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From methadone to buprenorphine or back to methadone. The Croatian experience

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Summary

In Croatia maintenance treatment is made widely available through a network of GP offices that covers the whole of the country. More than 50% of all GPs in Croatia have at least one patient in MT. Methadone was the only opioid agonist used for over a decade, but this changed when buprenorphine was introduced 4 years ago.

There is little difference in the regimen for the prescription and provision of the two medications: both are free of charge and are prescribed by GPs; in addition, there are no restrictions on the dose to be used or on 'take home' policy. The decision on which medication will be used is based exclusively on the clinical assessment and patient-doctor agreement.

The example of Croatia gives an opportunity to compare the acceptance of this medication by patients and doctors in situations of equal availability.

Key Words: Methadone-Buprenorphine Transfer, GPs

1. Introduction

Methadone and buprenorphine are the most widely used opiate agonists in the treatment of heroin addiction worldwide. Numerous studies indicate that the clinical characteristics and effects of both medications are similar and comparable [1, 3-5], but for different reasons the model for their provision is substantially different in many countries. Thus, the real 'public health value' of both medications remains strongly biased.

In Croatia maintenance treatment has been made widely available through a network of GP offices covering the whole of the country. More than 50% of all GPs in Croatia have at least one patient in MT. The model used for patient care is shared between Centres for Outpatient Treatment and General Practitioners.

The role of the Centres comprises: clinical assessment, the recommendation of Meth. or Bup. treatment, periodic evaluation, urine testing and psychosocial counselling,

The role of General Practitioners (GPs) in an Opioid Treatment Programme (OTP) is to prescribe methadone-buprenorphine, provide methadone dispensing, supervise consumption, and prepare 'take home' doses.

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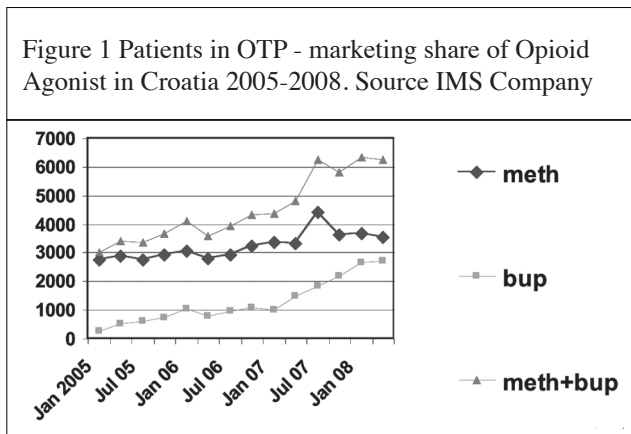
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The prescription and dispensation regimen for methadone is characterized by: a recommendation issued by a Centre, prescription by a GP, supervised consumption in a GP's of-

office in the first few weeks of treatment, 'take homes' as the usual form of dispensing. In the case of buprenorphine, the prescription and dispensation regimen is characterized by: recommendation issued by a Centre, prescription by a GP, dispensing in a pharmacy as happens with any other medicine, and exceptionally supervised consumption

It is important to stress that both methadone and buprenorphine are free of charge for virtually all patients.

Since its introduction in 2004 the use of buprenorphine has been rising steadily, while the use of methadone has remained stable (Figure 1).



The aim of this survey is to compare acceptance of these two medications in the 'real life environment' imposed by the model that requires this kind of availability.

Specific aims include evaluation of the: drug of choice, retention in treatment, and definition of which drug 'works better' on the basis of the number of switches.

In the city of Porec (30,000 inhabitants) there is a Centre for Outpatient Treatment that supports the network of 13 GPs who have heroin addicts in maintenance treatment. Porec is an example of the good level of cooperation established between Centre and GPs that can be quoted as an example of how the Croatian model for treating of heroin addicts works.

