DISCLAIMER

- This session was conducted for members of county-based teams in CA that are working to expand access to Medications for Addiction Treatment in jails and drug courts. The project is funded through California's Department of Health Care Services with State Opioid Response funding from SAMHSA. The content is being made available to all interested parties.
- Please note this content has not been professionally edited and the session was conducted using Zoom.

HEALTH MANAGEMENT ASSOCIATES

DHCS
California Department of HealthCareServices

Opioid Withdrawal

December 3, 2020

TODAY'S PRESENTERS

wellpath

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Disclosures:
Dr. Robinson and Donna Strugar-Fritsch disclose that they are employees of Health Management Associates, a national research and consulting firm providing technical assistance to a diverse group of healthcare clients.

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LEARNING OBJECTIVES

At the end of presentation participants will be able to:

- Identify signs and symptoms of opioid withdrawal
- Understand the rational for the treatment recommendations for opioid withdrawal

POLLING QUESTION

Mr. Johnson presents to your jail and reports having last used heroin 4 hours ago. During his nursing assessment you tell Mr. Johnson…

1. he will not get treatment for withdrawal symptoms
2. he will get medication for nausea and vomiting
3. he will get evidence-based treatment upon withdrawal
4. you don't care if he has withdrawal or not

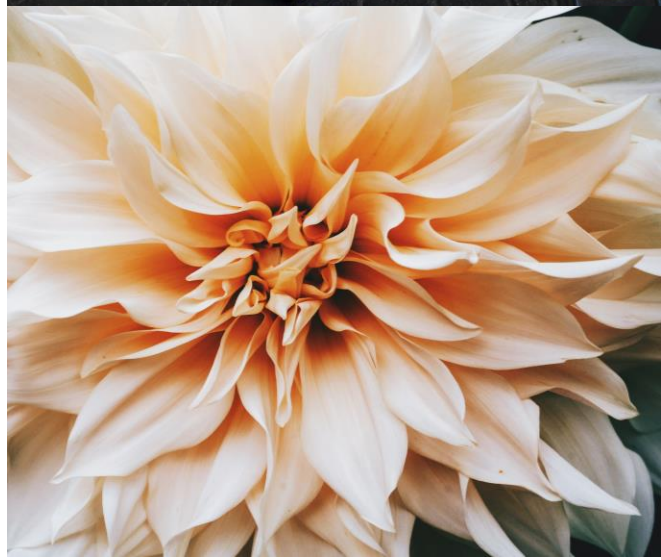
WHY USE MEDICATION FOR OPIOID WITHDRAWAL?

- Treatment is more effective than abrupt cessation due to risk of relapse, OD & death

"Forced withdrawal can undermine a person's willingness to engage in treatment in the future, compromising the likelihood of long-term recovery"

- NCCHC Promising Practice Guidelines

- Avoid deaths
- Avoid litigation
- Patients more agreeable; "they bloom like flowers"
- Facility cleaner and safer
- Improve reward system and motivation



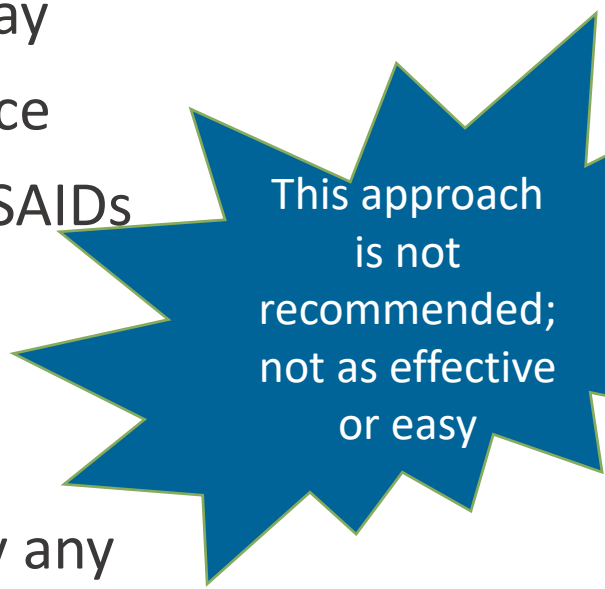
PEOPLE DIE FROM WITHDRAWAL BECAUSE

- Failure to take withdrawal seriously
- Failure to recognize withdrawal, because of other conditions
- Failure to use opioid agonists to treat withdrawal
- Failure to adequately and closely monitor withdrawal
- Masking of underlying life-threatening conditions by withdrawal

