

# Forum

THE QUARTERLY NEWSLETTER FOR CLINICAL HEALTH CARE PROFESSIONALS ON ADDICTION TREATMENT

Vol. 10, #3 • SUMMER 2001

## Clinicians Concur: Methadone Safe for the Heart

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### Practitioner Panel

#### Methadone and Heart Health

Recent actions in response to heart problems reported with LAAM (levacetylmethadol) have raised serious concerns in the opioid-addiction treatment community.

Last spring, European authorities withdrew LAAM from the market due to reports of patients taking the medication and experiencing cardiac rhythm disturbances, some life-threatening. In the US, the FDA strengthened warnings about such potential adverse events and highlighted them in a black box on product labeling. Also, electrocardiograms (ECGs) to assess heart rhythm are now indicated for all patients prescribed LAAM.

Similar to LAAM, might methadone be associated with any heart problems?

To help answer that question, *AT Forum* interviewed a panel of 6 practitioners with extensive experience in methadone maintenance treatment (MMT).

#### No Immediate Cause for Alarm

Robert Maslansky, MD - Medical Director, Addiction Rehabilitation Program, NYU School of Medicine, Bellevue Hospital Center, New York, NY - has more than 30 years experience in the field and has personally treated about 5000 MMT patients. In all that time, he says he has not seen any heart rhythm disturbances (arrhythmias) or ischemic heart disease (coronary attacks) that he would attribute to methadone. Furthermore, he has encountered very few abnormal ECGs in MMT patients to suggest chronic heart disease.

This is surprising, he admits, since 90% of patients smoke, which is a high

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### Program Update

#### Methadone Anonymous Comes of Age

A reader recently e-mailed the following to *AT Forum*:

*We now have Methadone Anonymous meetings at the methadone clinic I attend. Those of us who are serious about becoming active members of society needed somewhere to talk, to share, to help ourselves and each other. Merely coming to a clinic is not recovery. We have to do everything differently in our lives, think differently, and develop new coping skills. These meetings aren't like our mandatory therapy groups; the counselors do not facilitate unless we ask them to. We take turns being the chairperson, as in AA groups, and the meetings seem to be catching on.*

Methadone Anonymous (MA) was last discussed in *AT Forum* 6 years ago (Spring 1995, Vol. 4, No. 2). So, an update on this rapidly growing movement, now celebrating 10 years since its founding, is long overdue.

#### Born of Necessity

In 1991, Gary Sweeney, CACAD - Education Coordinator at Man Alive, a large methadone maintenance treatment (MMT) center in Baltimore - was attending a Narcotics Anonymous meeting to see a patient receive an "Anniversary Chip" (an award for sobriety time). When the woman expressed her gratitude for how methadone had helped her, she was ordered to return the Chip because the group viewed methadone as just another prohibited drug.

The woman fled the meeting in tears; Sweeney was outraged at the group. He decided to develop a 12-step program for MMT patients.

Sweeney modeled the program after

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## Events to Note

For additional postings & information, see:  
[www.atforum.com](http://www.atforum.com)

### NOVEMBER 2001

#### ASAM State of the Art Course

November 1-3, 2001

Washington, DC

Contact: 301-656-3920; [www.asam.org](http://www.asam.org)

#### AMERSA - Association for Medical Education & Research in Substance Abuse, 25th Annual Conference

November 8-10, 2001

Hilton Old Town; Alexandria, Virginia

Contact: 401-349-0000;

Isabel@amersa.org

#### ASAM Forensics in Addiction Medicine Workshop

November 29, 2001

Washington, DC

Contact: 301-656-3920; [www.asam.org](http://www.asam.org)

### SECAD 2001

#### Sponsored by National Association of Addiction Treatment Providers

November 28 - December 1, 2001

Sheraton Atlanta Hotel, Atlanta, Georgia

Contact: 1-888-506-7394;

[www.naatp-secad.com](http://www.naatp-secad.com)

#### ASAM Medical Review Officer Training Course

November 30 - December 2, 2001

Westin Fairfax Hotel, Washington, DC

Contact: 301-656-3920; [www.asam.org](http://www.asam.org)

### DECEMBER 2001

#### AAAP - American Academy of Addiction Psychiatry, 12th Annual Meeting & Symposium

December 13-16, 2001

Amelia Island, Florida

Contact: 913-262-6161; [Info@aaap.org](mailto:Info@aaap.org)

#### OPEC - Ohio Prevention & Education Conference

December 12-14, 2001

Columbus, Ohio

Contact: 800-788-7254;

[Robert.Canning@uc.edu](mailto:Robert.Canning@uc.edu)

### COMING 2002

#### ASAM 33rd Annual Meeting & Scientific Conference

April 25-28, 2002

Hilton Atlanta, Atlanta, Georgia

Contact: 301-656-3920; [www.asam.org](http://www.asam.org)

[To post your announcement in A.T.Forum and/or our Web site, fax the information to: 847/413-0526 or submit it via e-mail from [www.atforum.com](http://www.atforum.com)]

A.T.F.

