The Truth About Suboxone®

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What Is Suboxone And How Is It Different Than Subutex Or Buprenorphine?

Suboxone is a medicine made from two medications, buprenorphine and naloxone. The buprenorphine is the active ingredient. The naloxone is a blocking agent that is present only to prevent IV injection of Suboxone. When used under the tongue as directed, almost no naloxone is absorbed.

The various doses of Suboxone have two numbers such as 8/2, 4/1 and 2/.5, with the first representing the number of milligrams of Suboxone and the second number representing the number of milligrams of naloxone. Suboxone is available only as a sublingual film which is very easy and fast to be absorbed when taken properly.

Subutex® is no longer made, but was the pure buprenorphine product from the manufacturers of Suboxone. It was designed for people who cannot tolerate naloxone or pregnant women.

Buprenorphine is available in generic form from many suppliers. Unfortunately, experience suggests that it is less effective than brand Suboxone because it is not absorbed as well as Suboxone and thus even though it starts out with the same amount of medication, as little as 60% of the original medication makes it to the brain compared to Suboxone.

There is another branded version of Suboxone, called Zubsolv, although available only by pill and not by film. It is not clear if it is comparable to Suboxone. There is also a generic version, but it is too new to judge its efficacy.

How Does Suboxone Work?

Suboxone works by buprenorphine's very strong tendency to occupy the opiate receptors in the brain. The efficacy of Suboxone is directly related to the percentage of opiate receptors that are occupied by buprenorphine **AND** the state of neuroadaptation (the changes that occurred in the brain due to ongoing opiate intake) of the brain.

Neuroadaptation is important because as long as there is some degree of neuroadaptation, there will be withdrawal symptoms if opiates or buprenorphine is not present. Only when neuroadaptation has totally reversed itself through healing is withdrawal over. This can easily take more than a year if an individual took large amounts of opiates for a long period of time.

By occupying the opiate receptors, Suboxone works to fool the brain into thinking that that the neuroadaptation has reversed itself and thus withdrawal is over.

Does Suboxone Have To Be Taken A Special Way For It To Work Properly?

Suboxone cannot be started until the patient is in withdrawal from opiates, and must be taken using special techniques and at the proper doses in order to obtain the necessary amount of the medicine at the opiate receptors in the brain to control withdrawal symptoms. Unfortunately, the overwhelming majority of people do not take Suboxone properly and thus reduce by as much as 90% the amount of buprenorphine (the active component of Suboxone) that actually is present at the opiate receptors in the brain. Since the efficacy of Suboxone is directly related to the percentage of total opiate receptors that are occupied by a molecule of buprenorphine, improper technique when taking Suboxone or generic buprenorphine can easily make the difference between successful treatment and failure.

Essentially 100% of people who obtain Suboxone from the street or a friend do not take it properly and thus almost all fail to remain sober. Dr. Russ believes that improper technique when taking Suboxone is the main reason that many believe that Suboxone does not work effectively for opiate withdrawal.

The most common errors people make when taking Suboxone and buprenorphine are:

1. **Taking Suboxone with a contaminated tongue**
   Suboxone and buprenorphine are designed to be taken **under** the tongue (sublingually). This is a very sensitive area for absorption that is easily negatively affected by anything that produces even a thin film layer on the tongue. Therefore it is critical that the patient observe the proper technique to insure that the tongue is completely clear when the Suboxone or buprenorphine is taken.

2. **Swallowing Saliva After Taking Suboxone or Buprenorphine**
   Buprenorphine is destroyed and inactivated when it comes into contact with the normal acids in the stomach. When taking Suboxone or buprenorphine sublingually, 80-90% of buprenorphine ends up in the saliva with only 10-20% being directly absorbed into the tongue from direct contact with the medicine film or pill.

   Therefore, it is essential that people do not swallow their saliva when taking Suboxone or buprenorphine because they will be swallowing 80-90% of the buprenorphine, which is almost instantly and entirely broken down into other chemicals. These breakdown chemicals are very irritating to both the stomach and the brain, thus causing severe stomachaches and headaches in the region of the temples in about 40% of people who swallow even the slightest amount of buprenorphine.

