Understanding constipation and its treatment can aid patient comfort and satisfaction during MMT.

**Clinical Concepts**

**Constipation During MMT**

Constipation is a common side effect of all opioid drugs, including: heroin, morphine, other opioid painkillers, buprenorphine – and, of course, methadone. Half or more of all patients in methadone maintenance treatment (MMT) programs experience the disorder to some degree.[1]

It is important to emphasize that the constipating effect is not unique to methadone. And, in fact, some evidence indicates that methadone is less prone to cause constipation than other opioids.[2]

A better understanding of constipation and its treatment can greatly aid patient comfort and satisfaction during ongoing participation in MMT.

**Constipation Effects Vary**

All opioids act on the gut (intestine and large bowel) to slow natural motions and, at the same time, to increase fluid absorption.[1] These effects can create a condition in which bowel emptying occurs less frequently,

**Opioids**

Poster presentations are summaries of state-of-the-art research prior to more formal publication. This year’s AATOD Conference in Orlando, Florida (also see page 2) had a great number of worthwhile posters, and several are reviewed below.

**Flexible Drug-Screening Schedules Helpful**

Early and rapid identification of alcohol or illicit drug abuse is an essential component of addiction treatment. Current standards for drug testing during methadone maintenance treatment (MMT) require a minimum of 8 random toxicology screens per year.

Urine screening is the gold standard for determining illicit drug use. While positive urinalyses generally indicate drug use, these do not provide information about the pattern of such substance abuse.

How often must urine testing be done to detect various patterns of drug abuse?

Using a computer-generated model, researchers examined different frequencies of testing compared with several patterns and types of drug abuse. As expected, almost any frequency of urine screening will detect daily drug abusers; however, infrequent illicit drug use can go undetected for very long periods of time.

For example, the researchers found that a patient relapsing to a pattern of weekly cocaine use, and tested only 8 times yearly, could go nearly 11 months before the drug abuse is detected. In a patient using illicit opioids twice per month, and also having random urine screens twice monthly, it could take almost 4.5 months on average before the substance abuse is detected.

Continued on Page 5

Continued on Page 6
AATOD Holds 20th Anniversary Conference

In the wake of its hurricane season, Orlando, Florida, welcomed the 20th Anniversary AATOD (American Association for the Treatment of Opioid Dependence) Conference from October 16-20, 2004. This premier event serving the methadone maintenance treatment (MMT) community worldwide continues to grow, with more than 1,300 attendees from the U.S. (primarily) and 17 other countries.

J. Thomas Payte, MD served as Conference Chair, supported by Mark Parrino, MPA, President of AATOD, his staff, and a large number of volunteer workers. Here are highlights from several speakers.

Increasing MMT Access

In his opening remarks, Parrino recalled that AATOD has grown from a Northeast Regional Coalition in 1983 encompassing 8 founding states and the District of Columbia. At present, the Association comprises 21 state member chapters, representing more than 850 MMT programs in the U.S.

AATOD has been working to increase access to methadone treatment through the criminal justice system, using special funding from Mallinckrodt through the criminal justice system, increasing access to methadone treatment MMT programs in the U.S.

Increasing MMT Access continues on Page 3
and only 13% were transferred from methadone. Clark stressed that buprenorphine is not in competition with methadone.

He further emphasized that CSAT recognizes the importance of MMT-patient advocacy groups. His agency continues to support the various groups and wants to increase the ability of patients to help monitor services provided by MMT programs.

Addiction A Disease; Not A Disgrace

James McDonough – Drug Policy Coordinator, Executive Office of the Governor, Florida – asserted that there is a wave of recognition washing over the addiction field. “Treatment works,” he said, “and addiction is a disease, not a disgrace.”

In Florida, methadone accounts for increasing numbers of deaths. However, these are related to methadone prescribed for analgesia rather than coming from MMT programs. Overall, prescription drug abuse deaths exceed those for cocaine and heroin combined.

McDonough discussed some of the challenges and opportunities facing the addiction treatment field today. First, there do not appear to be any miracle cures and we need to maintain some healthy skepticism. Reject bad ideas, he said.

