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Risk Reduction With Buprenorphine–Naloxone and Methadone: Patient's Choice

To the Editors:

A recent study by Woody et al[1] demonstrated "… marked and approximately equal reductions in injection related risk" among subjects who applied for methadone maintenance but agreed to be randomized to receive either buprenorphine or methadone, and who remained in their assigned treatment condition for 24 weeks. It is respectfully suggested that this trial raises serious ethical issues while contributing little if anything to guide either clinicians or prospective patients.

Although the outcome of the 2 groups with regard to virtually all of the parameters measured was remarkably similar, a major distinction was observed with regard to retention: at the end of 24 weeks, 74% of methadone recipients were still enrolled compared with only 46% of those assigned to the buprenorphine arm. This finding is not unexpected when research protocol rather than applicant preference determines the treatment regimen to be provided. It is of particular concern given the clear risk of both morbidity and mortality associated with opioid dependence, and the very strong and consistent evidence of the favorable outcomes associated with methadone, which was the treatment of choice of all these subjects.

Furthermore, in this trial, buprenorphine recipients were subject to the same inflexible demands for observed "dosing" as are required by federal regulation of all those who receive methadone. Thus, for roughly half the 24 weeks of this trial, they were obliged to make visits to the OTP (not to a primary care provider) at least 6 days per week, and for the balance of the investigation could receive no more than 2 "take-home" doses weekly.[2] The protocol was thus the antithesis of what prevails in the "real world," where patients can receive prescriptions for as much as a month's supply of buprenorphine from the outset, to be dispensed by a community pharmacy.

The bottom line would seem to be that this study underscores the rationale for allowing those who need and seek care for opioid dependence to "vote with their feet," and for researchers and clinicians to respect that vote.

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Authors' Reply: "Risk Reduction With Buprenorphine–Naloxone and Methadone: Patient's Choice"

To the Editors:

We agree with the observation[1] that this trial did not represent the way patients are treated with buprenorphine–naloxone in clinical practice; however, it is important to point out that the main purpose of this study was to evaluate if buprenorphine–naloxone causes hepatotoxicity. Several previous case reports suggested that it does, and the FDA asked NIDA to conduct a trial to explore this question. The request was that the trial includes at least 300 patients who were treated with each medication for 6 or more months and had 4 or more postbaseline blood draws to test for liver enzyme changes. A randomized trial, as the gold standard for comparing interventions, was judged to be the best way to explore this question. It was necessary to do the study in methadone programs since both medications would available and the daily dosing minimized the risk of medication nonadherence due to diversion. All potential participants received thorough informed consent including the fact that they could drop out of the study at any time, agreed to be randomized before entering the study, and were not asked for their preferred treatment. The protocol was written at a time that patient requests for buprenorphine–naloxone treatment in primary care were expanding and before publication of the Cochran review[2] showing better retention with methadone than buprenorphine. Thus, the magnitude of the differential dropout that occurred was unexpected. Study findings showed no evidence of buprenorphine–naloxone induced transaminase elevations[3] thus addressing concerns that led the FDA to request the study, and methadone maintenance and other local treatment options were available to patients who dropped out of their assigned medication condition. HIV risk was one of several measures included for secondary analyses. We hope that these clarifications are responsive to the comments raised by this letter.

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These HIV data have not been presented; however, they will be presented at AMERSA, November 8, 2014, San Francisco, CA, and at the ACNP, December 2014.

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Recruitment by a Geospatial Networking Application for Research and Practice: The New York City Experience

To the Editors:

Social networking using mobile phone-based applications ("apps") has become widespread, with 89% of Americans aged 18–29 years reporting that they use social networking sites.[1] Men who have sex with men (MSM) use social networking sites at high rates in part because they are able to form private, anonymous, and relatively safe communities on these sites.[2,3] A variety of niche sites like Grindr, Manhunt, Adam4Adam, and Scruff have web pages and mobile phone-based applications for use by MSM, with a large proportion of MSM using such applications to find sex partners.[2–8] Several studies have documented the success of using social networking for HIV prevention[9–11] and recruitment for HIV prevention research.[12–14] Recently, researchers have reported the use of mobile phone applications for education[15] and as a tool to recruit MSM for research studies.[16]

Here, we describe our experience using a geospatial social networking application (Grindr) for recruitment into 3 different HIV prevention projects, including an HIV testing program, a social epidemiologic survey (NYCM2M), and an HIV vaccine trial [HIV Vaccine Trials Network 505 (HVTN 505)].

The HIV testing program was part of a national testing initiative with the goal of identifying undiagnosed HIV-infected MSM, with a specific focus on Latino and black men. Community-based organizations in approximately 20 cities across the United States participate in the testing initiative under a contractual relationship with Abt Associates. The testing program in New York City was implemented in 2012. Participants received a one-time risk-reduction counseling session and a rapid HIV antibody test at 1 of our 2 clinic sites or in our mobile van at various locations. MSM were eligible to participate if they were male at birth, had sex with men sometime during their lifetime, and were at least 16 years old. Participants were compensated with a $25 gift certificate or cash.

NYCM2M, a social epidemiologic study conducted between October 2010 and June 2013, aimed to describe associations between neighborhood characteristics and sexual behaviors and mental health among MSM. Participants completed a neighborhood locator questionnaire, an audio computer-assisted self-interview, and a social and sexual network questionnaire and received risk-reduction counseling and a rapid HIV antibody test.[17] Eligibility criteria for NYCM2M were male at birth, at least 18 years old, having anal sex with a man in the past 3 months, and communicating in English or Spanish. Participants received $50 for an NYCM2M visit.

HVTN 505 was a phase 2B vaccine efficacy trial in 21 sites in the United States that enrolled 2504 MSM and transgender women who had sex with men from June 2009 to March 2013.[18] Participants were randomized to receive 4 injections of vaccine or placebo over 6 months and were followed every 3 months for 2 years to complete a medical history, physical examinations, risk-reduction counseling, and HIV testing and to provide blood specimens. Men and transgender women were eligible if they were 18–50 years, HIV-uninfected, circumcised, and met behavioral risk criteria indicating risk for HIV acquisition. Compensation for HVTN 505 ranged from $25 to $75 per visit, depending on the type of visit.

Before placement of the advertisements on the geospatial social networking application, the 3 projects used a variety of recruitment methods. For the HIV testing program, a mobile van was taken to various community and public settings to recruit MSM. For the social epidemiologic study, venue-based time-space sampling was conducted.[17] Recruitment for the HIV vaccine trial was conducted by local print advertising, street, venue, and event outreach, participant referrals, and centralized national web recruitment, predominantly on sites such as Facebook and Adam4Adam.[19]

To recruit men using the geospatial social networking application, we placed advertisements for each project for one 24-hour period in each of the months indicated (Table 1). All the advertisements were text only (no images) and visible once to every user who opened the application in New York City, during the 24-hour period (see ads in **Supplemental Digital Content,** http://links.lww.com/QAI/A573). When the users clicked the advertisement (clicks), they were taken to a web page

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The findings and conclusions in this report are those of the authors and do not necessarily represent the views of the Centers for Disease Control and Prevention (CDC).