Last edited Apr 15, 2020

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Nursing Resource: Assessment and Management of Opioid Withdrawal

Opioid withdrawal can range from mild to severe. Unlike severe alcohol withdrawal, which can be life-threatening if untreated, the main medical risks of opioid withdrawal relate to secondary dehydration or electrolyte disturbance, and risky behaviour due to severe cravings. Buprenorphine/naloxone (Suboxone) is a very effective treatment for moderate-severe opioid withdrawal, and if available, should be considered first-line therapy for both acute symptom management and chronic treatment of opioid use disorder.

Telephone triage:

- If the patient is intoxicated or in severe distress and not making sense, ask them to pass the phone to someone in the household who is more sober and can give you more reliable information
- Remain calm and reassure the patient that you are here to help
- Find out what the patient's agenda is for the phone call, what they are asking for or concerned about
- Assess substance use history
    - Pattern of opioid use - Which opioids are used, how frequently, by which routes (ie. oral, nasal, or intravenous), and when they started using (ie. age or how many months/years ago). Date and time of last opioid use.
    - If using intravenously, ask about sharing and/or reusing needles or other injection equipment (spoons, filters, etc)
    - Any other substance use - alcohol, stimulants, benzos, prescription meds
    - History of withdrawal - Usual timeline and severity of withdrawal symptoms. What has helped in the past with their withdrawal?
- Assess current symptoms (use COWS score)
    - Physical - chills/sweats, body aches, nausea, diarrhea, tremor, runny nose, yawning, goosebumps, dilated pupils
    - Mental - restlessness, anxiety, irritability, cravings
- Review medical history and chronic meds (patient history and chart). If they are prescribed chronic meds, ask when they actually took them last.
- Decide whether they need to be assessed in person
    - Severe symptoms (COWS >36)
    - Acutely suicidal and unable to make a safety plan over the phone
    - Possible overdose or worrisome co-ingestions
    - High risk medical conditions (eg. uncontrolled T2DM with risk of DKA, meds that put them at particular risk of acute kidney injury or electrolyte disturbance)
    - Concern about possible bacteremia, endocarditis, osteomyelitis/discitis, etc

    - Evidence to suggest the patient may have unstable vital signs or dehydration (eg postural dizziness, palpitations, audible shortness of breath)
    - RN concern - strong feeling the patient should be assessed in person

Assessment (either via phone/video or in person if appropriate):
Try to collect as much info as possible before calling the MD… but in the case of severe withdrawal or unstable patient, call sooner so that treatment can be initiated while you continue to gather information.

- History
    - Substance use history, PMH, meds as above. You can get more details about their opioid use over time and whether it has changed more recently due to the pandemic or other situational factors.
    - Complete a COWS score (as well as possible given limitations of phone assessment) and have the form handy when you call the MD (they'll want the total, but may also ask which symptoms scored the highest)
    - Treatment history - Have they ever been on suboxone or methadone? If yes, when was that, and why did they leave the program? If they haven't been in a formal suboxone treatment program, have they ever bought suboxone and used it on their own to help with withdrawal symptoms?
    - Living situation - where do they live, who lives with them, any acute safety concerns at home, is there a reliable/sober person at home who can help them with their withdrawal
    - Circumstances of withdrawal - are they actively trying to stop using or are they just unable to obtain opioids at the moment? Is that likely to change?
    - Treatment goals - Are they interested in longer-term opioid agonist therapy, eg. joining the community suboxone program (if available)? If not, are they interested in pursuing abstinence, and has this ever worked for them before?
    - COVID-19 symptoms or contacts, recent travel history if applicable
- Physical exam (in person, or limited assessment done via video)
    - Vitals, gluc, general impression (well vs unwell, general mental status)
    - Physical signs of withdrawal - vomiting, tremor, agitation, sweats, dilated pupils
    - It may be necessary to defer the full head-to-toe exam until the patient's symptoms have improved
    - Don't forget to assess for possible infection and trauma in the patient with altered mental status, sweats, tachycardia, vomiting, etc
- Info from the chart:
    - Any recent lab results, details of past treatment for opioid use disorder (if available - many Health Canada charts have little to no information about community-based suboxone programs)