Opioid Withdrawal	COVID-19
Fever	Fever
	Cough
	Shortness of breath
Muscle aches	Muscle aches
Rhinorrhea	Rhinorrhea
Insomnia	Insomnia
Nausea & Vomiting	Nausea & Vomiting
Diarrhea	Diarrhea
Tachycardia	Tachycardia
Tachypnea	Tachypnea
Anxiety	Anxiety
Lacrimation	
Dysphoria	

HISTORICAL TREATMENT OF OPIOID WITHDRAWAL: "COMFORT MEDICATIONS"

1. Clonidine: start 0.1 mg bid for bone pain & arousal; may increase dose, but watch for hypotension
2. Imodium (loperamide) 4mg 1-2 tabs q1 hr for diarrhea, NTE 16 mg/day
3. Motrin (ibuprofen) 600 mg q 6hr for bone pain or NSAID of your choice
4. Tylenol (acetaminophen) 975 mg up to qid for pain not relieved by NSAIDs
   - Can use both Tylenol and NSAIDS at the same time
5. Benadryl (diphenhydramine) 25 to 50 mg q6hr for nasal congestion, insomnia or anxiety
6. Compazine (prochlorperazine) 10mg qid for nausea/vomiting; give by any route available
7. Bentyl (dicyclomine) 10 mg qid for abdominal cramping, not relieved by controlling diarrhea
8. Valium (diazepam):10-15 mg for muscle spasms and insomnia



ASAM GUIDELINES 2020: OPIOID WITHDRAWAL

Using opioid agonists is recommended over abrupt

Initiate buprenorphine after objective evidence of withdrawal

Provide adequate buprenorphine to suppress withdrawal symptoms

Alpha 2 adrenergic agonists are less effective than methadone and buprenorphine

Sources: Focus Update, ASAM National Practice Guideline Treatment of Opioid Use Disorder 2020
Gowing, L et. Al. (2017) Buprenorphine for managing opioid withdrawal Cochrane Database Sys Review 2(2)

