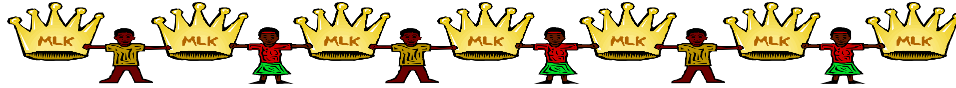
METHADONE MONTHLY

Third Edition

January 2006

We will be closed on Monday – January 16th in observance of Martin Luther King Day

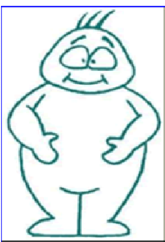


United Community Services, Incorporated hopes that everyone had a fun, safe and drug free New Years Eve.

The methadone staff was 100% compliant with 2005 urine collections. This is the first 100% compliance in 5 years! The Staff would like to thank everyone for their cooperation.

Our nurse Donna will be leaving January 20th for vacation and returning February 21st. Donna will be missed but we want to wish her a fun relaxing month. If you have anything you need to discuss with her please do so within the next week so she can make sure all the paperwork is done and your needs will be met while she is away. During her absence please see your counselor for any issues you would normally discuss with Donna.

Why does methadone make me put on weight?



There is actually nothing about the chemistry of methadone itself or the way if affects the body that would make a person put on weight. However, this is a common complaint of patients in MMT programs. A survey in 1984 reported that about 1 in 10 patients had gained weight, although 1 in 20 persons actually lost weight while on methadone. So, the situation is entirely opposite in different patients, which supports the view that methadone itself is not the cause.

One common explanation for the weight gain is water retention but, in most cases, it is found that the patient is taking other medications that cause water retention or there is another reason. Many medications, such as some (but not all) antidepressants, cause weight gain as a side effect. Furthermore, there is the fact that many persons in MMT are simply taking better care of themselves, and eating much better, than they did while leading a life of substance addiction. A more healthy diet (talk to a dietitian) and some regular exercise could go a long way in helping to control weight problems.

Some persons have believed that the prepackaged liquid form of methadone is fattening, which is untrue. For example, Methadose ®* cherry oral concentrate does contain sucrose syrup (a natural sugar) to deter potential injection of the product. However, in a 100 milligram dose there are only about 15 calories (or 1.5 calories in each milliLiter of Methadose) – about the same calories as in one Life Saver candy and ten times *less* than in a single can of a sweetened lemonade or cola drink.

This also means that the amount of sugar in this methadone product would not be harmful for persons with diabetes. However, if there are still concerns, Methadose ®* brand of oral methadone concentrate comes in a sugarless formulation, which also is unflavored and colorless.

*Methadose® is a registered trade mark of Mallinckrodt, Inc.; St. Louis, MO.
http://www.atforum.com/SiteRoot/pages/faqs/faqs2health.html#q25

Recently we have had inquiries about how to discontinue methadone. The following article explains the most effective way to withdraw from methadone having the least side effects.

How can I get off of methadone?

Since methadone creates a physical dependency on the drug, stopping it abruptly (e.g., “cold turkey”) would lead to intense withdrawal symptoms and drug craving. The accepted way of discontinuing methadone is called medically supervised withdrawal (MSW). Its main objective is to relieve or prevent uncomfortable withdrawal symptoms and craving while the patient gradually achieves an opioid-free state.

During MSW – sometimes erroneously called “detox” – the daily dose of methadone is decreased by small amounts over time, taking many weeks or months. This should only be done under the care of a doctor, and only after discussing the reasons for wanting to discontinue methadone and considering ongoing treatment alternatives. Relatively few persons who withdraw from methadone or other opioids, and who do not continue in some form of addiction treatment program, stay drug-free for any extended length of time.

A more rapid form of withdrawal, taking only hours, requires that the person first be put completely to sleep (under general anesthesia) in order to tolerate the otherwise severe withdrawal symptoms, and then certain medications are used to purge the body of methadone or other opioids. This method is expensive and still undergoing study in terms of its safety and long-lasting benefits. Many, if not most, persons undergoing this treatment have eventually returned to illicit-opioid abuse (relapsed).

Why is methadone harder to “kick” than heroin?

Surveys have found that substantial numbers of MMT patients are concerned about difficulties in withdrawing from methadone, claiming it is harder to “kick” than heroin. However, this is a persistent myth that was long ago disproved.

A blind comparison study years ago at a federal facility for addiction treatment in Lexington, Kentucky, found that withdrawal symptoms actually were less severe in patients maintained on methadone than in those taking equivalent doses of short-acting opioids like heroin. Because it is long-acting, withdrawal from methadone does last much longer than withdrawal from short-acting opioids. Therefore, a person who has experienced “cold turkey” withdrawal separately from heroin and methadone might say that “kicking” methadone was worse – because it lasted longer. This is one way the myth might have started and it ignores the fact that methadone withdrawal should never be done “cold turkey” to begin with.

However, gradual withdrawal from methadone, when properly done under medical supervision, can be virtually free of discomfort. On the other hand, patients who try to withdraw from methadone by themselves, on their own time and dose schedule, almost always experience undue discomfort and fail.

Also, some patients forget that the reason they came into MMT was because they could not stay away from opioid drugs on their own. When they decide to leave MMT and find they cannot just stop taking methadone, they blame the methadone rather than the heroin or other opioids that deranged their brain chemistry in the first place. For many former illicit-opioid-addicted persons, methadone is a lifelong medication necessary for stabilizing brain function; much like a person with diabetes needs insulin every day to live a normal life.

Sources: Rosenblum A, Magura S, Joseph H. Ambivalence toward methadone treatment among intravenous drug users. J Psychoactive Drugs. 1991;23(1):21-27.Velten E. Myths about methadone. NAMA Education Series, Number 3. March 1992.