Buprenorphine for Opioid Use Disorder: Prescribing a Way Out – Session ID# W235

Key points:

Addiction is a chronic disease.

If you are unsure of how to address opioid use disorder, consider using the SPIKES model for disclosure of bad news and determining a patient centered plan of care.

Buprenorphine is safer than pure opioid agonists such as morphine, hydromorphone, oxycodone and fentanyl.

Patients must be in a state of moderate withdrawal prior to initiating buprenorphine due to its strong binding affinity for the mu opioid receptor, as otherwise it can lead to "precipitated withdrawal".

Buprenorphine treatment for opioid use disorder can easily be incorporated into generalist family practice.

Worksheets:

Start thinking about one person in your practice who would benefit from treatment for opiate use disorder. Notes:

Case 1: 23 year old female injecting "purple heroin" for the past two years. She has tried several times to stop but doesn't make it longer than three days due to the withdrawal symptoms. She was with her boyfriend last night and she used more than usual and obtunded. She was revived by their naloxone kit and brought in by EMS. She required a naloxone drip. On handover this morning, your colleague tells you she is awake but feeling terrible. She wants to leave now to use. Your hospital does not have a supervised injection site (SIS) but you did just complete a workshop on buprenorphine.

Case 2: 31 yo male 1 year post MVA where he broke a clavicle & left tibia. Started on oxycodone, ortho continued to prescribe, and then you continued as well. You just came back from an FMF talk on opiate prescribing and had him leave a urine for drug screening. It has come back showing oxycodone, oxymorphone, hydromorphone, and morphine. You call him in to discuss.

SPIKES protocol –

"Detox" from opioids is not recommended due to increased risk of death from reduced tolerance and high rates of relapse. Offering opioid agonist therapy is the standard of care.

Use the COWS (clinical opioid withdrawal scale) to determine when a patient is able to start buprenorphine. A score of 12 or higher is important for a smooth start.

Induction can take place in the office, the ED, hospital bed, pharmacy or at home, depending on the clinical situation. See http://www.metaphi.ca/patient-resources.html for a brochure to give patients to guide their home induction. See http://www.metaphi.ca/provider-tools.html for tools for your emergency department and office.

The goal is to get the person stable as quickly as possible without side effects. The timing of follow up visits, timing of urine drug screens, and when to begin take home doses is all dependent on the clinical picture.

Buprenorphine/naloxone appears to be safe in pregnancy, and pregnancy is no longer a contraindication to taking it. It is safe in breastfeeding.

For patients with acute pain crises (broken ankle, etc), if they need opiates, they may need quite high doses of opiates. Hydromorphone and fentanyl can offset buprenorphine binding enough to provide top up pain relief.

Peri-operatively, it is very destabilizing to take someone off of opiate agonist therapy. As one possible side effect of this strategy is death, it is recommended to utilize non-opiate strategies as much as possible and be aware higher doses of opiates may be required in the immediate post-operative period than in someone without an opiate use disorder.

Resources:

MMAP https://ocfp.on.ca/cpd/collaborative-networks/mmap

ECHO Ontario Mental Health - https://camh.echoontario.ca/ampi/

Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/_____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past ½ hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 No tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessmen*t 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/ muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

From: Wesson DR, Ling W J Psychoactive Drugs 2003 Apr-June; 35(2): 253-9

How do I know how much to take *after* the first day?

After the first day you will probably have an idea about how many tablets you need to take to feel better. Starting on the second day of your treatment, you can take that total dose **all at once.**

So, for example, if you found that you needed a total of 8mg (four tablets) on the first day to feel well then on the second day you would take 8mg (four tablets) all at one time.

What do I do if I am still in withdrawal?

If you feel that you are still in withdrawal, you can adjust your daily dose upwards by 2-4mg (1-2 tablets).

What do I do if am sleepy?

If you feel sleepy then cut down on the amount of medication. So for example if you took 8mg (4 tablets) on the first day but are feeling a bit drowsy on the second day you can reduce your dose by 2-4mg (one to two tablets) on the second day. If you are very sleepy, then you should not take any medication and should call your doctor.

When should I come back to see the doctor?