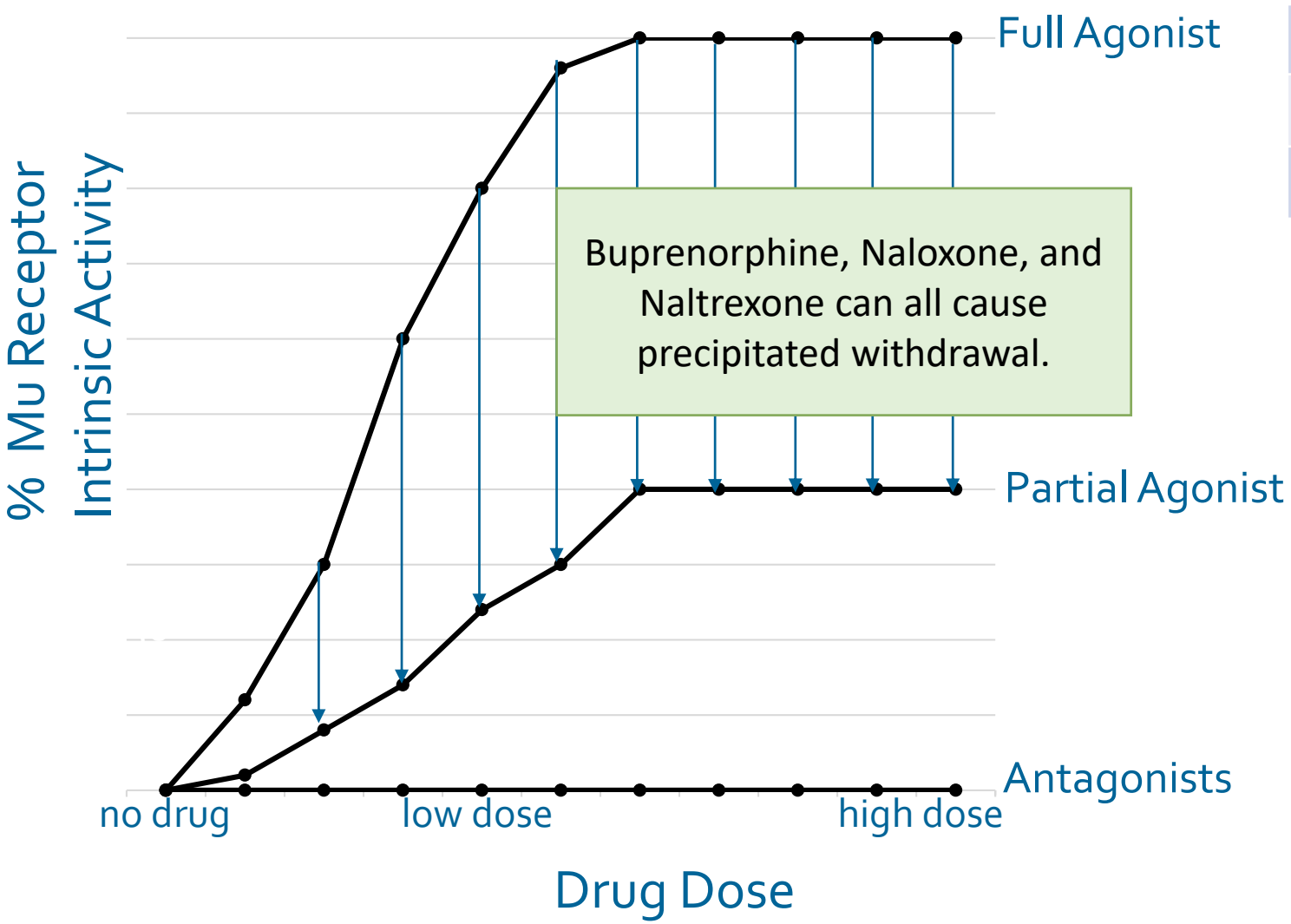
WHO IS AT RISK OF WITHDRAWAL

Exposure to steady state level of a substance causes neuroadaptation; this leads to the spontaneous onset of withdrawal symptoms when the substance is abruptly stopped or greatly decreased.

Opioid	Onset	Peak	Duration
Heroin	6 hours	By 3 days	4-7 days
Methadone	1-2 days	By 7 days	12-14 days
Fentanyl short acting	6 hours		
Fentanyl long acting	24-36 hours		

- Higher intensity withdrawal comes from:
  - Higher steady state drug levels
  - Longer duration of exposure
  - Rapid drug clearance from the body leads to more rapid onset of withdrawal and more intense withdrawal
- Duration of withdrawal is dependent upon the duration of the drug being consumed

WITHDRAWAL



	Onset	Peak	Duration
Naloxone	minutes		20 minutes
Naltrexone	minutes		1-2 days
Buprenorphine	minutes		1-2 days

Treatment for Precipitated Withdrawal

Continue Buprenorphine

- Give another dose
- May relieve symptoms

Stop Buprenorphine

- Treat withdrawal symptoms
- Start again tomorrow

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GOALS/ BENEFITS OF WITHDRAWAL MANAGEMENT

Goals	Benefits
Suppress withdrawal symptoms	Improved retention in treatment
Reduce or discontinue illicit opioid use	Decreases relapse
Decrease cravings	Improved abstinence
Blunt effects of illicit opioids if used	Decreased overdoses
Minimize side effects	
Maximize facility cleanliness (vomiting and diarrhea increase transmission of COVID…)	
Maximize safety of facility	

Source: O'Connor PG. JAMA. 2005; Mattick RP, Hall WD. Lancet. 1996

OPIOID WITHDRAWAL SYMPTOMS & SIGNS

- Symptoms are reported
- Signs are observed
- Symptoms and sign are generally on a continuum
- Most symptoms can be feigned except piloerection- DO NOT STOP WITH SYMPTOMS
- Signs aren't feigned, they are observed- USE YOUR CLINICAL JUDGEMENT
- COWS has become the standard assessment of withdrawal
- Other tools could be used
  - Clinical Institute Narcotic Assessment

Clinical Opiate Withdrawal Scale (COWS):

Scores:

- 5-12 mild
- 13-24 moderate
- 25-36 moderate to severe
- >36 severe

More important than the score is objective evidence of withdrawal

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 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

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

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 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

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 or 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: _____

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Source: Wesson and Ling. 2003 The clinical opioid withdrawal scale. Journal of Psychoactive Drugs 35 (2): 253-9.

