Initiating Medications For Opioid Addiction Treatment in the E.D.
Expanding the scope of emergency care during an addiction epidemic

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STR-TA Initiative

STR-TA Consortium
State Targeted Response Technical Assistance
Working with communities to address the opioid crisis.

- SAMHSA’s State Targeted Response Technical Assistance (STR-TA) Consortium assists STR grantees and other organizations, by providing the resources and technical assistance needed to address the opioid crisis.
- Technical assistance is available to support the evidence-based prevention, treatment, and recovery of opioid use disorders.

Funding for this initiative was made possible (in part) by grant no. 1H79TI080816-01 from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Working with communities to address the opioid crisis.

- The STR-TA Consortium provides local expertise to communities and organizations to help address the opioid public health crisis.
- The STR-TA Consortium accepts requests for education and training resources.
- Each state/territory has a designated team, led by a regional Technology Transfer Specialist (TTS) who coordinates the implementation of evidence-based practices.

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Contact the STR-TA Consortium

✧ To ask questions or submit a technical assistance request:

- Visit www.getSTR-TA.org
- Email str-ta@aaap.org
- Call 401-270-5900

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MAT in the ED - Learning Objectives
Learning objectives

Provide the Emergency Physician with a knowledge of:
- Opioid Use Disorder as a medical illness: dependence vs. addiction
- Overview and efficacy of MAT vs. non-agonist treatment
- Indications, dosing algorithms and potential complications of buprenorphine in the ED
- Buprenorphine prescribing rules, the "72 hour rule", DEA license "X-waiver"
- Rationale and evidence for community naloxone distribution, including a discussion of common misconceptions about this medication

Q. What Is The Status Of The Opioid Epidemic In The USA?
O.D. is now the #1 cause of death for Americans under age 50

1999-2016: more than 630,000 overdose deaths

Life expectancy for Americans is falling -- two years in a row

Drug overdose deaths, 1999 to 2016

2016

Around 66% of the more than 63,000 drug overdose deaths in 2016 involved an opioid.

In 2016, the number of overdose deaths involving opioids was 5 times higher than in 1999.

On average, 115 Americans die every day from an opioid overdose.

www.cdc.gov/drugoverdose/epidemic/index.html
Preliminary 2017 Data:

Opioid overdose deaths increase to ~134 Americans per day.

Fentanyl and fentanyl analogue related overdoses are the most rapidly growing type of opioid overdose deaths.

www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates
Addiction & Overdose: Deadlier than STEMI @ 1 Year

Of all patients (including patients not surviving to d/c):
- 7.3% Mortality Rate @ 1 Year
- OUD – a disease primarily of age 20 - 50

Qs: What is Opioid Use Disorder?
What is the difference between opioid dependence and addiction?
ADDICTION

ENDORPHINS
DYNORPHINS
DOPAMINE
REWARD
SYSTEM
MALFUNCTION

Patient’s suffering with O.U.D. USE TO:
GET HIGH
NORMAL
NOT FEEL SICK

Chemical Receptor
Imbalance – an organic
brain disease

DRUG SEEKING IS COMPULSIVE. DIFFICULT TO CONTROL.
ADDICTION > CONSEQUENCE.
RELAPSING & REMITTING.

TABLE 1  Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

<table>
<thead>
<tr>
<th>Category</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired control</td>
<td>• Opioids used in larger amounts or for longer than intended</td>
</tr>
<tr>
<td></td>
<td>• Unsuccessful efforts or desire to cut back or control opioid use</td>
</tr>
<tr>
<td></td>
<td>• Excessive amount of time spent obtaining, using, or recovering from opioids</td>
</tr>
<tr>
<td></td>
<td>• Craving to use opioids</td>
</tr>
<tr>
<td>Social impairment</td>
<td>• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use</td>
</tr>
<tr>
<td></td>
<td>• Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems</td>
</tr>
<tr>
<td></td>
<td>• Reduced or given up important social, occupational, or recreational activities because of opioid use</td>
</tr>
<tr>
<td>Risky use</td>
<td>• Opioid use in physically hazardous situations</td>
</tr>
<tr>
<td></td>
<td>• Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use</td>
</tr>
<tr>
<td>Pharmacological properties</td>
<td>• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount</td>
</tr>
<tr>
<td></td>
<td>• Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal</td>
</tr>
</tbody>
</table>

DEPENDENCE ≠ ADDICTION
Qs:

Why “MAT”?

