

WISAM Newsletter: May 25, 2017 Updates and Teleconference

Attendees: Aleksandra Zgierska (President), Matthew Felgus (President-Elect), Brian Lochen (Treasurer), Nameeta Dookeran (Chair, Education Committee), Subhadeep Barman, Bruce Weiss, Robert Sedlacek, Dr. Alt, Chandra Reddy, James Shropshire, Ted Hall, William Gaertner, Agron Ismaili

New trends in opioids across the State

Conference attendees mentioned different forms of **fentanyl** (eg, carfentanyl; fentanyl-laced other drugs, including heroin) as rather common drugs of abuse; they are particularly lethal due to their potency and the fact that users often may not know that they are taking fentanyl. On occasion, other unusual opioids were also noted, such as a designer opioid **U-47700** found on autopsy of an overdose victim.

In addition, there has been a rising awareness of **loperamide abuse**. Dr Hall discussed a case of a recent patient taking 10-15 tablets of loperamide per day in an attempt to self-detox off heroin. This patient received a long-acting naltrexone injection, which led to a precipitated severe withdrawal, with symptomatology typical for opioid withdrawal and pronounced GI symptoms. The withdrawal symptoms lasted approximately 1 week and responded to the usual opioid withdrawal management, with caveat of using more than average dicyclomine for the GI spasm. In addition, others mentioned cases of people taking 20-80 loperamide pills daily.

Loperamide is a peripherally-acting opioid, interacting with mu-opioid receptors in the gut. Under usual circumstances and dosing regimen, it does not have a significant absorption from the gut and does not cross the blood-brain barrier. However, when used in high doses or taken jointly with substances that increase its blood-brain barrier permeability (eg, ketoconazole; quinidine – of note, quinine is a key-ingredient in tonic water...), it can exert central morphine-like effects. Loperamide taken with quinidine was found to produce respiratory depression, indicative of central opioid action. We may see more of loperamide abuse as the information about loperamide as a medication to self-manage opioid withdrawal is circulation on the web; that's how Dr. Hall's patient found out about and started using loperamide...

Loperamide was shown to cause a mild physical dependence in preclinical, animal studies, with symptoms of mild opioid withdrawal observed following its abrupt discontinuation. When originally approved for medical use in the US, loperamide was classified as Schedule II Controlled Substance. Subsequently, it was transferred to Schedule V in 1977, then decontrolled in 1982. In 2015, case reports were published describing extremely high-dose loperamide as "poor man's methadone." In 2016, several reports were published about severe cardiotoxicity due to high-dose loperamide abuse, including two deaths, with the authors calling

for the FDA to limit the availability of OTC loperamide in an analogous manner to that of pseudoephedrine, so that it can be sold only in limited amounts.

MacDonald R et al. Loperamide dependence and abuse. *BMJ Case Reports*. 2015: bcr2015209705. [doi:10.1136/bcr-2015-209705](https://doi.org/10.1136/bcr-2015-209705). [PMID 25935922](https://pubmed.ncbi.nlm.nih.gov/25935922/).

Dierksen J et al. Poor Man's Methadone. *Am J Forensic Med Pathology*. 2015, 36 (4): 268–270. [doi:10.1097/PAF.0000000000000201](https://doi.org/10.1097/PAF.0000000000000201). [ISSN 0195-7910](https://pubmed.ncbi.nlm.nih.gov/25935922/).

Eggleston W. Loperamide Abuse Associated With Cardiac Dysrhythmia and Death. *Ann Emergency Med*, 2016, [doi:10.1016/j.annemergmed.2016.03.047](https://doi.org/10.1016/j.annemergmed.2016.03.047). [ISSN 0196-0644](https://pubmed.ncbi.nlm.nih.gov/27140747/). [PMID 27140747](https://pubmed.ncbi.nlm.nih.gov/27140747/).

Mukarram O et al. Loperamide Induced Torsades de Pointes: A Case Report and Review of the Literature. *Case Reports in Medicine*. 2016: 1–3. [doi:10.1155/2016/4061980](https://doi.org/10.1155/2016/4061980). [ISSN 1687-9627](https://pubmed.ncbi.nlm.nih.gov/27140747/).

Wightman RS et al. Not your regular high: cardiac dysrhythmias caused by loperamide. *Clin Toxicology*. 2016, 54 (5): 454–458. [doi:10.3109/15563650.2016.1159310](https://doi.org/10.3109/15563650.2016.1159310). [ISSN 1556-3650](https://pubmed.ncbi.nlm.nih.gov/27022002/). [PMID 27022002](https://pubmed.ncbi.nlm.nih.gov/27022002/).

Guarino B. [Abuse of diarrhea medicine you know well is alarming physicians](https://www.washingtonpost.com/archive/local/2016/05/04/local-abuse-of-diarrhea-medicine-you-know-well-is-alarming-physicians/2016/05/04/). *The Washington Post*. May 4, 2016.

