The Place of Methadone Therapy in the Hospice Setting
Pathways to Success Live Webinar Series™ Follow Up Questions
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1. **Is Methadone indicated for fibromyalgia? Are there studies indicating efficacy?**

   Methadone does not carry the indication for fibromyalgia because there was no clinical study back in 1940s when it was first discovered for fibromyalgia. Because Methadone is a very inexpensive medication that has been generically available for a long time now, it is unlikely that manufacturers will invest to study for this specific indication. The efficacy of Methadone for general neuropathic pain is suggested from expert clinical experiences and its theoretical mechanism of action towards to the NMDA receptor.

2. **I am wondering about the liquid for those patients with dysphagia or poor responsiveness. Is the concentration 5mg/5ml? Could it be compounded to 5mg/1ml?**

   Methadone also comes in 10mg/ml which is a concentrate that can be used in smaller quantity sublingually for patient with swallowing difficulty. Having Methadone Compounded to 5mg/ml will increase the cost of using Methadone.

3. **How would you go about converting FROM Methadone to another opioid?**

   There is no good consensus from experts of how this should be done. I often recommend converting from Methadone to another opioid to start at a very low starting routine dose, approximately 20-25% of the total daily Oral Morphine Equivalent (OME) and provide a sufficient breakthrough medication for patient to use during the transition. Patient will probably need a dosing adjustment every 2-3 days if using Fentanyl Patch or Morphine ER, or every day dosing adjustment if switching to Dilaudid Pump base the on prn dose needed that is to cover the portion of Methadone leaving the system. Because the beta-phase of methadone elimination is very individualized per patient, the time it takes to completely converting a patient to a different long-acting opioids varies.

4. **I wanted to add to your slide about when to consider methadone: patients who have a reasonable prognosis to benefit from methadone given the time it takes to reach steady state, patients with a solid support network in home to monitor for respiratory depression, and patients will stable pain situations (even if in pain) because inability to rapidly titrate methadone. My question: We use methadone mainly as an adjuvant mainly because the reasons of rapidly changing pain situations and limited prognosis at 2.5-5mg Q12H on top of their current pain regimen. Thoughts on using methadone as an adjuvant as opposed to primary treatment?**
    a. Thank you for the suggestion. I agree that starting Methadone will require more patient educations and a good monitoring and supported environment, especially during the initial transition so it should be considered as an option but not necessary as the first line long-acting opioid.
    b. For respiratory depression, my suggestion is to monitor it for all long-acting opioids (including Methadone) at initiation of therapy. Methadone as well as the other long-acting opioids (Fentanyl, Morphine ER, Oxycontin, etc) should not be used in situations when a rapid titration is required. When a rapid titration is necessary to treat acute severe pain, short-acting opioids are more appropriate because in case when we corrected too quickly than we want, we know the medication will be out of the system in a couple hours.
    c. Methadone can also be used in situation when patient's pain is changing quickly as a long-acting opioid to serve as a baseline opioid but not as a prn. I always recommending coupling Methadone with a short-acting opioid that is used to manage the breakthrough and changing pain situation. Until the patient is stable on a certain short acting opioid dose, Methadone dose can be increased accordingly to cover the routine breakthrough use of the short acting opioid and provide a more convenient dosing regimen.
    d. There are times when Methadone is used as an adjuvant at the lower dose, such as 2.5-5mg q12h to cover the neuropathic pain. I often recommend that when a patient is on a very high dose of opioid (>60mg Methadone per day) or patients that are not suitable to going through the opioid rotation. In general, when a patient had never taken Methadone in the past, the starting dose should not exceed >60mg per day according to the new CDC guideline. It is ok if the patient starts low and titrate up above 60mg Methadone per day but not to initiate therapy above that. In those scenario, it is appropriate to consider Methadone as adjuvant to another opioid that patient is already on.

5. **It takes time to start a patient on Methadone. When a patient is too close to death to benefit from methadone?**

    In general, Methadone is a long-acting opioid that provides convenient dosing for patient with severe and chronic pain. At the last couple days of life, I recommend to continue the use of short-acting opioid to manage pain and shortness of breath if possible and not to bother to start a patient on a long acting opioid. Methadone can be a back-up option if you really run out of choices to manage the very severe pain for the patient because it is a fast-acting opioid but I will still caution its use for the concern of respiratory depression.

6. **Once the patient is on the post 5 day Methadone dose, can you use Methadone for breakthrough pain?**
   I still do not recommend using Methadone for breakthrough pain because of the delayed beta-phase elimination characteristic. What that means is, patient may not be experiencing the full effect of the current prn dose until couple hours later and take another dose and ended up overdosing themselves and it will take days to correct the overdose.

7. **On your previous slide you put 570mg, but the division is for 370?**
   Thank you for pointing it out. The 570mg is a typo on slide #37. It should be 370.

8. **Can you use the Methadone tablet rectally instead of having a suppository compounded?**
   Yes. You can. You can wet the tablet with a little water prior using it rectally.

9. **There is a lot of negative stigma regarding Methadone and a lot of the doctors in our area refuse to prescribe it. What is your suggestion in how to persuade them to use it?**
   Yes, many of our hospice providers are in those areas. I think increasing education to the physicians in those area might be helpful. Sometimes, it is helpful to start the conversation with physician on one of those patient with difficult pain management and have the physician consider it as an option instead of having them change their practice completely. And feel free to share my presentation content with them if you find it helpful to educate them.

10. **What is the maximum dose of Methadone?**
    There is no true maximum dose for Methadone just like most of the opioids with careful titration. The CDC guideline recommends not to start Methadone at a dose exceeding 60mg per day. With careful titration, it can be used at higher doses. When Methadone is used for detox purpose, it can be safely used at doses >200mg per day.

11. **When you are converting from other opioids to Methadone, do you take into account incomplete cross-tolerance?**
    Yes. The sliding scale conversion factors we use also take into account for the incomplete cross-tolerance.