Managing Opioid Withdrawal in the Emergency Department With Buprenorphine

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OVERVIEW

Emergency departments (EDs) provide acute treatment for patients with opioid use disorder, including opioid overdose and opioid withdrawal, and serve as access portals for the initiation of medication-assisted therapy (also called medication for addiction treatment, or medication for opioid use disorder). To combat the public health crisis associated with opioid use disorder, the surgeon general, the Centers for Disease Control and Prevention, state governments, and many others have called on EDs to improve the quality of care offered to this patient population, particularly through the expanded use of buprenorphine.

Although much attention has focused on treatment of patients with opioid overdose, opioid withdrawal is a high-risk period that is associated with elevated mortality after discharge. More than half of patients who died from an opioid overdose were noted to have had a medical visit in the year before their death. Abstinence without medical intervention, whether voluntary (eg, "cold turkey," abstinence-based treatment) or involuntary (eg, incarceration), further increases the risk for overdose.

Because treatment of opioid withdrawal is a starting point for induction into medication-assisted therapy, the two are difficult to disentangle. In fact, they do not need to be separated, and they are discussed here together.

PATHOPHYSIOLOGY: WHO IS AT RISK FOR OPIOID WITHDRAWAL?

Opioid dependence must be present, by definition, for an individual to develop opioid withdrawal. The time course for the development of opioid dependence is variable, generally from days to weeks, contingent on factors such as the specific opioid formulation and routes and frequency of administration. Use of short-acting opioids such as heroin or oxycodone several times daily for at least 2 weeks is needed before opioid dependence develops. Furthermore, the degree of dependence, and thus the severity of opioid withdrawal, is directly related to the intensity (eg, dose, duration, continuity) of exposure. After sustained exposure, μ-opioid receptors adapt to the presence of opioid agonists, which tonically suppress neuronal excitability. When the μ-opioid receptors are unbound, neuronal disinhibition and hyperexcitability result in the clinical findings of opioid withdrawal.

OPPIOID WITHDRAWAL SYNDROMES

Opioid withdrawal manifests as 2 distinct yet reinforcing subsyndromes, psychological and physiologic. The physiologic findings include restlessness, nausea, vomiting, diarrhea, piloerection, diaphoresis, yawning, mydriasis, and mild autonomic hyperactivity. The psychological effects, including pain, anxiety, stress intolerance, irritability, and drug craving, coincide with the physiologic signs but may persist for weeks to months after physiologic normalization.
DIAGNOSIS AND ASSESSMENT OF OPIOID WITHDRAWAL

Opioid withdrawal is a clinical diagnosis based on the physical examination and patient history. There are several tools that may be used to assist in evaluation of opioid withdrawal severity. The most widely used tool is the Clinical Opiate Withdrawal Scale. The scale grades severity from 0 to 36 points in accordance with the evaluation of typical effects, including pulse, pupillary size, restlessness, and yawning. Although the scale was not developed for use as a guideline for buprenorphine initiation, its long-standing use in this role has been valuable.10 Unobserved or “home” induction, which is finding increasing use from the ED, is often guided by the Subjective Opioid Withdrawal Scale.11

TREATMENT OF OPIOID WITHDRAWAL

Although very uncomfortable, opioid withdrawal is rarely life threatening. However, untreated opioid withdrawal commonly results in return to high-consequence opioid use, with a high risk of overdose death after discharge from the ED.6,12,13 There is increasing pressure to make medication-assisted therapy a standard practice; Massachusetts recently mandated ED treatment of opioid use disorder.14 Nevertheless, despite the strong evidence supporting the benefit of medication-assisted therapy, there remains substantial variation in personal, institutional, and regional culture in opioid use disorder treatment approaches.11

Nonopioid Treatments

Self-treatment of opioid withdrawal (eg, kratom) and nonopioid pharmacologic treatment are described in Table 3.15,16

Opioid Agonist Treatment

The evidence-based approach and growing consensus in the ED is to use an opioid agonist (a form of medication-assisted therapy) to both treat opioid withdrawal and bridge to long-term treatment. Buprenorphine and methadone are both widely used and highly effective in safely stemming the physiologic and psychological effects of opioid withdrawal.17 Although hospital logistics often dictate the decision, buprenorphine is the preferred option in the ED.