COWS- DECIDE & TRAIN: ONLY USE ANCHORS OR USE ALL NUMBERS

- Pulse (objective)
  - 0 pulse<80
  - 1 pulse 81-100
  - 2 pulse 101-120
  - 4 pulse >120

- Sweating (over past 30 min-subjective & objective)
  - 0 no report of chills/flushing
  - 1 report of chills/ flushing
  - 2 flushed or observable moistness
  - 3 beads of sweat on face
  - 4 sweat streaming off face

- Restlessness (subjective & objective)
  - 0 able to sit still
  - 1 reports difficulty but able to sit still
  - 3 frequent shifting or moving extremities
  - 5 unable to sit still for more than a few seconds

- Pupil size (objective)
  - 0 pinned or normal
  - 1 possibly larger
  - 2 moderately dilated
  - 5 so dilated only rim showing

- Bone/ joint aches (subjective & objective)
  - 0 not present
  - 1 mild diffuse discomfort
  - 2 reports severe diffuse discomfort
  - 4 rubbing & unable to sit still

Patients should not exceed the lowest score in most categories without some objective evidence of withdrawal. NIDA

COWS

- Runny nose/ tearing (subjective & objective)
  - 0 none
  - 1 stuffy/ moist
  - 2 runny or tearing
  - 4 constantly running/ tearing

- GI upset (subjective & objective)
  - 0 no GI symptoms
  - 1 stomach cramps
  - 2 nausea or loose stool
  - 3 vomiting or diarrhea
  - 5 multiple episodes

- Tremor (subjective & objective)
  - 0 none
  - 1 tremor can be felt but not seen
  - 2 slight tremor observable
  - 4 gross tremor or twitching

- Yawning (objective)
  - 0 none
  - 1 Once or twice during assessment
  - 2 Three during assessment
  - 4 Several times/ minute

- Anxiety/ Irritability (subjective & objective)
  - 0 none
  - 1 reports anxious or irritable
  - 2 obviously anxious or irritable
  - 4 so anxious or irritable participation is difficult

- Gooseflesh (objective)
  - 0 skin is smooth
  - 3 piloerection felt or visible
  - 5 prominent piloerection

IMPORTANCE OF ASSESSMENT

- Taking care of the patient
  - A good history enables prediction of onset of moderate withdrawal
  - Last use
  - Amount used/day
- Drastic change
- Clinical judgement

- Protocol
- Magic # to initiation buprenorphine

TREATMENT OF OPIOID WITHDRAWAL: AGONISTS

Buprenorphine

- Objective evidence of withdrawal
- Initial dose 2-8mg
- Can monitor for 30 minutes, but not required
- Repeat or increase dose same or next day
- **Patient stabilizes 1-2 days**

- Target dose 16mg/ day

Methadone

- Evidence of withdrawal
- Initial dose 10-30mg
- May give second dose after 3 h
- Dose increase above 30 mg cannot occur for 7 days
- **Patient stabilizes in weeks**

- Target dose 60-120mg/ day

Giving other medication is not necessary if you treat all withdrawal symptoms with buprenorphine

TAPER BUPRENORPHINE FOR OPIOID WITHDRAWAL OR MAINTAIN BUPRENORPHINE FOR OPIOID WITHDRAWAL AND OPIOID USE DISORDER

- Taper over 4-30 days
- Data doesn't support this
- 85% of patient relapse within a year
- Relapse may lead to death
- 71% of deaths within 2 weeks of release from incarceration are due to overdose
- Medication decreases overdose death by 60%

Reasons for relapse:

- **Ongoing withdrawal symptoms**
- **Protracted withdrawal**
  - **Fatigue, insomnia**
  - **Poor tolerance to stress & pain**
  - **Cravings**
- **Triggers (conditioned cues)**

Source: Kleber (2007) Dialogues Clin Neuroscience

SUMMARY

ASAM

- Using opioid agonists is recommended over abrupt cessation
- Initiate buprenorphine after objective evidence of withdrawal
- Provide adequate buprenorphine to suppress withdrawal symptoms

NCCHC

- Using opioid agonists is recommended over abrupt cessation
- Screen everyone for withdrawal
- Initiate buprenorphine after evidence of moderate withdrawal

- ✓ Take a good history
- ✓ Use the COWS but most importantly
- ✓ **Use your observations & judgement**

QUESTIONS

EVALUATION

1. Overall, today's webinar was:
   A. Very useful
   B. Somewhat useful
   C. Not very useful
   D. Not useful at all

2. The material presented today was:
   A. At the right level
   B. Too basic
   C. Too detailed

CONTACT US

FOR ANY QUESTIONS OR COMMENTS

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Contact your HMA coach to discuss how to apply today's learnings.

A link to the recording of today's webinar and the slides will be posted on Addictionfreeca.org
Feel free to forward to others on your team.

HEALTH MANAGEMENT ASSOCIATES

DHCS

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UPCOMING EVENTS

Learning Collaborative #2
12/16/2020

Co-Occurring Disorders Webinar
1/21/2021

Pretrial Services Webinar
2/23/2021

Alcohol Withdrawal Management Webinar
February 2021
(Date TBD)

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