## Straight Talk... from the Editor

### Medically Speaking - Stamping out Slang

During our interview with Edwin Salsitz, MD - Director of the methadone medical maintenance program at Beth Israel Medical Center, New York - for the article in this edition on methadone and heart health, he also wanted to share his disappointment with the use of language in MMT programs. This is a topic he often stresses during his many excellent lectures to professional groups, and one we've repeatedly mentioned in this column.

#### Wrong Messages

"If addiction is a disease, why not use appropriate medical terminology in addiction treatment settings?" Salsitz asked. "Unfortunately, in this field a great deal of inappropriate slang is used in communicating with patients and professionals alike."

"Junkie, dope fiend, hard-core addict - what do these terms say about a person with the disease of addiction? Certainly, it would not be healthy to refer to a person with schizophrenia as a 'psycho'!"

"Another puzzling use of language is 'dirty urine,' referring to a positive toxicology screen," he continued. "We would never say that a person with a urinary tract infection, who has white cells or bacteria in their specimen, has a 'dirty urine.'"

"My opinion is that such terms send the wrong messages and negatively affect both the people who use and hear them," Salsitz insisted.

#### Unjustifiable Slang

"Isn't there some benefit, however, in using the everyday language of patients in order to relate well with them?" we wondered. "'Recalcitrant' just doesn't have the same ring as 'hard-core.'"

"Yes, you do have to make sure patients understand you and that there is effective communication," Salsitz agreed. "But, there's no reason patients can't come to understand that words make a difference. Why shouldn't we speak to patients in a professional manner, using proper medical terminology?"

"Just because we all understand street slang associated with addiction doesn't justify our using it," he continued. "In other areas of medicine, slang is never

used to describe signs, symptoms, or medical conditions. This is not the case with addiction treatment and it keeps us apart from mainstream medicine."

#### A Challenge to Readers

Salsitz further suggested that use of the term "addict" is demeaning, although it seems to be politically correct. More preferable would be "addicted person" or "patient with the disease of addiction," which avoids negatively dehumanizing the human being who is afflicted with a bona fide disease.

"My challenge to those in the field is to try *not* using the word 'addict' for two weeks," Salsitz proposes. "Instead, use 'addicted patient' or 'addicted person' and see if you feel better doing it that way. See if it makes a difference."

#### Survey - Talking to Patients

We want to know what our readers think about the use of language in addiction treatment settings. Please respond to the following statements:

1. Language affects attitudes and how patients feel about themselves.  
\_\_\_ agree; \_\_\_ disagree.
2. Using slang aids better communication.  
\_\_\_ agree; \_\_\_ disagree.
3. Medical terms would confuse patients.  
\_\_\_ agree; \_\_\_ disagree.
4. Using proper medical language helps foster recovery.  
\_\_\_ agree; \_\_\_ disagree.

Are you responding as a \_\_\_ medical staff member; \_\_\_ counselor/therapist; or, \_\_\_ patient

*There are several ways to respond:*

**A.** Provide your answers on the postage-free feedback card in this issue; **B.** Write or fax us [see info below]; or **C.** Visit our Web site to respond online. As always, your *written comments* are important to help us discuss the results in our next issue.

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A.T.F.

## Overcoming Obstacles to Optimum Methadone Dose

It is well established that, at an adequate daily dose, methadone maintenance therapy (MMT) effectively stems drug cravings and can eliminate illicit opioid use. However, achieving the best, or optimum, dose for any patient can be challenging.

In general, variations in patient response to medications pose a significant therapeutic dilemma. It has been estimated that as few as one third of patients derive intended therapeutic benefit from any prescribed drug. In the other two thirds, either the medication does not work as intended or is not well tolerated.

In the case of methadone, why might one patient thrive on 50 mg per day while another requires 500 mg/d or more for effective therapy?

### Adequate SML Important

To be effective, methadone must be present in the patient's blood serum in a sufficient quantity to prevent symptoms of withdrawal (abstinence syndrome) or intoxication (overmedication) throughout a 24-hour period. The concentration of methadone - serum methadone level (SML) - can be measured by a standard laboratory test and is expressed in nanograms per milliliter, or ng/mL.

Research has demonstrated that an SML of approximately 400 ng/mL, as measured just before methadone is taken for the day (representing the SML at its lowest point, called "trough" value), is usually adequate for stable methadone maintenance in most patients. However, research also has shown that there is often little correlation between methadone dose and SML: that is, different patients taking exactly the same daily dose may have very different SMLs.

