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eConsults

Address addiction medicine and related conditions in the primary care setting with advice from a specialist.

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eConsults

Address addiction medicine and related conditions in the primary care setting with advice from a specialist.

All patient, provider and specialist details have been removed to de-identify these eConsults.

Specialist Advice to Support Your Addiction Medicine, Infection Disease & Hepatology Treatment Plans

eConsults increase access to specialty care for patients so you can deliver faster care. Receive expert advice in as little as 4 hours with AristaMD.

SPECIALTY	PATIENT COMPLAINT	CLINICAL QUESTION
Addiction Medicine	Alcohol (ETOH)	• Patient is still not abstinent from alcohol. Can I add acamprosate to her naltrexone 50 mg daily dose to encourage abstinence? If so, what is the starting dose? • Patient is no longer sober; he would like to start medication. Do you recommend naltrexone or acamprosate? • What additional medication can be used for alcohol dependence, or should I increase naltrexone?
	Cocaine	• This patient has adequate counseling support through their employer and several outside groups. Is there anything I can prescribe that can help with cocaine addiction?
	Methamphetamine	• Is there any pharmacologic treatment that is appropriate, effective and relatively safe for treating methamphetamine use? • What is the best pharmacological therapy for depression and anxiety in a patient in early remission (2-3 months) from methamphetamine abuse?
	Opiates	• No local methadone clinic and insurance will not pay for more than 24mg of naloxone per day. Does the patient need an increase in medication or some other treatment? • Patient tapering buprenorphine reports restless legs at night and a runny nose. How long will these symptoms last? Can a medication like ropinirole help with restless legs? • Patient with suspected post-acute-withdrawal syndrome. What mental health diagnoses and relevant medications should be considered in this patient? • Please advise on medication for psychiatric comorbidity in a patient with opioid abuse disorder. Is there a medication or other treatment considerations for this patient with a history of visual and auditory persecutory hallucinations likely induced by insomnia caused by either drugs or detoxing? • What do you recommend for post-op pain management for a patient with a Butrans patch? I'd like to have a strategy in place prior to surgery for CMC joint arthritis.

SPECIALTY	PATIENT COMPLAINT	CLINICAL QUESTION
Gastroenterology/ Hepatology	Cirrhosis	• 42-year-old male with a medical history of alcohol abuse recently hospitalized for decompensated liver cirrhosis with ascites status post paracentesis. Can you recommend appropriate medications? • 48-year-old male with a current/chronic history of ETOH abuse. Cirrhosis was noted on his liver ultrasound (US). Alpha-fetoprotein (AFP), gamma-glutamyl transferase (GGT) and liver enzymes have worsened. Can you provide recommendations for primary care management? • Large spider angiomas on the upper back of a 65-year-old patient with a longstanding heavy alcohol intake of around 10 beers per day. Do I need to do any testing for cirrhosis?
	Hepatitis C Virus (HCV)	• 52-year-old female with opioid dependence is stable on Suboxone with Hepatitis C (HCV). Can I begin treatment with glecaprevir/pibrentasvir with regular testing? • 64-year-old male with HCV is a good candidate for Harvoni but needs a GI consult in order to receive medication approval through Medicaid. Can you review the attached labs and US ECHO? Does he need Right Upper Quadrant (RUQ) imaging? • I am treating this patient for Hepatitis C (non-cirrhotic) with Harvoni, and after 4 days of treatment, he has developed a mild disturbance in his balance. He takes methadone. Could Harvoni be raising the levels of methadone? Is there another treatment that you recommend to minimize this side effect? • Patient is a 36-year-old male with a new diagnosis of HCV AB positive. The nearest Gastroenterologist (GI) is a 2-hour drive, with no available appointments for many months. Can you tell me if Mayvret is an appropriate medication for this patient and how to follow up? • Recent test indicates HCV, but the genotype is not available. Is her level of HCV too low to provide a genotype? Should I repeat the HCV RNA/genotype test in a few months? Can I treat her with Harvoni or another drug, given the RNA level and no available genotype?
Infectious Disease	Human Immunodeficiency Virus (HIV)	• 33-year-old female reports recent high-risk exposure to HIV. Can you recommend the next steps for testing and treatment? • 45-year-old male with poorly controlled Diabetes Mellitus (DM) tested repeatedly HIV 'reactive'. HIV-1/2 Antigen and Antibody (AB) and HIV RNA negative. How do I interpret these results? What tests should I repeat? • Asymptomatic 34-year-old female patient's HIV-1/2 Antigen and Antibodies, Fourth Generation, with Reflexes, was equivocal. Upon repeat testing, she was found to be positive. Her HIV-1 RNA is not indicated. Do I need any further confirmatory HIV tests? Can I prescribe Biktarvy? • Do you recommend replacing or adjusting this patient's medication, given the significant change in his kidney function in the past 3 months? What labs do you recommend? • Patient diagnosed HIV-1 (confirmed genotype) started Biktarvy; maintained negative viral load for 2+ years. I'd like to continue managing him in primary care. What labs do you recommend? How often should I perform lab work? • PrEP patient with repeated (3x) 'reactive' HIV tetresults. Negative confirmatory test (2x). Third test was 'reactive'. Do you recommend additional testing? What is causing the repeated 'reactive' results?

