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CE ACCREDITATION STATEMENT

- **AMA Credit Designation Statement:**
  The American Society of Addiction Medicine designates this internet live course for a maximum of 1 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

- **ACCME Accreditation Statement:**
  This activity has been planned and implemented in accordance with the essential areas and policies of the Accreditation Council for Continuing Medical Education through the joint providership of The American Society of Addiction Medicine and The American College of Medical Toxicology. The American Society of Addiction Medicine is accredited by the ACCME to provide continuing medical education for physicians.
NONE OF OUR SPEAKERS HAVE ANY CONFLICTS OF INTEREST TO DISCLOSE
A 60-year-old administrator (senior leadership in area hospital system) requests ambulatory detoxification for combined alcohol and sedative dependence during COVID19.

He has several previous detoxification and treatment episodes that have required aggressive treatment regimens (including combinations of benzodiazepines and phenobarbital) to get his withdrawal under control in the past.
CASE 1

- The patient states that he is not able to take time off of work to go to a detox program, or inpatient setting, he enrolled in an outpatient program that had advertised ambulatory detoxification capabilities.

- He has numerous past episodes of treatment, including 3 months prior when he had a brief 2 week hospital stay (area inpatient unit) where he was started on XR-naltrexone after receiving combinations of diazepam and phenobarbital. He reports that he remained sober, attending meetings, and working with, “a few sponsors,” but then he started drinking in March, “and hasn’t stopped except one night since.” His drinking really picked up drinking during the early stages of the COVID19 pandemic and he cites stress related to, “making difficult decisions,” as reason for his drinking escalation.

- At least 5 prior ‘detox’ episodes in past 12 months and occasionally enrolled with an outpatient program, primarily for individual counseling sessions, and he’s also had several hospital-based detoxification episodes (presented to ED in withdrawal and admitted for several days at least once during past year).
The patient reports his drinking occurs mostly at night as soon as he returns home from work and that he takes lorazepam during the day, “to stop the shakes so I can get to work and through work.” Notes tremors, sweating, panic, anxiety, denies seizures and hallucinations. “People have noticed and I’ve lost a job because of it.”
The patient states he is drinking combinations of vodka and beer. He is vague but settles on either 750 mL vodka or 12-15 beers/day. He is taking, “something for my blood pressure,” but otherwise nothing except the lorazepam: 3 days prior he picked up Rx for lorazepam 30 tabs of 2 mg

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The patient is adamant he cannot go to detox again, inpatient, the ED, or other treatment as his work is, “critical during COVID19 I just cannot stop.” He mentions phenobarbital outpatient (he was involved in an ambulatory detox that used PB but also included ‘partial hospitalization’ and on-site daily assessment for 5 days several years ago –with daily dispensed meds).

**QUESTION:** Is he a candidate you will try to treat outpatient? If not ambulatory detox are there some medications that could be initiated?
The patient agrees to 3 days inpatient detox to “start” treatment and “stabilize”. He also agrees to stop taking the lorazepam and not continue to pick up the lorazepam from any of the providers he’s been using (verbal agreement for consent for reaching out to these providers). After 3 days he will continue with telemedicine contact daily for 5 days and on-site check in on Friday and Monday (he would enter detox over the weekend on Friday afternoon and leave 72 hours later if symptoms controlled). After this proceeding with regular contact, counseling, XR naltrexone and other support.
CASE 1

- The patient enters into detox and diazepam is utilized at 10 mg PO QID x 3 days and PRN if CIWA > 10 (after initial dose) with clonidine 0.2 mg PO q 4 hours PRN anxiety (MDD 1.2 mg).

- He is doing well with symptoms well-controlled. He’s eating and sleeping. He decides to leave early on Sunday evening after getting an XR naltrexone shot and that day’s 4th dose of diazepam essentially having completed 48 hours of detox (9 doses of 10 mg diazepam and clonidine).

