Washington doctors detail pros, cons of fentanyl addiction treatment methods

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There was a time, not long ago, when doctors had national protocols for using a leading opioid treatment drug.

Heroin was the opioid king then, and it was fairly smooth to transition

patients onto the medication buprenorphine, usually given as Suboxone, which reduces cravings for illicit opioids. Far trickier has been starting the medication with patients using fentanyl, a drug up to 50 times as powerful as heroin that's taken over the opioid market in the last several years.

Fentanyl's unique properties can send those starting buprenorphine into an agonizing state of sudden, or "precipitous," withdrawal, leaving providers scrambling to devise new approaches. But no universally adopted treatment protocols have taken hold so far.

"It's just kind of word-of-mouth and what's happening in your local community," said Dr. Nate Kittle, who oversees addiction care across HealthPoint, a nonprofit running primary and urgent care clinics throughout King County. "We're still learning the best ways to do this."

Doctors are trying a variety of methods:

Microdosing

Patients slowly build up the amount of buprenorphine they take, so they don't immediately go into an intense state of withdrawal. "The problem with this method is that it's complicated," Kittle said. A patient might start by cutting up a 2-milligram dissolvable strip of Suboxone (a widely used medication containing buprenorphine) into fourths and taking one of those microdoses the first day, maybe two the second and so on.

"The success rates are pretty low," Kittle said.

Aside from the difficulty in keeping track of the regimen, patients typically fear taking too much buprenorphine because they know it might cause withdrawal, he explained. So they get stuck.

There's also a constant choice patients must make: take their next dose or go back to fentanyl.

Macrodosing

Emergency room doctors are leading this method of giving large doses of the medication to patients on day one. Kittle describes the approach this way: "Just give them as much buprenorphine as we can and kind of overcome the fentanyl in their system."

Doctors have been surprised to find patients don't necessarily go into precipitated withdrawal.

"It's hard to explain," said Dr. Mark Duncan, a UW Medicine psychiatrist who treats addiction and co-directs a statewide learning collaborative. "The thing that I have come to appreciate is that a lot of the things that we took as fact were not accurate."

Emergency room physicians sometimes use this method while treating patients who have overdosed and received the reversal drug naloxone, which clears the system of fentanyl and makes it more receptive to buprenorphine.

In an emergency room, Duncan noted, providers can "hold a person's hand" and offer comfort medications.

Dr. Lily Lo said she and her colleagues are considering macrodosing patients at their Centralia drug treatment clinic, operated by Gather Church, where providers could monitor people for a couple of hours. But, she said, they're nervous about introducing the treatment option.

"We don't want to make somebody sick," she said. "Our first role is do no harm," she said.

Long-acting medications

Over the last year, Duncan has been using Sublocade, an injected medication that continuously releases buprenorphine for a month.

"It has been by far the most effective treatment I've seen for people who are using fentanyl," he said.

The big advantage, he and others say, is that Sublocade, which forms a depot of medication under one's skin, can only be surgically removed. So people are more or less committed for a month.

Another bonus is people don't have to fixate on taking their next dose of medication, which can feel eerily similar to feeding an addiction, said Gather care navigator Brooke Reder. Sublocade frees their mind of old habits, she said.

The manufacturer's instructions call for people to be on the short-acting form of buprenorphine for seven days before starting Sublocade, in part to make sure they can tolerate the medication.

"Everyone's kind of quickly realized that you don't really need to be on it for seven days," Duncan said. Maybe just one day or less.

Duncan, who's tracking patient experiences to share with the medical community, might even skip giving an advance dose of buprenorphine if someone has previously taken it without experiencing an allergic reaction.

Likewise, doctors are experimenting with how long to ask patients to abstain from fentanyl before starting on Sublocade. It's tricky because buprenorphine activates the brain's opioid receptors at only a 60% level. If fentanyl remains in the system, activating receptors at a higher level,

the medication could make them feel worse, not better.

Duncan may ask patients to abstain for about 24 hours, "but if that's too much, I'll say, 'OK. What can you tolerate?' If it's six hours, 'OK, then, start there.'"

In May, the U.S. Food and Drug Administration approved another long-acting, injected medication, called Brixadi, which has two versions, one releasing buprenorphine for a week, the other a month.

Adding ketamine to the mix

Some physicians are trying to ease the transition to buprenorphine by using tiny doses of ketamine, an anesthetic sometimes used recreationally because of its hallucinogenic effects.

Dr. Lucinda Grande, a physician at Lacey-based Pioneer Family Practice, had for years prescribed ketamine for chronic pain and depression when she saw research suggesting the drug holds promise for alleviating intense withdrawal symptoms.

Over the past year, she started using the method with addicted patients, refining her approach. "It definitely helps everybody to some degree," she said, adding one patient smiled through the process, with no withdrawal symptoms at all. "I'm really ecstatic."

Accessing and using ketamine adds a complicating factor, though. "It's too early to know if it will have widespread utility," Kittle said.