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Psychiatry and Addictions Case Conference

UW Medicine | Psychiatry and Behavioral Sciences

OPIOID WITHDRAWAL

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OBJECTIVES

1. Participants will be able to discuss characteristics and considerations of appropriate medically supervised opioid withdrawal.
2. Participants will be able to summarize the signs and symptoms of opioid withdrawal.
3. Participants will be able to compare and contrast treatment options for medically supervised withdrawal.

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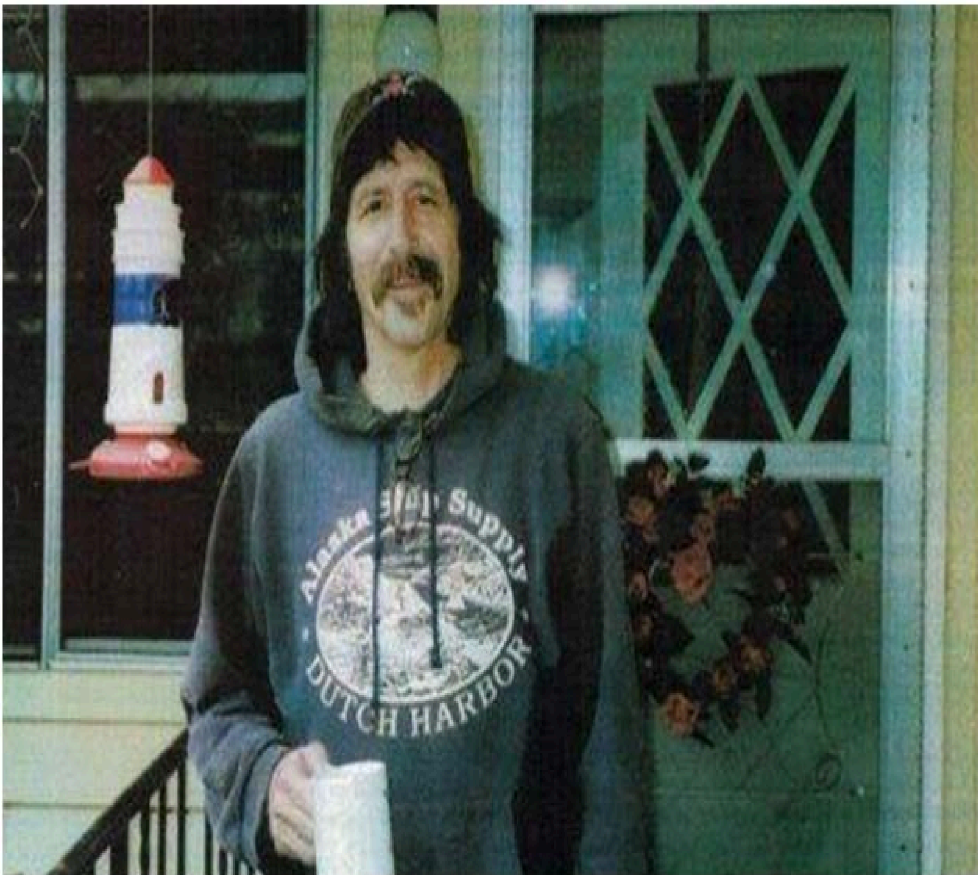
Desperation and death after Seattle Pain Centers close: 'The whitecoats don't care'

Originally published October 30, 2016 at 6:00 am | *Updated October 30, 2016 at 8:32 am*

HURTS, CANT SLEEP, CANT
EAT, CANT DO ANYTHING
AND ALL THE WHITECOATS
DONT CARE AT ALL.



MEDICALLY SUPERVISED WITHDRAWAL CONSIDERATIONS

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WHEN TO CONSIDER MEDICALLY SUPERVISED WITHDRAWAL

- Patient request
- No improvement in functioning
- Risks of continued use outweigh benefits
- Severe adverse events or overdose
- Substance use disorder
- Use of opioids is beyond recommendations
- Aberrant behaviors

Source: Interagency Guidelines on Prescribing Opioids for Pain, WA State, 2015

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PEG PAIN SCREENING TOOL

1. What number best describes your <u>pain on average</u> in the past week:

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your <u>enjoyment of life</u>?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

3. What number best describes how, during the past week, pain has interfered with your <u>general activity</u>?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere										Completely interferes

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OPIOID RISK TOOL

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

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A SUCCESSFUL WITHDRAWAL

- Physiologically stable
- Avoids hazardous medical consequences of withdrawal
- Minimizes discomfort
- Has dignity and respect
- Completes the taper
- Continues care for substance use

Source: Mattick & Hall 1996

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IS A HIGHER LEVEL OF CARE NEEDED?