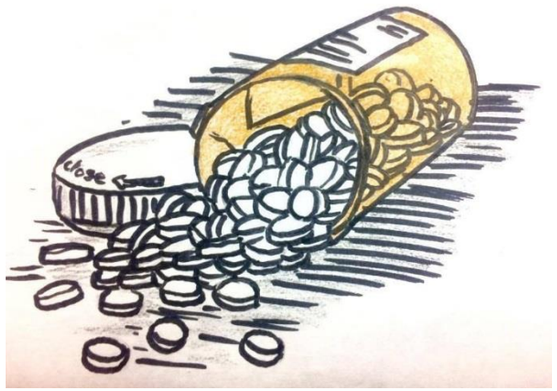
You should return to the doctor within a few days of starting this medication.

Your follow up appointment is booked for: _____

You can reach us with any questions at:

_____

How to Start Buprenorphine



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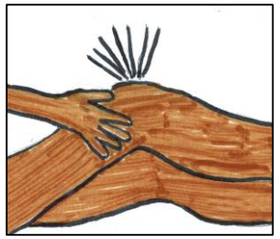
Creator: Dr. Anita Srivastava
Illustrators: Megan Nguyen, Akash Yoon

You have been prescribed a medication called buprenorphine. Usually, this medication is prescribed to treat an opioid use disorder.

Most patients take this medication once a day at their pharmacy. Later, some patients may take their medication home on certain days if they are doing well.

Your doctor has prescribed you the first few doses of buprenorphine to take at home to get you started on treatment. It is important that you read this guide for information on how to safely start this medication.

When do I take my first dose?



Before taking your first dose of buprenorphine, make sure that you are in opioid withdrawal. Otherwise, the medication can cause withdrawal and you may feel sick.

Usually, it takes several hours (12 hours or longer) after you have last used an opioid to go into withdrawal. This can take even longer if you have taken methadone. It is best to wait to take your first dose of buprenorphine until you feel like you are truly in opioid withdrawal.

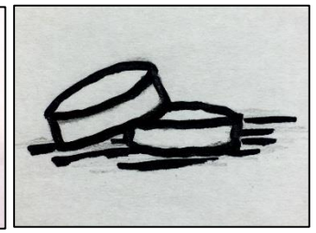
How do I take my first dose?

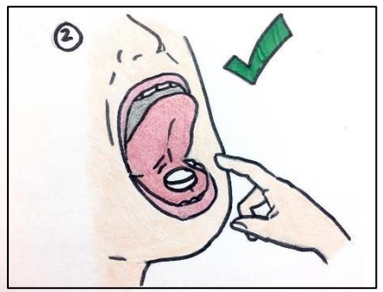
Your first dose will be either 2mg (one tablet) or 4mg (two tablets). Talk to your doctor about the best dose for you. Place the tablet(s) UNDER your tongue and wait for them to dissolve (this can take up to ten minutes). Taking a sip of water to moisten your mouth before you put the medication under your tongue may help it dissolve faster.

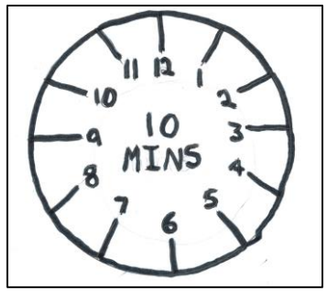
Do not swallow the medication: it will not work.

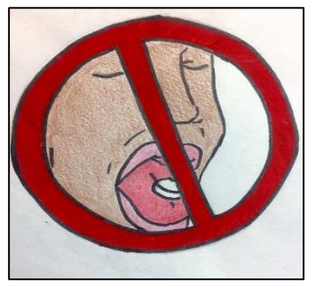
Do not mix with alcohol or benzos or opioids.

Do not drive until your doctor says it is okay.





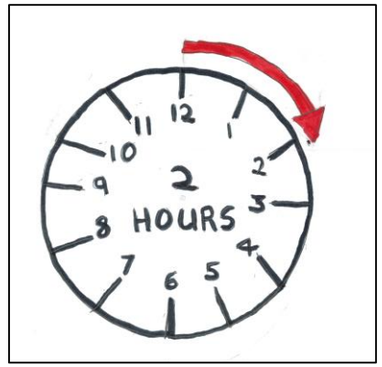




When do I take the next doses?

You should start to feel better within one to two hours of your first dose. If you feel well, you do not need to take anymore and can wait to see how you feel later.

However, if you feel like either the medication did not help or that you are still in withdrawal then you can take another one or two tablets UNDER your tongue. You can take one to two tablets (always under your tongue) every 2 hours to a maximum of 16mg (eight tablets) on the first day.



Do not take more than 16mg (eight tablets) on the first day or in the first 24 hours.