As a profession we need to determine what is good and to act on it. However, seeking perfection can be the enemy of the “good” – we cannot wait to perfect our approaches and need to grab on to what works, he said.

Finally, he expressed concern that the addiction treatment field does not do a good job of cultivating new generations of professionals to carry on the work. Creating training and education events (like the AATOD Conference) will bring the field to the next level should be a priority. We need a process that improves skills over time and always looks toward bringing in new generations of workers.

Methadone: “Boring” As A Street Drug

Mary Jeanne Kreek, MD – Professor and Head of the Laboratory of the Biology of Addictive Diseases, Rockefeller University, New York – reminded the audience that 2004 also marks the 40th anniversary of methadone maintenance treatment in the U.S. She noted that there are about 225,000 patients in MMT today; however, this number has not been increasing, despite the fact that there are an estimated 1 million heroin addicts in the U.S. and 8 million persons have abused prescription opioids.

Kreek concluded with several predictions and wishes for the future. She expects there will be progressive changes in regulations at all levels, recognizing the need for both clinics and addiction treatment specialists, particularly those offering more office-based treatments.

She also hopes there will be increasing acceptance and reimbursement of combined behavioral and pharmacotherapy approaches for addictive disorders. Kreek would like to see more funding for the treatment of HIV and hepatitis C in drug-addicted persons, which is lacking today in most regions of our country. Finally, she foresees that some day we will be able to utilize genetic information as a guide to providing more specific addiction treatments for individual patients.

Mark your long-range calendars now: the next AATOD Conference will be in April 2006, in Atlanta, Georgia.

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NEW SURVEY: Constipation?

In this edition we once again discuss an issue related to MMT that has received relatively little attention – constipation. We look forward to reader feedback on this topic, so please respond to the following survey questions:

1. What estimated percentage of patients at your MMT clinic have complained of constipation? _____%

2. Which of the following are recommended or prescribed? Check all that apply: 
   - more fiber in diet; 
   - more fluid intake; 
   - OTC laxatives; 
   - Rx laxatives; 
   - other (describe) ____________________________.

3. If laxatives are recommended or prescribed, which ones?

4. Are you responding as a patient, or a clinic staff member?

There are several ways to respond to AT Forum surveys: A. provide your answers on the postage-free feedback card in this issue; B. write, fax, or e-mail [info above]; or, C. visit our web site to respond online. As always, your written comments are important for helping us discuss the survey results in an upcoming edition.
Last summer, Charles “Charlie” LaPorte suggested that AT Forum should provide special recognition of “old timers” who made significant contributions during the evolution of methadone maintenance treatment (MMT). Sadly, before we could ask who he had in mind, Charlie passed away this past September at age 74 following a brief battle with cancer. Therefore, it seems most fitting that Charlie himself should be the focus of this first “MMT Pioneers” feature.

Putting Experience to Work

If ever there was a man who used his own experience, strength, and hope to help better the lives of others at all levels in the addiction treatment field it was Charlie. Born in Ponce, Puerto Rico, he grew up in the New York City area and struggled during his youth with heroin addiction.

Overcoming his opioid addiction during the 1960s, Charlie embarked on a career spanning more than 40 years in the MMT field. Along the way, he worked along side many of the pioneers – Drs. Vincent Dole, Marie Nyswander, Harold Trigg, and others – and was responsible for hiring professionals who are active in leading the field today.

Charlie began his career at Beth Israel Medical Center, New York City. Starting as an entry-level maintenance worker, he soon became a counselor in the drug detoxification unit. Rising steadily through the ranks, he became Admissions Supervisor at Beth Israel in 1970, responsible for a staff of 22 medical and social services personnel.

In 1972, he joined the Medical M Group MMT program (later called Gramercy Park Association) as Executive Director supervising 23 staff serving about 370 patients. From there, he went to the New York Division of Substance Abuse Services – DSAS, now the Office of Alcoholism and Substance Abuse Services) – as Deputy Director from 1980 to 1990. He was responsible for overseeing regulatory compliance of 130 MMT clinics treating 36,000 MMT patients state-wide.