Also, the 400 ng/mL SML is not a "gold standard;" some patients will require a much higher methadone concentration and others may do well with somewhat less. SMLs are generally more appropriate for confirming inadequate dose than for determining optimum dose. That is, in a patient complaining of withdrawal symptoms prior to their daily dosing, an SML of, say, 100 ng/mL would demonstrate inadequate dosing. Thus, the SML can help provide a convincing argument for raising daily dose; although it does not indicate how much the dose should be increased or the necessary SML to be achieved.

### Factors Affecting Response

Even at a seemingly adequate SML, a great many factors come into play in determining how a person will respond to any medication, and methadone is no exception. Some of these factors are listed in the **Table**.

Given those many influences, it can be appreciated that a "one methadone dose or SML fits all" approach would be quite inappropriate. But, how do the various factors affect response to methadone?

Drug "digestion," or metabolism, is a critical process. The metabolism of oral methadone begins in the gut and continues primarily in the liver, where enzymes break it down into inactive molecules that can be eliminated from the body by the liver

and kidneys. The amount of the principal enzyme - designated CYP3A4 - present in different persons can vary by as much as 30-fold in the liver and 11-fold in the gut. To a lesser extent, other enzymes aid in methadone metabolism and some of these also can vary in quantity.

Furthermore, overall liver function can have great impact. Liver impairment due to disease, such as hepatitis C, would be expected to decrease metabolism and raise methadone serum levels; the patient may require a decrease in dose to compensate. However, there is some evidence that at certain stages of HCV some patients actually require an increase in dose to remain stable.

In general, it has been suggested that, given any two patients taking exactly the same dose of methadone, the amount of active methadone in their systems can vary by up to 17 times. Thus, it can be appreciated that 50 mg of methadone in one person might have the equivalent effect of 500 mg in another - and vice versa.

### Interacting Agents

A great many drugs and substances can influence methadone's effects and patient dose requirements: some unexpectedly. For example, tobacco smoking increases the activity of certain liver enzymes, possibly leading to faster metabolism of methadone. A glass of morning grapefruit juice before methadone dosing may suppress the activity of certain enzymes in the gut, making the methadone dose more potent. Increased urine acidity - perhaps due to diet or large amounts of vitamin C - can increase excretion of methadone and lower its serum level.

Certain medicines - such as rifampin, carbamazepine, phenytoin, and many others - increase the action of liver enzymes that metabolize methadone, so the dose is "digested" faster. Conversely, other medicines - e.g., cimetidine, ketoconazole, diazepam, erythromycin, and others - decrease methadone metabolism, which results in greater potency of the dose. Interactions between methadone and other drugs can be very problematic, since it is usually difficult to determine in advance just what the effects will be and their extent

### Signs/Symptoms Guide Dosing

Since there are so many factors that can influence methadone potency, and SML results are not reliable for determining optimal dose, how can adequate dosing be achieved?

Vincent Dole, MD, a developer of MMT, stressed that an experienced clinician can judge the adequacy of methadone dose by its effects. He, and others, have suggested that optimal dose can be readily identified by looking for clinical signs, listening to patient-reported symptoms, considering the timing of these in relation to daily dose, and noting the patient's response to a change in dose.

The **Figure** (next page) demonstrates how signs and symptoms in a patient might be used as a guide for achieving optimal dose.

As the blood serum concentration of methadone is increased via more adequate dosing, objective

### Factors Affecting Response to Methadone

Sex, age, race	Physical disorders, disease, or infection
Body weight, size	Pregnancy
Alcohol and tobacco use	Liver and renal function
Illicit drug use	GI function
Prescribed and OTC medication	Stress
Herbal/alternative products	Genetic variations in metabolic enzymes
Diet and nutritional state	

Adapted from *Merck Manual*, 1999, and *Drug Interactions in Infectious Disease*, 2001

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## “Clinical Concepts” Continued from Page 3

signs of severe opioid withdrawal (abstinence syndrome) disappear. Further dose increases then can be guided by patient-reported subjective symptoms, which may persist long after abstinence signs have dissipated. If the methadone dose is too high, the patient will exhibit signs of opioid overmedication, or intoxication. Generally, signs of intoxication are opposite of withdrawal. For example, opioid intoxication causes the pupils to constrict, whereas the pupils are dilated during severe withdrawal.

At the optimal methadone dose, the peak and trough SMLs - i.e., the methadone high and low points - stay well within the therapeutic “comfort zone” throughout a 24-hour dosing period. The patient experiences neither opioid withdrawal nor intoxication.

