Chronic pain is one of the most common conditions for which people seek medical treatment; it affects more than 85 million Americans. In end-of-life care, in which the primary focus is the reduction or elimination of suffering, a significant number of patients still suffer with uncontrolled pain. In recent years, healthcare consumers have become more sophisticated, demanding better pain control. Therefore, physicians need to be familiar and competent with the various treatment options and pharmacologic management of their patients with chronic pain.

Although the primary responsibility of physicians is to nurture the physical and psychological well-being of their patients, it is also important that they serve as stewards of financial resources. In the past several years, there has been resurgence in the understanding of the pharmacologic and pharmacokinetic properties of methadone hydrochloride. This resurgence, coupled with methadone’s low cost, has led to increased use of this agent in the treatment of chronic pain.

Methadone hydrochloride is an effective, inexpensive, and relatively safe opioid to use in the treatment of patients with chronic pain. It is especially effective in management of pain during the final stages of life, as it is the only long-acting analgesic available in liquid form. However, because methadone has a long half-life, individual wide variations, and potential for accumulation and overdosage, physicians must judiciously and conscientiously prescribe it. Also, they should closely monitor patients during the titration phase and educate them with regard to basic pharmacologic properties and potential side effects. A plan to start at low doses and proceed slowly is applicable to methadone.

The mean plasma half-life of methadone is probably 15 to 60 hours, though even this range is extremely variable and dependent on single versus multiple dosing, individual adipose stores, and protein binding. This wide
variation in half-life contributes to methadone’s potential for toxic accumulation and has created difficulty with appropriately and easily dosing this medication.

Methadone has a rapid onset of action, with analgesic effects occurring within 30 to 60 minutes and an analgesic peak between 2.5 and 4.0 hours. Its oral bioavailability, though variable, generally exceeds 80%. It binds with mu, delta and to a lesser extent kappa opioid receptor sites.

Drug Interaction
Cytochrome P450 is the main isoenzyme involved in methadone biotransformation. Physicians must be sensitive to coadministration of other drugs that could result in either an increase or a reduction of methadone levels. Table 1 reflects examples of some of those medications.

Clinical Advantages
Although initially used in cancer patients, methadone is being increasingly used in the end-of-life care setting for patients with nonmalignant pain syndromes. As the only long-acting opioid liquid formulation, methadone provides an attractive alternative to the expensive transdermal fentanyl patch in patients with debilitating states of advanced dementia, in patients with arthritis, and in deconditioned bedridden individuals with adult failure to thrive who have generalized pain or allodynia and when patients can no longer swallow pills. Methadone’s high bioavailability and long duration of action with rectal administration make it a potential alternative to intravenous administration.

Whereas methadone and fentanyl have been shown to be safe in patients with renal failure, morphine and codeine with their active metabolites should be avoided and hydromorphone and oxycodeine should be used with caution. An additional advantage of methadone is its property as an N-methyl-D-aspartate (NMDA) receptor antagonist. This property contributes to a reduced propensity to develop opioid tolerance as compared with morphine and a greater efficacy in treating patients with neuropathic pain.

Figure 2 summarizes the advan-

Prescribing Methadone

Equianalgesic dosing of methadone is more complex than it is for other opioids. Unlike morphine, methadone exhibits wide variations in half-life among patients and must be cautiously prescribed, especially in individuals currently medicated with an opioid.

There are several approaches to prescribing methadone. In end-of-life care where some patients have noncancer pain syndromes and debilitated elderly have moderate pain, a reasonable approach is to start at 5 mg every 12 hours. Additional increases are determined based on the frequency and amount of short-acting opioid used for breakthrough or incidental pain and titrated accordingly every 3 to 5 days. The following examples demonstrate some of the established protocols for both initiating and converting to methadone.

**New Start: Opioid-Naive Patients**

This is the easiest method for initiating treatment with methadone in opioid-naive patients:
- Start methadone 5 mg every 6 to 12 hours.
- Titrate every 3 to 5 days until adequate analgesia is achieved.
- When steady state is achieved, switch to every 8- to 12-hour dosing schedule.
- Use methadone or a short-acting opioid as needed for breakthrough pain.

**Conversion From Morphine to Methadone**

Table 2 provides the conversion ratio of oral morphine to methadone.
- Start dosing every 6 hours for four to six doses; then, decrease frequency to every 8 to 12 hours.
- Use an immediate-release opioid as rescue dosing.

Switching From Another Opioid to Methadone

The process of switching from another opioid to methadone, especially when high doses are being used, is much more complex. Several conversion protocols are available. One example follows:

- Discontinue current opioid.
- Start methadone at a fixed oral dose every 3 hours as needed: Administer a fixed dose of methadone that equals 10% of prior daily oral morphine sulfate equivalent with a maximum dose of 30 mg.9,10
- **Example**—If prior daily opioid dose equals 150 mg of oral morphine sulfate equivalent per day; then, use 15 mg of methadone hydrochloride every 3 hours as needed.

(Note: This is not a 1:10 ratio, unless only one dose is given in 24 hours: 1:10 ratio would be 15 mg/d, not 15 mg per dose.)

On day 6, calculate total amount of methadone taken during previous 48 hours and convert to twice-daily methadone dose. If the patient actually took the 15 mg dose every 3 hours on days 4 and 5, then the correct dosing would be 60 g every 12 hours.
- **Example**—Patient is taking 600 mg of oral morphine sulfate equivalent per day. Because the oral morphine equiva-
lent is greater than 300 mg/d, use 30 mg of methadone hydrochloride as initial fixed dose and give 30 mg of methadone hydrochloride every 3 hours as needed. If patient has taken eight doses of 30 mg over 2 days on days 4 and 5, for a total of 240 mg in 48 hours, or 120 mg of oral methadone hydrochloride per day, then, on day 6, adjust methadone dose to 40 mg taken orally every 8 hours or 60 mg every 12 hours.9,10

Table 3 provides a cost comparison of methadone with equivalent medication doses of other opioids.11 Figure 3 provides a list of additional print and Web site resources.

Comment

Methadone is gaining recognition in the arsenal of pain management. With knowledge and initial cautious titration, physicians can readily manage and consider methadone with the other extended-release opioids of morphine, oxycodone, hydromorphone, and fentanyl. Methadone’s efficacy, long-acting liquid formulations, multiple routes of administration, and low cost make it a noteworthy contender in the treatment of patients with chronic pain.

Table 3

<table>
<thead>
<tr>
<th>Medication</th>
<th>Strength</th>
<th>Dosing Interval (h)</th>
<th>Cost (Average Wholesale Price*)</th>
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<tbody>
<tr>
<td>Fentanyl transdermal system (Duragesic)</td>
<td>100 µg/h</td>
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<td>Morphine sulfate extended-release capsules (Avinza)</td>
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<td>Oxycodone hydrochloride controlled-release tablets (OxyContin)</td>
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<td>Morphine sulfate controlled-release tablets (MS Contin)</td>
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<td>Methadone hydrochloride (Methadose)</td>
<td>40 mg</td>
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<td>$ 17</td>
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References