



BRITISH COLUMBIA
CENTRE ON
SUBSTANCE USE

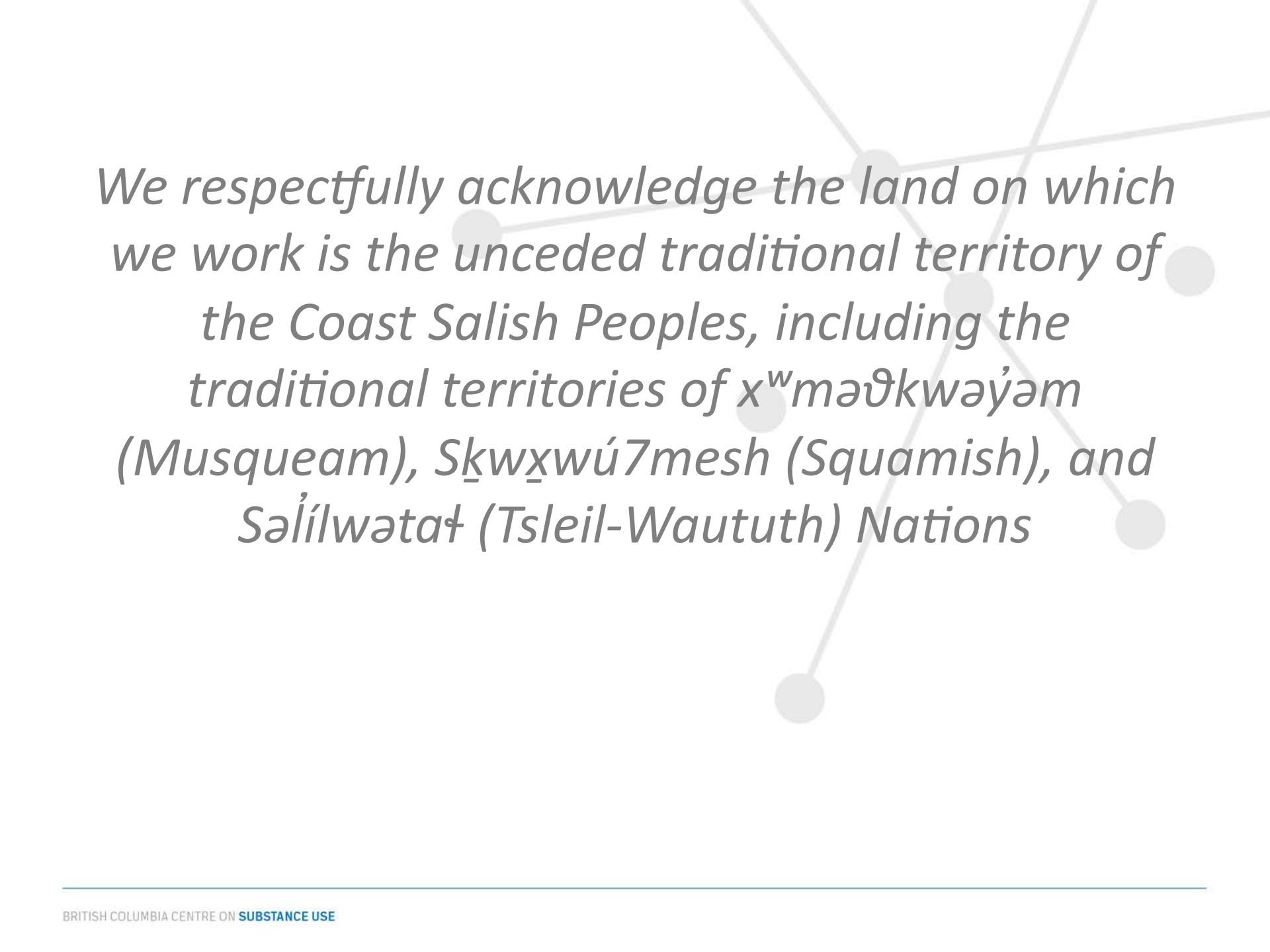
Networking researchers, educators & care providers

JUST THE NUGGETS

REVIEWING THE ESSENTIALS: OPIOID USE DISORDER IN THE ED

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We respectfully acknowledge the land on which we work is the unceded traditional territory of the Coast Salish Peoples, including the traditional territories of x^wməθkwəyəm (Musqueam), Sk̓wx̓wú7mesh (Squamish), and Səlílwətał (Tsleil-Waututh) Nations

Disclaimer 1

- Cases are based on real clinical scenarios, but have been adapted for simplicity
- Discussions will be based on simplest case examples
- Most care is nuanced!
 - Future webinars planned to review of complex presentation

Disclaimer 2



Some of the protocols described in this presentation have been developed in response to the ongoing opioid crisis due to fentanyl in the illicit drug supply, and may not be represented in current BCCSU Guidelines.

