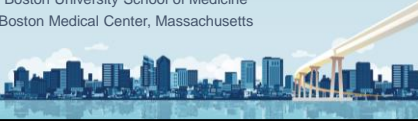


Opiod Use Disorder and HIV in 2022

R. Douglas Bruce, MD, MA, MS, MBA

Associate Chief of Clinical Affairs
Boston University School of Medicine
Boston Medical Center, Massachusetts



Financial Relationships With Ineligible Companies (Formerly Described as Commercial Interests by the ACCME) Within the Last 2 Years:

Dr Bruce has no relevant financial relationships with ineligible companies to disclose. (Updated 10/01/22)

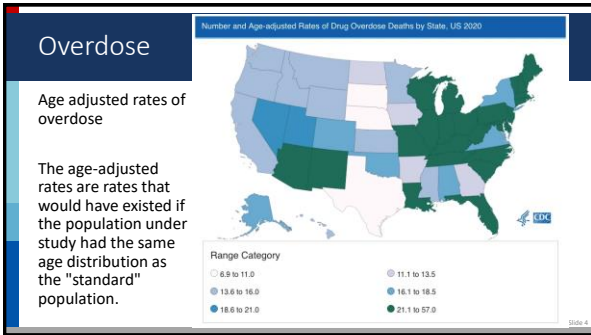
Slide 2

Learning Objectives

After attending this presentation, learners will be able to:

- Describe opioid use disorder
- Initiate treatment for opioid use disorders
- Describe the implications of opioid use disorders in people living with HIV infection
- Describe current options for addressing stimulant use

Slide 3



HIV and Substance Use Disorders is a GLOBAL problem

- In Dar es Salaam, HIV prevalence is estimated at 9.5%
- In 2009 Williams and colleagues reported on a sero-prevalence study heroin injectors in Dar es Salaam.
- Among heroin injectors, 87 of 315 men interviewed had HIV (28%) and 140 of 219 women (64%) for an average prevalence of 42%.

Slide 5

General Principles working with people with SUDs and HIV

- Treat all patients with dignity and respect
- People who use drugs are people
- Malingering, manipulation, etc. are all survival mechanisms people who use drugs use for survival.

Don't take it personally.

Slide 6

Substance Use Disorders

A state in which a person engages in compulsive behavior

- The behavior is **reinforcing** (that is, pleasurable or rewarding)
- There is a **loss of control** in limiting the intake of the substance

Slide 7

Why do people take drugs?

To feel good

To have novel:
feelings
sensations
experiences
AND
to share them

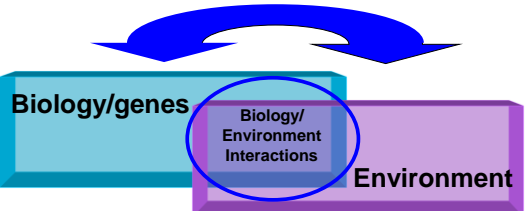


To feel better

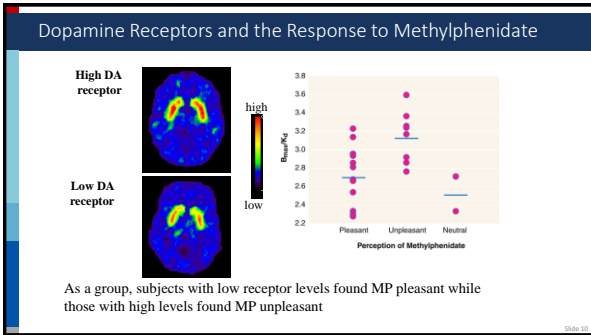
To lessen:
anxiety
worries
fears
depression
hopelessness

Slide 8

Why do some people develop a substance use disorder?



Slide 9



"I do what I don't want to do"

Drugs Are Usurping the same Brain Circuits that Food and Sex use to bring pleasure. That impacts Motivational Priorities

Slide 11

"Why is this taking so long???"

- You inherit a new patient: Bob is a 45 year-old who comes in for his refill of oxycodone of 30 mg tablets, two tablets every 6 hours for a total of 240 tablets for the month.
- You notice there hasn't been a urine toxicology in 5 years, but there have been a few recent Emergency Department visits for methamphetamine intoxication.
- Today, Bob is agitated, struggling to sit still, and wondering why the refill is taking so long....

