Methadone Deaths in Pain and Addiction Populations

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The Authors Reply: — We thank Drs. Grant and Baca for their thoughtful comments on our article,¹ and welcome the opportunity to respond to the assertion that there is little that can be done to manage risks associated with methadone prescribing in pain settings. In particular, the view that we overstate the ability to reduce risks appears overly pessimistic, may worsen methadone stigma, and is inconsistent with available data.

In order to elaborate on this point we review a study² examining the safety of using methadone in a Canadian pain clinic. A nurse management model enhanced monitoring of methadone use in 75 patients. The program consisted of three phases over 9 months: (a) a face to face educational session, (b) telephone calls during methadone titration, and (c) maintenance. Education focused on methadone pharmacology. Initial calls occurred 1 to 5 days later for close monitoring during initial treatment. For the titration and maintenance phases a questionnaire including reason for call, methadone dose, pain levels, activity levels, side effects and satisfaction with methadone was administered. Of 194 calls, 44% resulted in a methadone increase, and 11% led to methadone reduction or cessation. Over half the patients (57%) were either satisfied or very satisfied with methadone, and 8% stopped taking methadone due to efficacy or tolerability problems. No one developed significant morbidity or mortality. This study implies that there may be a place for methadone in the treatment of pain. Indeed, in Canada, methadone is often used as first line or second-line analgesic.² In the US there has been an effort to recognize situations where methadone analgesia offers advantage.³ Thus far, it appears that patients who have long-standing severe pain with a significant neuropathic component and who do not respond to other opioids may be suitable

candidates. Such patients typically have tried and failed multiple agents which provided inadequate relief or intractable side effects. Methadone may also offer benefits in patients with renal dysfunction. It differs from other opiates in that it has NMDA receptor antagonism. Blocking the NMDA may provide additional pain reducing properties over typical opiates and may attenuate the process of developing opioid tolerance.³

We agree with Drs. Grant and Baca that costs alone should not be driving medication considerations. Nevertheless, there appears to remain a role of methadone in the treatment of chronic pain.⁴ More research and improved physician education and prescription practice guidelines may help elucidate this role.

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