- ≥90 MED daily
- Comorbid substance use, mental health issue
- Comorbid medical issue
- On methadone or fentanyl
- ≥8 on Opioid Risk Tool
- Problems following opioid care plan

Sources: Group Health and Washington State Opioid Guidelines

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WITHDRAWAL SYMPTOMS

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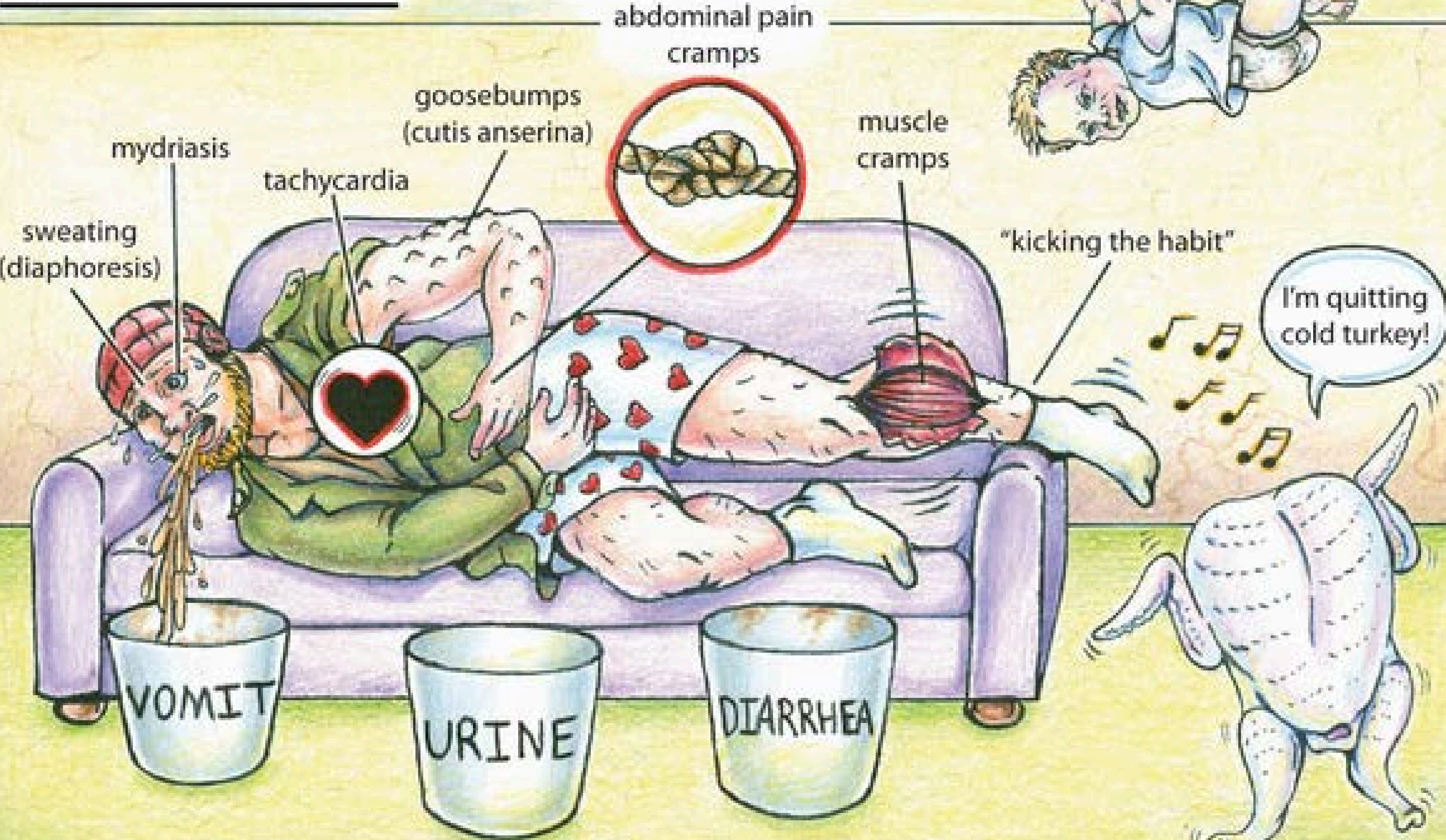