During the early 1990s, Charlie became Executive Deputy Director of PROMESA, Bronx, NY, which was the largest substance abuse provider to Hispanics in the state. Finally, from 1994 to the time of his death, he was Administrative Director at the Hunts Point Multi-Service Center, Substance Abuse Services, New York, NY, where he was responsible for clinical and administrative functions.

Patients Come First

“Charlie always put the patients first – meeting them where they were, without lofty middle-class standards for success in treatment,” notes Ira Marion, MA (Executive Director, Division of Substance Abuse; Albert Einstein College of Medicine; New York, NY). “He also never lost his cultural perspective and was concerned that programs hire minorities and remain sensitive to the cultural differences among patients.”

Similarly, Rafael C. Colon (Deputy Administrator at Hunts Point Multi-Service Center and a friend of Charlie’s since childhood) says, “First and foremost, Charlie believed in the patients and he fought for them in every way. He made certain their rights were upheld, that they received the best treatment that was possible. At DSAS during the 1980s, he wrote a lot of the rules and regulations governing MMT programs in New York and expanded capacity.”

Marion agrees, “During his tenure at DSAS, Charlie was responsible for methadone getting adequate attention as a treatment modality; until then, it had been largely ignored and neglected. Because he had run a program himself, Charlie understood the problems. He also was able to help MMT programs integrate HIV/AIDS treatment into their services.”

However, “Charlie was a foot soldier as well as a commanding officer,” according to Beny J. Primm, MD (President, Urban Resource Institute; Executive Director, Addiction Research and Treatment Corporation; Brooklyn, NY). “He could talk on any level when it came to addiction treatment, particularly methadone.”

“Charlie also provided a great deal of encouragement to many people in the field, guiding them in their career decisions,” recalls Mark W. Parrino, MPA (President of AATOD [American Assn. for the Treatment of Opioid Dependence], New York, NY). In 1974, Charlie offered Parrino his first position in the MMT field, as a counselor at the Medical M Group.

A Creative Mind

“Charlie was a creative person who could look to the future,” Parrino says, “and he had a good sense of the political realities behind any situation. He also had a talent for managing very difficult situations and finding the talented people he needed to work with him.”

For example, Parrino remembers how during the early 1980’s Charlie conceived of a program that would provide treatment using methadone for jailed opioid addicts, rather than the “cold turkey” detoxification that was common at the time. He proposed starting a program at the Rikers Island Correctional Facility in New York City.

By 1987 Charlie’s vision became a reality known as KEEP (Key Extended Entry Program). The premise was that every opioid addict entering prison would get some form of treatment; at the least, humane detoxification. For short-term sentences, inmates could be maintained on methadone and then connected with a community MMT program after release.

Marion notes that, “This link to the criminal justice system – providing jail-based addiction treatment – continues today as one of Charlie’s most vital and enduring legacies.”

Don’t Let Them Forget

“Shortly before he died,” Primm says, “Charlie told me, ‘Don’t let people forget what we’ve all accomplished in this field to help patients.’”

Certainly, Charlie will be long remembered by all who knew him through the years and became better professionals in the MMT field or received better patient care as a result. He also will be missed and remembered by his wife Elizabeth, their children, and his many grandchildren to whom we offer sincere condolences.
or in which the stools are hard and small, or where bowel movement causes difficulty or pain – constipation.[3,4]

A desired frequency of bowel movement is difficult to define, and daily movements are not necessarily essential for good health. Normal bowel patterns can range from 3 movements each day to only 3 per week.[4]

Because active opioid abusers may experience frequent withdrawal, with diarrhea as a symptom, constipation is often not noticed as a problem prior to MMT. For patients who develop constipation during MMT, it tends to be worse early in treatment while the body becomes accustomed to long-acting methadone.[1]

With time, constipation may become less troublesome; however, this can take months or even years.[5] For most patients, appropriate lifestyle changes and treatment are most helpful in relieving constipation.

