SUBSTANCE ABUSE IN OLDER ADULTS: AN OFTEN OVERLOOKED PROBLEM

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Learning Objectives:
- Describe the most common substances abused by older adults.
- Identify older adults who may be abusing substances including prescription medications.
- Differentiate among pharmacotherapy treatment options for substance abuse in older patients.

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Substance Abuse in Older Adults: An Often Overlooked Problem

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April 24, 2014

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• Describe the most common substances abused by older adults
• Identify older adults who may be abusing substances including prescription medications
• Differentiate among pharmacotherapy treatment options for substance abuse in older adults

Misperceptions About Substance Abuse and Age

• Substance abuse is underdiagnosed and undertreated.
• This may be due, in part, to the assumption that substance abuse discontinues as a person ages
  Although there is some decline, there is still a subset of person who will be using illicit substances in older age.
Rates of Alcohol/Drug Screening

- Subjects
  - Patients ≥ 65 years of age (N=4139) admitted to a level 1 trauma center in the Midwest between 2006-2010
  - Tested for any detectable level of alcohol, amphetamines, barbiturates, benzodiazepines, cocaine, opiates, phenylcyclidine, tetrahydrocannabinol, and tricyclic antidepressants

- Results
  - 31.5% were screened for alcohol, 12.1% screened for drugs
  - 60.9% male, 39.1% female
  - Of these, 27.1% screened positive

Ekeh AP et al. Substance Abuse. 2014;35;51-5

Rates of Alcohol/Drug Screening

<table>
<thead>
<tr>
<th></th>
<th>≥ 65 years of age (%)</th>
<th>&lt; 65 years of age (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol - any</td>
<td>11.1</td>
<td>42.1</td>
</tr>
<tr>
<td>Alcohol - &gt; 80 mg/dL</td>
<td>69</td>
<td>82.4</td>
</tr>
<tr>
<td>Drugs - any</td>
<td>48.3</td>
<td>73</td>
</tr>
<tr>
<td>Opiates</td>
<td>92.9</td>
<td>62.5</td>
</tr>
<tr>
<td>Marijuana</td>
<td>2.5</td>
<td>20.3</td>
</tr>
<tr>
<td>Cocaine</td>
<td>3.3</td>
<td>14.6</td>
</tr>
<tr>
<td>Amphetamine</td>
<td>1.2</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Adapted from: Ekeh AP et al. Substance Abuse. 2014;35;51-5

- Limitations
  - Unable to determine if some results were due to legitimate prescriptions.

Silent Generation (1925-1945) vs Baby Boomers (1946-1964)

- Increase in drug abuse among persons age 50 and above
  - 4.3 million adults (4.7%) have used an illicit drug in the past year
  - Drug use generally higher in adults in their 50s than those over 65

- Difference in drug of choice
  - Marijuana more common than nonmedical use of prescription drugs for persons 50-59 years of age
  - Nonmedical use of prescription drugs more common than marijuana for persons over 65 years of age.

- Gender difference in persons 50 years and older
  - Marijuana more common for males
  - Females nonmedical use of prescription drugs and marijuana similar.

ED Visits Due to Illicit Drug Use by Older Adults

- Rates of illicit drug use increased from 2.7% in 2006 to 4.6% in 2008 in adults ages 50-59 years
- 118,495 ER visits involved illicit drug use by adults 50 years and older in 2008
  - Most commonly abused drugs
    - Cocaine (63.0%)
    - Heroin (26.5%)
    - Marijuana (18.5%)
    - Illicit stimulants (5.3%)

[Citation: http://www.samsha.gov/samshaNewsletter/Volume_18_Number_5/OlderAdults.aspx. Accessed on 3/31/14.]