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CHARACTERISTICS OF WITHDRAWAL

- Onset and duration varies by substance
  - Short-acting (eg, heroin, oxycodone): onset 8-12 hrs; peak 48-72 hours
  - Long-acting (eg, methadone, buprenorphine): onset 24-48 hr; peak 3-5 days
- Not medically dangerous (usually) but EXTREMELY uncomfortable
- Can last up to several weeks

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COMPLICATED WITHDRAWAL

- GI: vomiting-> electrolyte imbalances, dehydration
  - PO/ IV fluids
- Cardiac issues -> autonomic instability can exacerbate underlying issues
- Fever
  - Should be self-limited, if not look to other causes (eg, abscess, PNA)
- Pain
  - Will worsen, esp dental and low back pain

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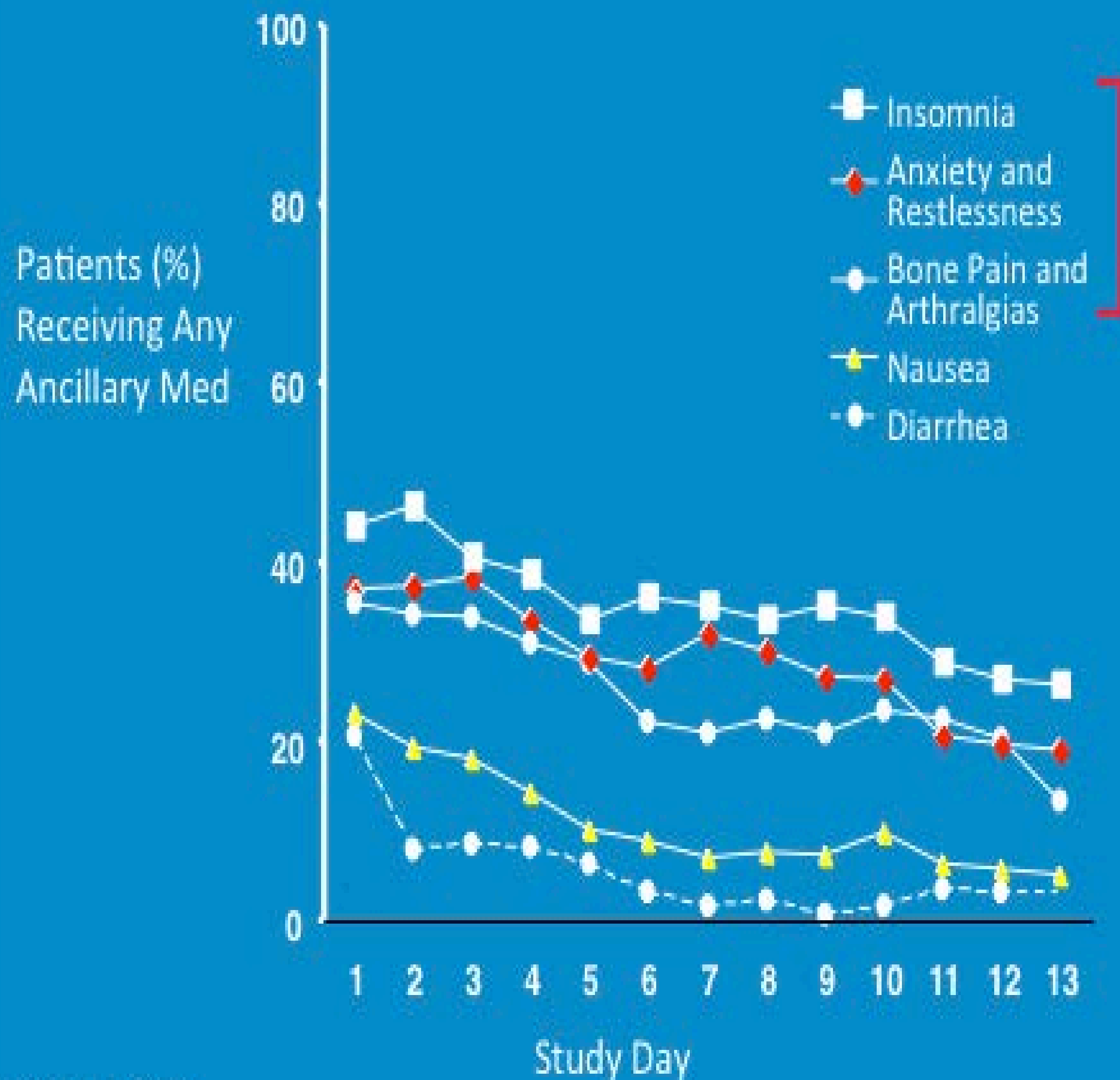