Slide 12

People who use drugs and urine toxicology

- When the Urine Drug Testing does not match what is prescribed, consider plausible etiologies:
 - Patient ran out early due to increased pain and UDT is negative due to washing out
 - Patient had a false positive or false negative UDT
- Problematic behavior in clinic could mean many different things:
 - Inadequately treated pain
 - Poor coping skills
 - Relapse to drug use

Slide 14

"But it isn't really a problem" – change is a process

- **Transtheoretical Model of Change:**
 - Helping patients to move along the stages of change
 - MI – "Roll with resistance"
- **Harm Reduction**
 - Syringe exchanges
 - Naloxone
- **When helping hurts**
 - Enabling vs. boundaries

Slide 15

The Life of a Person with Opioid Use Disorder

Diagrammatic summary of functional state of typical "malline" heroin user. Arrows show the repetitive injection of heroin in uncertain doses, usually 10 to 50 mg but sometimes much more. Note that addict is hardly ever in a state of normal function ("straight").

Slide 16

Treatment for Opioid Use Disorder

Pharmacological Treatment

- Buprenorphine, Methadone, Naltrexone

Behavioral Treatment (Therapy)

- Motivation Interviewing – getting you motivated to do treatment
- Cognitive Behavioral Therapy – getting you to think differently about drug use

Slide 17

Summary of Pharmacology

- Methadone
 - Only in OTP
 - Efficacious, best retention
- Buprenorphine
 - Office based
 - Efficacious, retention less than methadone
- Naltrexone
 - Office based
 - Efficacious
 - Retention less than methadone & buprenorphine

Slide 18

Mu-Opioid Receptors and Treating OUD

Binding Potential (Bmax/Kd)

4 -

0 -

MRI

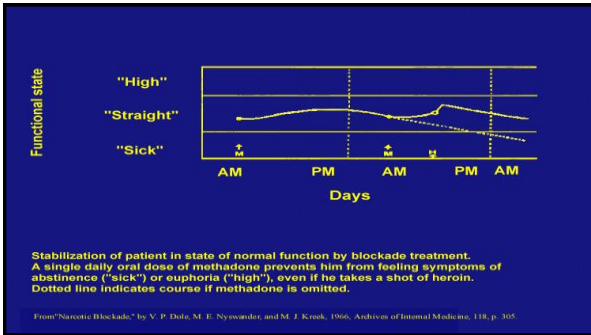
Bup 00 mg

Bup 02 mg

Bup 16 mg

Slide Courtesy of Laura McNicholas, MD, PhD

Slide 19



It's Friday at 4 PM.....

- Amanda is a 30 year-old female who comes into your clinic and, after much creative and interesting conversation, you conclude that the oxycodone you were giving for back pain is not in the urine toxicology, but morphine is...

Slide 21

Practical Initial Step: Screening

Screen patients for substance use disorders using standardized questions:

- How many times in the past year have you had 5 or more standard drinks in a day?
- How many times in the past year have you used an illegal drug or a prescription medication for nonmedical reasons?

Slide 21

Practical Next Step: Think about systems

- Provision of low threshold, rapid access, appropriately dosed treatment (e.g., buprenorphine, methadone, or other treatments)
- Culturally appropriate counseling for addiction [can be simple (NA) to more complex (CBT)]

Slide 24

Practical Steps: Treat everyone

- Treatment of the medical issues associated with addiction (e.g., HIV, hepatitis B/C, and Tuberculosis)
- There is **NO** data to support denying or waiting to start patients on ART or any other treatment.
- Prescribe naloxone and consider becoming a buprenorphine provider
- Review guidelines on the treatment of chronic pain and re-evaluate how you prescribe opioids

Slide 25

Key Points on Substance Use and HIV

- Ongoing substance use is **not** a contraindication to ART.
- ART reduces the risk of HIV transmission to sexual and drug using partners.
- Selection of ART among individuals who use substances should account for
 - Potential adherence barriers
 - Co-morbidities which could impact care (e.g., advanced liver disease from alcohol or HCV),
 - Potential drug-drug interactions, and
 - Possible adverse events associated with the medications.

<https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv/22/substance-use-disorders-and-hiv> Slide 26

Methamphetamines and Cocaine (Come to the Workshop)

Methamphetamines:

- No pharmacological agents have demonstrated efficacy through Phase 2 trials. Morley, K. C., et al. (2017). "Pharmacotherapeutic agents in the treatment of methamphetamine dependence." *Expert Opin Investig Drugs* 26(5): 563-578.
- Interest in Lisdexamfetamine as an agonist (recent 2021 paper showing dosing safety and ??? benefit in small numbers – don't try this at home).

Cocaine:

Multiple RCTs on disulfiram – if you can get someone to take it, it works.

Slide 27

Questions??????

- Contact: rdbruce@bu.edu and rdbruce@mit.edu

Slide 28

Q and A Session

2022 Ryan White HIV/AIDS Program CLINICAL CONFERENCE