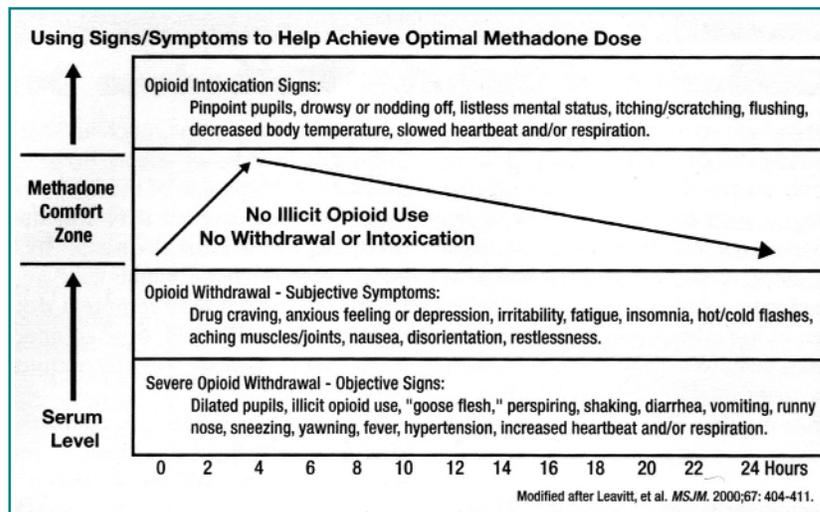
### Average Dose Misleading

In practice, this optimal dosing strategy relying on signs and symptoms may result in daily methadone doses that some clinicians might consider unduly high. However, most patients still would require doses in a more conservative range.

For example, the **Bar Graph** depicts the distribution of methadone doses among 1200 patients in one large MMT program that provides individualized adequate dosing (data courtesy of CAP Quality Care). A portion of patients in this program require high doses - 1.3% are administered 500 mg/d or much more; 6 patients receive 900 to 1400 mg of daily methadone, typically splitting the dose into smaller increments.

However, the vast majority (85%) are under 200 mg/d and the average daily dose among those patients is 92 mg. More than half of all patients, 58%, have doses below 100 mg/d and nearly 20% of patients are in the 1 to 50 mg/d range, with many of them at various stages of medically supervised methadone withdrawal.

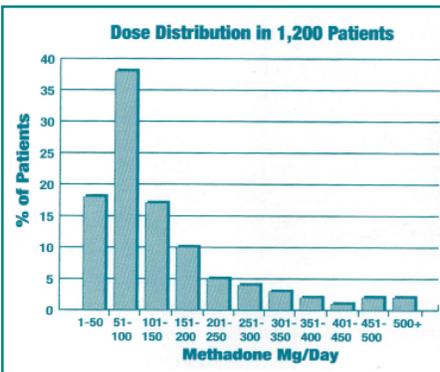
Average dose values for a particular clinic can be misleading in the face of truly optimal dosing practices. Patients at the high end of the continuum tend to drive the average upward, perhaps giving the perception that all patients are at high doses, whereas the dose-distribution is actually skewed toward the more conservative end of the spectrum. Still, it should be recognized that a significant proportion



of patients (42% in this example), due to the various factors mentioned above, may require daily methadone doses greater than 100 mg/d; some greatly in excess of that threshold.

### Brave New World

A relatively new and interesting field of medicine, called clinical pharmacogenomics, identifies genetic differences among individuals that play critical roles in determining drug response. For exam-



ple, one of the enzymes that plays an important role in methadone metabolism - CYP2D6 - is virtually absent in a portion of the population and results in increased serum methadone levels. Another segment of the population has very high CYP2D6 enzyme activity and may help account for so-called “fast metabolizers” who seem to “eat-up methadone” and require high doses.

Genetic differences, called polymorphisms, affecting how individuals metabolize drugs have been identified in more than 20 drug-metabolizing enzymes. These variations can determine whether a person either will fail to respond to a drug or suffer an excessive or adverse response of some kind.

Further complicating the picture, there may be genetically determined indi-

vidual differences in how drugs act in the body, their pharmacodynamics. New research suggests that there may be genetic variations in opioid and/or dopamine receptors in the brain, and these would affect patient response to methadone.

Some experts predict that, with advances in genomic research, a brave new world of gene-based medicine lies just over the horizon. Clinicians will be able to more accurately predict how an individual patient will respond to drug therapy. However, genetic variation is still only one factor in human drug response, and it seems doubtful that laboratory tests will ever replace careful listening to the patient and the clinical intuition of a skilled practitioner.

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# Survey Results - Realistic Goals

"Practitioner Panel"  
Continued from Page 1

The Winter 2001 edition of *AT Forum* (Vol. 10, No. 1) questioned how success in methadone maintenance treatment (MMT) can best be gauged. What sort of results or outcomes should be expected?

