ΟΚΥπΥ
Οργανισμός Κρατικών Υπηρεσιών Υγείας

Θεραπεία της Διαταραχής Χρήσης Οπιοειδών με φαρμακευτική υποβοήθηση με υποκατάστατα οπιοειδών: Η Κυπριακή εμπειρία

Λάμπρος Σαμαρτζής MD PhD, Ψυχίατρος,
Υπηρεσίες Ψυχικής Υγείας - ΟΚΥπΥ

Θεραπεία (ορισμός):

Η βελτίωση της ψυχικής, σωματικής ή/και κοινωνικής λειτουργικότητας του ασθενούς,

- ως αποτέλεσμα συγκεκριμένης θεραπευτικής παρέμβασης ή
- συνδυασμού θεραπευτικών παρεμβάσεων
  - φαρμακευτικών,
  - ψυχοθεραπευτικών ή/και
  - κοινωνικών παρεμβάσεων.

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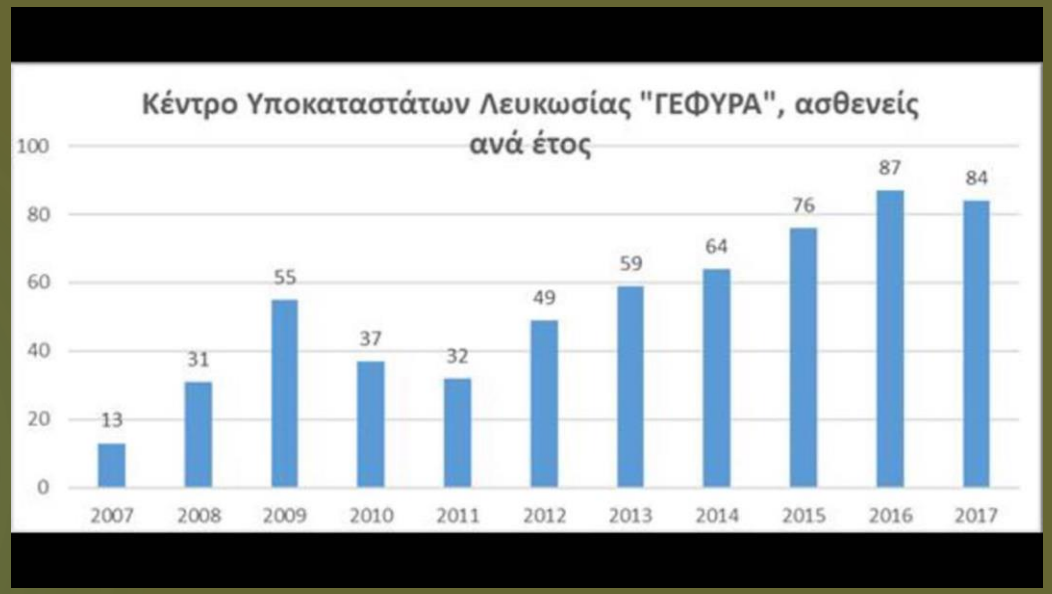
Οπιοειδή

- Μέχρι το 2007, στην Κύπρο δεν υπήρχε θεραπεία με υποκατάστατα οπιοειδών (OST).
- Η μόνη διαθέσιμη θεραπεία ήταν οι θεραπευτικές κοινότητες προσανατολισμένες στην πλήρη αποχή από τα οπιοειδή.
- Τον Αύγουστο του 2007 άνοιξε στη Λευκωσία η πρώτη μονάδα θεραπείας υποκατάστασης οπιοειδών, με την ονομασία "Γέφυρα".
- Η μονάδα ξεκίνησε με αριθμό 13 ασθενών το 2007, οι οποίοι αυξήθηκαν σε 32 το 2011 και σε 84 το 2017.



- Το πρόγραμμα Μείωσης Βλάβης ¨ΓΕΦΥΡΑ¨ μετά το 2011 έγινε σταδιακά «χαμηλής ουδού», με βάση διεθνή τεκμηρίωση για καλύτερη αποτελεσματικότητα.