This includes innovative and novel approaches specific to emergency settings that are based on clinical experience. There is currently little evidence or research into the effectiveness of some of these protocols, therefore clinical judgement is advised.

Outline and Learning Objectives

Opening remarks and welcoming prayer

5 x 7-10 minute case presentation and discussion

- Diagnosis of opioid use disorder (OUD)
- Withdrawal management
- Buprenorphine/naloxone start
- Giving a missed dose of opioid agonist therapy (OAT) in the ED
- Harm reduction and safer use

5-10 minutes: Closing remarks and Q+A



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Diagnosis of OUD – Simplified

Case 1

- 24 YO male brought in by EHS post overdose
 - Prior history: visits for stimulant induced psychosis, no prior visits for overdose
 - Pharamanet review: no medications

Does this person have an opioid use disorder (OUD)?

Case Discussion



- What questions and sources could help you tease out a diagnosis of OUD?
- Does opioid use or overdose equate to a diagnosis of OUD?
- Do you need the DSM V to confirm?
- Which of your patients on shift should you consider screening for OUD?

The Nugget

- ✓ OUD label sticks
- ✓ Determines benefit of treatment (OAT)
- ✓ Opioid use ≠ OUD
- ✓ Keep key presentations = need to screen
 - SSTI (cellulitis, abscess), overdoses

- ✓ Always confirm through “DSM V” criteria - use shortcuts!
 - Only 2-3 criteria
 - Withdrawal
 - Cravings
 - Consequences
 - If still unclear, consider referral or review full criteria



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Withdrawal Management

Case 2

- 42 YO female presents with severe nausea, vomiting, and abdominal pain which she attributes to opioid withdrawal (feels “dope sick”)
- You suspect appendicitis and have ordered imaging.
- She now wants to leave to self treat her withdrawal.

Case Discussion

- What can you do to support her?
 - Medications?
 - Environment?
- What are important questions to ask?
- What is your approach to withdrawal management in the department?
- What are things to consider when ordering opioids for withdrawal?

The Nugget

- ✓ Let patients guide you – ask them what they need
- ✓ Always assess for possible buprenorphine/naloxone start
- ✓ If declines or contraindications → order IR opioids early
- ✓ Support referral for OAT start/continuation and community resources

ORDER EXAMPLE

- ✓ Morphine (oral liquid or tabs) 20-30mg po q2h PRN
- ✓ Indicate for withdrawal, cravings and pain
- ✓ Order hydromorphone 4-6mg po q2h PRN if renal impairment
- ✓ Reassess in 1 hour – increase to 30-40mg q2h PRN



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Starting Buprenorphine/naloxone like a Pro

Case 2 Continued

- Visit 1
 - Her CT is negative, and she improves throughout her stay.
 - Unfortunately, she leaves prior to receiving discharge instructions.
- Visit 2
 - She returns 2 days later in severe withdrawal.
 - She thought she could hold out and go “cold turkey”.
 - Her last use of fentanyl was 24 hours ago, and she wants to start the medication you suggested on her last visit – buprenorphine/naloxone.

Case Discussion



- Is this person a good buprenorphine/naloxone candidate?
- How can you confirm they are ready?
- What are you trying to avoid? How do you recognize it?
- What is your initial dose? What are you reassessing?
- Can you give larger dose?
- What are your end points?

