An Office-Base Induction of Buprenorphine/Naloxone using PEER Guideline

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PEER PATIENTS EXPERIENCE EVIDENCE RESEARCH

Faculty/Presenter Disclosures

- **Faculty: Jessica Kirkwood: Clinical Lecturer UofA, Boyle McCauley Health Centre**
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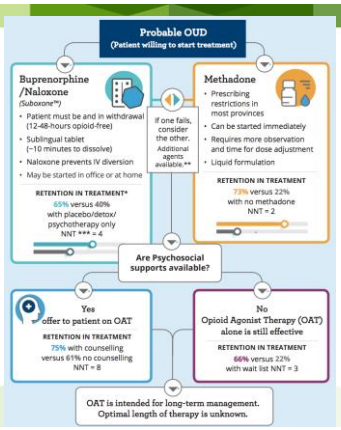
Learning Objectives

At the end of this session, participants will be able to:

- Initiate a patient on Buprenorphine/Naloxone
- Provide ongoing care and support



About Buprenorphine/Naloxone

- Buprenorphine + Naloxone
  - Naloxone present to deter IV misuse
- Administration: Sublingual tablet
  - 2 generic dosing strengths - 2mg/0.5mg & 8mg/2mg
- Mechanism of Action: Partial opioid agonist, high affinity for mu receptor
- Most common adverse events: Nausea, Constipation
- Onset of action: 30-60 mins
- Peak effect: 1-4 hours
- Duration of action: Up to 2-3 days at higher doses

Suboxone Training Program Handbook - https://www.suboxonetrainingprogram.ca/wp-content/uploads/2017/09/SUBOXONE-Training-Program-Handbook-1.pdf

Think of a car

Methadone = a fast car going 180 Km per hour

Buprenorphine = A car going 50 Km per hour

Naloxone = 0 Km per hour

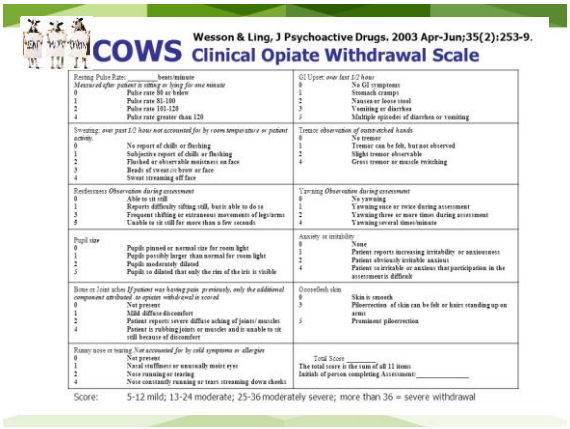
https://www.youtube.com/watch?v=3D9UiyddtDM

Precipitated Withdrawal

- Buprenorphine has a **high affinity** for the opioid receptors and will displace other opioids off the receptors
- Because it has **lower intrinsic activity**, the person goes into precipitated withdrawal because the receptors are only partially stimulated
- If this happens, it causes opioid **withdrawal** symptoms

Office-Based Induction

- **In order to avoid precipitated withdrawal:**
  - Ensure there has been a **minimum time period** since last opioid use
    - 12-24 hours since last use/dose
  - Evaluate the patient to see if they are in moderate-severe opioid withdrawal state
    - **Clinical Opioid Withdrawal Scale (COWS) > 12**
  - Provide the patient with a **low initial dose** to minimize risk of precipitating withdrawal

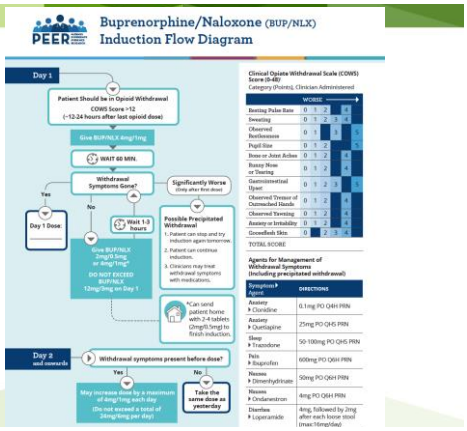


COWS Clinical Opiate Withdrawal Scale

Wesson & Ling. J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

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 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 Piloerection of skin can be felt or hairs standing up on arms 5 Prominent piloerection
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: _____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal



Office-Based Induction: Day 2

- The daily dose is established as equivalent to the total amount that was administered on Day 1 plus additional doses for day 2.
- Doses may be subsequently increased in 4 mg increments each day as needed for ongoing treatment of withdrawal symptoms and cravings
- Dose may be increased to a maximum dose of 24 mg /day
- If side effects occur, the dose should be maintained or lowered until side effects resolve

Home Inductions

- Take-home inductions can be an effective alternative to office based inductions, for some individuals.
- Provide the patient with the Subjective Opiate Withdrawal Scale (SOWS) as a way to self-measure their level of withdrawal.
- Provide education to the patient about the need to be in withdrawal before starting the buprenorphine/naloxone.
- Ideally, the patient should be able to call a provider with questions

Caring for a Patient on Buprenorphine/Naloxone

- The goal dose is 16 – 24mg. You can adjust up or down by 4 mg per day.
- See the patient weekly until they are stable, then extend the prescriptions to every 4 weeks, or longer, depending on patient stability.
- If ongoing cravings, withdrawal or substance use can consider increasing beyond 24mg.

Ongoing Care for a patient on OAT

- When seeing a patient for a follow up visit ask:
  - Adequate dose?
  - Side effects?
  - Substance Use?
  - Cravings?
  - Sleep?
  - Psychosocial functioning

OAT and concurrent Benzodiazepine use

- Opioids and benzodiazepines both decrease respiratory drive.
  - should not be co-prescribed.
- Observational data suggests:[1,2]
  - 6x increased risk of opioid overdose death when sedative-hypnotics are combined with opioids.
  - In patients on OAT for OUD, this risk is lower at ~2x
- If a patient is on benzodiazepines, prescribed, or illicit, that is not a reason to withhold OAT.

Med Care. 2017 Jul;55(7):661-668. Drug Alcohol Depend. 2017 May 1;174:58-64.

Special Considerations

- Pregnancy
- Acute pain or injury
- Elective Surgery
- Hospitalization
- Incarceration
- Bottom Line: Do NOT stop OAT for any of these circumstances.

Tapering

- Involuntary
  - Risks > Benefits?
- Voluntary
  - Pt driven
  - Maximize chance of success
  - Poor prognosis if - using other substances, pregnant, unstable physical or mental health, poor psychosocial fxn
  - May take up to a year or longer to successfully complete cessation and few pts have a good prognosis

Questions?