Cocaine

- In general, users tend to experience adverse events (e.g. cerebral aneurysms, myocardial infarction) at earlier ages
- Persons of older age are already more predisposed to certain conditions that may be more likely to occur due to the use of cocaine
  - Myocardial infarction
  - Cerebrovascular accident
  - Delirium
  - Heat stroke


Heroin

- Prescription opioids have replaced heroin as the opioid of choice among all age groups
- However, the population of elderly heroin users who began use at an earlier age do not seem to have changed their use of heroin much
- The “length of the career” of a person who uses heroin has a direct relationship to negative social and health-related outcomes
- Long-term use also associated with a gradual decline in overall global mental health


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Marijuana

- Is usually not continued from earlier in life
- Instead it is often reinitiated in older age in response to stress, loss of appetite, and/or pain
- Cognitive effects
  - Acute intoxication increases latency time and decreases the ability to respond to stimuli while driving.
- Elderly are more likely to experience a cardiac event from smoking marijuana due to increases in cardiac workload
  - HR can increase by 20-100% after smoking and last up to three hours
  - 4.8 fold increase in the risk of a MI during the first hour of smoking marijuana


Early-Onset vs Late-Onset

- Early-Onset: ~90%
  - Many baby boomers came of age in the 1960s/1970s when a drug-centric lifestyle was glamorized (heroin, cocaine)
  - “Hippie” culture (LSD, marijuana)
- Late-Onset: ~10%
  - Painful medical conditions
  - Development of psychiatric conditions
  - Social risk factors
    - Bereavement
    - Social isolation
    - Financial difficulties
    - Poor support systems


Risk Factors for Substance Abuse in Older Adults

- Less than 65 years of age
- Unmarried
- Male
- Low SES
- Current methadone maintenance treatment
- Comorbid mental illness
- Substance abuse among close family members or friends
- Criminal involvement
- Social isolation/poor social support
- Inmate status
Risk Factors for Prescription Medication Misuse in Older Adults

• Cross-sectional study - 11 outpatient clinics on the East Coast
• 163 older adults with chronic pain and receiving opioid medications
• Increased risk of opioid abuse
  - Higher levels of pain severity, depressive symptoms, lower physical disability scores
• Not associated with opioid abuse
  - Alcohol problems, spirituality, social support, social network


Depression and Substance Abuse

• Patients 60 years or older with depression seeking outpatient services at a clinic on the West Coast
• Recent alcohol and drug use, heavy episodic drinking, and history of alcohol-related problems were common
• Other results

<table>
<thead>
<tr>
<th>Use in Prior 30 Days</th>
<th>Males (%)</th>
<th>Females (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>53</td>
<td>50</td>
</tr>
<tr>
<td>Marijuana</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>Sedatives</td>
<td>16</td>
<td>9</td>
</tr>
</tbody>
</table>


Alcohol – Changes in Aging

• Smaller volume of distribution
• Decreased capacity to tolerate stress
• Increased sensitivity of organ systems
• Decline in lean body mass, body water, and alcohol dehydrogenase activity
• Less perceived impairment
• Decreased performance on divided attention tasks and measures of coordination
• Increased interactions with medications.

Alcohol and Health Risks

- Driving impairment
- Dementia
- Liver disease
- Cardiomyopathy
- Hypertension
- Suicide
- Impotence
- Hypoglycemia
- Pancreatitis
- Falls
- Delirium
- Depression
- Insomnia
- Diabetes
- Cancer
- Anxiety
- Malnutrition


Alcohol Screening Tools

Standardized Rating Scales

- Alcohol Use Disorders Identification Test (AUDIT)
  10 item, clinician administered screening tool
  Evaluates quantity/frequency of drinking, physiological dependence, and harmful use
  Scoring: ≥ 8 = heavy drinking/alcohol use disorders
- CAGE (Cut down, Annoyed, Guilty, Eye-opener)
  4 item, clinician or self-administered screening tool
  Scoring: 2 = suggestive of problem drinking, further assessment should occur

Michigan Alcoholism Screening Test – Geriatric Version (MAST-G)

- Specific to the senior population
  Questions highlight the special employment and social situations of someone who is retired and how that can relate to alcohol abuse
- Sensitivity of 93% and a specificity of 65%
- 24 questions
  5 or more “yes” responses indicate the presence of potential alcohol problem. Further assessment is suggested.
Pathophysiology

- Short-term alcohol intake
  - NMDA receptor inhibitor
  - GABA-A receptor agonist
- Long-term alcohol intake
  - NMDA receptor upregulation
  - GABA-A receptor downregulation
- Cessation of alcohol intake
  - Rebound stimulatory effect