Is this Necessary?

Does it really work?

Isn’t Counseling Sufficient?

What Happened To “Just Say No”?

MAT: MEDICATIONS FOR ADDICTION TREATMENT is the MOST EFFECTIVE Treatment for Opioid Addiction

- Opioid addiction does not respond to the same treatments as alcoholism.
- Abstinence based therapies generally DO NOT WORK: ~ 95% annual relapse rate.
- Twelve Step programs alone have a <5% rate of sobriety at one year, when treating Opioid Use Disorder.
- Retention rates in MAT programs vary broadly, dependent upon multiple factors, with 1 year sobriety of ~10 to 80%, but average ~40-50%.
SPOILER ALERT

Compared to patients receiving MAT, UNTREATED patients with OUD have at 1 year:
• >2.5 X all cause mortality
• > 8 X overdose mortality


In 1996, France responded to its heroin overdose epidemic by training GP’s to prescribe bupe

Over 8 years....
3x increase methadone treated patients (~15K pts) + 4.5X increase in bupe tx pts (~90K pts)
90% reduction in heroin overdoses!
**Heroin overdose deaths and opioid agonist treatment: Baltimore, MD, 1995–2009**

- Rapid expansion of access to bupre treatment
- Rate of heroin overdose deaths drops in half
- Despite a substantial increase in local heroin purity

Schwartz et al, Am/ Public Health, 2013 May;103(5):917-22

**Opioid Agonist Therapy is Much More Effective than Drug Counseling!!**

Swedish Study:
- 40 patients, all heroin users, randomized
- Daily supervised med administration for the first 6 months

Retention at 1 year:
- 75% in the bupe group
- 0% in the placebo group

1 year Mortality:
- 0% in the bupe group
- 20% in the taper group

Review specifically studied value added of routine, mandatory counseling sessions in methadone MAT programs

“… adding any psychosocial support to standard maintenance treatments does not add additional benefits.”

Everyone Needs a Therapist.

The evolving truth about O.U.D.:

It takes an opioid agonist to treat opioid addiction.
Q: But How Does It Work in the ED?

Beginning MAT in the ED: The warm hand-off

Yale; D’Onofrio: Emergency department-initiated buprenorphine/naloxone treatment for opioid dependence: a RCT

- 329 ED patients with OUD, screened, and randomized:
  - ~1/3 to the referral group (patient is handed a pamphlet)
  - ~1/3 to the brief intervention group + facilitated referral (Health Promotion Advocate)
  - ~1/3 to the buprenorphine treatment group (and brief intervention + referral)

MAIN OUTCOMES AND MEASURES:

- Enrollment in, and receiving, addiction treatment 30 days after randomization was the primary outcome.

YALE (D’Onfrio) ED – Initiated Bupe

(continued)

Needed inpatient addiction treatment services?

- Bupe group: 11% (95% CI, 6%-19%, P <0.001)
- Referral Group: 37% (95% CI, 27%-48%, P <0.001)
- Brief Intervention Group: 35% (95% CI, 25%-37%, P <0.001)
Qs:
Which Medications are Used in MAT?
What is Vivitrol?
How is methadone different from Buprenorphine?
Is this helpful in acute opioid withdrawal?
MAT: MEDICATIONS FOR ADDICTION TREATMENT is the MOST EFFECTIVE Treatment for Opioid Addiction

MAT:
Naltrexone
Methadone
Buprenorphine ("bupe")

Depot Naltrexone: Vivitrol

Patient must have already completed withdrawal, or completely weaned off mu agonist therapy (or will precipitate withdrawal). No opioids x 7 days before starting.

