Buprenorphine offers a way to rise from the ashes of addiction

One of the most rewarding aspects of being a physician is having a direct impact on alleviating patient suffering. On the other hand, one of the more difficult elements is a confrontational patient with unreasonable expectations or inappropriate demands. I have experienced both ends of the spectrum while engaging with patients who have opioid use disorder (OUD).

An untreated patient with OUD might provide an untruthful history, attempt to falsify exam findings, or even become threatening or abusive in an attempt to secure opiate pain medication. Managing a patient with OUD by providing buprenorphine treatment, however, is a completely different experience.

There is no controversy about the effectiveness of buprenorphine treatment for OUD. Patients seeking it are not looking for inappropriate care but rather a treatment that is established as an unequivocal standard with proven results for better treatment outcomes[1-3] and reduced mortality.[4] Personally, I've found offering buprenorphine treatment to be one of the most rewarding aspects of practicing medicine. It is a real joy to witness people turn their lives around with meaningful outcomes such as gainful employment, eradication of hepatitis C, reconciliation of broken relationships, resolution of legal troubles, and long-term sobriety. Being a part of lives that are practically resurrected from the ashes of addiction by prescribing medicine is indeed an exceptional experience.

On April 28, 2021, the Department of Health and Human Services provided notice for immediate action allowing for any DEA-licensed provider to obtain an X-waiver to treat 30 active patients without educational prerequisite or certification of behavioral health referral capacity.[5] The X-waiver requirements were reduced, as outlined by SAMSHA,[6] to a simple online notice of intent[7] that can be completed in less than 5 minutes.

I encourage my colleagues to obtain the X-waiver by the simplified process, start prescribing buprenorphine, and be a part of the solution to the opioid epidemic. Of course, there will be struggles and lessons learned, but these can most certainly be eclipsed by a focus on the rewarding experience of restoring wholeness to the lives of many patients.

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How best to treat "long-haulers" with reactive arthritis?

In the June Photo Rounds column, "Foot rash and joint pain" (*J Fam Pract*. 2021;70:249-251), Badon et al presented a case of chlamydia-associated reactive arthritis (ReA), formerly called *Reiter syndrome*, in a 21-year-old man following *Chlamydia trachomatis* urethritis. We would like to point out that, contrary to the conventional definition of ReA, in which the causative pathogen can't be cultured from the affected joints,[1] chlamydia-associated ReA is associated with evidence of chronic joint infection that, while not cultivable, can be confirmed by real-time polymerase chain reaction testing of metabolically active pathogens in synovial tissue and/or fluid.[2]

C trachomatis and *C pneumoniae* are the most frequent causative pathogens to elicit ReA.[3] Short-course antibiotics and anti-inflammatory treatments can palliate ReA,

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but these treatments often do not provide a cure.[3] Two controlled clinical trials demonstrated that chlamydia-associated ReA can be treated successfully with longer-term combination antibiotic therapy.[4,5] ReA is usually diagnosed in the acute stage (first 6 months) and can become chronic in 30% of cases.[6] It would be interesting to know the long-term treatment and outcome data for the case patient.

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Authors' response

My co-authors and I appreciate the excellent comments regarding our Photo Rounds column, "Foot rash and joint pain," and would like to provide some additional detail.

After our patient's 27-day hospital stay, he was admitted to a rehabilitation center for continued inpatient physical therapy for 14 days due to weakness and deconditioning. Following his discharge from the rehabilitation center, the patient was still confined to a wheelchair. He was prescribed an oral prednisone taper (as mentioned in our article) and celecoxib 200 mg bid and referred for outpatient physical therapy. At a follow-up appointment with the rheumatologist, he received adalimumab 80 mg followed by 40 mg every other week, which led to improvement in his range of motion and pain. Two months after outpatient physical therapy, the patient was lost to follow-up.

We agree with Dr. Hahn et al that many of these patients with chlamydia-associated ReA become "long-haulers." In medicine—especially when rare diseases are considered—we must often make decisions without perfect science. The studies referenced by Dr. Hahn et al suggest that combinations of doxycycline and rifampin or azithromycin and rifampin may treat not only chlamydial infection, but ReA and associated cutaneous disease, as well.[1,2] While these studies are small in size, larger studies may never be funded. We agree that combination therapy should be considered in this population of patients.

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In medicine—especially when rare diseases are considered—we must often make decisions without perfect science.

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