Stages of Alcohol Withdrawal

<table>
<thead>
<tr>
<th>Stage</th>
<th>Onset</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6-24 hours</td>
<td>Tremor, anxiety/depression, irritability, nausea, vomiting, increase in body temperature/pulse rate and insomnia</td>
</tr>
<tr>
<td>2</td>
<td>10-72 hours</td>
<td>Visual/auditory/tactile hallucinations, whole body tremor, vomiting, diaphoresis, sleep disturbances and hypertension</td>
</tr>
<tr>
<td>3</td>
<td>6-48 hours</td>
<td>Major motor seizures occur in patients who normally have no seizures and have normal electroencephalograms.</td>
</tr>
<tr>
<td>4</td>
<td>3-10 days</td>
<td>Agitation, global confusion, disorientation, hallucinations, fever and autonomic hyperactivity (tachycardia and hypertension)</td>
</tr>
</tbody>
</table>


Adverse Outcomes Related to Alcohol Withdrawal

- Alcohol withdrawal seizures
- Delirium tremens (DTs)
  - Prolonged course of treatment
  - Average of 6.5 days longer in the hospital
  - Average of 5.2 days longer in the ICU
  - Increased mortality of ~5%


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Other Alcohol-Related Complications

<table>
<thead>
<tr>
<th>Wernicke Encephalopathy</th>
<th>Korsakoff Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acute, usually reversible encephalopathy</td>
<td>• Amnesia (anterograde and retrograde) with confabulation that develops after chronic alcohol use</td>
</tr>
<tr>
<td>• Results from a thiamine deficiency</td>
<td>• Usually irreversible</td>
</tr>
<tr>
<td>• Triad of delirium, ophthalmoplegia and ataxia</td>
<td>• Caused by a thiamine deficiency</td>
</tr>
</tbody>
</table>

Alcohol Withdrawal

General Treatment Guidelines

• General presentation
  - Mild symptoms: Supportive nonpharmacological therapy and continued monitoring
  - Moderate symptoms: Medication to address symptoms and reduce the risk of major complications
  - Severe symptoms: Benzodiazepines in the amounts necessary to control symptoms as well as continued close monitoring until symptoms are controlled.

• History of withdrawal symptoms
  - Provide one of the recommended medications at the time of presentation regardless of the severity of withdrawal

• Notable comorbid conditions
  - Consider medication even if withdrawal is mild to moderate

Additional Considerations

• Treatment should allow for individualization of the dose so that patients can receive large amounts of medication rapidly if needed

• The use of a structured assessment scale for initial assessment and subsequent monitoring is recommended
CIWA Protocol
Standardized Rating Scales
• Clinical Institute for Withdrawal Assessment – Alcohol, Revised (CIWA-AR)
  Gold standard for alcohol withdrawal
  10 item, clinician administered scale
  Scoring
  • Mild withdrawal: < 10
  • Moderate withdrawal: 10-18
  • Severe withdrawal: > 18

Benzodiazepines
• Benzodiazepines
  Gold standard for the treatment of alcohol withdrawal
  Better documented efficacy, a greater margin of safety and lower abuse potential.
  • However certain benzodiazepines have a higher liability for abuse.
  • Administration of benzodiazepines in a symptom-triggered fashion both reduces the total amount of benzodiazepine administered and shortens the duration of therapy.
  • Usually for 3-5 days (some patients may require up to 10 days)

<table>
<thead>
<tr>
<th>Duration</th>
<th>Medication</th>
<th>t1/2 (h)</th>
<th>Advantage (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short</td>
<td>Oxazepam</td>
<td>2.5-5.7</td>
<td>Safer for patients with hepatic dysfunction</td>
</tr>
<tr>
<td></td>
<td>Lorazepam</td>
<td>6-8</td>
<td></td>
</tr>
<tr>
<td>Long</td>
<td>Chlordiazepoxide</td>
<td>6.6-25</td>
<td>May allow for a smoother course of withdrawal</td>
</tr>
<tr>
<td></td>
<td>Diazepam</td>
<td>20-50</td>
<td>May have superior efficacy in the prevention of delirium</td>
</tr>
</tbody>
</table>

Benzodiazepines
• Benzodiazepines
  All benzodiazepines appear to be equally efficacious in reducing the signs/symptoms of withdrawal.

