Emergency Care During an Opioid Addiction Epidemic

### in withdrawal
- desires treatment for opioid addiction

### exclusions from ED buprenorphine initiation
- 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

<table>
<thead>
<tr>
<th>buprenorphine Rx</th>
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<tbody>
<tr>
<td>4/8 mg sublingual</td>
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<tr>
<td>1 tab SL bid - can dispense 6 to 14 tabs</td>
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### 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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**Harm Reduction** for all opioid misusers

- all patients at high risk for OD should receive take home naloxone
- 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 safe injection practices 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?

### open door policy: if unwilling to be treated for addiction now, return anytime, we’re here 24/7

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*reuben j. strayer - @emupdates - emupdates.com/help*