Increasing use in correctional facilities and residential programs.

Some patients opt for Vivitrol after "detoxing" or after completion of an abstinence program.

Overall outpatient numbers are still low.

NOT a medication to be initiated in the E.D.
**MAT: Methadone**

Very Effective Medication for Opioid Use Disorder:
- The "gold standard" by which other treatments are measured.
- Long half-life (~ 24 hrs), full mu agonist.
- The dosing is very patient specific.
- Nearly all methadone clinics (addiction treatment) use liquid methadone (to deter diversion).
- Many regard methadone as 2nd line medication – for patients who fail office-based buprenorphine treatment.

**HOWEVER:**
Requires daily travel to the clinic.
May not be available in suburban & rural areas.
Inconvenient for many occupations - daily dosing at a clinic.
Dosing at the methadone clinic means congregating with other patients with OUD: Pros & Cons.
The E.D is NOT the place to begin methadone treatment.
Prescribing Methadone – DON’T

PRESCRIPTION FORM – very RISKY!
High risk drug for treating chronic pain by prescription.
24 hr ½ life for dependency, but only ~ 8 hr ½ life for pain relief.
Slow onset ~ 3-4 hours to peak.
24 hr ½ life for potential effects of respiratory depression.
Vast majority of Methadone deaths are from treatment for pain by Rx, or diverted use, rather than in an addiction clinic.
Vast majority of diverted methadone is in the tablet form (the prescription form).

BUPRENORPHINE (“BUPE”)
Nuts & bolts

- “Partial agonist”
- Long half-life: ~ 36 hours (treating dependency)
- Rapidly effective
- Binds tightly to the Mu receptor (blocking other opioids)
- Induces less euphoria (particularly after the first dose)
  - Many patients get no euphoria from bupe ever.
- Very effective analgesic.
- A MUCH SAFER OPIOID
**Nuts & bolts of bupe**

a safer opioid

“Partial agonist”:

Has a ceiling effect on respiratory depression

“No more respiratory depression at 32mg than at 16mg”

However, may potentiate respiratory depression effects of alcohol, and other sedating medications (e.g. benzos).

- **Important consideration when prescribing** bupe.

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**Nuts & bolts of bupe Tx**

Long half-life: ~ 36 hours:

- When dosed daily, at a therapeutic dose, maintains the patient at a therapeutic level – a ‘steady state’
- Thus eliminating withdrawal symptoms and cravings
- Concept Similar to methadone, which has a half-life of ~ 24 hours

However, bupe is:

- Easier to dose.
- SAFE for office based treatment

Beginning MAT with bupe in the E.D. does NOT preclude or complicate transitioning the patient to methadone in an addiction clinic (if that is a better option for that patient).
Nuts & bolts of bupe -- a safer opioid

Effective within 15 minutes (sublingual), and peak effects at ~ 1 hour.
SL bioavailability ~ 50%
Be sure it goes under the tongue.
Buccal ~ 28%
Oral (swallowed) ~ 15%
  • High rate of first pass metabolism

Nuts & bolts of bupe Tx

“Suboxone” (others: “Zubsolv” and “Bunavail”)
Combinations of buprenorphine and naloxone (tablets or strips)
“Suboxone,” is a 4:1 ratio of bupe/naloxone.
Naloxone has a very poor sublingual and oral bioavailability (~ <2%).
Included to prevent the dissolution and IV injection of buprenorphine.
In my E.D. we only use the generic mono-product bupe:
  – directly administered by a nurse
  – less expensive
Bupe is the superior drug for treating opioid withdrawal

The old and inferior treatment of opioid withdrawal:
ED RN flogs to get an IV placed (and the nurse is miserable)
Multiple doses of Zofran, Phenergan, clonidine … Perhaps Haldol, benzos, ketamine …
The Patient is eventually sedated and sleeps a long time in the ED – consuming a lot of bed space and RN resources.
Although the patient isn’t vomiting, he/she doesn’t feel much better.
None of these medications address the underlying problem. Patient returns to using opioids.