Benzodiazepine Resistance

- **Definition**
  - More than 50 mg of diazepam or 10 mg lorazepam required to control symptoms within the first hour
  - Doses greater than 200 mg diazepam or 40 mg of lorazepam fail to adequately control symptoms during the initial 3 to 4 hours of treatment

- **Complications**
  - Prolonged hospital course
  - ICU admission
  - Endotracheal intubation
  - Mechanical ventilation


Alternative Therapy

- **Phenobarbital**
  - Clinically acceptable alternative
  - Margin of safety may be lower when high doses are needed
  - Retrospective cohort study in an inner-city municipal hospital
  - Subjects admitted to the medical ICU for the treatment of severe alcohol withdrawal
  - Institution of guidelines emphasizing escalating doses of diazepam and barbiturates
  - **Results**
    - Significant reduction in the need for mechanical ventilation ($p = 0.008$)
    - Trends toward reduction in ICU stay and nosocomial infections


Alcohol Withdrawal

- **Anticonvulsants**
  - Valproic acid, carbamazepine, etc.
  - Not FDA approved
  - Should not be used as first-line treatment especially in cases of severe withdrawal

**Ethyl alcohol is not recommended!!**

APA Substance Use Disorders Practice Guidelines, 2006
Adjunctive Therapy

- Thiamine 100 mg IV/IM/PO daily
  - Prevention of Wernicke's encephalopathy
  - Should be administered before glucose
- Folate and multivitamins
- Fluid replacement
- Electrolyte replacement
- Beta-blockers and clonidine
- Neuroleptic agents
  - May be used as adjunct treatment for delirium, agitation, hallucinations and delusions.
  - Can lower the seizure threshold so should not be used as monotherapy
- Anti-emetics

Mayo-Smith MF.  JAMA.  1997; 278:144-151.

Alcohol Dependence Pharmacological Treatments

- First-Line Treatment
  - Naltrexone (ReVia®, Vivitrol®)
  - Acamprosate (Campral®)

Alcohol Dependence Pharmacological Treatments

- Second-Line Treatment
  - Disulfiram (Antabuse®)
  - Second-line treatment for motivated individuals only
  - Can be harmful to older patients
  - Other Possibilities?
    - Topiramate (Topamax®)
    - Gabapentin (Neurontin®)
    - Baclofen
    - Nalmefene
    - Selective serotonin reuptake inhibitors
    - Ondansetron (Zofran®)
Naltrexone

- MOA: Mu opioid receptor blockade,
- Decreases cravings, alcohol-induced euphoria, and alcohol intake
  - Moderate efficacy for decreasing relapse to heavy drinking (may prevent a lapse into turning into a full relapse) but not for decreasing rates of total continuous abstinence
- Best predictors of success: Family history of alcoholism, early age of onset of drinking problems, high levels of the active metabolite and adherent to medication

Naltrexone

- Dosing: 50 mg PO daily or 380 mg IM monthly
  - Must be opioid-free for at least 7-10 days
- Onset: 15-60 minutes for PO, 2-3 days for IM
- T1/2: <10 hrs (oral), 5-10 days (IM)
- Contraindications: Current opioid use, acute hepatitis, severe hepatic impairment
- Warning/precautions: Risk of dose-related hepatocellular injury, injection site reactions

Naltrexone

- Adverse effects: Nausea, headache, insomnia or fatigue, dizziness, nervousness, elevated CPK
- Monitoring: LFTs, injection site reactions
- Duration of treatment: At least 6 months – 1 year
- Patient Education
  - Need to be aware that they will be insensitive to opioid analgesia unless toxic doses are administered
Acamprosate

- MOA: NMDA receptor antagonist, GABA receptor activation
  - Modulates and normalizes the NMDA receptor system (but not effective for acute withdrawal symptoms)
  - Possibly restoration of GABA/glutamate balance
- Decreased cravings, alleviates negative reinforcement
  - May be beneficial in maintaining abstinence
  - Increases continuous abstinence rates for 3-12 months
- Dosing: 666 mg po three times daily
  - CrCl 30-50 mL/min: Reduce dose to 333 mg po three times daily