Although the use of **kratom** is more prevalent in other states, we have only seen isolated cases of kratom abuse and related physical dependence with withdrawal symptoms similar to opioid withdrawal; treatment of kratom withdrawal is similar to that of opioid withdrawal, but symptoms may even be more severe and refractory than those due to “regular” opioids, as noted in a case report published by WISAM’s member, Dr. Galbis-Reig (<http://www.wisconsinmedicalsociety.org/WMS/publications/wmj/pdf/115/1/49.pdf>).

The tele-conference attendees also noted the use of **promethazine and diphenhydramine** as potential “enhancers” of other opioids or alcohol. Dr Barman has reported several recent cases of **dextromethorphan** abuse. Of note, his lab routinely tests for dextromethorphan and kratom on urine drug testing, in addition to a comprehensive plethora of more prevalent substances of abuse. Many labs do not perform such comprehensive testing, which may contribute to under-diagnosing of cases related to less-typical drugs.

Overall, it is hard if not impossible to keep up with all the new designer opioid analog drugs. The Wisconsin regulatory board is trying to keep up and Wisconsin in general is ahead of many other states on banning these drugs. Based on the local and national autopsy results from those who sustained an overdose death, most overdose deaths are related to a concomitant use of multiple sedating substances, with prescription-based opioids more common than illicit opioids (heroin, designer ones, etc). Many of the overdose deaths have been linked to co-prescribed opioids and benzodiazepines. According to Dr. Barman, almost 100,000 prescriptions for opioid and benzodiazepine combination were issued in Wisconsin in the recent quarter of 2017. This is a high number, but in fact it slightly decreased from the previous quarter. **Dr. Barman will lead a discussion on opioid and benzodiazepine co-prescribing and ways to effectively help patients taper off benzodiazepines during our next teleconference in June.**

New trends in methamphetamine use across the State

Methamphetamine use is common in the northern part of the state and is slowly yet progressively moving south.

Ways to efficiently check the PDMP database in routine clinical care

Some clinicians use delegates (eg, medical assistants, MAs) to prepare information on all patients to be seen in a given day. Dr. Barman's MA checks the PDMP and "pulls" the data summary into a single PDMP per patient, then emails such PDF summaries to him for all patients to be seen on that day who are known to need a prescription for controlled substances. Emailing of protected, confidential patient information can be possible within one health system, assuming this health system has adequate firewalls and other ways to protect emailed data; this approach may not be secure if emailing outside of such protections.

Many prescribers check the PDMP data by themselves, but typically "batch" such checks and do it for all patients scheduled on a given day (either on the morning of, and the day before, the scheduled visits). It typically does not take more than 15-20 mins for 12-18 patients. Some prescribers use a hybrid of engaging the delegates and checking by themselves; if a trained delegate flags the patient as 'problematic,' for example due to the PDMP-issued alerts, then the clinicians log-in to assess the record by themselves. Prescriber is always responsible for PDMP information even if a delegate checks it.

It would work best if the PDMP was integrated into the EHR. Several vendors (including Epic) have promised a future interface with PDMP but none are imminent. Many health systems have introduced an 'alert' to have prescribers acknowledge their check and awareness of the PDMP content before they can e-prescribe a controlled substance. Dr. Dookeran puts documentation of the PDMP check to the note section of each controlled substance prescription. It seems that there are still prescribers in Wisconsin who do not seem to understand why they need to check the PDMP or that it is the law in Wisconsin.

Addressing workforce shortages, including strategies to help primary care and others start treating addiction

Several ideas were discussed as possible means to improve patient access to addiction care:

- 1) Telemedicine
- 2) Encouraging addiction specialists to travel to underserved areas to see patients at the local clinics and/or to mentor clinicians at these clinics to treat addiction issues
- 3) Mobile clinics, eg, vans equipped in appropriate equipment and allowing for electronic charting and PDMP access, to bring a specialized team to rural areas
- 4) There are not enough specialists though, therefore, it is important to create feasible pathways for non-addiction trained primary care clinicians to learn about addiction and its treatment, and feel empowered to implement this knowledge in their clinics.
 - a. Dr. Shropshire, a family physician who is thinking about initiating treatment for patients with addiction in his primary care clinic, has been inspired by the new opioid prescribing guidelines. Implementation of these guidelines has facilitated his learning more about opioid use disorder and its treatment. Educating primary

care clinicians may help them transition from opioid prescribers to those who also treat opioid addiction, but they need more tools.

- b. Development of mentoring structure and formal partnership between an addictionologist (Hub) and primary care clinicians (Spokes) can promote expansion of treatment for opioid addiction into primary care. The addictionologist could mentor other, non-addiction trained prescribers within a given organization and beyond; this could include a PCP shadowing an addictionologist. The Hub and Spoke model has been effective in Vermont.

Facilitation of transferring stable patients from addiction medicine practices to primary care clinicians can free up spots for more acute patients in the specialists' practices and be a less intimidating first step for PCPs to start prescribing medications for addiction. It is important to break the misconception that addiction patients equal difficult or high-burden patients.

