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Methadone: does stigma play a role as a barrier to treatment of chronic pain? (eng) By: Shah S, Diwan S, Pain Physician [Pain Physician], ISSN: 2150-1149, 2010 May-Jun; Vol. 13 (3), pp. 289-93; PMID: 20495594;

Introduction: The synthetic opioid methadone is a promising analgesic for the management of chronic neuropathic pain. Methadone therapy is increasing as its advantages are being realized over other opioids. Methadone's lack of known active metabolites, high oral bioavailability, low cost, and its additional receptor activity as an antagonist of N-methyl-D-aspartate receptors make it an attractive analgesic.

Methods: We surveyed 550 pain physicians to determine their prescribing practices of methadone. The study was approved by our Institutional Review Board. A list of 550 pain physicians, which included practitioners in private practice, university settings, and community hospitals, were obtained and surveys sent via mail. The list was obtained through the American Pain Society's membership list. Out of 550 surveys sent, 124 replies were returned.

Results: The 124 surveys that were returned included pain physicians from various settings: 20 responses from physicians practicing at a university setting, 16 responses from a community setting, 54 responses from a private setting, one from university and community settings, 7 from community and private settings, 3 from university and community and private settings; 23 did not specify. Of the 124 physicians, 111 prescribe methadone in their pain practice. Of the 13 physicians who do not prescribe methadone, the main reason for not using the drug for 5 physicians was because of social stigma, 2 because of minimal experience with the drug, 2 because the drug was not effective, one because of lack of knowledge, and one because of potential adverse effects. Of the 111 physicians who use methadone, 55 stated that social stigma was the most common reason patients refuse to take methadone for

the treatment of pain, 44 because of adverse effects, and 5 stated "other" as the reason patients refuse to take methadone. Of 111 physicians who prescribe methadone, 100 prescribed it for neuropathic pain, 101 for somatic pain, 80 for visceral pain, 78 for cancer pain, and 34 for sickle cell pain. Also, 21 stated that methadone was the primary opioid they prescribed. Of the 111 physicians who prescribe methadone, 86 start methadone at low dose and titrate up to minimize side effects. Fourteen clinicians load methadone and titrate down to minimize adverse effects while maintaining analgesia.

Conclusion: The majority of survey responders (90%) prescribed methadone in their pain practice, but on a very limited basis; 59% state <20% of their patients are on methadone. Three times a day dosing schedule was the most typical regimen (57%) while 77% prefer to titrate up on the dosage. It seems interesting that many clinicians do not prescribe methadone as a primary analgesic. One reason for this is due to the social stigma of its use in treatment of heroin addicts. Also, a lack of widely recognized treatment algorithms or guidelines to assist clinicians with opioid conversions and maintenance might be playing a role. The role of stigma as a barrier to adequate treatment of chronic pain among pain physicians prescribing practices is a fundamental, yet unexplored issue.

Database: MEDLINE with Full Text