Advances in the treatment of substance use disorder in Cyprus L Samartzis - BJPsych International, August 2018

Οπιοειδή

- Το πρόγραμμα Μείωσης Βλάβης ¨ΓΕΦΥΡΑ¨ μετά το 2011 έγινε σταδιακά «χαμηλής ουδού», με βάση διεθνή τεκμηρίωση για καλύτερη αποτελεσματικότητα.

- Τα κλινικά χαρακτηριστικά που εφαρμόστηκαν σταδιακά στο πρόγραμμα OST περιλαμβάνουν
  - Μείωση ¨αυστηρότητας¨, κατάργηση ¨θεραπευτικών κυρώσεων¨
  - Αύξηση της προσβασιμότητας ώστε να αποφεύγονται οι λίστες αναμονής,
  - Χρήση εξατομικευμένων θεραπευτικών επιλογών σχετικά με την επιλογή παρεμβάσεων και την τιτλοποίηση της δόσης,
  - Οι ψυχοκοινωνικές παρεμβάσεις έγιναν προαιρετικές
  - Ευελιξία στη διάρκεια θεραπείας
  - Σχεδιασμός θεραπείας επικεντρωμένος στη Μείωση της Βλάβης και όχι στην πλήρη αποχή,
  - Έμφαση στη διατήρηση στο πρόγραμμα ασθενών χαμηλής συνεργασίας/συμμόρφωσης (δηλ όσους πάσχουν και από διαταραχή προσωπικότητας ή/και άλλες συννοσυρότητες).

Opioid substitution therapy: Lowering the treatment thresholds.Kourounis G, Richards BD, Kyprianou E, Symeonidou E, Malliori MM, Samartzis L. Drug Alcohol Depend. 2016 Apr 1;161:1-8

Σημαντικές Νέες Προσεγγίσεις

- Μείωση αυστηρότητας (Θεραπεία και όχι σωφρονισμός)
- Λιγότερο αυστηρό θεραπευτικό πλαίσιο (μόνο θετική ενίσχυση positive reinforcement)
- Χαλάρωση νομοθεσίας
- Θεραπεία αντί ποινής σε αδικήματα που σχετίζονται άμεσα με την υποστήριξη της χρήσης
- Δεν αρκεί η ψυχοθεραπεία - Δεν αρκεί μόνο το φάρμακο
- Μείωση στίγματος για αύξηση προσβασιμότητας
- GDPR σεβασμός, αυστηρή τήρηση
- Κοινωνικό Κράτος (στέγαση, νομική προστασία, επιδόματα, ΕΕΕ, επαγγελματική υποστήριξη)

- Νέα Φάρμακα – Πλουραλισμός:
    - Μεθαδόνη
    - Βουπρενορφίνη
    - Βουπρενορφίνη + Ναλοξόνη
    - Naloxone (Nyxoid 1.8mg IN)
    - Ναλτρεξόνη
    - Μορφίνη Retard
    - Heroin Replacememt Treatment, HRT

- Νέες δομές:
    - Μεθαδόνη
    - Drug Consumption Rooms
        - (Παράνομα ναρκωτικά, νόμιμη δομή, χρήση υπό «επιτήρηση»)

ΟΚΥπΥ
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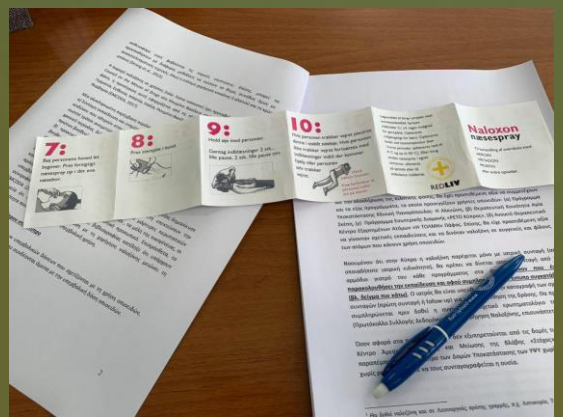
7:
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Naloxon
næsespray


