analgesic effect. The proper dose is enough!
Due to cross-tolerance the doses will likely be significantly higher than those in opioid-naïve patients.
3. Doses are usually provided more frequently than in opioid-naïve patients.
Pain that is not relieved 1-2 hours will not improve by waiting for a 3- 4 hour interval. Inter-dose intervals should be adjusted to prevent the onset of pain, not in reaction to a recurrence of pain.
4. Please call the patient's program physician above for further information.

Please treat our patients with the compassion, dignity, and respect that they deserve as you would expect us to treat a patient of yours that might need our services at some time.

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