Don’t Meth Around

Anti-heroin and anti-HIV meds get along about as well as Mariah and Whitney -- hardly at all.

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Meth-takers: Many meds used to treat HIV may queer your body’s breakdown of this common anti-heroin medication, often raising but occasionally lowering the amount of methadone in your blood. And meth can mess with levels of other pharmaceuticals -- by boosting them (and increasing side effects) or lowering them (and reducing effectiveness). So which-ever drug combo you’re on, taking care to adjust your metha-done dose may mend med mêlées.

At their worst, such interactions can cause body-wracking pain. “The most significant interactions occur with NNRTIs, particularly nevirapine [Viramune] and efavirenz [Sustiva],” says Gerald Friedland, MD, director of the AIDS program at the Yale University School of Medicine. These two non-nukes increase the body’s metabolism of methadone, quickly diminishing its effects, which can normally suppress cravings for 24 to 36 hours. With no methadone in the system, takers are hit with the misery of withdrawal.

Because service providers may dismiss withdrawal complaints as a drug-seeking manipulation, Friedland says, it’s important that your AIDS doc contact the clinic ASAP. Other drugs that may lower methadone levels include the anti-HIV meds abacavir (Ziagen), lopinavir (Kaletra), nelfinavir (Viracept) and ritonavir (Norvir), and the anti-TB drugs rifampin and rifabutin (Mycobutin, also an anti-MAC drug). While not all meds reduce methadone levels enough to trigger obvious withdrawal signs such as vomiting or sweating, a more subtle increase in drug craving may occur. And because withdrawal’s risks are more immediate and palpable than HAART’s benefits, HIVers may feel more compelled to treat their heroin addiction than their HIV infection.

“Clinics shouldn’t dismiss out of hand a request for an increased dose of methadone by a patient on HAART,” says Friedland, who suggests slowly stepping up the methadone dose, 5 to 10 mg daily, for HIVers in withdrawal. Nor should physicians rule out a drug regimen with a convenient dosing schedule because of an interaction. “Doctors should make the meth clinic understand that an increased methadone dose is needed,” Friedland says. Doctors should also be cautious when stopping a methadone-taker’s HIV meds. For example, after discontinuing non-nukes, it may be wise to keep HIVers on a higher methadone dose for several weeks, because it could take that long for the non-nuke to completely leave the blood.

It’s important to note that the antifungal drug ketoconazole (Nizoral), commonly prescribed to PWAs, can increase methadone blood levels. Some taking this drug may need to reduce their

methadone dose, although savvy doctors use this interaction to their patient’s benefit -- to increase the effectiveness of low-dose methadone in states where laws prohibit higher, more effective doses.

On the flipside, methadone doubled AZT blood levels in one study, leading to more antiviral punch but also to more side effects -- some of which, ironically, mimic withdrawal. Check with your doctor about reducing AZT doses. By contrast, methadone can reduce levels of ddI and d4T, so dosages of the nukes may need to be increased. The only way to know that dosages have been correctly adjusted is by monitoring viral load changes.

For meth users, the bottom line is pharmacokinetics -- the way the body handles a drug. When considering possible HAART choices, discussing with your doc the known methadone interactions is a step in the right direction.

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