THE NATIONAL ALLIANCE OF ADVOCATES FOR BUPRENORPHINE TREATMENT
— naabt.org —

Keeping You Informed

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This is an interactive Newsletter. As you scroll over the Newsletter, if the hand turns into a pointing finger, that means – with a click of your mouse – your browser will open to the website which relates to that item.

Vocabulary of Addiction Medicine

"A drug that soothes the cravings of dope sick addicts" was how the **Boston Herald** defined methadone in an article this past July. Would they describe a medication for paralysis *as "a drug to ease hobbling cripples"*? Why is the discipline of addiction medicine subject to so much derogatory slang terminology? Why do people continue to use it while words like crippled, retarded, and crazy have vanished from medical lexicon?

This stigmatizing vocabulary is not only stereotyping patients but compromising the discipline of addiction medicine. A lawmaker will be less likely to support "A drug to soothe cravings of dope sick addicts" than a "medication to treat chemical dependencies". Insurance companies, when choosing what they will cover, would be less likely to provide coverage for *dope fiends* or *crack heads*. Funding agencies are faced with similar choices.

During the war on drugs many of these derogatory terms were introduced into the vernacular. It was an effort to create a negative image of the substance, in hope of dissuading people from using it. Education took a backseat, mainly because little was actually known about the subject. As when little was known about lightning, people were told the gods were angry. We are now at a point in science where we understand what addiction is and no longer need to scare people toward abstinence by perpetuating stigmatizing terminology.

Education is proving to be a superior tool. Using medical terminology in place of slang, when appropriate, will benefit both patient and provider. Our effectiveness at reducing the stigma associated with addiction will impact the future availability of funding and treatment. See *Breaking the Stereotype* at naabt.org.

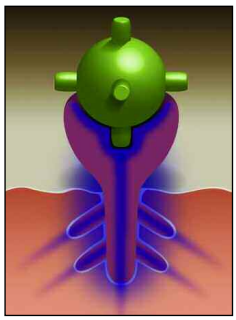
Edwin A. Salsitz, MD.,FASAM was one of the first experts in addiction medicine to recognize the stigmatizing effects of slang and urged colleagues to limit the use of it. See *Links* at naabt.org to read Dr. Salsitz's 2002 letter.

SAMHSA has compiled a **Guide to the Use of Language** with explanations and recommendations. This can be downloaded from our *Links* page.

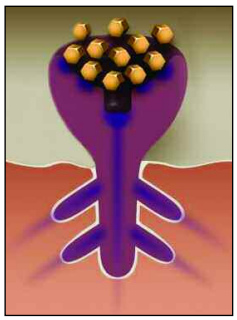
Precipitated Withdrawal Syndrome

What is it?

Precipitated withdrawal syndrome (PWS) can occur when an antagonist (or partial antagonist, such as buprenorphine) is administered to someone dependent on full agonist opioids (hydrocodone, oxycodone, heroin, methadone, etc.) while still experiencing agonist effects. Due to Buprenorphine's high *affinity* and low *intrinsic activity* at the mu receptor, the partial antagonist displaces agonist opioids from the receptors, without activating the receptors to an equivalent degree, resulting in a net decrease in agonist effect, thus precipitating a withdrawal syndrome.



Full Agonist Opioid, maximum opioid effect.



Partial Agonist Opioid/ Antagonist Opioid (Buprenorphine), less opioid effect.

Affinity: The strength with which a drug binds to its receptor.

Intrinsic activity: The degree to which a drug activates its receptor.

Agonist: drugs that activate a receptor (full effect).

Antagonist: a drug that binds to a receptor *without* activating it (no effect).

What to do about it?

The best way to avoid this condition in practice is through patient education. Once the risk of under-reporting last use is understood, PWS can be avoided. The patient should be educated, prior to the induction appointment, of what precipitated withdrawal is and how *they* can avoid it.

PWS puts the patient at risk for concluding that Buprenorphine is ineffective, the doctor may not know how to help, or both. Either situation leaves the patient in a precarious state physically and emotionally.