NYXOID 1,8 mg
naloxon
næsespray
nässpray
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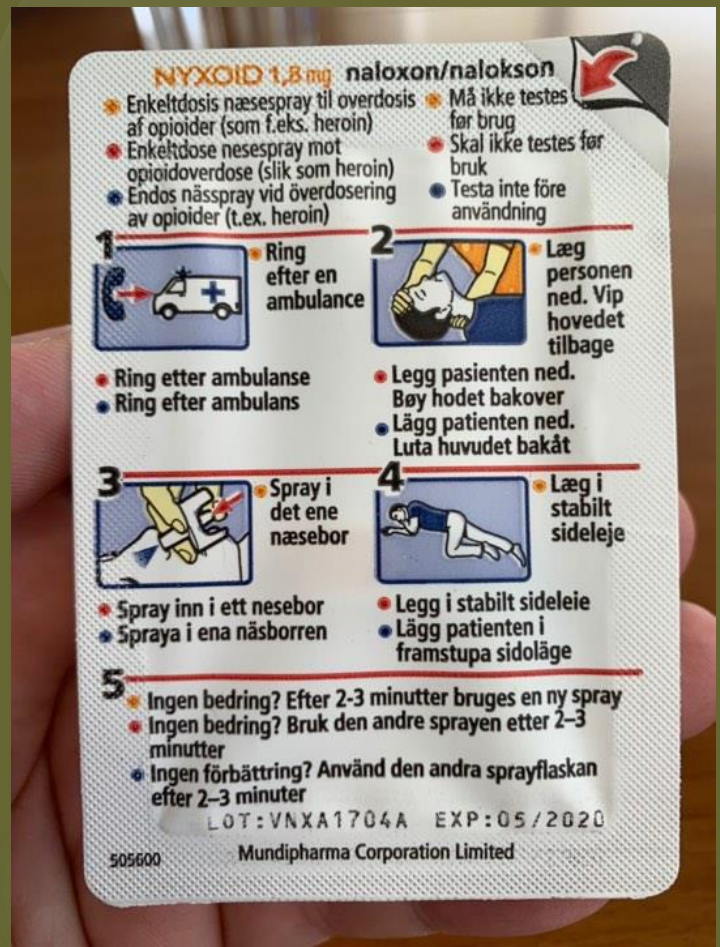
NYXOID 1,8 mg naloxon/nalokson
Enkeltdosis næsespray til overdosis af opioider (som f.eks. heroin)
Enkeltdose nesespray mot opioidoverdose (slik som heroin)
Endos nässpray vid överdosering av opioider (t.ex. heroin)
Må ikke testes før brug
Skal ikke testes før bruk
Testa inte före användning
1
Ring efter en ambulance
Ring etter ambulanse
Ring efter ambulans
2
Læg personen ned. Vip hovedet tilbage
Legg pasienten ned. Bøy hodet bakover
Lägg patienten ned. Luta huvudet bakåt
3
Spray i det ene næsebor
Spray inn i ett nesebor
Spraya i ena näsborren
4
Læg i stabilt sideleje
Legg i stabilt sideleie
Lägg patienten i framstupa sidoläge
5
Ingen bedring? Efter 2-3 minutter bruges en ny spray
Ingen bedring? Bruk den andre sprayen etter 2–3 minutter
Ingen förbättring? Använd den andra sprayflaskan efter 2–3 minuter
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BMJ Open

Opioid substitution therapy as a strategy to reduce deaths in prison: retrospective cohort study

Sarah Larney,[1,2] Natasa Gisev,[1] Michael Farrell,[1] Timothy Dobbins,[3] Lucinda Burns,[1] Amy Gibson,[4] Jo Kimber,[1] Louisa Degenhardt[1,5]

To cite: Larney S, Gisev N, Farrell M, *et al*. Opioid substitution therapy as a strategy to reduce deaths in prison: retrospective cohort study. *BMJ Open* 2014;**4**: e004666. doi:10.1136/bmjopen-2013-004666

► Prepublication history and additional material is available. To view please visit the journal (http://dx.doi.org/10.1136/bmjopen-2013-004666).