SPECIALTY

Addiction Medicine

CHIEF COMPLAINT

Opiates

COMMENTS TO SPECIALIST

The patient is a 52-year-old male with chronic back pain and subsequent opioid abuse. He is 4 years sober, participates in Narcotics Anonymous, and is generally compliant. He is on Suboxone given to him by a previous primary care provider at 4-1 BID and has done well on this (although he says he has bad days of continued pain).

We don't have a psychiatrist in town. The nearest psychiatrist is a 2.5-hour car drive, and the wait to be seen by a psychiatrist is long.

I would like to take over medication management for Suboxone. I know a federal waiver is no longer required for up to 30 patients per primary care provider.I am planning on continuing the medication at the current dose.

However, I would like a coherent plan that includes behavioral health, a medication contract, and regular appointments to ensure this medication is given responsibly.

MAIN QUESTION

Can you provide guidance on any established protocols for managing and monitoring this patient?

Response from eConsult Specialist

ELLIE MCCANDLES, MD, PHD, PSYCHIATRY & ADDICTION MEDICINE
NPI: 1000000514

SUMMARY

Treatment options available at the primary care level.

DETAILS

Here are some points to consider when continuing the buprenorphine regimen of a patient who is being treated for opioid dependence.

- Buprenorphine can now be prescribed for any reason, including opioid dependence, without a DEA waiver.
- The typical range of buprenorphine is 8-16mg per day prescribed for opioid use disorder as sublingual buprenorphine/naloxone film (2, 4, 8mg, etc.), buprenorphine/naloxone tabs (2, 4mg) and buprenorphine tabs (2, 4mg).
- Although the buprenorphine/naloxone combination is formulated as an abuse deterrent, it has not been known to make much of a difference when compared to the buprenorphine-only product.
- The product label says not to divide the tabs or films. However, they are often prescribed as 1/2 or 1/4 tabs or films as the product is not time released but is a long-acting molecule.
- Prescribing other non-opioid medications for chronic pain typically follows the usual guidelines. This may include acetaminophen, NSAIDS, gabapentinoids, skeletal muscle relaxers, Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs)s and TCAs.
- Co-prescribing with benzodiazepines should be done with caution, as with any opioids.
- Prescribing other opioids for chronic pain in addition to buprenorphine is usually done by clinicians experienced in pain management with opioids.
- For acute pain and postoperative pain, short courses of other opioids such as tramadol, hydrocodone, hydromorphone and fentanyl can be used. Codeine and morphine do not work as well in combination with buprenorphine due to lower binding affinity for the opioid receptor.
- For surgery, buprenorphine is usually continued during the perioperative period, often with a reduced dose, such as 50% of the usual dose, starting 3-5 days before surgery. Short-acting opioids such as hydromorphone and fentanyl are thought to work better when added to a regimen of buprenorphine.
- Periodic urine testing should be done to monitor for drug use.
- The duration of treatment depends on multiple individual patient factors. Some patients may need to be maintained indefinitely to prevent relapse.

Ellie McCandles, MD, PhD — 01/25/23 15:40 PST

Ellie McCandles, MD, PhD, Psychiatrist & Addiction Medicine Specialist — Response Date Stamp

SPECIALTY

Gastroenterology

CHIEF COMPLAINT

Cirrhosis

COMMENTS TO SPECIALIST

Patient appointment for follow-up US. He denies bleeding and has not consumed alcohol in 7 years after diagnosis of cirrhosis. No drug use and a nonsmoker.