Bupe is the superior drug for treating opioid withdrawal

The New and Improved method:
1) Ondansetron 8mg ODT
2) **Buprenorphine** (usually 8mg)
   [If needed, repeat in 30 minutes]
3) Pt feels much better, engages in dialogue with a social worker or peer counselor about a clinic follow up.
The entire ED visit: 60-90 minutes.
No difficulty IV start, no conflict. And … rapid turnaround, happier nurses!
Best of all: the patient has experienced treatment for opioid use disorder!!
Qs: Who is a good candidate buprenorphine in the ED?
Who is not?

Patient selection for beginning MAT

Patient selection PITFALLS FOR E.D. BUPE INITIATION

1. The very mild withdrawal patient who states, “I feel like the withdrawals are just starting” is an ideal candidate for … counseling and referral:
   – Check a COWS score!
   – In acute withdrawal, COWS usually should be at least 8 to give a dose in the ED -- if no other contraindication
   – No need to precipitate withdrawal
   – Consider a buprenorphine prescription if you can
2. Patients should meet criteria for moderate or severe opioid use disorder (OUD) to be prescribed bupe for the treatment of OUD. However, any patient can receive a dose of bupe for acute withdrawal.

<table>
<thead>
<tr>
<th>DSM-5 criteria for OUD</th>
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<tbody>
<tr>
<td>1. Take more/longer than intended</td>
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<tr>
<td>2. Desire/unsuccessful efforts to quit opioid use</td>
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<tr>
<td>3. A great deal of time taken by activities involved in use</td>
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<tr>
<td>4. Craving, or a strong desire to use opioids</td>
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<tr>
<td>5. Recurrent opioid use resulting in failure to fulfill major role obligations</td>
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<tr>
<td>6. Continued use despite having persistent social problems</td>
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<tr>
<td>7. Important activities are given up because of use</td>
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<tr>
<td>8. Recurrent opioid use in situations in which it is physically hazardous (e.g. driving)</td>
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<tr>
<td>9. Use despite knowledge of problems</td>
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<tr>
<td>10. Tolerance</td>
</tr>
<tr>
<td>11. Withdrawal</td>
</tr>
</tbody>
</table>

**Severity**

<table>
<thead>
<tr>
<th>Presence of Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild: 2-3</td>
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<tr>
<td>Moderate: 4-5</td>
</tr>
<tr>
<td>Severe: &gt;6</td>
</tr>
</tbody>
</table>

3. METHADONE in the last 48 hours (not an absolute contraindication):
   - Unpredictable precipitated withdrawal can occur
   - Unless pt is in severe withdrawal, consult an expert first

4. Intoxicated -- alcohol, benzodiazepines, stimulants, etc...
   - Unpredictable immediate results
   - At risk for polypharmacy synergistic respiratory depression, with polydrug use after discharge
   - Do your best to engage and encourage them to consider the ED an "open door" to return when sober
### Patient selection PITFALLS FOR E.D. BUPE INITIATION

5. "Chronic pain patients" taking medically prescribed opioids:
   - Many "chronic pain" patients have truly painful conditions, but also have developed opioid dependence, and experience opioid induced hypersensitivity, tachyphylaxis, and withdrawal – reported as pain flares
     - Although may be excellent candidates for tx with bupe for pain (and OUD) -- very effective analgesic.
     - However, the dosing is different for chronic pain
     - Better handled in clinic

6. Patients with severe medical illnesses: renal failure, advanced liver disease, heart failure, severe COPD:
   - Not an absolute contraindication, may be a good option
   - HOWEVER, this treatment must be COORDINATED. Requires a team approach.