Acamprosate

- Onset: Rapid
- T1/2: 20-30 hrs
- Contraindications: Severe renal impairment (CrCl<30 mL/min)
- Warnings/precautions: Suicidal ideation
- Adverse effects: Diarrhea (dose-related), insomnia
- Monitoring: Mental status including suicidal thoughts/behaviors
- Duration of therapy: At least 6 months to 1 year

The COMBINE Study

- Study design: RCT (N=1383) with nine treatment groups
- Endpoints: % days abstinent, time to first heavy drinking day
- Results:
  - Medical management plus either naltrexone or behavioral intervention resulted in the highest rates of abstinence (80%)
  - Acamprosate (as monotherapy or combination therapy with naltrexone) did not appear to offer any benefit
- Limitations: Exclusion of patients with psychiatric or substance use related disorders

Opioid Intoxication

- Miosis
- Out of it (sedation)
- Respiratory depression and decreased tidal volume
- Pneumonia (aspiration)
- Hypotension/hypothermia
- Infrequency (constipation, decreased bowel sounds, urinary retention)
- Nausea
- Emesis/euphoria


Opioid Overdose

- Unconscious (coma)
- Pinpoint pupils
  - Terminal anoxia results in fixed and dilated pupils
- Slow, shallow respirations (< 10 respirations per minute)
- Bradycardia (pulse < 40 per minute)

Management of Acute Opioid Intoxication

- Discontinuation of opiates
- Use of supportive measures
- Treatment of other medical problems
- Administration of an opioid antagonist
  - Naloxone
- Watch out for multiple abused agents!!
Naloxone

- Indication: Opioid intoxication (reverses the effects of opioids in overdose situations)
- Dosing: 0.4-2 mg IM/IV every 2-3 minutes up to a total max dose of 10 mg
- Onset: Very rapid (2-5 minutes)
- Warnings/Precautions: Cardiac instability, pulmonary edema, seizure activity
- Adverse Effects: Cardiac, respiratory, injection site reactions
- Monitoring: Respiratory function, HR, opioid withdrawal symptoms

Differential Diagnosis

<table>
<thead>
<tr>
<th>Substance(s)</th>
<th>Syndrome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and/or benzodiazepine</td>
<td>Anxiety, restlessness, irritability, insomnia, hyperreflexia, tremor</td>
</tr>
<tr>
<td></td>
<td>Tachycardia, hypertension, diaphoresis, hyperthermia, muscle fasciculations</td>
</tr>
<tr>
<td></td>
<td>Seizures, delirium, death</td>
</tr>
<tr>
<td>Cocaine and/or Stimulants</td>
<td>Hypersomnia, hyperphagia, depressed mood</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Anxiety, depression, irritability, headaches, poor concentration, sleep disturbance, increased BP/HR</td>
</tr>
</tbody>
</table>

Opioid withdrawal does not generally cause tremor, confusion, delirium or seizures and patients are seldom lethargic or tired. If these symptoms are observed, other substances may be involved.

Symptoms of Opioid Withdrawal

**Not pleasant but rarely life-threatening for most patients**

<table>
<thead>
<tr>
<th>Time from last Use</th>
<th>Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-4 hours</td>
<td>Drug craving, anxiety, fear of withdrawal</td>
</tr>
<tr>
<td>8-24 hours</td>
<td>Generalized malaise, flu-like symptoms, myalgia/arthritis, anxiety, restlessness, insomnia, yawning, rhinorrhea, lacrimation, diaphoresis, abdominal cramps/pain, mydriasis, piloerection, muscle twitching</td>
</tr>
<tr>
<td>1-3 days</td>
<td>Tremor, GI distress (nausea, vomiting, diarrhea), anorexia, dehydration, hypertension/hypotension, tachycardia, tachypnea, hyperthermia, hyperglycemia, chills, extreme restlessness</td>
</tr>
</tbody>
</table>


"SLUD"
Clinical Opiate Withdrawal Scale (COWS)

An objective measurement of withdrawal severity

- Resting pulse rate
- Sweating
- Restlessness
- Pupil size
- Bone or joint aches
- Runny nose or tearing
- GI upset
- Tremor
- Yawning
- Anxiety or irritability
- Gooseflesh skin

Each item is worth between 0 - 4 (or 5) points.
*A score of greater than 36 is considered severe withdrawal and detoxification with an opioid agonist is recommended.