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Revised 5 March 2014
Accepted 7 March 2014

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[2]Alpert Medical School, Brown University, Providence, USA
[3]School of Public Health

ABSTRACT

Objectives: To describe deaths in prison among opioid-dependent people, and examine associations between receipt of opioid substitution therapy (OST) and risk of death in prison.

Design: Retrospective cohort study.

Setting: Adult prisons in New South Wales (NSW), Australia.

Participants: 16 715 opioid-dependent people who were received to prison between 2000 and 2012.

Interventions: Opioid substitution therapy.

Primary outcome measures: Natural and unnatural (suicide, drug-induced, violent and other injury) deaths in prison.

Results: Cohort members were in prison for 30 998 person-years (PY), during which time there were 51 deaths. The all-cause crude mortality rate (CMR) in prison was 1.6/1000 PY (95% CI 1.2 to 2.2/1000 PY), and the unnatural death CMR was 1.1/1000 PY (95% CI 0.8 to 1.6/1000 PY). Compared to time out of OST, the hazard of all-cause death was 74% lower while in OST (adjusted HR (AHR): 0.26; 95% CI 0.13 to 0.50), and the hazard of unnatural death was 87% lower while in OST (AHR: 0.13; 95% CI 0.05 to 0.35). The all-cause and unnatural death CMRs during the first 4 weeks of incarceration were 6.6/1000 PY (95% CI 3.8 to 10.6/1000 PY) and 5.5/1000 PY (95% CI 2.9 to 9.4/1000 PY), respectively. Compared to periods not in OST, the hazard of all-cause death during the first 4 weeks of incarceration was 94% lower while in OST (AHR: 0.06; 95% CI 0.01 to 0.48), and the hazard of unnatural death was 93% lower while in OST (AHR: 0.07; 95% CI 0.01 to 0.53).

Conclusions: Mortality of opioid-dependent prisoners was significantly lower while in receipt of OST.

Strengths and limitations of this study

- This study is based on a large, statewide cohort with mortality outcomes determined via population-based registries.
- Cohort members were not randomly allocated to treatment.
- Data regarding onset of opioid dependence and current opioid dependence were not available.

Unnatural deaths in prison are of particular concern due to their preventable nature. Unnatural deaths include suicides, violent or drug-induced deaths and other injury-related deaths. Studies in developed countries have found that unnatural deaths comprise 48–59% of all deaths in prison, with suicide being the most common cause of unnatural death.[2–5] These figures suggest considerable opportunities to reduce unnatural deaths in prison.

Opioid-dependent people commonly experience imprisonment,[6] and there are several reasons to believe that opioid-dependent prisoners may be at particular risk of unnatural death in prison. Drug withdrawal has been implicated as a possible trigger for suicide in the first days of incarceration.[7 8] Additionally, use of illicitly obtained opioids while in prison[9] carries with it the risk of overdose. To the best of our knowledge, deaths in prison specifically

JAMA. 2015 Apr 28;313(16):1636-44. doi: 10.1001/jama.2015.3474.

JAMA FULL TEXT PMC FREE Full text

Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a randomized clinical trial.

D'Onofrio G[1], O'Connor PG[2], Pantalon MV[1], Chawarski MC[3], Busch SH[4], Owens PH[1], Bernstein SL[1], Fiellin DA[5].

Author information

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2 Department of Internal Medicine, Yale School of Medicine, New Haven, Connecticut.
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5 Department of Internal Medicine, Yale School of Medicine, New Haven, Connecticut4Yale School of Public Health, New Haven, Connecticut.

Abstract

IMPORTANCE: **Opioid**-dependent patients often use the **emergency** department (ED) for medical care.

OBJECTIVE: To test the efficacy of 3 interventions for **opioid dependence**: (1) screening and referral to **treatment** (referral); (2) screening, brief intervention, and facilitated referral to community-based **treatment** services (brief intervention); and (3) screening, brief intervention, ED-initiated **treatment** with **buprenorphine/naloxone**, and referral to primary care for 10-week follow-up (**buprenorphine**).