### Basic E.D. Dosing concepts:

- Screen out high risk patients (previous slide)
- Base the first dose on:
  - Patient’s use history (average daily opioid use) – high vs. low
  - Severity of withdrawal
  - Example: ~ lower dose user, mild to moderate w/d: consider 4mg of bupe
    ~ high dose user, in at least mild w/d: start at 8mg of bupe

OR ... refer to a protocol (see a few attached at the end of this presentation)
**Basic E.D. Dosing concepts:**

- Repeat dosing every 30+ minutes as necessary to get the patient comfortable:
  - Then the pt can have a meaningful conversation with a social worker/advocate for clinic referral.
- If no contraindications:
  - Consider bupe loading (up to 24-32mg total)
  - Or, if you have an X-Waiver: **write the patient a short-term bupe Rx**
    - Prolongs the return of withdrawal symptoms,
    - Gives the patient more time to get to a clinic, without having to return to the ED
- Avoid bupe loading in the polypharmacy patient

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**Qs:**

**Are There Any Precautions?**

**What Is Precipitated Withdrawal?**
Nuts & Bolts of Bupe Tx

Binds tightly to the Mu receptor (blocking other opioids):
- Displaces full agonist opioids (heroin, morphine, methadone, etc.)
- Requires high doses of naloxone to displace bupe.
- Patients must be in withdrawal – (or craving post w/d) – to benefit from bupe!
- PRECIPITATED WITHDRAWAL CAN BE HORRIBLE.

Avoid Precipitating Withdrawal with BUPE

- Find out what the patient uses (if possible):
  - Type of opioids used
  - Low dose user, high dose user
  - Last use (how many hours ago)
- Ensure the patient is in adequate withdrawal (or withdrawal completed)
  - Can be in mild withdrawal for short acting opioids,
  - At least moderate for long acting opioids (e.g. methadone)
- Perform a COWS score:
  - A quick 11 element scale, which includes elements such as heart rate, pupil size, rhinorrhea, tremor, and restlessness.
  - COWS ≥ 8 mild, ≥ 13 moderate, ≥ 36 severe.
  - Takes <1 minute to score
Treating Buprenorphine Precipitated Withdrawal

Treating Precipitated Withdrawal:
- Also not well studied. Somewhat controversial.
- Can offer non-opioid Tx.
- Alternatively .. More bupe!
  - Titrate additional doses, while the patient is monitored, until withdrawal symptoms have subsided.
    - Not well published, but according to most experts this is most effective.

CAUTION:
- Nausea is a common adverse effect of buprenorphine.
- Do not assume that all nausea induced by buprenorphine is due to precipitated withdrawal.

Bupe After Naloxone for O.D?

To Avoid Precipitating further withdrawal:
- This has not been well studied
- **Shared decision-making with patient**
- If pt only uses short acting opioids (e.g. heroin, oxycodone), may consider initiating bupe:
  - Be prepared to monitor pt until the naloxone would have worn off.
  - Offer non-opioid w/d tx as well
- After NALOXONE, caution with giving bupe to pts on long half-life opioids, such as methadone, MS Contin, Opana, etc
Qs: Don’t E.D. Docs Need a Special License to Use this Drug?

DATA 2000/ X-Waiver

- Drug Addiction Treatment Act of 2000
- Provided a “waiver” to treat opioid addiction outside of a traditional opioid treatment program (e.g. “methadone clinic”).
- Applies to schedule III, IV and V medications with FDA approval to treat addiction…
  (pssst… Buprenorphine is the only one!)
DATA 2000/ X-Waiver

✧ “for the treatment of opioid use disorder, including maintenance, detoxification, overdose reversal, and relapse prevention”

✧ “the practitioner has the capacity to provide directly, by referral, [or in other manner] appropriate counseling and other appropriate ancillary services.”