MAIN QUESTION

What would you suggest for these labs? Does he need a biopsy?

Response from eConsult Specialist

SHIVANI PATEL, MD, GASTROENTEROLOGY
NPI: 1000000012

SUMMARY

Treatment options available at the primary care level.

DETAILS

There is no need for additional treatment for thrombocytopenia (secondary to cirrhosis and hypersplenism). He would benefit from a platelet transfusion at the time of Total Hip Replacement (THR).

No concern for spontaneous bleeding unless his platelet count is less than 30,000.

Use labs to calculate his MELD score every 6 months (https://optn.transplant.hrsa.gov/data/allocation-calculators/meld-calculator/). If his MELD score exceeds 15, he will need a referral for a liver transplant evaluation.

Recommended Patient Actions: Abstain from alcohol. Avoid aspirin, NSAIDs and anticoagulants unless medically necessary.

Shivani Patel, MD

05/16/23 15:40 PST

Shivani Patel, MD, Gastroenterologist

Response Date Stamp

SPECIALTY

Hepatology

CHIEF COMPLAINT

Hepatitis C

COMMENTS TO SPECIALIST

This patient has a history of positive hepatitis C antibody testing and sharing needles. This is the second positive test from 2 years ago, per patient. She is now asymptotic.

MAIN QUESTION

Given the history of needle sharing more than 5 years ago, do we assume she has a history of infection that is now resolved? Should I begin treatment or check additional labs?

Response from eConsult Specialist

KEVIN AGATE, MD, HEPATOLOGY

NPI: 1000000024

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SUMMARY

Treatment options available at the primary care level.

DETAILS

Thank you for the consultation on this patient. Per the available records, this is a 28-year-old patient with a known history of needle-sharing and prior known positive Hepatitis C antibody. Hepatitis C antiviral treatment history is unknown.

Per the most recent labs obtained, the patient has a positive Hepatitis C antibody and a Hepatitis C RNA result 'not detected.' The patient's HIV screen is negative, and liver function tests are within normal range.

Based on the above, the patient does not appear to be actively infected with the Hepatitis C virus. This infers that the patient either spontaneously cleared the virus following a prior infection or was successfully treated with HCV antiviral therapy. The patient's Hepatitis C antibody is expected to remain positive lifelong, even with treated/resolved infection and repeating this antibody test is not advised for this reason. A negative Hepatitis C RNA (viral load) affirms that an active infection is absent.

No further diagnostic evaluation or treatment is indicated for concern of active Hepatitis C infection currently. The patient should be counseled to continue abstaining from needle-sharing as she already does.

Kevin Agate, MD

05/02/23 13:52 PST

Kevin Agate, MD, Hepatologist

Response Date Stamp

SPECIALTY

Infectious Disease

CHIEF COMPLAINT

HIV

COMMENTS TO SPECIALIST

A 26-year-old male with HIV, HCV and a history of treated syphilis needs evaluation. He had a Rapid Plasma Reagin (RPR) titer of 1:1 and denies sexual intercourse. RPR titer increased to 1:32. He reports that for the last couple of years, his RPR titer continues to increase even after being treated multiple times. He is also having side effects from Biktarvy (50-200-25 mg once daily), as he is losing hair. Labs attached.

MAIN QUESTION

Please provide recommendations on medication adjustments, review RPR titer and provide guidance for ongoing management.

Response from eConsult Specialist
RACHEL JONES, DO, INFECTIOUS DISEASE
NPI: 1000000003

SUMMARY

Treatment options available at the primary care level.

DETAILS

I have never seen a patient lose hair due to Biktarvy, nor can I find anything about this in the package insert. I would be more suspicious that it is related to syphilis or some other etiology.

Please assess if his HIV is well-controlled and inquire about the treatments administered for syphilis in the past.

He needs a lumbar puncture to exclude neurosyphilis, even if he is asymptomatic. Does he have any ocular symptoms, otic symptoms, or neurologic symptoms?

If no ocular, otic or neural involvement can be demonstrated, I would treat with penicillin G benzathine 2.4 milliunits per liter (mU/L) once a week for three weeks.

Please let me know if you have any further questions or require a follow-up consult.

Rachel Jones, DO

03/09/23 18:55 PST

Rachel Jones, DO, Infectious Disease Specialist

Response Date Stamp

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