CONCLUSIONS AND RELEVANCE: Among **opioid**-dependent patients, ED-initiated **buprenorphine treatment** vs brief intervention and referral significantly increased engagement in addiction **treatment**, reduced self-reported illicit **opioid** use, and decreased use of inpatient addiction **treatment** services but did not significantly decrease the rates of urine samples that tested positive for opioids or of HIV risk. These findings require replication in other centers before widespread adoption.

Table 3. Opioid-free Treatment of Opioid Withdrawal.*

Medication†	Target Symptoms	Dose‡
α_2-Adrenergic agonist		
Clonidine (Catapres)§	Increased pulse rate and blood pressure, anxiety, chills, piloerection	0.1–0.2 mg orally every 4 hr up to 1 mg/day; hold dose if blood pressure <80 mm Hg systolic or <50 mm Hg diastolic; by day 5, start to decrease dose by 0.2 mg/day
Clonidine patch	Increased pulse rate and blood pressure, anxiety, chills, piloerection	The patch is an alternative for patients 100–200 lb (45.4-90.7 kg), with oral dose augmentation, but few data are available
Benzodiazepine		
Temazepam (Restoril)	Insomnia	15–30 mg orally at bedtime
Diazepam (Valium)	Anxiety	2–10 mg orally as needed every 4 hr, up to 20 mg/day
Gut-acting opioid: loperamide (Imodium)	Diarrhea	4 mg orally initially, then 2 mg as needed for loose stools, up to 16 mg/day
NSAID: naproxen (Aleve)	Bone, muscle, joint, or other pain	500 mg orally twice daily as needed (take with food)
Antiemetic		
Prochlorperazine (Compazine)	Nausea and vomiting	5–10 mg orally every 4 hr as needed
Ondansetron (Zofran)	Nausea and vomiting	8 mg orally every 8 hr as needed

* A physical examination should be performed, and abscesses from injections and related conditions should be treated. Human immunodeficiency virus infection, hepatitis, and other infections should be ruled out or treated. The patient should be screened for his or her willingness to participate in a rehabilitation program. NSAID denotes nonsteroidal antiinflammatory drug.

† Medications are administered according to symptoms; not all medications are administered to every patient. Also, there are few definitive data indicating that any drug of a class (e.g., naproxen as an example of an NSAID) is superior to any other drug of the class. The medications listed are examples of only one possible medication. Data are from Kowalczyk et al.[21] and Gowing et al.[22]

‡ Doses are approximate.

§ Clonidine is used on an off-label basis for opioid withdrawal. Tizanidine (Zanaflex) is an alternative α_2-adrenergic agonist cited in the literature and used on an off-label basis for opioid withdrawal, and outside the United States, lofexidine at a dose of 0.4 mg every 4 hours (up to 2 mg per day) has been used.

Treatment of opioid-use disorders MA Schuckit, New England Journal of Medicine, 2016

Table 4. Treatment for Symptoms of Opioid Withdrawal with the Use of a Taper with Long-Acting Opioid Agonists or Partial Agonists.*

Step	Oral Methadone	Sublingual Buprenorphine
Preparation	Perform physical examination	Perform physical examination. Administer buprenorphine approximately 12–48 hr after most recent opioid use and while patient is having early withdrawal symptoms (e.g., score >10 on the Clinical Opiate Withdrawal Scale†)
Initial dose	If patient is participating in a methadone program, verify dose; start taper 10 mg below that level; if patient is not participating in a methadone program, start at 10–30 mg administered in divided doses	4–8 mg
Stabilization at effective dose	7–14 days	2–5 days
Taper	Administer 10–20% of initial dose every 1–2 days over 2–3 wk or more	Decrease dose to 0 by reducing dose 10–20% every 1–2 days over 2 wk or more

* To ensure the patient's health and to relieve withdrawal symptoms, a long-acting opioid agonist or partial agonist can be administered and then slowly tapered. If possible, the patient should be cared for in an inpatient or outpatient rehabilitation program. All doses are approximate for an average patient and vary according to the patient's condition and additional medications. It is very important to check the patient 1 to 3 hours after the medication is administered in order to adjust the dose and avoid doses that are too high or too low for the individual person.