- On a telemedicine visit to try and talk him out of leaving detox he appears well (is going to leave for work the next day) and gabapentin 900 mg (1 and ½ of 600 mg tabs) are ordered QID x 5 days with VPA 500 mg PO BID x 14 days, a clonidine patch 0.2 mg/week and clonidine 0.1 mg PO QID PRN (extra one at night if not sleeping).

- He picks the meds up on the way home from detox when his wife had driven in to pick him up.
The next AM he calls his counselor and states he’s had a few beers and stayed home from work. His wife left to go to their lake house after he started drinking. Provider clarifies that he hasn’t started his medications for ambulatory detox, “I should have started them when I got home I wasn’t thinking I felt fine then in the morning I didn’t feel good so had a few beers today.”

With reassurance he can start the meds as long as he’s not drinking he agrees to the original plan/regimen.

He stops drinking and starts the meds and later in the day is feeling better.

He takes an Uber to work the next day, “because I felt great it was working well.”

The following day he’s driving in (against provider advice) but he’s reporting no alcohol use and he stops in the clinic that evening and provides UDS and check in:
CASE 1

- 2 days out of detoxification facility – anxious but calms during discussion. HR 70's wearing clonidine patch.
- Well groomed
- Oriented, not confused
- No ataxia
- Tremor that settles
As he is interviewed

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CASE 1 - ANOTHER F/U ON SITE

- Appropriate UDS results now one month in and “not drinking things are going great” attends counseling/group (Zoom®)

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The patient calls his counselor on Monday AM 3 months into his treatment. “I started drinking Friday night at a BBQ with friends and haven’t stopped. Friday it was vodka a liter I picked up on the way home from work and Saturday and Sunday it’s been 15 beers, this AM 6 beers until I stopped and I don’t know what to do. I need some Valium or something.”

Provider reaches him early in the afternoon as his counselor had been in contact with him, “he mentioned several times he was going to get benzodiazepines from a previous provider,” his wife was concerned about this she mentioned (on dual call –though he’s waived consent to speak directly with her).

The patient stopped taking the gabapentin and VPA on Friday night when he started drinking. He had 1-2 of the clonidine on Saturday but nothing else. He hasn’t put on a clonidine patch and is asking for, “a few Ativan or Valium so I can get to work. What about phenobarbital weren’t we going to do that at one point?”
Patient is refusing to go to a detox, ED or inpatient. Would you order any outpatient medications for withdrawal or instruct him on the meds he stopped taking that weekend?

He is having trouble taking his pulse (“I don’t think its fast”) more preoccupied about “what if I go into withdrawal,” and “when I…”

Wife is at home with him and confirms he’s been drinking only since that Friday, “that I’m aware of.”
Patient ultimately given following plan (discussed with his wife and she wrote it out for him he was having trouble writing/organizing dosing instructions):

- Gabapentin two x 800 mg x 1 ‘now’ then QID (this is at 2:30 PM so two then and two more doses that night).
- VPA 1000 mg PO then and then 500 mg later that night and then 500 mg PO BID.
- Clonidine patch 0.2 mg place and take 0.1 mg PO QID with extra dose available at night x 1.
- Provider will f/u in AM with call.
- He is “napping” when counselor calls later.

That evening counselor is called he is aware that his Dr sent in a prescription of benzodiazepines back/forth about if he’s going to go get it (mostly reported as anticipatory if “what if I have w/d at work) was doing ok after nap and start of meds.
He picked up a lorazepam Rx from prior provider – no answers to calls VM left to f/u with counselor and detox continue XR naltrexone but not to take gabapentin, VPA or clonidine while drinking and taking lorazepam.

- Question: Any recs/thoughts at this point?
35-year-old physician is referred by his employer for a residential evaluation due to signs of impairment while at work.

He reports increased stress with taking care of patients diagnosed with COVID-19.

During the evaluation, he admits to daily use of kratom and requests medication management of acute withdrawal.

After stabilization, he is interested in taking a medication to prevent relapse on kratom.

What are the considerations for treatment regimen?