- c. Some PCPs can be reluctant to start providing buprenorphine – yet one more opioid; but they may be more receptive to starting the use of naltrexone. Helping to set up naltrexone practice will be discussed at WISAM annual conference in Sept (see info below).
- d. Including education about addiction and its treatment in primary care residency and medical school curricula can address the workforce shortages down the road. Waukesha and Madison based Family Medicine Residencies have expressed interest. We should all try to reach out to the training programs and encourage expansion of such education – one of the options is to refer them to the upcoming annual WISAM conference (info below), especially the Saturday buprenorphine and naltrexone trainings. Ideally, both residents and faculty of the training programs would receive training.

Tele-conference adjourned at 8:01 PM.

Next WISAM Monthly Teleconference will occur on Thursday, Jun 22, 2017, 7-8 PM

Please let Cindy Burzinski, WISAM's Executive Administrator, know if you have suggestions for topics to discuss at the upcoming teleconference or if there are any errors in the current document: Cindy.Burzinski@fammed.wisc.edu

Teleconference phone-in information:

- 1) Dial the phone number 1-855-947-8255 or 1-630-424-2356
- 2) Enter the passcode 7986 842 followed by##

After June, our next teleconference will take place in October 2017.

We will NOT hold teleconferences over the summer (July-August) and in September when we are meeting in person at the WISAM annual conference.

WISAM 2017 Annual Conference will occur on Sept 14-16, 2017 in Madison, WI

Please mark your calendars for the **WISAM 2017 Annual Conference**
September 14-16, 2017, Pyle Center, Madison, WI

Thu and Fri: educational topics and workshops

Sat: buprenorphine training (AM); naltrexone training (PM); and workshop on the Wisconsin Medical Examining Board opioid prescribing guidelines (PM) that will provide the state-required opioid-related 2 CME credits.

OTHER IMPORTANT REMINDERS

The ASAM Review Course in Addiction Medicine is coming up on July 27-29 in Dallas, TX. More details can be found at: <http://www.asam.org/education/live-online-cme/the-asam-review-course-2017>

The ASAM Treatment of Opioid Use Disorder Course, includes the information on the buprenorphine waiver requirements, for physicians and NPs/PAs can be found at: <https://elearning.asam.org/buprenorphine-waiver-course>

Please remember to renew your **ASAM / WISAM membership** or consider becoming a member (open to all clinicians). More details can be found at: <http://www.asam.org/membership>

RESOURCES

TO ENHANCE CLINICAL CARE RELATED TO ADDICTION MEDICINE

FREE CSAM Webinars

These live webinars are FREE for all clinicians (4th Fri of the month, 12-1 PM PST). Current series of 12 monthly webinars is designed to support the implementation of Medication Assisted Treatment (MAT) in primary care. In general, CSAM (California Society of Addiction Medicine) offers great resources, available at: <http://cme.csam-asam.org/content/buprenorphine-resources#overlay-context=courses>

FREE Provider's Clinical Support System (PCSS) for Medication-Assisted Treatments (PCSS-MAT: <http://pcssmat.org>) and Opioid Prescribing (PCSS-O: <http://pcss-o.org>): excellent free resource, funded by a grant from SAMHSA; it offers free webinars available "real-time" or via the archived library. One can sign up for regular news emails from them.

FREE David Mee-Lee's monthly Tips and Topics, sent via email (one needs to sign-up to it), it is an excellent resource:
dmeelee@changecompanies.net
<http://www.changecompanies.net>

FREE Join Together Daily News is a news service from the Partnership for Drug-Free Kids that provides daily or breaking news on the top substance abuse and addiction news that impacts our work, life and community. It also provides original reporting and/or commentary features published every Wednesday by influential thought leaders in the addiction field or staff.

<http://www.drugfree.org/join-together/>

PAID The Carlat Report: Addiction Medicine (however, it appears to be a paid resource, ~\$109/year); a link to the copy of the recent report is attached so that you can get a flavor of what it is: http://carlataddictiontreatment.com/sites/default/files/CATR_May2016.pdf

The National Academy of Sciences (IOM) Report on Cannabis

“The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research” was published in Jan 2017; free copy is available for a limited time at the following web site:

https://www.nap.edu/login.php?record_id=24625&page=https%3A%2F%2Fwww.nap.edu%2Fdownload%2F24625.

- a. The report’s tone is generally favorable toward use of cannabis as medicine despite not-so-convincing evidence on some of the recommendations.
- b. The report is surprisingly sparse on discussing potential adverse effects of cannabis and cannabinoids (in general).
- c. The report makes recommendations regarding the need for more research.
- d. Provides should familiarize themselves with the report as patients (and other professionals) are likely to ask questions about this issue.
- e. It’s worth remembering that marijuana is illegal in Wisconsin; professional societies, including the ASAM/WISAM, do not endorse its use (as a plant) for medicinal purposes due to lack of convincing evidence for effectiveness, while, at the same time, presence of evidence for harms, including addiction (as outlined in a recent ASAM’s white paper on this topic); cannabis produces sedating effects, which can potentiate sedating effects of other substances, eg, opioids.