2. Patients and methods

Heroin addicts who asked for and met the clinical criteria for Opioid Agonist (OA) treatment in the Centre for Addiction Treatment in Porec from 2005 to 2007. The only exclusion criterion was that of having been in Opioid Maintenance treatment recently (less than 3 months), prior to induction. The total number of patients was 71. Baseline characteristics are reported in table 1. The medicines used were methadone, in 5 mg. tablets, and buprenorphine, in 2 mg. s.l. tablets, which in that period were the only forms of these medications available in Croatia.

Patients got information on both drugs (intrinsic activity,

Table 1. Baseline sample characteristics (N=71)

	M (min-max)
Age (yrs)	24 (17-34)
Heroin Use (yrs)	4.7
	N (%)
Gender (males)	62 (87.3)
i.v. use	35 (49.2)
HIV positive	0 (0.0)

side-effects, overdose potential, dispensing regimen, and its implications on working schedules and travel costs. Unless there were compelling reasons to the contrary, the patient's preference for one or other drug was respected. Most of the patients had had previous experiences with one or both medications, mostly illegally (table 2). From the start all the patients were informed that the drug could be switched at any time in response to a reevaluation of needs and results.

Table 2. Patient's previous experience with methadone-buprenorphine (N=71)

	%
Methadone or buprenorphine	74.4
Methadone	64.4
Buprenorphine	53.2
Both	43.2

3. Results

After an interview, the initial assessment and the doctor-patient agreement, the two medications were chosen in almost equal numbers of cases. Dose at the end of induction was 43,2 mg for methadone and 4,5 mg. for buprenorphine (table 3).

About 20% of the patients in both groups changed their medicine of first choice, with no significant difference between groups. There was a significant difference in

the moment of the switch. This happened at 3,2 weeks after induction with buprenorphine and 15.3 months with methadone (table 4).

There were no significant differences in retention in treatment in the two groups (table 5).

Table 3. Drug of choice and doses

	N	%	Final dose
Methadone	34	47.8	43.2
Buprenorphine	37	52.2	4.5

Table 4. Nr of switched to and the time after induction

	Switched to	Nr	%	Time after induction
Methadone	Bup	7	20.6	15.3 mts
Buprenorphine	Meth	8	22.0	3.2 weeks

Table 5. Retention in treatment

	N	%	Dropouts	Retention %
Total	71	100	15	78.9
Buprenorphine	37	52.1	7	81.1
Methadone	34	47.8	8	76.5

4. Discussion

This small-scale survey from one of the centres in Croatia demonstrates what really happens with the patients and their treatment in the course of time.

The main outcome feature – retention in treatment – was virtually identical in the two groups, but, as must be stressed, was generally very high. The final doses chosen were low when compared with the recommended ones, but it was adjusted according to assessment and patients preferences. What is typical is the phenomenon of patients who request and sometimes insist on receiving lower doses, driven by the idea of ‘gradual detoxification’.

There were low, virtually identical percentages of switches in the two groups. This was probably due to good assessments and respect for the patients preferences.

Lastly, it is important to stress that in the model where the two opiate agonists have similar prescription and dispensation procedures (with slightly more comfort on the buprenorphine side) and where the patients’ preferences are respected, the level of acceptance and the main indica-

tors for the two medications were virtually identical. This is consistent with the interesting and controversial Swedish 3 G study, where the authors conclude that “close to half of patients do well on bup/nlx” [2]; in this case, however, there was no “stepped care strategy”:

5. Conclusions

Opioid agonist treatment in Croatia is provided exclusively in Primary Health Care settings. Methadone and buprenorphine are provided under similar conditions that enable comparison of their effectiveness and acceptance in ‘a real situation’.

In Porec, with 30,000 inhabitants, 13 GPs provide maintenance treatment for their heroin-addicted patients in collaboration with the local Centre for Addiction Treatment. The results of follow-ups with patients new to treatment demonstrate that methadone and buprenorphine receive a virtually identical degree of acceptance by patients and providers. It confirms the importance of both medications for the maintenance treatment of heroin addicts.

Monitoring and respecting patients’ preferences seem to be crucial in obtaining good outcomes, especially in terms of retention in treatment.

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