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MANAGEMENT WITHOUT MEDICATIONS

“Management of this syndrome without medications can produce needless suffering in a population that tends to have limited tolerance for physical pain.”

Source: SAMHSA TIP 45

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WITHDRAWAL MEDICATIONS

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AARONCOHEN

Originally Published June 19, 2013

YouTube Viewings: 128,396

How to Stop Opiate Withdrawals with Over The Counter Medications - Part 1

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WHO IS AT RISK OF WITHDRAWAL/ WHO TO TAPER

- Regularly scheduled opioids
- Longer than a few days- three weeks
- Higher than starting doses
- Taper length
  - opioid doses
  - duration
- Naloxone challenge

Source: VA Tapering and Discontinuing Opioids Factsheet, 2013

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WITHDRAWAL MEDICATIONS

- Suboxone: partial agonist
  - Waiver needed
- Methadone: agonist
  - At SAMHSA clinics and detox centers
  - While hospitalized
- Clonidine: alpha-adrenergic agnoist
  - Relieves many of the signs
  - Not subjective symptoms

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COCHRANE REVIEW 2009

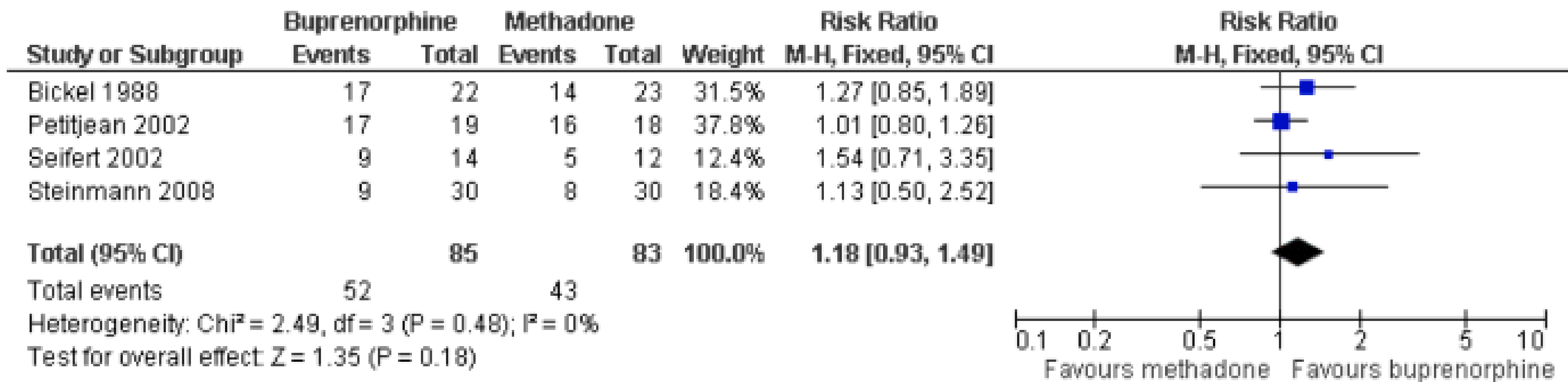

Figure 4. Forest plot of comparison: 1 Buprenorphine versus methadone, outcome: 1.1 Completion of withdrawal.