Methadone is a full agonist at the μ-opioid receptor and commonly used through opioid treatment programs for maintenance treatment, with daily oral doses ranging from 10 mg to greater than 100 mg. A methadone dose of 10 mg intramuscularly or 20 mg orally significantly reduces the Clinical Opiate Withdrawal Scale score in ED patients with opioid withdrawal.18 At this recommended dose, methadone will not lead to consequential sedation or respiratory depression in awake patients.

Buprenorphine is a unique μ-opioid receptor partial agonist with minimal euphoric reward and a ceiling effect on both sedation and respiratory depression. It is generally administered as a sublingual (not swallowed) tablet or strip and is available for intravenous use as an analgesic.
There is currently no definitive approach to the ED dosing strategies for buprenorphine. Office-based clinical guidelines for induction are not practical for ED use because of their low dosing and slow titration.  

There are few formal studies of buprenorphine for the treatment of opioid withdrawal. In 2 small studies, patients with a history of heroin use who presented in withdrawal (Clinical Opiate Withdrawal Scale score \( \geq 13 \)) and were receiving 8 mg SL and had a mean reduction in Clinical Opiate Withdrawal Scale score of 7 points (from 15 to 8), whereas those treated with 24 mg SL buprenorphine experienced a larger mean reduction in Clinical Opiate Withdrawal Scale score (from 17 to 2). Given the paucity of approaches that are ED specific, there is variation in current practice. In general, patients in the ED can be expected to require buprenorphine at least 8 mg SL to achieve substantive relief, and the majority of patients markedly improve with a 16-mg SL total dose; the maximum is 32 mg SL. 

Excessive buprenorphine dosing causes mild sedation, but the use of insufficient buprenorphine risks the premature return of opioid withdrawal and craving during the high-risk period immediately after discharge from the ED. For this reason, certain guidelines recommend up to 32 mg SL as an induction dose to prolong the duration of opioid withdrawal suppression after discharge. Reasonable caution, particularly in regard to the elderly, patients with decreased respiratory function, or those with co-occurring sedative use, should be exercised when higher doses are used. 

An immediate concern with initiating buprenorphine is the displacement of a full agonist by a partial agonist that can result in precipitated opioid withdrawal. The development of precipitated opioid withdrawal depends on several factors, including the relative plasma concentrations and receptor affinities of the agonist and partial agonist. For example, the relative antagonism after administration of a large dose of buprenorphine (partial agonist/high binding affinity) to a patient receiving methadone (full agonist/low binding affinity) will likely result in precipitated opioid withdrawal, whereas patients receiving buprenorphine can receive full-agonist opioids for analgesia without concern for precipitated opioid withdrawal.

The relief provided by buprenorphine increases with worsening opioid withdrawal severity and increased dose of buprenorphine. Although a Clinical Opiate Withdrawal Scale score of 8 is a suggested minimum for initiation by some guidelines, at least one objective sign of opioid withdrawal indicates readiness to initiate buprenorphine. More conservative guidelines suggest withholding buprenorphine until the Clinical Opiate Withdrawal Scale score is 13. Particular caution should be taken with patients receiving methadone; most guidelines recommend waiting at least 48 hours since last use and until objective signs of withdrawal are present.

There is no consensus for the optimal initial buprenorphine dose. Some guidelines recommend a lower initial dose of buprenorphine (eg, 2 to 4 mg SL). However, because the treatment for buprenorphine-precipitated opioid withdrawal is administration of additional buprenorphine, a larger initial dose may carry less risk of precipitated opioid withdrawal. This seemingly paradoxical effect occurs because of optimization of partial agonist stimulation as the buprenorphine dose increases before reaching its ceiling dose.  

Although no single algorithm can account for the clinical complexity encountered in emergency practice,
A reasonable approach is shown in Figures 1 and 2. A common induction target dose before ED discharge is 16 mg SL, which may be comfortably increased as provider experience and judgment increase. A recently available injectable depot formulation provides several weeks of opioid withdrawal suppression, but it is costly and has not yet been studied for use in the ED.

