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Methadone - Buprenorphine Long Acting (LA) switch: A proposal for a patient comfortable dosage matching table

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Background:

In detention, to date, the methadone-Buprenorphine LA switch has been implemented at the request of patients for various reasons including:
- the reduction of sedative effects,
- to get rid of the "drug addict" label and therefore of the stigma, until then obliged by the daily passage at fixed time to the health unit.

In order to respond to patient demand, the physician must apply the recommendations of the High Dosage Buprenorphine (HDB) SMPC, which requires a reduction to 30 mg/d of methadone before initiating HD Buprenorphine, without, however, specifying the dosage to be applied.
The strict application of the SMPR is very painful for patients and is unthinkable for methadone dosages above 50mg/d.
There are two reported methods of switching methadone to HD Buprenorphine:

- SMPC: with a step down to 30 mg/d of methadone
- Bernese Experience: known as "microdosing method" with the introduction of HDB at the same time as the reduction of methadone

These two methods have their limitations and disadvantages. We have chosen a third way, discussed and validated with patients

The objective of this communication is to share our experience with the presentation of a corresponding dosage table allowing the switch in less than a week in a comfortable way for the patients.

Materials & Methods

- Pragmatic and retrospective analysis of before/after dosages of successful methadone to HD Buprenorphine allowed clinicians to jointly define a dosage equivalence table applicable to all initial methadone dosages.
- 4 centers participated to the first step of collecting retrospective data:
  1 French center : Villeneuve-lès-Maguelone, France
  3 centers in Australia: Hunter New England Local Health District, Lakeview withdrawal unit, Dr John Hunter Hospital

The analysis identifies 3 levels of switch (= Table 1):

methadone dosage (md) mg/day	Buvidal® monthly (mg)
md < 50	64 à 96
50 < md < 90	96 à 128
md > 90	128

Table 2 :

	Patient number	methadone dosage (mg/day)	First daily dosage Sublingual BHD (mg)	Final daily dosage sublingual BHD (mg)	Initial Buvidal monthly dosage	Final Buvidal monthly dosage (mg)
md < 50	1	30	2	4	64	64
	5	25	2	4	64	64
	7	25	2	4	64	64
	12	40			64	**96**
	12	40			64	**96**
	14	17,5			64	64
	15	40			64	**128**
	16	30			64	**128**
50 < md < 90	2	60	4	8	96	96
	6	80	6	8	96	96
	8	80	6	12	96	96
	10	60	4	8	96	96
	17	72,5			96	96
	18	62,5			96	64
	19	80			96	**128**
md > 90	3	90	4	12	96	**128**
	4	90	4	12	96	**128**
	9	140	8	12	128	128
	11	100	4	8	96	96

The application of the corresponding table 1 has since January guided the change of treatment for 19 patients (8 patients in Australia, 11 patients in VLM, France) in a way that is clinically and psychologically satisfactory for the patients (presented in table 2):

The protocol applied step by step is:

J1 - Stop Methadone treatment (ideally on Sunday to finish the switch period before the next week-end)

J1 to J3 and more if necessary: No TSO treatment during 36-48h until the first symptoms of withdrawal

J… - Middle stage with BHD Sublingual form:

- First dosage between 2 - 4 mg according to clinical signs and last methadone dosage,
- then between 6 and 12 in 2 to 3 days,
- then switch to Buvidal®

J… - The First Buvidal® dosage is define in Application of table 1; If necessary, Buvidal® dosage adaptation with weekly 8 mg dosage as recommended in the Buvidal® SMPC

Conclusions:

This method has made it possible to respond to the demand of all patients with a methadone treatment who wished to switch to a monthly form of BHD whatever their methadone dosage in a short time (less than a week) and in a way that was quite comfortable for the patients.
Since the switch, patient satisfaction can be estimated by the 100% retention of patients in Buvidal® treatment.

Points interesting to observe in this first experience:
- the switch takes between 3 and 6 days depending on the initial methadone dose.
- Very few adjustments in Buvidal® dosage have been necessary in the follow up
- No adjuvant treatments need to be prescribed during and for the switch
- As dosage adjustments of concomitant treatments of patients, we can observe in the follow up of patients, the use of less BZD and sleeping pills and more melatonin
- Main patient satisfaction feed-back: No longer thinking about Treatment every day, being free of the daily burden with a better stabilization
- Main HCP satisfaction feed-back: opportunity to have more time for care and not only for daily treatment dispensing

Disclosures :
-Of the author with the pharmaceutical industry over the last 3 years: Congress invitations, consulting contract: Camurus, Indivior, Bouchara Recordati
-This work is carried out independently of the pharmaceutical industry and did not require any financing for its realization except a collaboration between the quoted clinicians.