Unfortunately the biggest consequence of taking Suboxone and buprenorphine incorrectly is a massive insufficiency of buprenorphine molecules occupying the opiate receptors of the brain. **Since the benefit from and efficacy of the treatment is directly related to the percentage of opiate receptors occupied by a buprenorphine molecule, it is easy to understand how any individual who does not take their Suboxone properly will have a much smaller (as little as 1/10th) chance of success by maintaining lasting sobriety from opiates.**

Dr. Russ has worked consistently to develop the most efficient and effective techniques for taking Suboxone and buprenorphine, both in film and pill form so that his patients who follow the "Dr. Russ Suboxone Protocol" are likely to transfer 90-95% of the buprenorphine from a film or pill compared to as low as 10% when taken improperly. Transfer differences between 90% and 10% mean the difference between Suboxone being a "miracle drug" and ineffective.

What Is The Proper Dose Of Suboxone?

This is a subject with much debate. Many doctors feel that between 8-16 milligrams is a sufficient dose, while some feel that 24 milligrams is necessary when the individual had a severe opiate use pattern. Most of the literature says that the proper dose needed is the dose necessary to occupy approximately 85% or less of the opiate receptors in the brain. This level of occupancy will stop most symptoms of withdrawal, but almost never totally stops withdrawal.

Sadly most of the generic preparations of buprenorphine are substantially less efficient (up to 40%) in transferring the buprenorphine from the pill to the opiate receptors in the brain, which means that even if taken properly they produce up to 40% less buprenorphine molecules at the opiate receptors. Said another way, when using generic buprenorphine, one must compensate by increasing the dose compared to the Suboxone dose to obtain the same therapeutic effect.

Dr. Russ believes very strongly that it is essential to stop 100% of the withdrawal symptoms because the last symptoms to stop with Suboxone treatment is craving, which is the main cause of withdrawal-triggered relapse. Unfortunately, craving is also the first symptom to return if an individual is no longer taking a sufficient amount of Suboxone.

In order to totally stop withdrawal symptoms including craving, it is necessary to 100% saturate the opiate receptors. Therefore, it is Dr. Russ' strong belief that if only 85% of the opiate receptors are occupied, as is recommend by Suboxone's manufacturer, the patient's chance of relapse with opiates is greatly increased compared to when 100% of their opiate receptors are occupied by buprenorphine.

Dr. Russ' patients with moderate to severe opiate problems (more than 350 mg of oxycodone or its equivalent) consistently state that they need a total of four 8/2 films

taken in two doses per day to 100% stop withdrawal symptoms including craving. Consequently, **Dr. Russ' guideline for Suboxone dosing is the least amount necessary to totally stop withdrawal symptoms 24/7**, which for many people is 32 milligrams per day.

Is Suboxone Effective For Opiate Withdrawal Control?

When taken properly, Suboxone is the most effective and easiest way to control opiate withdrawal. Using the Dr. Russ Suboxone Protocol, almost all of my patients have a 100% cessation of their opiate withdrawal symptoms within 3 hours of starting Suboxone. In fact, within three hours virtually everyone feels the way they did just prior to the way they felt before they took their first opiate.

Since the Dr. Russ Suboxone Protocol is based on human physiology and because the physiological changes that result from ongoing opiate intake are so consistent from individual to individual, it is essentially guaranteed that patients will succeed in ending their withdrawal symptoms and succeed in getting off of Suboxone when their brain is healed back to its pre-opiate state, provided that they 100% comply with the Dr. Russ Suboxone Protocol.

Unfortunately, there are two exceptions to healing 100%: 1) all people who become dependent on/addicted to opiates of any type will have a life long hypersensitivity to opiates, meaning that if they ever take opiates again, for any reason, their chance of rapidly becoming re-addicted is much higher than people who have never been opiate dependent/addicted; and 2) people who have taken methadone, even just once, have a slightly lower chance of their opiate altered brain totally healing, especially if they were part of a methadone maintenance program for at least several months and/or at doses in excess of 50 milligrams.

Is Suboxone Effective For Pain Management?

Suboxone, through its active ingredient buprenorphine, functions much like a moderate strength opiate and thus can be used for non-opiate pain management. It is hard to quantify its strength as an analgesic, but it is somewhere around 20% the power of morphine or oxycodone. Perhaps Suboxone's greatest advantage as a pain reliever is that after an initial reduction of strength during the first several weeks of use, there appears to be little to no tolerance to Suboxone, compared to opiates where the tolerance continually increases with time.