**Figure 1.** Algorithm for treatment of opioid withdrawal. *BID*, Twice a day.

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**Clinical Diagnosis of Uncomplicated Opioid Withdrawal**

*based on history and physical exam*

- Confirm time since last opioid use (typical)
  - Short-acting (e.g., heroin, morphine IR): >12 hours
  - Extended release formulations like OxyContin*): >24 hours
  - On methadone maintenance: >72 hours (consider methadone in these patients)

**Assess Withdrawal Severity**

*Objective signs and Clinical Opiate Withdrawal Scale (COWS)*

- Mild or less (COWS < 8)
  - No buprenorphine indicated
    - Re-assess patient and COWS in 1-2 hours
- Moderate to severe (COWS ≥ 8)
  - Give buprenorphine 4-8 mg SL based on severity of withdrawal
    - Re-assess after 30-60 min
      - If clinical withdrawal present?
        - No
        - Yes

**Discharge planning**

*Providers should maximize the total dose administered.***

**X-waiver.** Prescribe 16mg SL buprenorphine/naloxone daily for 3-7 days, or until follow-up appointment if known.

**Non-X-waiver.** Patients may return for up to 3 days in a row for interim treatment.***

**Follow-up**

All patients should be provided the highest level of available care navigation assistance and the shortest possible wait time to a follow-up appointment with a treatment/recovery provider. Warm handoff preferred if available.

**Preventative Health**

Strongly consider offering overdose prevention education, a take-home naloxone kit, hepatitis C and HIV screening, and reproductive health counseling.

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**Administer Additional Buprenorphine 8-24 mg SL**

*(Target 16 mg SL total for most patients)*

- **Sample discharge prescription for a 3-day supply**
  - Buprenorphine/naloxone 8 mg/2 mg SL tablet or film
  - Take 2 tablet/film once daily in AM
  - Dispense #6
  - No Refills
  - [can be used BID, with appropriate dose adjustment]

**High Dose Option**

Higher initial total doses of 24-32 mg may increase the magnitude and duration of withdrawal relief.

*Good option for patients with barriers to follow-up care, such as lack of insurance or housing*

*Discharge prescription can still be written as above*

*The risk of over-sedation and respiratory depression is increased, especially if combined with alcohol, benzodiazepines or other sedatives.*

**Precipitated Opioid Withdrawal**

If after buprenorphine: administer additional buprenorphine, up to 16 mg.
If after naloxone: Expert opinion varies, buprenorphine may be tried but withdrawal short lived
If after naltrexone: buprenorphine should be considered

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*Complicating factors include viable pregnancy, chronic opioid therapy for pain, anticipated surgery, methadone use, intoxication with alcohol, benzodiazepines, or other sedative, post overdose reversal with naloxone, serious acute medical illness such as heart failure, liver failure, kidney failure, or respiratory failure.*

*www.samhsa.gov/programs-campaigns/medication-assisted-treatment/legislation-regulations-guidelines/special*
Initial clinical assessment

- Is the patient experiencing moderate opioid withdrawal (OW)? The clinical opioid withdrawal scale (COWS) may be used if unsure,
- Is the time since last use of opioid consistent with OW?
- Is there a complicating factor to be addressed prior to administration of buprenorphine?
  - Mild withdrawal—is it too early for buprenorphine administration?
  - Altered mental status—co-intoxicant, decompensated psychiatric disease
  - Methadone use—methadone is usually a better option
- No laboratory testing is required, pregnancy testing, Hepatitis C and HIV, and urine drug screening may be offered.
- No initial counseling or psychosocial intervention is required.
- Interest in long-term treatment is not required.

First dose

- Typically, 4-8 mg sublingual (SL) buprenorphine or buprenorphine/naloxone
- Initial doses ranging from 2-32 mg SL may be considered depending on the clinical situation

Clinical Reassessment at 30-60 minutes

- Marked and unequivocal improvement in signs and symptoms confirms clinical diagnosis of OW and that buprenorphine is well tolerated.
- Lack of improvement should provoke reassessment of the clinical situation and treatment.
  - Is there a primary medical issue such as sepsis from an injection-related infection?
  - Is there persistent or worsening (precipitated) withdrawal suggesting insufficient partial agonism (higher buprenorphine dose needed, up to 16 mg)?
  - Is there worsening withdrawal suggesting antagonist effects (POW?)

Completion of treatment and discharge

- If the patient is comfortable after the first dose no additional treatment is required.
- Additional doses can be administered in the ED to prolong duration and magnitude of effect; typical daily doses of SL buprenorphine range from 8-32 mg.
- X-waivered
  - Prescribe for patients wishing to continue buprenorphine treatment or as a harm reduction rescue measure
  - Prescribe sufficient days of buprenorphine for patients awaiting entry into a treatment program
  - In general, the prescribing X-waiver provider must have a face-to-face visit with the patient. Under emergency circumstances a two-way audio-visual encounter (Telehealth) can be used to provide up to a 5-day prescription.
- Non-X-waivered
  - Provide a patient awaiting entry to a treatment program with once-daily direct administrations of buprenorphine for up to three consecutive days from the ED.
  - Care navigation will increase rates of engagement in long-term treatment for OUD and should be provided if local resources allow.

