Case-Application: Stimulant Use in a Patient w/ OUD

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Disclosures

- Lynda – none
- Brian – none

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Learning Objectives

- Upon completion of the session, participants will
  - Identify the challenges of treating stimulant use disorder
  - Learn to improve provider/patient communication
  - Understand implications of actual interventions in real cases.

Livingston High School Alumni of the Season (Fall 2021)

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Patient X

- First contact with patient January 2017, age 30
- Presented to the hospital for DV/assault at 13 weeks of pregnancy
- Reported opioid and cocaine use and was requesting treatment for OUD
- Started using cocaine and heroin around age 16
  - $100/day cocaine
  - 120mg oxycodone daily + heroin
- Family hx of substance use disorder
- 6 children all in DCPP custody

January 2017

- Admitted to the hospital for buprenorphine induction
- After discharge, presented to the ED complaining of withdrawal
- Reported ‘bup flushed’ by boyfriend but pharmacist witnessed patient sell the medication immediately upon receiving it
- Re-admitted for buprenorphine induction
- Presented to the ED multiple times each week complaining of assault, but would leave either AMA or before evaluation
- Housing instability: ED SW tried to secure housing for patient but not accepted anywhere because she had not been adherent in the past

February 2017

- Finally induced on buprenorphine during a hospital admission
- First follow-up in out-patient addiction clinic
- Dose slowly increased over the course of the month
  - SW: 'not committed to recovery'
- Abstinent from opiates – mental health worsened
- 'terrible home environment' – sick mother, verbal abuse, chaotic household
- IOP referral but never went

March 2017

- Psychiatric admission
- Depression/SI
  - Felt to be substance-related
  - Only medication prescribed was Seroquel, which she was already on
- Social issues identified
  - Housing
  - Domestic violence
  - Volatile relationships

April-May 2017

- Multiple presentations to the ED for re-induction on buprenorphine
- Started daily observed therapy
  - ‘must come for daily dosing in order to continue’
  - ‘otherwise refer to methadone’
- Brief incarceration – was treated with buprenorphine
- Continued cocaine and illicit opiates as well as buprenorphine
- Only received buprenorphine on the days she showed up
- Delivered baby at 35 weeks – immediately placed in foster care by DCPP

October-November 2017

- Not engaged in treatment for OUD from June until October despite multiple attempts to reach her and frequent ED utilization for DV issues
- Overdosed – re-engaged
  - ‘buprenorphine not effective’
  - Injectable naltrexone ordered and administered
- Requested resumption of buprenorphine right after the injection
  - Still using opiates
  - Prior auth initiated for plan for DOT
- Lost to follow-up

April-May 2018

- Told primary care ‘I am taking a break from treating my substance abuse’ – was given a prescription for naloxone
- Addiction inpatient consultation for buprenorphine induction after pregnancy test +
  - Was observed in the hospital removing the buprenorphine tablet from her mouth during induction
  - Plan was to discharge to OTP for daily observed therapy

July 2018

- Addiction inpatient consultation for opioid withdrawal after missing two days of methadone
- Reported that she tried buprenorphine at OTP but was quickly switched to methadone
- Lost to follow-up until…

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January 2020

- Patient was in neighboring primary care office to addiction medicine clinic, noted to be overdosing
- Received 2 doses of naloxone which resulted in reversal
- Given one day of buprenorphine, planning DOT
- Long-acting injectable buprenorphine ordered
- Did actually follow-up!
  - Multiple weekly visits
  - Attended PHP
- First dose of injectable buprenorphine administered

February, March, April 2020

- Struggled with cravings – sublingual buprenorphine prescribed
- Received dose #2 and 3
- ‘does not want to continue injectable buprenorphine if she has to take additional sublingual buprenorphine to manage cravings

May-November 2020

- Received dose #4
- Refused subsequent doses
  - 'not working for me'
- Treatment with sublingual buprenorphine only
- Mother died, brother died
- 'struggling with her mood' but was taking her buprenorphine and abstaining from opiates (appropriate buprenorphine levels)
- UDS: methamphetamine, cocaine, fentanyl ('pressed?')

December 2020-March 2021

- Longer time between prescriptions, consistent follow-up
- In March, buprenorphine levels in UDS started dropping
  - Reported that she was swallowing the tabs because they were making her nauseated
  - Came in for an observed dose to reiterate proper self-administration of buprenorphine

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April-May 2021

- Started presenting a few days late for her appointments consistently
  - ‘ran out of buprenorphine’ to explain low buprenorphine levels
- Started attending regular appointments for counseling
- Cocaine use, opiate (fentanyl) use and continued very low buprenorphine levels

June-August 2021

- Lots of reported travel – Texas, Kentucky
  - Typically in a hurry
  - ‘calling from the airport’ for refills
- Using ‘the majority’ or ‘some’ of her buprenorphine
- Reports that she is calling daily to try to get an inpatient bed
- Opiates and cocaine
- Walked in, asking for injectable buprenorphine – med ordered
- No-show 9/1, 9/15…

What’s next

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Questions

- In the line of harm reduction, how long are you comfortable to tolerate and continue MAT for OUD in outpatient settings for patients who are using:
  - i. opiates/ fentanyl and/or Methadone/ Bup and cocaine
  - ii. opiates/fentanyl and/or Methadone/Bup and Methamphetamines
  - iii. opiates/ fentanyl and/or Methadone / Bup and K2, Bath salt etc
- What are your criteria to refer to a higher level of care and discharge from MAT outpatient treatment for noncompliance?

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