Readers were asked to respond to two questions:

1. What percentage of patients in MMT should be able to achieve complete abstinence from illicit opioids?
2. What percentage of patients should still be retained in MMT after at least one year?

There were 136 respondents to the survey, who also included many write-in comments to suggest outcomes of importance besides the two above.

## Limited Expectations

Traditionally, it is believed that patients do best in MMT if they stay longer and abstain from illicit opioids. These also are performance measures that most clinics find the easiest to evaluate; however, survey respondents seemed to have rather limited expectations.

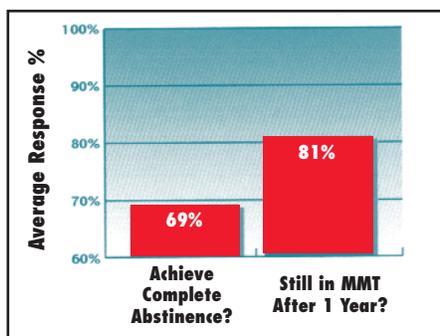
In answer to the first question, respondents felt that only 69% of patients on average should be able to achieve abstinence from illicit opioids via participation in MMT. The median response was 76% (i.e., the midpoint, with half above and half below). Responses ranged from 0% to 100%, although fewer than 1 in 5 of respondents had high expectations, saying 100% of patients should be able to achieve abstinence. **See graph above.**

Respondents believed that 81% of patients on average (median 90%) should remain in treatment beyond one year. Again, responses ranged from 0% to 100% and only about one in three survey responders felt that 100% of patients should be able to achieve that goal.

## Pragmatism or Pessimism?

It should be noted that the survey did not ask how many patients "could" achieve each of the goals, but how many "should."

While the majority of responses are optimistic that higher goals should be attainable, there still appears to be some



pessimism. Many in the MMT field - perhaps 80%, according to the survey - seem to believe it is unrealistic to expect that *all* patients can completely abstain from illicit opioid use. And, two thirds apparently feel that it is impractical for all patients to remain in treatment for a year or longer.

Whether such perspectives actually are based on the practical realities of the current MMT environment - and are, therefore, pragmatic - or express deeply negative attitudes cannot be determined from the survey.

## What Else Matters?

Perhaps, emphasizing abstinence and retention places a focus on the wrong treatment goals. Survey respondents suggested other worthwhile outcomes, summarized in the **table**. While they all seem important, some of these goals can be difficult to measure and quantify; hence, they have not received much attention in research studies.

An easily measured variable is methadone dose, and many respondents indicated that adequate dosing is a major factor for improving treatment outcomes. Unfortunately, achieving adequate and individualized dosing remains problematic, and some MMT programs view doses above certain levels as unfavorable outcomes. (See the article in this issue on the challenge of optimal methadone dose.)

Finally, one respondent wrote, "Abstinence from *all* drugs of abuse is the single most important goal; except, 'pot' [marijuana] is okay." It seems some persons have their own agendas.

Other Worthwhile MMT Goals	
Adequate methadone	Better social relationships
Reduced criminality	Improved family life
Gainful employment	Treatment compliance
Harm reduction behavior	Abstinence from all substances of abuse
Improved health	Better overall quality-of-life
Participation in AA or NA	

risk factor for coronary artery disease. Also, about a quarter of patients during the course of a year may use cocaine, presenting a further risk for heart attack.

Maslansky goes even further to suggest that methadone may help protect the heart from certain disorders. He and colleagues conducted a study, as yet unpublished, that evaluated 1,161 patient-years of methadone therapy. There were absolutely no fatal heart attacks among those patients.

He concedes that the relatively young age of MMT patients on average and the fact that many deaths are from causes other than cardiac conditions might account for some lack of heart problems seen in MMT programs. However, Maslansky believes, this is still a population at high cardiac risk, and his study suggests at the least that there are no acute heart-harmful effects of methadone.

## Helping Aging Hearts

"In my experience, methadone is completely benign in terms of cardiac problems," asserts Peter Tenore, MD, Medical Director, Trailer-1 Clinic, Albert Einstein College of Medicine, New York, NY. Having been in the MMT field since 1984, he has treated about 5000 patients.

Similar to Maslansky's observations, Tenore has not seen any heart problems associated with methadone, even though these patients are at higher risk of cardiac disorders than the general population. Normal all-cause mortality in MMT treatment is 1 to 2%, Tenore notes, largely due to prior unhealthy lifestyles or neglect of health. However, if patients leave treatment, mortality skyrockets to 10 or 15%.

Considering the benefits of methadone treatment in terms of improving general health, this presumably could benefit heart health as well, he stresses. And, as part of the therapeutic environment, patients typically decrease cocaine use, which otherwise would be quite harmful to the heart.