† Scores on the Clinical Opiate Withdrawal Scale range from 0 to more than 36, with higher scores indicating a greater severity of withdrawal.

Treatment of opioid-use disorders MA Schuckit, New England Journal of Medicine, 2016

Οπιοειδή και Μείωση Βλάβης

- Ο αριθμός των χρηστών οπιοειδών υψηλού κινδύνου στην Κύπρο εκτιμάται ότι δεν υπερβαίνει τους 1200.
- Το 2018, 209 από τους 1168 χρήστες οπιούχων υψηλού κινδύνου βρισκόταν υπό θεραπεία υποκατάστασης οπιοειδών (OST).
- Ο μέσος αριθμός των θανάτων που προκαλούνται από τα ναρκωτικά στην Κύπρο είναι 8 ανά έτος.
- Μερικοί από αυτούς - σχεδόν οι 9 από τους 10 - αφορούν νέους άνδρες IV χρήστες οπιοειδών.
- Αυτός ο αριθμός θανάτων που σχετίζονται με οπιοειδή, περιλαμβάνει:
  - τα παράνομα οπιοειδή,
  - την εκτροπή των νόμιμων οπιοειδών από ιατρική για ψυχαγωγική χρήση, καθώς και
  - τα νόμιμα συνταγογραφούμενα οπιοειδή για ιατρική χρήση.

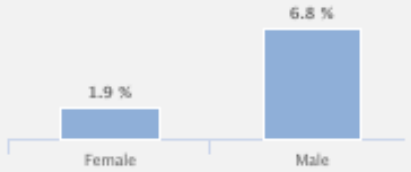
THE DRUG PROBLEM IN CYPRUS AT A GLANCE

Drug use

in young adults (15-34 years) in the last year

Cannabis

4.3 %



Other drugs

MDMA	0.3 %
Amphetamines	0.1 %
Cocaine	0.4 %

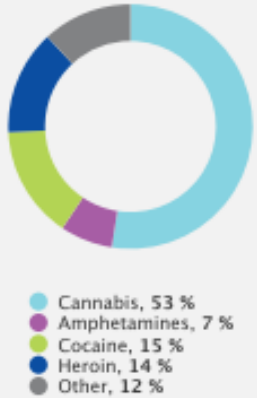
High-risk opioid users

1 168

(916 - 1 536)

All treatment entrants

by primary drug



Opioid substitution treatment clients

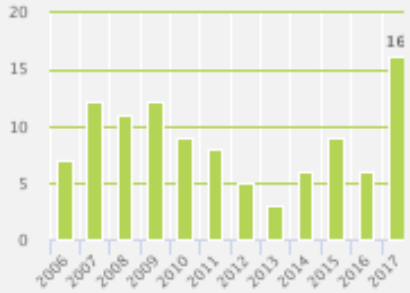
209

Syringes distributed

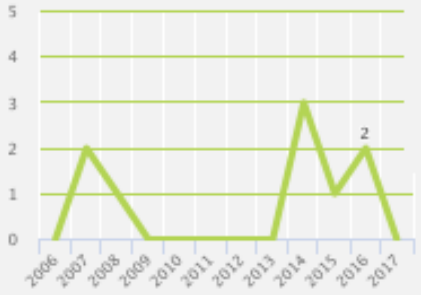
through specialised programmes

245

Overdose deaths



New HIV diagnoses attributed to injecting



Source: ECDC

Drug law offences

945

Top 5 drugs seized

ranked according to quantities meas
kilograms

1. Herbal cannabis
2. Cocaine
3. MDMA
4. Cannabis resin
5. Amphetamine

Population

(15-64 years)

582 452

Source: Eurostat Extracted on: 18/03/2019

NB: Data presented here are either national estimates (prevalence of use, opioid drug users) or numbers reported through the EMCDDA indicators (treatment clients, syringes, deaths and HIV diagnoses, drug law offences and seizures). Detailed information on methodology and caveats and comments on the limitations in the information set available can be found in the EMCDDA Statistical Bulletin.

