Switch Pain Patients to Methadone With Caution

BY JANE SALODOF MACNEIL
Southwest Bureau

Clinicians should not rely on standard conversion tables when switching chronic pain patients to methadone from other opioid analgesics, according to three pain experts who have published guidance on methadone prescribing.

The widely available tables were designed mainly for acute single-dose pain control and not for long-term use. If a table calculates too high a dose, a patient could be at risk of overdose, they warned in separate interviews.

"Yet those tables have been utilized for chronic use, and that is a serious problem," said Dr. Lynn Webster of Lifetree Pain Clinic in Salt Lake City. "They have to be abandoned. … It is particularly dangerous to go from other opioids to methadone."

One pill does not relieve pain, so some at-risk patients pop another pill and maybe one more pill, not realizing that the drug is accumulating within them.

Dr. Webster recommended starting opioid-tolerant chronic patients on a ceiling dosage of 20 mg/day (10 mg if they are elderly or infirm) and slowly increasing the dosage (J. Opioid Mgmt. 2005;1:211-7). The previous opioid should not be stopped abruptly but titrated down while the methadone dosage increases. Dosage changes, he added, should be limited to once a week at most to allow side effects to become evident.

Dr. Howard Heit of Fairfax, Va., coauthor of a paper on universal precautions in pain medicine (Pain Med. 2005;6:107-12), said he uses the tables only "as a very, very rough guide." When he switches a patient to methadone from another opioid, he multiplies whatever the conversion tables list by 20%-30% and titrates up slowly over time.

"I could always add medication, but I can't take out medication if the patient is on the floor, not breathing," he said, describing methadone as a useful but unforgiving drug.

Lee A. Kral, Pharm.D., a faculty member at the University of Iowa Pain Center, Iowa City, tackled the conversion chart problem with a retrospective study to assess the efficacy and tolerability of methadone in chronic pain patients. She was scheduled to report on 107 patients at a November meeting of the American Society of Regional Anesthesia and Pain Medicine.

The average daily methadone dose was 20.5 mg, and the mean duration of therapy 21 months, according to Dr. Kral's abstract. About half the patients had adverse effects, the most common of which were sedation, gastrointestinal symptoms/constipation, cognitive difficulties, and headache. Although 29 patients stopped taking methadone, only 12 did so because of adverse effects.

Dr. Kral said she is not aware of sleep apnea in any of the Iowa patients, perhaps because they are kept on low doses. Methadone is not dangerous, she maintained. It is different, and it is misunderstood. "You can't put that kind of a label on a medication," she said. "They are all dangerous in different ways."

To help primary care physicians understand the pharmacokinetics and pharmacodynamics that distinguish methadone from other opioids, Dr. Kral collaborated with a family physician in writing a guide to methadone treatment for pain. They explained that methadone, a mu-opioid agonist, has a short-lasting analgesic effect but a long half-life, and that its metabolism varies among individuals. Pain relief, which may last as little as 3-6 hours at the start of methadone therapy, becomes longer with repeated dosing. Yet plasma levels can take 5-7 days to stabilize (Am. Fam. Physician 2005;71:1353-8).

In light of methadone's long half-life, Dr. Webster and Dr. Heit stressed that overdose risk may be highest at the outset of therapy. One pill does not relieve pain, so some at-risk patients pop another pill and maybe one more pill, not realizing that the drug is accumulating within them. "What they are trying to do is control their pain," Dr. Webster said.

Education is vital, Dr. Webster said. Patients must understand that it could be fatal to deviate from the dosage or to mix methadone with alcohol, other prescriptions, or illicit substances. ■