Providing *adequate* methadone doses also can be important for reducing cardiac risk factors in the long term, Tenore believes. "If you don't give the patient an adequate dose, you've made the person uncomfortable and less attentive to the healthful aspects of their recovery." He notes that the average daily methadone dose at his clinic is 91 mg, although there is no upper limit on

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## "Practitioner Panel" Continued from Page 5

adequate dose and he has not seen any negative cardiac effects of higher doses.

Furthermore, considering that the patient population in MMT is aging, and cardiac risk factors naturally increase with age, continued methadone treatment is helpful in controlling factors that would tend to encourage heart disorders. Hypertension, high cholesterol, tobacco use, diabetes, and inactive lifestyles are of concern in those patients, Tenore says, and these conditions generally improve during MMT.

He predicts that, "In coming years, I expect we will see far less heart disease in our older patients who are benefiting from methadone maintenance than otherwise would be expected if they weren't in treatment."

### Benefits Overcome Risks

Marc Gourevitch, MD - Director of Addiction Medicine, Albert Einstein College of Medicine Montefiore Medical Center, Bronx, NY - also has not encountered any cardiac problems that he attributes to methadone. He has been an MMT practitioner for about 11 years and has personally treated more than 1000 patients.

However, this is a complicated issue, he emphasizes. "By the time patients come into treatment, they may have other illnesses or conditions that can impact heart health. Therefore, it is possible that uncommon adverse effects of methadone have been overlooked or gone unnoticed."

"Do I think that we should stop prescribing methadone if new information becomes available that methadone is associated with rare occurrences of heart problems? *Not at all,*" Gourevitch emphasizes. "Still, it's important to delve further into the science, so that the care of individual patients can be optimized and safety concerns laid to rest."

What about patients coming into MMT who have known cardiac risk factors?

"As far as I know, there are no published data indicating that methadone negatively affects heart health in humans. If somebody had a history of arrhythmia or coronary artery disease, I would treat them the same as any other MMT patient - same dosing. I might do an ECG to check their heart rhythm at baseline and I would discuss this with the patient, but the data aren't there to suggest that methadone is harmful to such patients," Gourevitch states.

**... there are no published data indicating that methadone negatively affects heart health in humans.**

### Cocaine Complications

During his 15 years in the addiction treatment field, Philip Paris, MD - Director of Medical Services, Mount Sinai Hospital Narcotics Rehabilitation Center, New York - has treated approximately 3000 MMT patients. He notes that he has not seen any arrhythmias or cardiac-related deaths directly associated with methadone.

According to Paris, however, this is not to say that there are no deaths in patients during MMT. As with any other population of patients, there is a certain percentage of mortality and some of those deaths can be heart-related.

Paris does recall one case of life-threatening arrhythmia, but that was in a patient treated with LAAM who also was severely abusing cocaine. Because the arrhythmia recurred after the patient discontinued LAAM, the cocaine was a likely cause of arrhythmia, he believes.

### High Dose Safe?

Marc Shinderman, MD - National Medical Director of CAP Quality Care's 3 clinics in Chicago, IL and Portland, ME - has overseen more than 15,000 MMT patients in his 28-year career. While heart disorders have not been prominent among MMT patients in general, Shinderman has seen occasional problems over the years. However, neither he nor his consulting cardiologists attribute those to methadone itself.

Some cardiac adverse events were due to conditions patients had before entering treatment and others were newly developed due to age, illness, or accident (one patient was shot in the chest). Three patients needed heart pacemakers inserted, but they typify the sort of risk factors found in some MMT patients. Two had close family members who experienced sudden cardiac death, thus suggesting possible hereditary factors. One patient had hepatitis C. All were taking multiple pre-

scribed medications that might influence changes in cardiac electrical signaling. The patients' past abuses of alcohol and cocaine also may have significantly damaged their hearts prior to MMT, Shinderman believes.

Roughly 15% of patients at Shinderman's clinics receive greater than 200 mg of methadone per day; about 1.3% are administered more than 500 mg/d. Do higher methadone doses pose a potential cardiac health risk?

Shinderman notes that his clinic routinely performs ECGs on all patients approaching 500 mg/d and, so far, the findings have almost always been normal. In those patients referred for specialist evaluations due to questionable ECG results, the cardiologists confirmed that methadone was not the cause and no restrictions were imposed on dose limits.

To further examine the issue, Shinderman performed ECGs on 12 patients receiving between 500 and 1400 mg/d of methadone (average 812 mg/d), although none of the patients had ever complained of any heart distress. All but one of the ECG readings were within normal limits. In one woman taking 1000 mg/d the ECG reading at first seemed abnormal; however, it turned out that the reading was exactly the same as it had been 10 years earlier when she was on 100 mg/d of methadone. The woman, who also is HCV positive and taking various medications, is quite physically active, jogging or bicycling daily, and has experienced no heart symptoms at any time, Shinderman comments.

