Opioid dependence

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| Addiction medicine & toxicology,gastroenterology & hepatology,General medicine,intensive care,...

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James talks to Dr Jonathan Brett from Drug Heath Services at Royal Prince Alfred Hospital.

Jonathan Brett is an advanced trainee in clinical pharmacology and addiction medicine. He is on the editorial board of the Australian Prescriber and was on the editorial board of the Theraputic Guidelines committee for Toxicology and Wilderness Medicine. Jonathan also sits on the Population Health Sciences Research Ethics Committee of NSW. He has an inteterest in opioid biology and the quality use of opioids.

Management of the opioid dependent patient on the wards

with Dr Jonathan Brett, Drug Health Services at Royal Prince Alfred Hospital, New South Wales, Australia

1. Assessment

Opioid Withdrawal

- Time to onset of withdrawal symptoms depends on the opioid they have been using and its half-life
- Methadone (long acting opioid agonist used in the management of opioid addition) has a very long half-life so sometimes we don't see toxicity for 48 to 72 hours after dose commenced
- Clinical Opioid Withdrawal Scale (COWS) uses 11 symptoms and signs of opiate withdrawal: Resting pulse rate, Sweating, Restlessness, Pupil Size, GI upset, Bone or joint aches, Runny Nose and Tearing, Tremor, Anxiety or Irritability, Goosebumps and yawning
- Rates withdrawal into mild, moderate or severe Ensure BP reading is real (do a manual)

Opioid Toxicity

- Deterioration of LOC may be related to opioid toxicity but could also be related to other pathology so a thorough history and examination is required
- Pinpoint pupils and a low respiratory rate suggest opioid toxicity
- Start with ABC's when assessing the patient and get help if there is respiratory depression or compromise

What to ask a patient who is on methadone

- Who is their prescriber?
- Where do they usually get it dispensed?
- What is the most recent prescription dose?
    - In hours call the pharmacy that dispenses and get most recent script faxed or call the Pharmaceutical Services branch who keep a record of all authority prescriptions http://www.health.nsw.gov.au/pharmaceutical
- If it is out of hours and you can't get the prescription dose, be guided by the drug health service

2. Management

Opioid withdrawal

- Commonly Methadone is started at 20-30mg for moderate to severe opiate withdrawal but this needs to be prescribed with drug health service advice
- Buprenorphine (partial opioid agonist) can also be used for opioid withdrawal but it can precipitate withdrawal if there are still opioids on board. This should be guided and prescribed with Drug Health. In many respects it is safer than Methadone

Acute pain and the patient is on methadone or buprenorphine

- Continue Buprenorphine or Methadone at normal dose
- May need larger than normal doses of short acting opioids, such as morphine, because they have tolerance and receptor occupancy. A larger doe is needed to overcome the competitive effect at the receptor
- Patients with opioid dependence often have their pain under-treated
- Use multimodal analgesia with paracetamol and NSAIDS

What if the patient is also nil by mouth?

- Don't withhold IV Morphine and PCA's from patients in acute pain
- Methadone can be given sub cut but this MUST be guided by pharmacy and Drug Health as the dose can be different
- Buprenorphine can be given sublingually so it doesn't need to be changed if the patient is NBM

Opioid overdose or toxicity

- Naloxone is the antidote for opioid toxicity
- Toxicity may be delayed if the opioid has along half life like Methadone
- Giving Naloxone to the opioid toxic patient:
    - Peri-arrest or opioid naive patient with opioid toxicity can give 400mcg IV
    - Beware of precipitating withdrawal in the opiate dependent patient. Consider giving smaller doses and titrating 40-80mcg at a time
    - Naloxone is shorter acting than most opioids and repeat doses or infusions may be required

Take home messages

- Opioid withdrawal is very unpleasant but not life threatening
- Addiction and drug health services should be consulted before prescribing methadone or buprenorphine and can provide useful advice about acute pain management in the opiate dependent patient

Related Podcasts

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- Code Black

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