If a patient does experience PWS the common treatment is to increase the dose of buprenorphine by 2 to 4mgs. hourly, until symptoms subside. See ***TIP40*** for more on PWS and the unique pharmacology of Buprenorphine.

NAABT is completing a sheet for distribution that will serve as a guide to preventing precipitated withdrawal. It will be available for download on our Literature page, or you may request printed copies be sent to you.

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News Stories

For the complete text of these stories and others, please visit naabt.org where news is posted as it happens

11/22/2005

Depot Buprenorphine

A number of companies are conducting studies on new forms of buprenorphine medications to treat opioid addiction.

One – **Probuphine** – can potentially provide up to six months of continuous delivery of buprenorphine. It is placed subcutaneously in the upper arm area in a 15-minute procedure, and removed at the end of treatment. Another potential product – **Norvex** – is comprised of biodegradable micro pellets administered intramuscularly. It slowly dissolves over a period of 4-6 weeks, providing a continuously diminishing dose.

Continuous long-term delivery of buprenorphine may potentially eliminate some challenges associated with daily oral therapy, including poor compliance, and variable blood levels. Both of these drugs are still in clinical trials and not FDA approved.

See NAABT *News* page for details.

SAMHSA Releases New Treatment Improvement Protocol on Medication-Assisted Treatment for Opioid Addiction in OTPs

A new Treatment Improvement Protocol, TIP 43, released in late October by SAMHSA provides treatment providers, physicians and other medical personnel with current information on medication-assisted treatment for people addicted to opioids. Although this 332-page volume primarily focuses on methadone, many of the same principles apply to Buprenorphine. The PDF version of the publication is available on the *Literature* page at naabt.org.

What's New at NAABT.org

National Patient Waiting List and Physician Matching System

NAABT has developed, and and is currently testing, a national patient list. This list was borne out of the need for a more efficient way to connect patients to certified physicians. At the same time, it alleviates the burden of physicians' maintaining their own patient waiting lists by allowing them immediate access to the NAABT list when there is an available treatment opening.

It is completely confidential. Patients can get onto the list online themselves, through the help of a counselor, social worker, or other advocate or organization. It can also serve as a referral system for physicians.

A physician would log in and see a list of patients in his/her area currently awaiting treatment. The patient is asked 15 questions, on a short application. Physicians can view these answers to determine if a patient is an appropriate match. If so, an email is sent to the selected patient(s) with instructions to call the physician's office to discuss treatment further.

A single physician can contact up to 10 patients in less then 3 minutes, by using the system. Patients can register in under 3 minutes, and are required to respond to a renewal email every two weeks if they have not found treatment, maintaining a fresh list.

More will be available on the waiting list in the coming months.

Read details of the patient waiting list.

In Coming Months

- Advocacy
- Pregnancy and Buprenorphine
- Results of Patient Waiting List Pilot

NAABT.org

All NAABT literature is available on the naabt.org Literature page as PDF files of literature for you to download and view or print for your convenience. http://naabt.org/education/literature.cfm For multiple copies of NAABT Literature, please email your request to MakeContact@naabt.org.

The Physician Locator (Doctor/Patient button) sorts physicians by distance in geographic proximity, regardless of city, town, county, or state borders.

Current Newsletters are available at the naabt.org homepage. Past editions are available as PDF files on our *Literature* page, under Other Literature.

Happy Holidays

All of us at NAABT extend our warmest wishes for a safe, happy, healthy Holiday Season. And all the best in 2006.

Mission Statement

The National Alliance of Advocates for Buprenorphine Treatment is a non-profit organization formed to help people, in need of treatment, find treatment providers who are willing and able to treat opioid dependency in the privacy of a doctor's office. Our website offers answers to frequently asked questions, a glossary, actual patient experiences, a discussion board, information on the history and treatments of opioid addiction, current news on the subject and more.

This newsletter is provided to keep you informed on matters relating to Buprenorphine Treatment. Please feel free to contact us at newsletter@naabt.org with feedback, suggestions, or perhaps you would like to contribute a story. Also feel free to photocopy or print as many as these newsletters as you wish for distribution.

To add yourself or someone you know to the mailing list, please either write us or email us at subscribe@naabt.org.

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