CASE RECOMMENDATION FORM

Presenter Credential: NP-C

Original Case Summary (Presented January 2025)

A 61-year-old woman with commercial insurance and a long, complex history of chronic pain management was referred for guidance on transitioning from methadone to buprenorphine. She has been treated for pain "for years," cycling through multiple pain clinics and was discharged from her most recent clinic in August 2024 for a contract breach; pharmacy staff also cautioned the provider to "watch her," and prior records were unavailable. Her history includes somatization disorder and previous work as an RN. Current medications include methadone 10 mg QID, multiple doses of gabapentin, alprazolam, methocarbamol, ondansetron (taken daily), Victoza, and several other chronic medications. Past records show high-dose methadone, Norco, and Xanax use in 2015. She is adherent overall and expressed a desire to be on the safest medication possible for fibromyalgia. A transition attempt was initiated using 2 mg buprenorphine at the midday dose, but she reported significant symptoms (shakiness, weakness, nausea, diaphoresis), and it was unclear if this represented withdrawal or an adverse reaction.

Follow-Up Summary (12/10/25)

Now 62, the patient began methadone tapering in January 2025, with monthly follow-ups. The first five months were challenging due to difficulty determining the correct titration schedule and the patient frequently reverting to her prior dosing. In September, a detailed, date-based medication plan was introduced, specifying exact methadone reductions and dosing instructions for her compounded buprenorphine. This structured approach successfully reduced methadone from 40 mg/day to 20 mg/day. However, she consistently refuses to increase buprenorphine as directed due to nausea and vomiting; when symptoms flare, she postpones dose increases for several days. The provider now seeks guidance on whether to continue tapering methadone alone rather than replacing it with buprenorphine.

Recommendations:

Compounded Buprenorphine Issue

- The current compounded product is swallowed—not sublingual—and therefore not absorbing as intended.
- Oral swallowed buprenorphine undergoes extensive first-pass metabolism and provides almost no therapeutic benefit. What she is receiving is essentially a micro-dose exposure, which aligns with her symptoms.
- **Immediate fix:** switch her to the correct **sublingual** buprenorphine formulation.

Buprenorphine & Methadone Management

- Prioritize discontinuing methadone; it is contributing significantly to the confusion around her symptoms.
- Aim to taper off methadone fully within the next 1–2 weeks if clinically safe.
- Once buprenorphine reaches approximately 8–12 mg/day, stop methadone altogether.
- Nausea could also be due to the combination of methadone + buprenorphine.

Transition Strategy

- Move to a faster, more structured transition plan once the correct buprenorphine form is obtained.
- Prepare the patient for a realistic, imperfect process—withdrawal symptoms are expected during transitions, even when done correctly.
- Given the complexity and her sensitivity, consider inpatient induction if outpatient efforts continue to struggle.

CASE RECOMMENDATION FORM

Pain & Fibromyalgia Management

- Opioids generally worsen fibromyalgia; methadone may be contributing to hyperalgesia.
- Buprenorphine is the preferred long-term option for pain control.

Somatic Symptom Considerations

- Key management strategy: frequent, consistent visits, including when she is well.
- Leverage team-based support—pharmacy, social work, case management—to maintain regular touchpoints.
- Provide psychoeducation about unexplained symptoms being common and often without identifiable cause; normalize without dismissing.

Consider presenting follow-up for this patient case or any other patient cases at a future ECHO Clinic session.

Shannon McDowell, Program Manager. Office: 208-364-9905, sfmcdowell@uidaho.edu