

CONTINUING METHADONE FOR ANALGESIA: AN INTRODUCTION FOR FAMILY PHYSICIANS

This guide is to provide information on your patients' ongoing pain management needs after they have been stabilized on methadone by a specialist pain clinic. The information provided here is a short introduction to *Recommendations for the Use of Methadone for Pain* (<https://www.cpsbc.ca/files/pdf/DP-Methadone-for-Analgesia-Guidelines.pdf>), which is available on the College of Physicians and Surgeons of BC website. Note that Health Canada has lifted the restriction on prescribing methadone, both for analgesia and for opioid use disorder, so College authorization is no longer required.

Methadone is frequently used in chronic pain management and for pain management in palliative care because of its effectiveness in difficult pain syndromes, relative lack of side effects and reduced risk of tolerance.

Switching patients to methadone can be a complex procedure, especially if the patients were previously receiving high doses of opioids. Physicians with limited pain management experience may understandably be reluctant to start patients on methadone without specialist support under these circumstances. However, once the switch to methadone has been completed and patients are on a stable dose, they will not require the services of a specialist clinic; just regular supervision from their family physicians who then assume their key role of ongoing follow-up.

Physicians need to be aware of the safety issues specific to methadone and to agree to see these patients regularly, at least every two months. The specialist clinics will provide consultative support should difficulties arise. The handbook provided by the College provides detailed information on drug interactions and can be kept for reference in ongoing care.

An excellent Canadian CME-accredited free 1-hour online module is available to learn the key points about methadone [<http://www.methadone4pain.ca/>]. The following information is a very brief summary of the key points that are covered in the module.

Pharmacology of Methadone

The therapeutic window of effectiveness for analgesia is much narrower than that for opioid dependence, so methadone should be taken every 8 hours for pain management rather than once a day as for addiction. Methadone can be used for breakthrough pain in cancer patients once they are on a stable dose every 8 hours, but should not normally be used for incident pain because of methadone's long half-life and potential for drug accumulation.

Patients with stable continuous pain should not require supplemental short-acting opioids once the optimal methadone dose is reached. When dose adjustments are required because of changes in patients' condition, titration increments (up or down) should be no more than 10 per cent of the total daily dose and should be made no more frequently than three days apart (or longer, for elderly patients).

Methadone is metabolized primarily by the liver, and does not require significant dose modification for renal failure. If liver function deteriorates, methadone dose reduction should be considered. In rapidly deteriorating renal failure, minor dose adjustment may be necessary.

Methadone Prescriptions

Methadone can be dispensed as flavoured oral solution or as tablets. Methadone is dispensed most inexpensively in 10 mg/ml solution, but can be provided as tablets if necessary. Tablets are preferred when starting methadone, as measurement of the higher strength solution can be challenging when volumes are small. Extreme caution should be applied when using solutions to avoid inadvertent overdose. If patients are visually impaired, exhibit tremors, have difficulty with fine motor skills, or risk making measurement errors, tablets should be prescribed rather than solution. Although the cost of tablets is currently covered by Pharmacare only for patients in the BC Palliative Care Benefits Program, tablets are relatively inexpensive and are usually covered by extended health plans. Methadone tablets are available in 1 mg, 5 mg, 10 mg and 25 mg strengths, and are scored.

A duplicate prescription should be used for methadone as for other controlled drugs, paying close attention to the concentration of methadone liquid (or strength of tablets) and the total amount to be taken per dose. To avoid confusion at the pharmacy, write "For Pain" on prescriptions. Prescriptions can be written to cover the period between appointments (up to two months), but should be dispensed at shorter intervals, the frequency being determined by individual circumstances. Writing "Part Fill OK" will lead to 30-day dispensing.

Methadone and End of Life Care

If a patient has been using oral methadone for analgesia and becomes unable to swallow, methadone liquid is well absorbed rectally, with very similar bioavailability as when taken orally. Patients can therefore switch to the rectal route with the oral liquid preparation without any need for change in dose, providing the rectum is empty. Methadone suppositories can also be made up by a compounding pharmacy but are less reliably absorbed.

If doses are low or moderate, the 10mg/ml solution is also well absorbed buccally/sublingually. Each dose can be divided into small aliquots (~0.5ml [5mg] at a time) to ensure maximal absorption. Methadone liquid can also be compounded up to 40mg/ml if large doses are required.

Switching the patient to an alternative injectable opioid such as morphine, hydromorphone or fentanyl may be effective, but often does not provide as good analgesia as methadone, and equianalgesic charts do not apply, so dosing can be difficult to establish. Please consult a specialist for guidance on this if unsure.

Injectable methadone is no longer commercially available.