ADDICTION

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Letter to the Editor

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TIME TO REVISIT UNEVEN POLICY IN THE UNITED STATES FOR MEDICATION FOR OPIOID USE DISORDER DURING COVID-19

In complying with the best practice approach to contain the spread of the COVID-19 infection, medical facilities in the United States have transitioned their mode of care delivery from in-person to remote, and in some cases suspended non-emergency procedures. The Substance Abuse and Mental Health Services Administration (SAMHSA) has revised guidelines for the evaluation of Opioid Use Disorder patients for whom medication for opioid use disorder (MOUD) is considered. SAMHSA has decided, "to exempt occupational treatment programmes (OTPs) from the requirement to perform an in-person physical evaluation. For any patient who will be treated by the OTP with buprenorphine if a programme physician, primary care physician, or an authorized healthcare professional under the supervision of a program physician, determines that an adequate evaluation of the patient can be accomplished via telehealth". This benefits patients on maintenance methadone and buprenorphine as well as those seeking to start buprenorphine; however, these revisions do not apply to patients in need of starting methadone. SAMHSA's website specifically indicates: "For new OTP patients that are treated with methadone, the requirements of an in-person medical evaluation will remain in force."[1]

SAMHSA, in its FAQ section, says that it "made this determination on the basis that eliminating the in-person physical examination requirement for new methadone patients could present significant issues for a patient with OUD." The only explanatory statement on the website is that an initial in-person physical examination is needed for OTP clinicians to assess and evaluate risks inherent in methadone titration.

When considering candidacy for methadone treatment, the risks and benefits are evaluated as with any other pharmacological treatment. Risks for methadone treatment and adverse effects associated with methadone treatment are many, and careful review of the patient's medical history is of paramount importance. The critical aspects of the medical history include neurological, pulmonary, gastrointestinal, cardiac, and renal/genitourinary statuses. It is imperative to make note of any history of seizures, head trauma, or brain tumors considering methadone's sedative effects, as well as associated seizure risk. The associated respiratory depression that can occur, means any history of asthma, sleep apnea, or chronic obstructive pulmonary disease must be ascertained. Methadone is metabolized in the liver and can cause nausea, vomiting, and decreased bowel transit. Subsequently, it would be important to investigate for a history of hepatitis, pancreatitis, cholelithiasis, intestinal obstruction, liver disease, or jaundice. Cardiac side effects include hypotension, arrhythmias, and ischemia, therefore documenting any history of cardiac abnormalities is imperative. A history of renal insufficiency is also pertinent given that methadone is renally excreted and any history of genitourinary surgery and benign prostatic hypertrophy should also be noted. Last, injection sites should be visually examined for signs of active infection.

We wish to express our concern regarding SAMHSA's decision to keep a requirement for a physical examination for methadone induction during this time of risk of Covid-19 transmission in the medical setting in lieu of a phone call with or without video. All methadone comorbid conditions and risk factors can be assessed through the medical history, vital signs, EKG, and laboratory studies, making the physical examination adjunctive. It is our opinion that the risk of not having an OUD sufferer in treatment exceeds the risk related to the lack of the initial physical examination during this state of emergency. There may not be a complete alternate to physical examination, but video conferencing could serve the purpose to much extent, and of course, to mitigate the harm.

Patients referred to the two treatments present with similar comorbidities and risk factors. Although buprenorphine carries a better side effect profile, many of the risks are similar in nature, if not degree. The referral mechanisms available to address any presenting comorbidities are the same in both scenarios. The in-person physical examination requirement for methadone treatment perpetuates stigmatization of methadone that OTPs have labored under since the introduction of methadone as a treatment for opioid addiction. We applaud SAMHSA's flexibility in modifying the guidelines during this pandemic, and the option to evaluate opioid use disorder patients by telehealth goes far in reducing the risk of Covid-19 exposure to health professionals and patients while maintaining MOUD accessibility during times that many patients hesitate to visit clinics and hospitals. The risk in maintaining the physical examination requirement for methadone initiation can be a roadblock in offering the most adequate MOUD modality based on each individual patient's need. We urge SAMHSA to revisit the COVID-19-related guidelines and amend on a clearly articulated rationale that would benefit our patients.

Keywords Buprenorphine/naloxone, Covid-19, medication for opioid use disorder, methadone, MOUD, opioid treatment programs, OTPs, SAMHSA.

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