Treating Constipation

There are a great many different products and combinations – both via prescription and over-the-counter (OTC) – marketed as laxatives (loosening the bowels) to treat constipation. Yet, there is little detailed medical research describing a best approach.

MMT patients should be encouraged to first consult with clinic medical staff, rather than purchasing over-the-counter products or using home remedies on their own.

Four measures have been recommended for dealing with constipation during MMT and best results are achieved by applying all of them:[5]

1. a stool softener (such as a docusate formulation);
2. a lubricant (mineral oil preparation);
3. a natural laxative (such as stewed prunes or prune juice); and
4. extra fluids (at least 2 quarts of water daily).

A well-balanced diet high in fiber – including bran, fruits, and vegetables – while cutting down on white bread, cakes, and sugar is important. Regular exercise helps, since it improves digestion and reduces stress.[1,3]

Establishing a regular bowel habit is beneficial. The best time is usually during the first hour after breakfast; sitting for at least 10 minutes without rushing or straining; regardless of whether stool can be regularly passed.[4]

In persistent or difficult cases, it may be appropriate to rule out causes for the constipation other than opioid maintenance. Besides poor diet and lack of exercise, these could include: irritable bowel syndrome (IBS), an underactive thyroid gland, a colon or rectal tumor, and other medications (e.g., antidepressants, iron supplements, aluminum-containing antacids, and others).[3,4]

Clinician Suggestions

According to Howard A. Heit, MD, FACP, FASAM – a national lecturer on the relationship of pain and addiction medicine – constipation should be automatically treated in all persons prescribed opioids, including methadone, since it is probably the major side effect and patient complaint. Patients should be instructed on this at their first clinic visit.

Heit recommends a “mush-push” approach to laxative medication. Two components include a stool softener (for example, docusate) and a mild bowel stimulant (such as, a senna-containing product). An osmotic agent, like lactulose or polyethylene glycol, may be prescribed as needed. Osmotic agents increase the amount of water in the stool by drawing water from the bowel lining.

Heit advises against using bulk-producing agents, such as methylcellulose or psyllium (also see, side box). In some patients taking opioids, these products may worsen constipation.

Similarly, Edwin A. Salsitz, MD, FASAM – Medical Director, Office-Based Opioid Therapy, Beth Israel Medical Center, New York – notes that about half of the MMT patients he treats complain of constipation. He usually prescribes an osmotic agent (polyethylene glycol) and patients adjust the dose to achieve the desired laxative effect. Attention to diet, adequate water intake, and exercise are emphasized.

In his practice, Salsitz has not observed any long-term harm related to methadone’s opioid effects in the bowel. “Constipation is a biologically expected result of chronic opioid treatment and is usually easily treated,” he says.

However, he notes that the constipation issue is often used as yet another way to stigmatize methadone treatment. This is unfair, Salsitz suggests, since the constipating effect of methadone is easier to treat effectively than the troublesome side effects of many other medications.

References:


Metamucil® in Methadone?

A persistent myth claims that methadone tablets contain the laxative Metamucil®. While this is completely untrue, the possible origin of this story is interesting.

Methadone tablets contain an ingredient called microcrystalline cellulose, which is a biologically inactive substance made from wood pulp that is added in small amounts merely to help hold the tablets together. However, “microcrystalline cellulose” probably became confused with similar-sounding “methylcellulose” – a product that does help relieve constipation in some persons by absorbing water and softening stool in the intestine.

The mental leap from “methylcellulose” to “Metamucil” added further confusion. However, Metamucil is a laxative based on a natural fiber called “psyllium” and contains no methylcellulose.

Methadone tablets contain neither methylcellulose nor Metamucil and, in practice, those laxative products are not usually recommended for MMT patients.

*Metamucil is a registered trademark of Procter & Gamble.*
Thus, the early detection of substance abuse, while avoiding costs of overly frequent drug testing, presents a clinical challenge. MMT clinic staff need to be flexible in matching the urine-screening schedule to the suspected pattern of drug abuse. The less often the patient is believed to be abusing drugs, the more often urine screens need to be performed.