What are the considerations for drug testing/monitoring?
KRATOM COMPOSITION

- Leaf analysis (Thailand)
  - 40 structurally related alkaloids, flavonoids, terpenoid saponins, polyphenols, and various glycosides.
  - >25 indole alkaloids with:
    - anti-nociceptive, anti-inflammatory, anti-depressant and muscle relaxant properties

American Academy of Addiction Psychiatry, 2019
Kratom, A Substance of increasing Concern
Thomas M. Penders, MS, MD
Cornel N. Stanciu, MD, MRO, FASAM, FAPA
KRATOM ACTIVE CONSTITUENTS

- Mitragynine
- 7-Hydroxymitragynine

- Both are opioid R-agonists
- In vivo: tolerance, cross-tolerance to morphine, and a precipitated withdrawal when naloxone is administered.

KRATOM DRUG SCREENING

- Standard urine drug screens do not detect Kratom
  - Special confirmatory testing is needed
    - Gas chromatography coupled with mass spectroscopy (GC-MS)
    - Liquid chromatography with linear ion-trap mass spectroscopy
    - Electrospray tandem mass spectroscopy
- Detected in urine samples for 5-6 days
  - Case report in a chronic user - positive result (GC/MS) 14 days after cessation

Kaewklum et al. 2005
Philipp et al., 2009, 2010a, 2010b
Arndt et al., 2011
Lu et al. 2009; Lu et al. 2014.
Kapp, F.G. et al 2011
CASE 2 – KRATOM DEPENDENCE

- 2 patients described in 2018 case report
- Numerous anecdotal reports and forum discussion
- Buprenorphine + clonidine vs SSRI/SNRI
- Cases also describe use Kratom to d/c buprenorphine...


Stanciu C., Gnanasegaram, S., Penders TM. et al.; Kratom Withdrawal – A Systematic Review with Case Series; J Psychoactive Drugs. 2018


Takayama, Hiromitsu. "Chemistry and pharmacology of analgesic indole alkaloids from the rubiaceous plant, Mitragyna speciosa." Chemical and Pharmaceutical Bulletin 52, no. 8 (2004): 916-928. doi.org/10.1248/cpb.52.916
Wine

Reading a life of Alexander the Great, Alexander whose rough father, Philip, hired Aristotle to tutor the young scion and warrior, to put some polish on his smooth shoulders. Alexander who, later on the campaign trail into Persia, carried a copy of The Iliad in a velvet-lined box, he loved that book so much. He loved to fight and drink, too. I came to that place in the life where Alexander, after a long night of carousing, a wine-drunk (the worst kind of drunk—hangovers you don’t forget), threw the first brand to start a fire that burned Persepolis, capital of the Persian Empire (ancient even in Alexander’s day). Razed it right to the ground. Later, of course, next morning—maybe even while the fire roared—he was remorseful. But nothing like the remorse felt the next evening when, during a disagreement that turned ugly and, on Alexander’s part, overbearing, his face flushed from too many bowls of uncut wine, Alexander rose drunkenly to his feet, grabbed a spear and drove it through the breast of his friend, Cletus, who’d saved his life at Granicus. For three days Alexander mourned. Wept. Refused food. “Refused to see to his bodily needs.” He even promised to give up wine forever.

(I’ve heard such promises and the lamentations that go with them.) Needless to say, life for the army came to a full stop as Alexander gave himself over to his grief. But at the end of those three days, the fearsome heat beginning to take its toll on the body of his dead friend, Alexander was persuaded to take action. Pulling himself together and leaving his tent, he took out his copy of Homer, untied it, began to turn the pages. Finally he gave orders that the funeral rites described for Patroklos be followed to the letter: he wanted Cletus to have the biggest possible send-off. And when the pyre was burning and the bowls of wine were passed his way during the ceremony? Of course, what do you think? Alexander drank his fill and passed out. He had to be carried to his tent. He had to be lifted, to be put into his bed.)
Mark Your Calendars!

ADDICTION TOXICOLOGY CASE CONFERENCE

Fridays @ 1pm ET

- August 21, 2020
- September 4, 2020
- October 2, 2020