Study or Subgroup	Buprenorphine Events	Buprenorphine Total	Methadone Events	Methadone Total	Weight	Risk Ratio M-H, Fixed, 95% CI
Bickel 1988	17	22	14	23	31.5%	1.27 [0.85, 1.89]
Petitjean 2002	17	19	16	18	37.8%	1.01 [0.80, 1.26]
Seifert 2002	9	14	5	12	12.4%	1.54 [0.71, 3.35]
Steinmann 2008	9	30	8	30	18.4%	1.13 [0.50, 2.52]
Total (95% CI)		**85**		**83**	**100.0%**	**1.18 [0.93, 1.49]**
Total events	52		43			

Heterogeneity: $Chi^2 = 2.49$, df = 3 (P = 0.48); $I^2 = 0\%$
Test for overall effect: Z = 1.35 (P = 0.18)

- Buprenorphine equivalent to methadone
  - 61% vs. 52% completed (RR 1.18)

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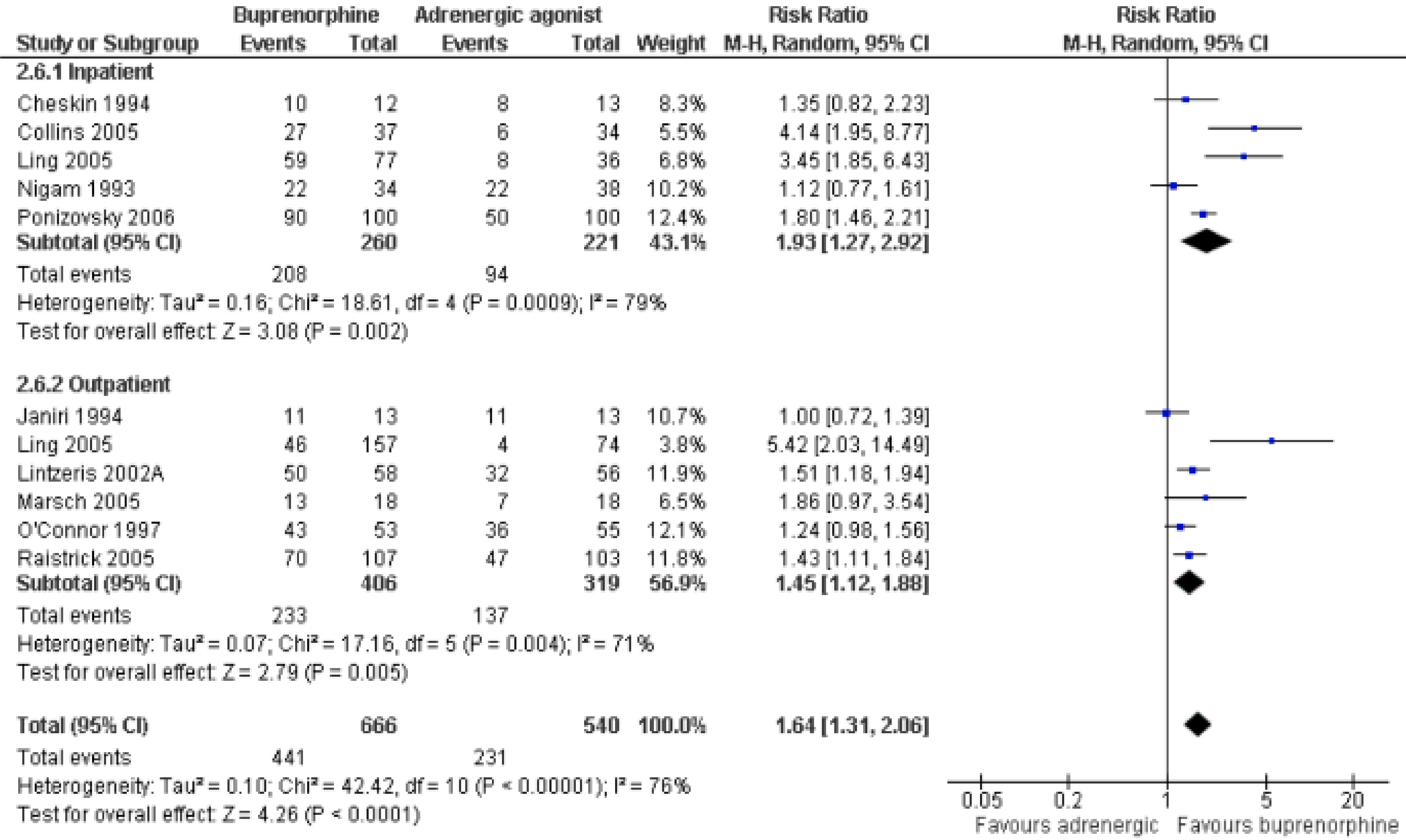