Carlson GA, Crosby RD, Specker SM. Patterns of drug use vs. frequency of urine drug screens: what is cost effective. Poster presented at: AATOD Conference; October 16-20, 2004; Orlando, FL.

AD/HD Symptoms Common During MMT, Affect Outcomes

Attention deficit/hyperactivity disorder (AD/HD) was once considered a childhood disorder and only recently has it become more recognized in adults. Researchers reviewed 687 continuous admissions at a midwestern MMT program to determine the rate of AD/HD symptoms and their influence on treatment outcomes.

They found that 58% of the patients had one or more AD/HD symptoms. Another 19% reported symptoms that significantly disrupted functioning, and these patients were more likely to be only moderately successful in MMT at 9 months after admission.

A 20-item AD/HD symptom checklist included such items as: impatience, difficulty concentrating, irritability, sudden changes in mood, and acting impulsively. “Moderate success” was described as less than a quarter of urinalyses positive for illicit drugs, employed or looking for work, and no criminal activity.

The poster author concluded that special interventions for patients with AD/HD, including medications, may be necessary for them to achieve more successful outcomes during MMT.

Carlson GA. Role of attention deficit/hyperactivity disorder in methadone treatment outcome. Poster presented at: AATOD Conference; October 16-20, 2004; Orlando, FL.

Services in MMT Programs Need Improvement

This study measured the availability of treatment-related and ancillary services at 172 MMT Programs from September 1998 through February 2000. The research was conducted as part of the Center for Substance Abuse Treatment Methadone Accreditation Project Evaluation Study, which evaluated the implementation of the new accreditation-based regulatory approach.

Services evaluated included: general medical care; AIDS-related care; and educational, vocational, financial, legal, transportation, childcare, and housing/shelter assistance.

The most common specialized services offered were for patients with HIV/AIDS and women. The least commonly offered were services specifically for racial/ethnic minorities and patients involved with the criminal justice system.

The authors concluded that providing a range of treatment-related and ancillary services is essential for MMT programs providing comprehensive treatment. However, their findings suggest that only a small percentage of patients are receiving these services and such services are not necessarily being offered directly at the clinic site.

Offering services on site generally increased the probability that they were received by patients; whereas, offering them through other arrangements did not have a similarly strong or consistent effect. More specifically:

- Given the high level of HIV and hepatitis infection among this patient population, access to general medical and AIDS-related medical care is a necessary component of ensuring patient health. If patients must go to other providers for these services, it raises concerns that many may not be receiving the care they need.

- Ancillary services are typically provided through linkages with other organizations, mostly through informal arrangements. These arrangements were not found to increase the probability that patients received the services. Instead, ensuring the continuum of patient care is best accomplished by providing these services on site.

- Most MMT programs are not taking direct responsibility for ensuring that patients have a means of getting to the clinic or adequate child care. These are both known to be barriers to treatment.

- The lack of programs offering specialized services for many populations — including non-English speaking patients and patients with psychiatric diagnoses — is of particular concern.


Get Nutrition Info on the Web*

US government sites on nutrition can be found at: http://www.nal.usda.gov/fnic/efex/000033.html


University of Maryland Medicine offers information on diet and substance abuse at: http://www.ummm.edu/ency/article/002149.htm

For helpful precautions on purchasing nutritional supplements, see:

- Twenty-Five Ways to Spot Quacks and Vitamin Pushers. Practical guidance from Quackwatch at: http://www.quackwatch.org/01QuackeryRelatedTopics/spotquack.html

NOTE: Numerous popular books also are available on topics relating to addiction recovery and nutrition; however, these should be approached cautiously. Many are poorly researched or unsupported by clinical evidence, and some promote diets or nutritional supplements that may be inappropriate for patients in methadone maintenance treatment.

Patients should always consult a qualified healthcare provider before starting a nutrition improvement or exercise program.

*Access to all sites was confirmed in October 2004.
Nutrition Important

Our feature article in the Spring 2004 edition of AT Forum (Vol. 13, #2) focusing on diet and nutrition during methadone maintenance treatment (MMT) — titled “Feeding Recovery” — generated a great deal of interest. There were nearly 250 responses to a reader survey on the subject (60% were from MMT clinic staff).