Can You Become Addicted To Suboxone?

Technically it is possible to become addicted to Suboxone in an opiate naive individual (someone who has not become addicted to opiates), yet this almost never occurs because most people taking Suboxone are already addicted to opiates. If an individual does become addicted to Suboxone, the best treatment is to taper them off of the Suboxone over the course of several weeks.

Many people misinterpret the withdrawal symptoms that they encounter when they stop taking Suboxone as Suboxone withdrawal. Almost 100% of the time these symptoms are not Suboxone withdrawal symptoms, but rather the return of the primary withdrawal symptoms from their former opiate use when the Suboxone is no longer present to prevent the symptoms from occurring.

Is It Hard To Get Off Of Suboxone?

Suboxone was designed with the goal of controlling a patient's withdrawal and then tapering them down until they no longer need Suboxone because their withdrawal is over. Until the brain is totally recovered from the neuroadaptation that is a normal brain response to ongoing opiate intake beyond several weeks or months, withdrawal symptoms will persist unless an individual is taking sufficient amounts of Suboxone using the proper techniques to fool the brain into physiologically perceiving that withdrawal is over. When their brain has totally recovered/healed from the opiate-induced physiologic changes, Suboxone is no longer needed because the withdrawal process is over.

Since Dr. Russ developed his latest Suboxone protocol in October, 2011, 100% of his patients who have totally complied with the protocol by taking the proper amount of Suboxone until their brains are totally healed, have either gotten off of Suboxone with little to no difficulty.

Said another way, patients need to be treated with Suboxone until their withdrawal is totally over, a process that can easily take more than a year for heavy long-term opiate users (more than 300 milligrams of oxycodone per day). Light users of opiates, (60-300 milligrams of oxycodone per day) typically take 3-6 months of proper Suboxone treatment before their withdrawal ceases and they can stop taking Suboxone. People who have taken 10-60 milligrams of oxycodone typically can be tapered off of Suboxone in weeks to 1-2 months.

What is even more impressive than our ability to get virtually anyone off of Suboxone if they comply with our protocol, is that 100% of the patients (with whom we ongoing have contact) who have stopped taking Suboxone by following the protocol are still sober and claim that they have no craving for opiates. This group includes post-treatment sobriety durations that range up to 27 months (the time since the implementation of the most recent protocol), which greatly exceeds the national sobriety rate of 24.3% at 6 months.

Sadly, most Suboxone providers are not successful at getting their patients off of Suboxone. Consequently, they end up keeping their patients on Suboxone, in essence creating a Suboxone maintenance program, or terminate them prematurely (before their withdrawal has completely stopped, which essentially guarantees an opiate relapse because they succumb to the craving component of their ongoing long-term withdrawal state.

What Is The Difference Between Being Treated With Suboxone And Methadone?

Many people incorrectly think that Suboxone treatment and methadone maintenance are essentially the same. While it is true that both are used as a remedy for opiate dependence, they really are quite different.

Suboxone treatment is designed to control active withdrawal and then via a progressive dose reduction called a “taper” the patient is weaned off of Suboxone when their withdrawal is over and hopefully remains sober. Suboxone treatment is provided most often as an outpatient treatment by a Federally approved doctor. Most providers require patients to come in for visits once a month after the patient is stabilized on Suboxone. Unfortunately Suboxone providers are limited to 100 patients by law.

Methadone maintenance is designed to transfer the patient’s dependence from opiates to methadone, an opiate-like medicine. Methadone is provided at licensed methadone clinics that typically require the patient to come daily. Also, most methadone clinics try to maintain the patient on methadone and do not try to wean the patient off of methadone. Several negatives associated with methadone maintenance is the lack of an exit strategy, the need to go to the clinic daily, less than optimal environment at many clinics with lots of active drug users present, as well as just about any type of drug one might desire.

Dr. Russ feels that at this point the only reason for methadone maintenance is cost since methadone costs pennies per dose while Suboxone is quite expensive, up to $40 per day. Also many, including Dr. Russ, feel that methadone frequently causes some permanent changes that is not the case with Suboxone.

A less known use of both methadone and Suboxone is pain management. In this realm, methadone is clearly vastly more powerful than Suboxone. This is the one area where methadone can be administered in a doctor’s office and not a clinic.