- Buprenorphine > clonidine
  - RR 1.64 for completing treatment

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SUBOXONE

- μ- partial agonist (buprenorphine) + naltrexone
- Can precipitate withdrawal sx
- Ceiling effect
- Waiver needed
  - Except on inpatient

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Day	Bup/ Nx Dose (mg of bup)
1	4(+4 if needed)
2	8
3	16
4	14
5	12
6	10
7	8
8-9	6
10-11	4
12-13	2

Source: Short-term Opioid Withdrawal Using Buprenorphine Findings from the NCT Study

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METHADONE

- Long-acting μ- receptor agonist that replaces heroin and other opioids and restabilizes the site
- Underdosing and overdosing are both risks
  - Physical exam can provide clues
- Dosing depends on reported use
  - Up to 30-40 mg/ day
  - Can do challenge dose
  - Reduce 5-10 mg daily for 3-5 day taper

Source: SAMHSA TIP 45

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CLONIDINE

- α - agonist
- Wide, off-label use for opioid withdrawal
- No intoxication potential?
- No special licensing needed
- Completion rates for clonidine detoxification are low

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CLONIDINE

- 0.1 mg test dose should be given with BP before and after dosing
- 0.1- 0.2 mg q4-6 h PRN withdrawal sx, max 1.2 mg in first day and 2.0 mg in future days
- Taper to avoid rebound hypertension

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COWS PROTOCOL

Resting Pulse Rate: Record Beats per 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

Sweating: Over Past 1/2 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

Restlessness Observation During Assessment

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

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

Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate 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

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

COWS PROTOCOL

GI Upset: Over Last 1/2 Hour	
0 = no GI symptoms 1 = stomach cramps 2 = nausea or loose stool	• 3 = vomiting or diarrhea • 5 = multiple episodes of diarrhea or vomiting
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
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
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
Gooseflesh Skin	
0 = skin is smooth 3 = piloerection of skin can be felt or hairs standing up on arms	• 5 = prominent piloerection

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ULTRA-RAPID DETOXIFICATION?

- Low rates of long-term success
- Pt needs 20% of previous day's dose to avoid w/d sx

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Table 4. Medications used to treat symptoms during gradual opioid taper

Target symptoms	Medication	Dosing
Hypertension, tremors, sweats, anxiety, restlessness	Clonidine [1]	0.1 mg three times daily as needed
Anxiety, restlessness	Hydroxyzine [2] or Diphenhydramine [2]	25 mg every 6 hours as needed
Insomnia	Hydroxyzine [2] or Diphenhydramine [2]	25–50 mg daily at bedtime as needed
Nausea/vomiting	Promethazine [2]	25 mg every 6 hours as needed
	Metoclopramide [2]	10 mg every 6 hours as needed
Dyspepsia	Calcium carbonate	500 mg 1–2 tabs every 8 hours as needed
	Mylanta, Milk of Magnesia	Follow package instructions.
Pain, fever	Acetaminophen (Tylenol)	500 mg every 4 hours (not to exceed 3 g/24 hours)
	Ibuprofen	400 mg every 4 hours as needed
Diarrhea	Loperamide [2]	4 mg initially, then 2 mg every loose stool as needed; maximum 16 mg/day
Muscle spasm	Methocarbamol [2]	1,000 mg every 6 hours as needed

Source: Group Health Opioid Guidelines

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LONG-TERM MANAGEMENT

- Do not abandon a patient under any circumstances
- Refer for needed specialty services
- Advise patient on the loss of tolerance after detoxification to avoid future overdose
- Naloxone kit

Source: VA guidelines, NICE guidelines

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RESOURCES

- Center for Substance Abuse Treatment. Detoxification and Substance Abuse Treatment. Treatment Improvement Protocol (TIP) Series, No. 45. HHS Publication No. (SMA) 15-4131. Rockville, MD: Center for Substance Abuse Treatment, 2006. http://store.samhsa.gov/shin/content//SMA15-4131/SMA15-4131.pdf
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- Washington State Agency Medical Directors Group (AMDG). Interagency Guideline on Prescribing Opioids for Pain. Olympia, WA: Washington State Agency Medical Directors' Group; 2015. http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
- Group Health. Safety Guideline for Patients on Chronic Opioid Therapy for Chronic Non-Cancer Pain. Group Health Cooperative,2016. https://www.ghc.org/static/pdf/public/guidelines/opioid.pdf

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