Methadone is a synthetic opioid used for managing opioid dependence and as a second-line opioid analgesic. A dramatic increase in methadone use for pain has occurred over the last 10 years, with shared worldwide experience indicating that methadone has become one of the most important agents for treating opioid-nonresponsive pain in palliative care. Despite this, fewer than 1 in 10 medical practitioners in BC are authorized to prescribe methadone for analgesia. A survey conducted as a palliative care residency project (report in press, Pain Research and Management) found most physicians who are already authorized to prescribe methadone report experiencing little difficulty obtaining authorization through the College of Physicians and Surgeons of BC. In general these prescribers also support the requirement for authorization because of the need to avoid potentially serious drug interactions and overdoses. As well, survey results indicated that many physicians not authorized to prescribe methadone would be willing to apply for authorization in order to continue methadone prescriptions for a patient treated initially by a palliative care physician or pain specialist.

Results from a survey of more than 800 BC family physicians indicate that most physicians already authorized to prescribe methadone for analgesic purposes support the requirement for authorization and believe the authorizing process is not burdensome.
Methadone for pain in palliative care

The paucity of family doctors able to take over care of methadone prescribing for stable patients is a barrier to methadone’s use by palliative care and pain and symptom management teams, and limits our ability to allow anticipated natural deaths to occur at home, in hospice, and in residential care under the care of family physicians, rather than in acute care hospitals.
consuming. Most problems with methadone occur within the first 4 weeks of therapy or after inadvertent coadministration with an interacting drug, most frequently ciprofloxacin. Additionally, caution is advised when administering methadone while stopping certain metabolism-inducing drugs such as carbamazepine.

**Most problems with methadone occur within the first 4 weeks of therapy or after inadvertent coadministration with an interacting drug, most frequently ciprofloxacin.**

**Authorization process**

In Canada, the risks of methadone use are managed by a federal prescribing restriction. Exemptions from this restriction for analgesic purposes are obtained separately from the exemptions for addiction treatment, and the administration of these exemptions is delegated solely to provincial regulatory agencies such as the College of Physicians and Surgeons of British Columbia (CPSBC). In BC, authorization to prescribe methadone for opioid dependency requires an 8-hour course, followed by a preceptorship period and interview, plus registration of individual patients receiving methadone. By contrast, authorization to prescribe methadone for analgesic purposes is acquired by reading the CPSBC’s “Recommendations for the Use of Methadone for Pain” and six selected articles, followed by a brief phone interview to confirm that key safety issues specific to methadone are well understood. Registration of individual patients receiving methadone for pain relief has not been required for approximately 10 years, though many older physicians remember this being a requirement.

Most of the physicians we surveyed who were authorized by the CPSBC to prescribe methadone considered the authorization process effective and not overly difficult or burdensome. Physicians surveyed who had not previously considered becoming authorized had limited knowledge of the authorization process, but were willing to explore it if asked to do so.

Comments from respondents already authorized to prescribe indicated that most see a need for some mechanism to ensure prescribers are properly informed on the safe use of methadone in palliative care (e.g., “Use can be tricky—some training/experience necessary”). Comments also indicated almost all felt positive about the authorization process (e.g., “Very good organized process. The careful education [not onerous, given by a college registrar] was most helpful”).

A small number of authorized prescribers disagreed, with one respondent condemning the process: “The exemption is a tragic piece of historical silliness and it creates great difficulties for patients and those few of us with an exemption... Get rid of the exemption please.”

Only 20.5% of family physician respondents in a position to provide palliative care but not currently authorized to prescribe methadone recalled having had any training or education on methadone for analgesia. The number of these physicians who reported having received education about methadone for analgesia declined with age, dropping off after graduation from a high of 38% for those younger than 40 years, to 24% for those 40 to 50, to 18% for those 50 to 60, and to only 6% for those over 60. However, even looking at the younger age groups, these numbers are not sufficient to ensure equitable access to this important treatment modality.

Despite a variety of perceived barriers and misconceptions, over half of respondents not authorized to prescribe methadone stated that they would be somewhat or very likely to apply for an exemption to continue methadone prescriptions for a patient after treatment was initiated by a palliative care physician or pain specialist.

**Conclusions**

It was reassuring to find that survey respondents already authorized to prescribe methadone for analgesia reported that the process of obtaining authorization was easy, and that on the whole they were supportive of the requirement for authorization because of pharmacological concerns that pre-
Methadone for pain in palliative care

Subscribers must be aware of to avoid inadvertent overdose. It was also reassuring to find that many respondents not authorized to prescribe methadone were willing to consider obtaining authorization so that their patients might benefit from this cost-effective agent for quality pain management.

Acknowledgments
The author would like to thank Drs Ryan Liebscher and Jessica Wilford for their excellent work on the physician survey project. She would also like to thank the Prostate Cancer Foundation of BC for financial support provided through the Gordon Dunn Pioneer Award.

Competing interests
The author has received honoraria from Paladin Labs Inc., manufacturer of the methadone tablet Metadol, for speaking at medical education events about one of the company’s other products, Abstral.

References

Using methadone for pain: Practice points

- To apply for an exemption from the federal restriction on methadone prescribing, contact the College of Physicians and Surgeons of BC at www.cpsbc.ca. State clearly that you are seeking authorization to prescribe methadone for pain. You will need to read “Recommendations for the Use of Methadone for Pain” (www.cpsbc.ca/files/u6/Methadone-Program-Recommendations-for-the-Use-of-Methadone-for-Pain-PUBLIC.pdf) and some references, and then have a brief telephone interview with a deputy registrar.
- Switching a patient to methadone from high doses of other opioids can be complicated and should be done only by physicians with sufficient knowledge and experience using methadone for pain, or in consultation with a palliative care physician.
- Methadone has a long and variable half-life: changes in dose can take more than 3 days to achieve full effect. Start low and go slow whenever possible.
- Methadone can interact with other drugs in potentially serious ways.

When a patient is taking methadone for pain, check with a reliable pharmacological resource (e.g., as provided by the CPSBC), before stopping or starting any other medication.
- Methadone can cause prolongation of the QT interval and predispose to torsade de pointes. Check the patient’s ECG if the dose of methadone is above 150 mg/day, or if the patient has any other conditions or is taking any other drugs that might also prolong the QT interval.
- Methadone doses should be reduced if liver function deteriorates, but do not have to be adjusted in cases of renal failure.
- When a patient becomes unable to take oral methadone, suppositories can be made up by a compounding pharmacy using the same dose as used for the oral route. Oral methadone liquid can also be administered rectally.
- Injectable methadone may be ordered in advance through Health Canada, and emergency supplies can be obtained from most tertiary palliative care units.