DATA 2000/ X-Waiver

✧ Requirements:
  – Active state medical license (including PA, APRN)
  – Valid individual DEA
  – Eight-hour course for MD/DOs
  – PA/APRNs require 24 hours
  – Patient limits apply to patients treated “at any one time” (30/100/275)
### Get Waivered!

**American Society of Addiction Medicine**  
Online only course ($199)  
Multiple half and half courses

**The American Osteopathic Academy of Addiction Medicine**  
Half and Half Course, twice a month for FREE!

**American Psychiatric Association**  
Online or 8 hour in person

**Providers Clinical Support System**  
www.pcssnow.org  
4.25 hr. in person (frequently by webinar), 3.75 hrs. online  
8 hour online (FREE – October 2018)  
8 hour live – FREE!  
Multiple times per month – FREE!

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### Qs: Aren’t There Rules About Using Bupe In The ED?
“Three Day Rule”

In the outpatient setting:

“According to DEA … the “three-day rule” allows a practitioner who is not separately registered as a narcotic treatment program or certified as a waivered DATA 2000 physician, to administer (but not prescribe) narcotic drugs to a patient for the purpose of relieving acute withdrawal symptoms while arranging for the patient’s referral for treatment, under the following conditions:

- Not more than one day’s medication may be administered or given to a patient at one time.
- Treatment may not be carried out for more than 72 hours
- The 72-hour period cannot be renewed or extended"


Three Day Rule

- Is it necessary to be able to refer a patient to an opioid addiction treatment clinic, to administer bupe in the ED for withdrawal or MAT?
- Officially, it is required …
- The DEA cares about DIVERSION of prescribed, or dispensed, bupe.
- The DEA is far, far less concerned about medications ordered and administered in hospitals.
Qs: What’s the role of naloxone in this opioid epidemic?

Broad Support for Community Naloxone Distribution

Surgeon General’s Advisory on Naloxone and Opioid Overdose

Surgeon General of the United States Public Health Service, HHS, Jerome Adams, is emphasizing the importance of the overdose-reversing drug naloxone. For patients currently taking high doses of opioids as prescribed for pain, individuals misusing prescription opioids, individuals using illicit opioids such as heroin or fentanyl, health care practitioners, family and friends of people who have an opioid use disorder, and community members who come into contact with people at risk for opioid overdose, knowing how to use naloxone and keeping it within reach can save a life.

April 5, 2018

BE PREPARED. GET NALOXONE. SAVE A LIFE.
**Take Home Naloxone Program**

Many EDs are developing "take home" naloxone programs to engage patient and friends and families of patients with OUD:

- Distributed to patients/friends/families of individuals at risk of opioid overdose by ED staff 24 hours/day
- Prescription is another model, but filling can be problematic (state dependent)
- Patients are willing to engage in discussions about their health!

**Comparing Naloxone Formulations**

<table>
<thead>
<tr>
<th></th>
<th>Generic Intramuscular</th>
<th>Evzio™ Auto-Injector</th>
<th>Generic Intranasal</th>
<th>Narcan® Nasal Spray</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dose</td>
<td>0.4mg/ml</td>
<td>2mg/0.4mL</td>
<td>1mg/mL</td>
<td>4mg/0.1mL</td>
</tr>
<tr>
<td>Titratable Dose</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assembly required</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cost</td>
<td>$</td>
<td>$$$</td>
<td>$5</td>
<td>$5</td>
</tr>
</tbody>
</table>

- Prescription and quantity:
  - #2 single-use 1 mL vials PLUS #2 3 mL syringes 28-25 gauge 1.5 inch 3M needles; 2 refills
  - #1 two-pack of two 2 mg/0.4 mL prefilled auto-injector devices; 2 refills
  - #2 mL Laser-Lock nasal spray vial plus #2 mucosal atomization devices (MAA-300); 2 refills
  - #1 two-pack of two 4 mg/0.2 mL intranasal devices; 2 refills
Key Points