Opioid Withdrawal Pharmacological Treatment

- Withdrawal
  - First-line
    - Buprenorphine (Buprenex®)
    - Methadone
  - Second-line
    - Clonidine (Catapres®)
- Adjunct agents
  - Clonidine (Catapres®)
  - Baclofen
  - Ibuprofen (Motrin®, Advil®)
  - Promethazine (Phenergan™)
  - Diphenoxylate/atropine sulfate (Lomotil®) or loperamide (Imodium A-D)

Opioid Dependence Pharmacological Treatment

- Methadone (Dolophine®, Methadose®)
- Buprenorphine/Naloxone (Suboxone®)
- Naltrexone (ReVia®, Vivitrol®)
  - Second-line treatment
    - Initial dose of 25 mg then 50 mg po daily
Methadone

- Must be dispensed in licensed treatment programs
  - Patients must be currently addicted and have a history of opioid dependence of at least 1 year
  - Exceptions: Recent release from a correctional facility, previous treatment, pregnancy
- MOA: Full opioid agonist
- Decreases illicit use, reduces psychosocial and medical morbidity, improves overall health status, decreases criminal activity, improves social function

Methadone

- Dosing
  - Initial: 20-30 mg po on day 1, may give additional doses but do not exceed 40 mg on day 1
  - Titrate by 10-20 mg po daily
  - Usual withdrawal dosing range: 40-60 mg po daily
  - Usual maintenance dosing range: 80-120 mg po daily
- Onset: Within hours
- Duration: 24-36 hours
- Metabolism: 3A4, 2B6, 2C19

Methadone

- Contraindications: Respiratory depression, acute bronchial asthma, paralytic ileus, concurrent MAOI therapy
- Warnings/Precautions: QTc prolongation, respiratory depression, risk of abuse/dependence
- Other adverse effects: Hypotension, constipation, nausea/vomiting, sedation, dizziness, CNS depression
- Monitoring: Respiratory rate, EKG
- Duration of treatment: Indefinitely

Geriatric patients usually require smaller doses of opioids and may need slower titration schedules
Buprenorphine

- May only be prescribed by qualified providers
  Qualified providers can treat up to 100 patients after one year
- MOA: Partial mu agonist with high affinity for the mu receptor, weak kappa receptor antagonist
- Reduces drug craving and withdrawal symptoms
- Dosing: 4 mg SL, up to 8 mg on first day in clinic/office the titrate up to 16 mg/day by day 3.
  Usual dosing range: 12-24 mg po daily
  Maximum dose: 32 mg po daily

Geriatric patients usually require smaller doses of opioids and may need slower titration schedules

Buprenorphine

- Metabolism: Mainly 3A4
- Onset: 20-40 minutes
- Duration: 24 hours
- Warnings/Precautions: CV and respiratory depression, hepatic impairment, abuse potential, reported deaths with combination of IM benzodiazepines and buprenorphine
- REMS: Patient medication guide
- Other adverse effects: Headache, insomnia, nausea/vomiting, withdrawal syndrome
- Monitoring: LFTs

Methadone vs Buprenorphine

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Methadone</th>
<th>Buprenorphine-Based Regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respiratory Depression</td>
<td>Greater risk</td>
<td>Lower risk (due to ceiling effect)</td>
</tr>
<tr>
<td>Withdrawal Symptoms (downward titration and discontinuation)</td>
<td>More</td>
<td>Fewer</td>
</tr>
<tr>
<td>Drug Interactions</td>
<td>More</td>
<td>Fewer</td>
</tr>
<tr>
<td>Stigma</td>
<td>Greater</td>
<td>Less</td>
</tr>
</tbody>
</table>

*Approximately 25% of patients will not respond to methadone.*

Stigma of Receiving Maintenance Therapy for Opioid Dependence

- Primary care or HIV specialty clinics who serve Medicaid enrollees in New York State
  - 59.8% willing to provide buprenorphine
  - 32.6% willing to provide methadone

Summary

- Substance abuse/misuse is often underdiagnosed and undertreated in the older population
- Prescription medication and marijuana are commonly misused/abused agents although older adults may use other illicit substances as well
- Screening should be conducted on a routine basis
- Comorbidities and age-related changes must be taken into account when choosing pharmacological agents