Αναθεώρηση του επιστημονικού πλαισίου Υποκαταστάτων – Κύπρος 2018

- Ονομασία δομών: «Μονάδες φαρμακευτικά υποβοηθούμενης θεραπείας της εξάρτησης με χρήση υποκαταστάτ
  οπιοειδών»
- Εμβάθυνση στον όρο Μείωση Βλάβης
- Συμπερίληψη ανηλίκων και εγκύων
- Δεν διακόπτεται το take home όταν είναι θετικός σε άλλη ουσία αν δεν υπάρχει έκδηλος κλινικός λόγος
- Σε καμιά περίπτωση δε θα διακόπτονται τα φάρμακα (take home) χωρίς ιατρική οδηγία (το take home είναι
  μέρος της συνταγογράφησης). Ο κίνδυνος από τη διακοπή είναι μεγάλος.
- Εξατομικευμένη προσέγγιση
- Δεν χρησιμοποιούμε τα φάρμακα ως συμπεριφορικό εργαλείο (πχ για επιβράβευση)
- Buprenorphine θα μπορούσε να χορηγείται κατευθείαν με συνταγή από το φαρμακείο (δημόσιο ή ιδιωτικό)
  μειώνοντας κατά πολύ το κόστος της παρεχόμενης υπηρεσίας και αυξάνοντας την προσβασιμότητα (ανάλυση
  κόστους εκκρεμεί)

Neuropsychiatr Dis Treat. 2014 Apr 7;10:587-598. eCollection 2014.

Utilizing buprenorphine-naloxone to treat illicit and prescription-opioid dependence.

Mauger S[1], Fraser R[2], Gill K[2].

Author information

Abstract

OBJECTIVES: To review current evidence on buprenorphine-naloxone (bup/nx) for the treatment of opioid-use disorders, with a focus on strategies for clinical management and office-based patient care.

QUALITY OF EVIDENCE: Medline and the Cochrane Database of Systematic Reviews were searched. Consensus reports, guidelines published, and other authoritative sources were also included in this review. Apart from expert guidelines, data included in this review constitute level 1 evidence.

FINDINGS: Bup/nx is a partial μ-opioid agonist combined with the opioid antagonist naloxone in a 4:1 ratio. It has a lower abuse potential, carries less stigma, and allows for more flexibility than methadone. Bup/nx is indicated for both inpatient and ambulatory medically assisted withdrawal (acute detoxification) and long-term substitution treatment (maintenance) of patients who have a mild-to-moderate physical dependence. A stepwise long-term substitution treatment with regular monitoring and follow-up assessment is usually preferred, as it has better outcomes in reducing illicit opioid use, minimizing concomitant risks such as human immunodeficiency virus and hepatitis C transmission, retaining patients in treatment and improving global functioning.

CONCLUSION: Bup/nx is safe and effective for opioid detoxification and substitution treatment. Its unique pharmaceutical properties make it particularly suitable for office-based maintenance treatment of opioid-use disorder.

KEYWORDS: Suboxone, Zubsolv, clinical management, methadone, opiate detoxification, opiate substitution

Harm Reduction services – Cyprus - 2019	
OST Buprenorphine+Naloxone	YES
OST Methadone	NOT YET
Needle and syringe exchange	YES
Drug Consumption Rooms	NOT YET
Heroin Replacement Treatment (HRT)	NOT YET
Naloxone self-injection for overdose reversal	YES

Η Μείωση Βλάβης δεν είναι πρόγραμμα ούτε παρέμβαση:

Είναι γενικευμένη θεραπευτική προσέγγιση (approach), που πρέπει να διαχέει κάθε θεραπευτικό πρόγραμμα και κάθε θεραπευτική παρέμβαση.


Thank you!