✧ Addiction is a disease
✧ Treatment works
✧ You DON’T need a waiver to treat withdrawal with buprenorphine
✧ Methadone, buprenorphine and Naloxone save lives
✧ You can be part of the solution

Thank you!
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Kathryn Hawk, MD
Kathryn.hawk@gmail.com
TREATMENT PROTOCOLS & ADDITIONAL DISCUSSION CONTENT

Emergency Care During an Opioid Addiction Epidemic

In withdrawal desires treatment for opioid addiction
Exclusions from ED buprenorphine initiation include:

- On high dose (usually prescribed) opioids very intoxicated (with other substances)
- History of overdose

Verify adequate withdrawal is crucial:

- If inadequate withdrawal, buprenorphine will precipitate withdrawal

- Use COMS to your favorite medical calculator

- CO2 should be < 3, the higher the better

- If not, do not be a warden to treat withdrawal with buprenorphine in the ED

- Buprenorphine 4 mg sublingual

- The higher the COMS, the larger the dose

- It causes withdrawal symptoms in low doses (2 mg 30 mg)

- Absorb in 30-60 minutes

- Avoid smoking

- Optional testing during buprenorphine initiation

- CO2, serum lab, (Tc, Hb, Hct)

- If inadequate dose present, can do with prescription

- If expected delay in accessing buprenorphine (>24 h), consider high dose initiation in consultation with addiction specialist

- Advise no dangers of embolisms use white on blue

- Refer to bup-capable provider/district

- Smaller the ED buprenorphine dose, the tighter the followup has to be, up to 6 h

- In withdrawal does not desire treatment

- Consider buprenorphine initiation anyway

- Alternative: methadone 20 mg IM

- Use non-opioid analgesics (acetaminophen, tramadol, chlorpromazine, NOS, antihypertensives, antiemetics, etc.)

- Refer to ongoing addiction care

- Harm reduction (see box)

- In withdrawal does not desire treatment

- Engage, encourage to move to treatment

- Refer to ongoing addiction care

- Priority for Emergency Care

- Prevent opioid-naive patients from becoming mistakes by your prescription

- Calculate benefit harm; whenever an opioid prescription is considered, and if opioid, prescribe small if of low dose, lower risk pills

- Immediate Release Morphine Sulfate (MR)

- 15 mg tablets, 1 tab of 4.5 mg, evans, p.o., dose 4.5

- Writing: “I have a problem, I need help”

- Aggressive move to treatment

- ED-initiated buprenorphine

- Referral to specialty followup

- Resumed, unerring “I overdosed”

- Harm reduction (see box)

- Supportive stance; open door

- Partially revealed: “I have chronic pain and need opioids”

- Avoid opioids in ED or by prescription

- opioid alternatives for pain

- Express concerns that opioids are causing harm

- Unverified: “I have acute pain and need opioids”

- Risk strictly with red/yellow flags

- PEMPR—earn permission to will-pretend

- If low risk, treat as partially revealed

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High dose ED bupe MAT induction: No longer just for the addiction specialist. Coming to an ED near you!
But if We Start Administering Bupe In the E.D…

“The E.D. will be awash with drug seekers, trying to get bupe!”

EDs which have started bupe programs have not seen significant visits increase, opioid- seeking patient visits may decrease.

If more patients did come to the ED hoping to start MAT, would that be a bad thing?

These patients are coming to the ED anyway.

Might not more patients suffering from opioid addiction get into treatment?

MAT is a long term program

High rate of failure with short term “detox” approach.

Most opioid addicted patients will need many months, if not years of treatment, for some many years or even lifelong Tx.

This neuroadaptation to opioids is unique to opioid addiction, as opposed to alcohol dependency.

We must think of opioid dependency/addiction as we think of DM, HTN, and other chronic illnesses.

Successfully weaning off opioids for the long term (not just “Detox”) is a slow, gradual process.

Opioid Addiction Treatment is a journey, and a marathon -- not a Sprint