Emergency Care During an Opioid Addiction Epidemic

in withdrawal
desires treatment for opioid addiction

<u>exclusions from ED buprenorphine initiation</u>
on methadone
on high dose (usually prescribed) opioids
very intoxicated (with other substances)
buprenorphine allergy

verifying adequate withdrawal is crucial
if inadequate withdrawal, buprenorphine will precipitate withdrawal
plug COWS into your favorite medical calculator
COWS should be ≥ 8, the higher the better

you do not need to be x-waivered to treat withdrawal with buprenorphine in the ED

buprenorphine 4-8 mg sublingual
the higher the COWS, the larger the bup dose
if unsure of withdrawal symptoms or borderline COWS, dose 2 mg q2h

observe in ED for 30-60 minutes
provide sandwich

optional testing during buprenorphine initiation
HCG, urine tox, LFTs, Hep C, HIV

if waivered doc present, can d/c with prescription

if expected delay in accessing buprenorphine (≥24h), consider high dose initiation in consultation with addiction specialist

advise on dangers of etoh/benzo use while on bup

refer to bup-capable provider/clinic
the smaller the ED buprenorphine dose, the tighter the followup has to be, esp if no Rx

buprenorphine Rx

buprenorphine/naloxone 8/2 mg sublingual tabs 1 tab SL bid–can dispense 6 to 14 tabs	alternatively, **patient can return to ED** while awaiting followup: on days 2 and 3 dose 16 mg SL x-waiver not required to dose in ED on days 2&3 however cannot continue beyond 3 days by law
if concern for suboxone abuse/diversion, can skip Rx or ↓Rx (though suboxone safer than street opioids)	

in withdrawal
does not desire treatment

consider buprenorphine initiation anyway
alternative: methadone 10 mg IM
can use non-opioid Rx but much less effective
clonidine, NSAID, antiemetic, antidiarrheal
haloperidol, ketamine

refer to ongoing addiction care

harm reduction (see box)

not in withdrawal
does not desire treatment

engage, encourage to move to treatment

refer to ongoing addiction care

Harm Reduction for all opioid misusers

all patients at high risk for OD should receive <u>take home naloxone</u>
high risk for OD: prior OD, use of illicit opioids, high daily dose (>50 MME), concurrent use of sedatives, recent period of abstinence, uses alone

if IVDU, encourage <u>safe injection practices</u> and refer to local needle exchange/safe injection site
Do you lick your needles?
Do you cut your heroin with sterile water?
Do you discard your cotton after every use?
Do you inject with other people around?
Do you do a tester shot to make sure a new batch isn't too strong?

<u>open door policy</u>: if unwilling to be treated for addiction now, return anytime, we're here 24/7

not in withdrawal
desires treatment for opioid addiction

if waivered doc present, can prescribe buprenorphine for home initiation

alternatives:
return to ED when withdrawing
hold in ED to await withdrawal

refer to bup-capable provider/clinic

Priorities for Emergency Care

Prevent opioid-naive patients from becoming misusers by your prescription

calculate benefit:harm whenever an opioid prescription is considered, and if opioid Rx, prescribe small # of low dose, lower-risk pills

Immediate Release Morphine Sulfate (MSIR)
15 mg tabs, 1 tab q4-6h prn pain, disp #9

Willing: **"I have a problem, I need help"**
aggressive move to treatment
ED-initiated buprenorphine
arranged speciality followup

Revealed, unwilling: **"I overdosed"**
harm reduction (see box)
supportive stance, open door

Partially revealed: **"I have chronic pain and need meds"**
avoid opioids in ED or by prescription
opioid alternatives for pain
express concern that opioids are causing harm

Unrevealed: **"I have acute pain and need meds"**
risk stratify with red & yellow flags
PDMP - move positives to willingness
if low risk, treat as opioid-naive
if high risk, treat as partially revealed

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