### Risk Factors Important

As Director of Methadone Medical Maintenance, Beth Israel Medical Center, New York, NY, Edwin Salsitz, MD has closely followed more than 300 patients during the past 16 years. He has not seen any adverse cardiac symptoms or heart disorders related to methadone.

However, he has seen a few cases of coronary artery disease and heart attacks in patients who have certain risk factors, primarily tobacco smoking. Secondary risk factors in his patients have included obesity, high cholesterol, and hypertension. "Those cardiac events were normally expected," Salsitz believes, "especially those associated with smoking."

Patients in medical maintenance (i.e., treated in private medical practice) tend to be healthier than the overall population in MMT, mainly because there is a low rate of HIV, Salsitz observes. However, about 70% of his patients have chronic hepatitis C,

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which is typical of the overall addiction treatment population, and liver disease can be a risk factor for heart problems.

Salsitz was lead author of a study that followed a group of 132 compliant methadone patients treated in medical maintenance during a 15-year period (*Mt Sinai J Med.* 2000;67[5-6]:388-397). There were 20 deaths, although none were attributed to long-term methadone therapy. Only 3 deaths were caused by heart disease; however, these represented 3 of the 8 smoking-related deaths. In the study overall, tobacco smoking was the most prominent cause of death, followed by hepatitis C (4), and AIDS (3).

### Demonstrated Safety

Practitioner testimonials do not qualify as rigorous clinical research evidence. Still, taken together, the 6 interviewed MMT medical directors represent 117 years of collective experience in treating more than 29,000 opioid-addicted persons with methadone; some of those patients for many years. Quite significantly, they did not report a single heart problem attributed to methadone.

This helps confirm the vast experience and research with methadone spanning more than 30 years and finding that it is a safe medication when properly used, rarely producing adverse events. As the practitioner panel noted, the health risks, cardiac and otherwise, for opioid-addicted persons not in treatment are great and death rates are high. Therefore, the MMT environment, of which methadone is a central component, might be viewed as providing a multifaceted risk-reduction approach potentially contributing to better heart health.

**Report Available:** *AT Forum* has developed a special "white paper" titled "Does Methadone Maintenance Treatment Affect Heart Health?" It summarizes scientific evidence responding to the question, with a special emphasis on cardiac electrical conduction issues, and includes 62 references. This is available by checking the appropriate box and mailing the feedback card in this issue, or in electronic format at [www.atforum.com](http://www.atforum.com) under the "Current/Past Issues" tab, "Unpublished Reports" section. **A.T.F.**

## “Program Update” Continued from Page 1

Alcoholics Anonymous. Only the first of AA's 12 steps mentions alcohol: "We admitted that we were powerless over alcohol, that our lives had become unmanageable." Inserting "illicit drugs and alcohol" in place of "alcohol" was the only change needed to adapt all of the steps for methadone patients.

### Early Growth

Sweeney was soon joined in his efforts by Duncan McGonagle, RN, C, CARN (currently at Beth Israel Medical Center, MMTP, New York) and later by Fred Christie, MA, CASAC (founder of AFIRM - Advocates For the Integration of Recovery and Methadone - Long Beach Medical Center, New York). Together, the trio have helped spread the word and assist in the startup of hundreds of groups.

According to Sweeney, there are today at least 600 MA chapters worldwide. Christie says there is an MA presence in 25 of the United States, with up to 45 weekly meetings in New York State alone. McGonagle notes that there are now meetings in Israel, Australia, England, Spain, Scandinavian countries, Russia, and many other countries. There even has been an inquiry from China.

### Following Tradition

Most MA meetings are hosted by MMT clinics. However, Sweeney stresses that the clinic merely should provide meeting space - as would a local church or community center, for example - without any attempt to exert control over the meeting or its participants.

It is also important that MA groups give something back to the host organization in the form of at least a token space rental fee or volunteer services. This is in accordance with essential AA traditions requiring each group to be independent and fully self-supporting through its own contributions. A collection basket is usually passed at meetings and the usual contribution is a dollar or two, if the person can afford it.

MA groups also adhere to other AA traditions, such as a prohibition of professionalism. Group leaders are "trusted servants"; they do not make decisions for the group or act as therapists. Furthermore, discussions of controversial issues are not permitted; for example, MA meetings are not platforms for debating treatment concerns or politics.

MA is not an advocacy organization; it neither endorses nor opposes any causes

relating to addiction treatment or other matters. Each group's primary purpose is to help members abstain from illicit drugs and alcohol and help others to achieve such sobriety.

### 12-Stepping

Since there are still few MA meetings in most locales, MMT patients are also encouraged to attend AA meetings on a regular basis. Some patients choose to also attend Narcotics Anonymous (NA) or Cocaine Anonymous (CA) meetings. Both organizations are modeled after AA principles and traditions.