The Nugget

- ✓ **Keys to success = avoid precipitated withdrawal**
 1. **Patient identification**
 - Time since last use: >24 hours for fentanyl
 - Signs: COWS >13 (use calculator or app)
 - Objective signs > subjective
 2. **Verbal “informed consent”**: discuss the risk and confirm plan
 3. **Reassess frequently**

- ✓ **2mg SL q1-2h**
- ✓ **Confirm taking properly**
- ✓ **Increase to 4mg q1-2h if**
 - after 3-4 doses (6-8mg)
 - if severe symptoms
- ✓ **Precipitated withdrawal**
 - Onset 15-30 min
- ✓ **Aim for 12-16mg or symptom resolution**

Plan for continuation

- ✓ **Bridging script or next day follow up**
- ✓ **Connect with supports in community**



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Dosing OAT in the ED (Methadone)

Case

- 23 YO male, PMHx OUD on methadone (MMT) 140mg
- Presents with suicidal ideation in the evening, pending assessment by psychiatry
- Missed 2 doses of MMT, and now in withdrawal
- He is requesting his dose of methadone

Case Discussion

- Is this patient appropriate to administer a dose of methadone in the ED?
- What else could you give?
- What can influence the amount of methadone to give?
 - Do you need to take other opioid use in account?
- Who could you call for guidance?
- Do you need to call their community pharmacy if a dose is given in the ED?

The Nugget

- ✓ **When?** → Prolonged stay in ED, pharmacy closed
 - Support getting dose at pharmacy as much as possible! Safest + promotes continuation on OAT
- ✓ **Who?** → Otherwise well/stable and not sedated
 - Stable, awake and talking - likely safe to give a dose. This is what happens in community pharmacies.
- ✓ **How?** → Know how many days missed by reviewing Pharmanet, but know its limitations.
 - 0-2 days missed: no changes
 - 3 days and beyond: will need dose reduction – review with provider with experience.
- ✓ **Safety?** → avoid double dosing/wrong dose
 - Always notify pharmacy of dose being dispensed
 - Know your hospital protocol for dosing
 - Reach out for help!



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Harm Reduction and Safer Use

Case

- 19 YO female presents for the first time to your ED seeking care for OUD.
- She disclosed to her family her current use after she became unwell with a forearm cellulitis. She has had several overdoses at home, since she has been using alone in her room.
- She is considering buprenorphine/naloxone in the future but does not want to start now.

Case Discussion

- How do you support her in safer use and connection to community while she considers potentially starting OAT?
- Can EDs in BC dispense safer use supplies?
- What if there are no overdose prevention sites or supervision sites in your community?
- What community resources can you tap into to support your patient outside of hospital/after discharge?

The Nugget

- ✓ **Discharge planning - promote safety and support**
 - Reduce harms of infection: safer use supplies, disposal containers
 - Reduce harms of overdose: THN, apps or overdose hotlines, OPS/SCS
 - Support connection to community: outreach and/or peer support if available, clear pathways for patients and family
- ✓ **Set your ED up for safer use supplies**
 - <https://towardtheheart.com/> for delivery
- ✓ **Think beyond the pamphlet – support your patients in accessing resources**

24/7 Addiction Medicine Clinician Support Line



Telephone consultation for physicians, nurse practitioners, nurses, mid-wives, and pharmacists providing addiction and substance use care.

Available 24/7, 365 days a year. More info at www.bccsu.ca/24-7.

CALL 778-945-7619

Provincial Opioid Addiction Treatment Support Program



Provincial Opioid Addiction Treatment Support Program

Online Course



Next Webinar – Buprenorphine/ Naloxone in the ED

November 25th 2021



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[https://www.bccsu.ca/
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CONTINUING PROFESSIONAL DEVELOPMENT
FACULTY OF MEDICINE

LOUD in the ED presents

BUPRENORPHINE/NALOXONE IN THE ED

Join us for a case-based discussion!

This will be session 2 of 6 in a webinar series exploring ways to enhance care experiences for the treatment of people with opioid use disorder in the ED.

In our second webinar, we will review the management of precipitated withdrawal, emerging approaches to starting buprenorphine/naloxone and micro-inductions.



**November 25, 2021
5:00 PM to 6:30 PM**

**Register at
bit.ly/EDessentials2**

Keep an eye out for the rest of the series!

Dec 14: Not just naloxone, Advancing a First Nations Perspective

Jan 20: Creating safer care experiences

Feb 2022: Managing pain and withdrawal in patients with OUD in the ED

Mar 2022: Overview of medication for OUD





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