The vast majority (88%, see graph) believe that nutrition plays an important role in addiction recovery. Yet, a much smaller percentage of clinics assess patients’ nutritional status (34%) or educate them about proper nutrition (38%). And, only 1 in 5 clinics routinely prescribe a remedy of some sort for improving diet and nutrition.

The most frequently prescribed “remedy” was vitamins/minerals; however, only 16% of all responding readers indicated this is done at their clinics. About 11% of readers indicated that special diets are prescribed for patients, and 6% prescribe amino acid supplements. Only one reader indicated that patients with special needs are referred to a dietician for consultation.

Readers Express Concern

Comments from readers are always helpful in better understanding survey responses. Here is a sampling:

“I am a nurse in recovery who feels the importance of proper nutrition to assist in brain function is not emphasized enough.”

“There isn’t enough education on nutrition and supplements and, with all the additives and preservatives in our foods – not to mention all the fast foods – it’s difficult to eat right to begin with.”

“We don’t recommend vitamins or supplements for our patients, we provide educational literature.”

“I recently discontinued MMT after many years, using a slow taper (taking 3 years) and proper nutrition. I stopped all refined sugars and eliminated carbohydrates. I also started a high protein diet with multiple small meals each day to keep up my energy. I feel that without proper nutrition and exercise I could not have gotten my [brain chemistry] balanced on its own.”

“I have been on methadone for more than 20 years and never has any clinic staff member mentioned nutrition. I took it upon myself to research the subject and learn what role it could play in recovery.”

“Such nutrient shortages also hinder the rate and quality of addiction recovery.”

We don’t recommend vitamins or supplements for our patients, we provide educational literature.”

“I recently discontinued MMT after many years, using a slow taper (taking 3 years) and proper nutrition. I stopped all refined sugars and eliminated carbohydrates. I also started a high protein diet with multiple small meals each day to keep up my energy. I feel that without proper nutrition and exercise I could not have gotten my [brain chemistry] balanced on its own.”

“I have been on methadone for more than 20 years and never has any clinic staff member mentioned nutrition. I took it upon myself to research the subject and learn what role it could play in recovery.”

“Some are quite expensive and it is difficult, if not impossible, for the average healthcare practitioner or patient to know which to choose for a particular purpose.

As a start, reliable medical authorities recommend a standard once-daily multivitamin/multimineral pill for all adults,[13,14] and this would be especially important for patients in addiction recovery. A month’s supply of a generic vitamin/mineral supplement – USP (US Pharmacopeia) approved – can be purchased for about one dollar.

At the same time, the experts advise against taking excess vitamins or minerals, greater than 100% of the recommended daily value, unless special patient needs have been carefully assessed.[13,14] Mega-doses of vitamins found in some supplements might be harmful in certain cases.

Continued on Page 8
Survey Results: Feeding Recovery
Continued from Page 7

In their survey responses, a few readers mentioned nutritional products that are promoted specifically for treating opioid addiction or for patients maintained on methadone. The theory behind such products seems reasonable: the addicted brain becomes chemically unbalanced and specific nutritional supplements can restore a more natural state to aid in recovery.

In addition to vitamins and minerals, amino acids often are recommended since they serve as building blocks for important proteins in the brain.[15] Prices for such products can range from $20 to $60 for a single month’s supply, or much more if ingredients are purchased separately.

However, it is important to note: to date, there have been no published clinical studies on the effectiveness or benefits of these nutritional supplement products in MMT patients. Furthermore, current federal regulations do not require extensive information from manufacturers of nutritional supplements on the safety, effectiveness, or quality of their products.[13,16] Therefore, consumers and healthcare practitioners usually do not have reliable information for making purchasing decisions.

This is not to say that nutritional supplements cannot be important for aiding MMT patients in recovery. However, the lack of research or sufficient information suggests that any investment in such products must be made cautiously. See Side Box on page 6 for where to find purchasing guidance.

References