However, Sweeney emphasizes, there is no need at meetings for patients to discuss their medications, including methadone or other prescribed drugs. McGonagle agrees, "abstinence from all mood-altering chemicals, not prescribed by a physician, is the primary goal of all chemical-addiction-oriented 12-step programs. Methadone should not be an issue, even at MA meetings - it is a medication, period."

Yet, some AA members (as well as many NA and CA participants) are not completely accepting of methadone as a medicine. The solution, Christie explains, is that "there are usually many different AA groups in any metropolitan area and MMT patients should search out those in which they feel most welcomed and comfortable."

In most AA groups today, the medications one takes is a non-issue and a personal matter. Discussions of medical treatments are discouraged, since there is an unwritten tradition that, "No AA member should play doctor." When it comes to methadone, a patient's openly commenting on his/her MMT program would be an irrelevant distraction from full participation in AA, or in an MA group for that matter.

### Who's In Control?

As with AA and similar 12-step programs, MA relies on underlying principles of spirituality. While this is not the same as religion, it is often a source of misunderstanding and controversy.

Christie notes that in modifying the 12-steps for MA the word "God" was removed and replaced with "Higher Power." Still, acceptance of spiritual faith as a guiding force in one's life is a sticking point for many addicted persons.

McGonagle says, "We suggest that the individual develop a concept of a 'power greater than themselves.' Sometimes a

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newcomer will use the group as a Higher Power. The important idea is to get MA members 'out of themselves' and away from any notion that they are the Higher Power and totally in control of their addictions or their lives."

The coming together of people with common problems to share their experience, strength, and hope with each other can indeed be a powerful force on a spiritual plane. Some people, even avowed atheists, have succeeded by using the group as their Higher Power, at least initially.

**Into Action**

Some time ago, pre-MA, Joan Zweben, PhD noted, "Enhancing the partnership between 12-step programs and professional treatment is emerging as one of the most important therapeutic tasks today in the addictions field." Enlightened MMT clinic staff can serve vital supportive roles in working with patients to promote their participation in 12-step programs and acceptance of spiritual concepts. Doubts or fears expressed by patients can open many doors to therapeutically helpful interactions that benefit participation in both the MMT program and 12-step groups.

McGonagle notes that, once regular MA meetings get started at a clinic, the environment usually changes for the better. Patients seem to more fully realize the benefits of MMT in terms of their more active participation in treatment, less illicit drug use, looking after their health, taking care of their families, and generally improving their lives in other ways.

MMT clinic staff can do much to help organize MA programs and encourage patients who show an interest.

First, it would be helpful if staff become familiar with how AA groups operate, since those essentially serve as the prototype for MA. At the least, clinic staff can attend open AA meetings that welcome the public; patients can attend closed meetings that include only addicted persons seeking recovery.

Second, there also is a great deal of AA literature available, including helpful manuals on starting and running local groups. Furthermore, Christie, Sweeney, and McGonagle stand ready to answer questions and assist in starting MA groups. (See below for contact information.)

While 12-step program participation may not be uniformly beneficial for everyone, it has withstood the test of time and

proved invaluable for a great many. In the final analysis, when asked, "How does MA work?", most group members and MMT staff simply respond, "It works very well."

**For More Information...**

Visit the **Methadone Anonymous**

Web site hosted by AFIRM at

<[www.afirmfwc.org/methanon.htm](http://www.afirmfwc.org/methanon.htm)>

The following persons may be contacted by staff or patients for Methadone Anonymous information packets and to answer questions about starting a local meeting:

- **Gary Sweeney** - Tel. 410-837-4292 ext. 243; Fax 410-837-0639; GarySweeney@aol.com
- **Fred Christie** - Tel. 516-897-1330 (days) 516-889-8142 (evenings); Fax 516-897-1149 AFIRMFWC@aol.com
- **Duncan McGonagle** - Tel. 718-522-2218 (evenings); Duncan73@aol.com

To learn about other 12-step programs, contact:

- **Alcohol Anonymous** - <[www.alcoholics-anonymous.org/](http://www.alcoholics-anonymous.org/)>; Alcoholics Anonymous, Grand Central Station, PO Box 459, New York, NY 10163. The web site has listings of local chapters, or check local phone directories in any sizable US metropolitan area for a service office.
- **Narcotics Anonymous** - 16155 Wyandotte St., Van Nuys, CA 91406
- **Cocaine Anonymous** - Box 1367, Culver City, CA 90232; 213-559-5833.

\* See: Zweben JE. Recovery-orientated psychotherapy: facilitating the use of 12-step programs. *J Psychoactive Drugs*. 1987;19(3)243-251

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