Complicating factors

- Is there a viable pregnancy? If so, fetal monitoring during treatment may be considered. Pregnancy is not a contraindication to the use of buprenorphine with our without naloxone.
- Is the patient under full agonist treatment for either pain or OUD? If so, methadone may be the more appropriate treatment.
- Will the patient require surgery or full agonist opioids for acute pain? If so, full agonist opioid may be the more appropriate treatment. Alternatively, buprenorphine can be started and continued as a lower dose, more frequently dosed regimen, such as 2-4mg Q 4-8 hours, with additional high-affinity full agonist opioids as needed.
- Opioid withdrawal co-occurring with sedative intoxication (alcohol, benzodiazepines) may require complex management not easily protocolized. The PDMP may include information about other controlled substance prescriptions that may contribute to substantive withdrawal.
- Expert opinion varies on the optimal timing for buprenorphine administration after naloxone-POW. Better understanding of both the complex pharmacokinetic interactions involved and clinical study is required before evidence-based clinical recommendations are possible. Buprenorphine should be strongly considered in a patient with naltrexone-POW.

Figure 2. Guideline for treatment of opioid withdrawal. OUD, Opioid use disorder; PDMP, prescription drug monitoring program.
REGULATORY AND LEGAL ISSUES

It is a common misconception that the administration of buprenorphine requires a Drug Addiction Treatment Act of 2000 X-waiver. In fact, short-term treatment with direct administration of any opioid approved for use in maintenance or detoxification treatment (typically buprenorphine or methadone) is permitted under the “3-day rule” (Title 21, Code of Federal Regulations, Part 1306.07). Under this rule, discharged patients may return to the ED daily to receive the medication for up to 72 hours. An X-waiver is required to prescribe buprenorphine for the treatment of opioid use disorder. Any provider who holds a Drug Enforcement Administration registration may apply for an X-waiver after an 8-hour training program and examination. Although abbreviated training programs designed for emergency physicians may provide the needed tools for ED buprenorphine use, they currently do not suffice to gain prescribing privileges. Prescribing methadone for opioid use disorder is not covered by an X-waiver and is not allowed outside of an opioid treatment program. However, admitted patients with opioid use disorder may receive buprenorphine or methadone indefinitely to permit the ongoing treatment of a concomitant medical issue.

Buprenorphine diversion may occur, but its abuse potential and risk profile remain substantially better than that of full-agonist opioids. State prescription drug monitoring programs typically collect buprenorphine dispensing data and specifically omit data on opioid treatment program dispensing of methadone (by law).

State law and insurance providers vary in their requirements for previous authorization and other administrative expectations. These sometimes impede the ability to readily obtain prescribed buprenorphine, although an ED pharmacist or care coordinator may provide assistance.

DISSPOSITION

Local resources determine the available options for patients who would like to continue buprenorphine treatment. As noted, providers with an X-waiver can prescribe buprenorphine until the next available treatment appointment. If no waivered provider is available, a systematic plan for next-day or at least rapid follow-up should be developed. This may include a warm handoff to a treatment provider (eg, face-to-face interaction), which results in better treatment engagement than an appointment or a referral. More advanced programs include care coordinators, a “bridge clinic” (perhaps as part of the ED) for immediate treatment access, or a recovery coach program to assist in navigating the health care system. Although long-term engagement in outpatient opioid use disorder treatment is always the goal, because of the fragmented system of care return visits to the ED should not be discouraged.

For admitted patients, buprenorphine or methadone will reduce craving and the risk of leaving against medical advice because of untreated opioid withdrawal.39 As with many ED therapies, those started in the ED are often continued in the hospital; ED partnership with hospital-based care teams will promote continuity of treatment and engagement in long-term treatment after discharge.

SUMMARY

Because EDs have the opportunity to influence opioid-related morbidity and mortality, developing a systematic approach is increasingly important to optimize patient outcomes. The best-practice approach supports the administration of buprenorphine in the ED, with adequate titration to both quell withdrawal and mitigate the risk of opioid use after discharge. This initial dosing serves as induction into medication-assisted therapy, and rapid referral, preferably directly to a treatment program, is optimal. Return visits for buprenorphine dosing for up to 3 days or prescribing buprenorphine for a duration needed to ensure treatment access is an alternative.