In-person medical management:
(note that these are guidelines, not medical directives - you will need to consult a physician for orders as usual)

- If the patient has severe vomiting or signs of dehydration or acute infection, start an iv
- If symptoms are mild (COWS <8), or if there is some contraindication to suboxone, proceed with symptom management medications (see below)
- If symptoms are moderate-severe, and no contraindications to suboxone, proceed with withdrawal management using suboxone (see below)
- Labs
    - Uncomplicated opioid withdrawal generally doesn't require any labs, but if there is diagnostic uncertainty or concern about co-occurring infection or medical illness (including acute dehydration due to severe vomiting/diarrhea) then they may be useful
    - Consider iStat Chem8, VBG, troponin if clinically appropriate
    - Consider: CBC, lytes, BUN, Cr, LFTs, gluc. Tylenol/ASA levels and urine drug screen if overdose/co-ingestion suspected, appropriate cultures if infection suspected, STI/BBI testing if pt is at risk and hasn't been tested recently
    - If the patient is being considered for the community suboxone program, there may be "admission labs" typically done by the program - consider getting these done now

Outpatient medical management

- During the COVD-19 pandemic, we are trying to support physical distancing and self-isolation measures by assessing and treating patients at home whenever possible. Innovative approaches to pandemic withdrawal management might include dispensing medication and having it delivered to the patient's home, ideally to be taken by the patient with the assistance of a reliable household member and in consultation with a nurse by phone as needed.
- If the phone triage process determines that the patient does not need to be seen in person, proceed with the full assessment by phone.
- If the assessment reveals mild withdrawal (COWS <8) - encourage oral hydration and basic supportive care (including symptom management meds if needed), and ensure the patient can call back if symptoms worsen.
- If the assessment reveals moderate-severe withdrawal (COWS >8), but no indications for in-person assessment and management, consider appropriateness for outpatient management. They should:
    - Be reasonably medically stable
    - Be safe at home and have at least one responsible household member who can assist with their treatment
    - Be able to contact the nursing station (by phone, text, or video) for ongoing follow up, and be able to get to the nursing station if needed
- Additional considerations for outpatient withdrawal management
    - The household member taking responsibility for the medication and treatment assistance should be clearly identified and the nurse should speak with them directly to ensure they understand and consent to this role

    - If suboxone treatment is being considered, the assistant will need to speak with a nurse or physician daily for dose adjustments until a stable dose is reached - ensure there is a plan for how this will happen.
    - Make a clear plan for safe storage of suboxone - ideally in a lock box
- Items to include in the package delivered to the household
    - Medications (clearly labeled) - discuss with MD what quantity to dispense
    - Lock box for suboxone, if appropriate/available
    - Instructions for the assistant, and a flow sheet for them to record assessments done and meds given
    - Contact information for the nurse monitoring the treatment
    - Patient handouts, such as the “Helping someone through alcohol withdrawal” info sheet, resources from SLFNHA, CAMH, etc.

Usual management of opioid withdrawal using suboxone:

- When COWS >8, give suboxone 4mg sl
- If symptoms improve initially, but then recur later in the day, give another 4mg sl at least 2 hours later. Maximum dose in the first 24 hours is 8mg
- Additional symptom management meds may be used as needed, but it is generally not recommended to give suboxone and clonidine at the same time due to risk of hypotension/bradycardia
- After initial stabilization:
    - If planning maintenance suboxone treatment, reassess daily. It is not necessary to do a formal COWS score each time, it is fine to just ask the patient about their withdrawal symptoms. The dose is generally increased by 2-4mg per day until withdrawal symptoms have mostly or completely resolved. Most patients stabilize within a few days at a dose of 18mg or less.
    - If unable to offer maintenance suboxone treatment, we would recommend: increase the dose daily as above until withdrawal symptoms are controlled, maintain at that dose for 1-2 days, and then do a rapid taper, decreasing the dose by 2mg each day down to zero. Patients being tapered in this way will require additional symptom management meds and a LOT of support as the risk of relapse is quite high

Usual management of opioid withdrawal using symptom management:

- Nausea/vomiting
    - Gravol 50mg po/iv/im q4h prn OR Gravol suppository 100mg pr q8h prn
    - Ondansetron 4-8mg po/iv q8h prn
- Diarrhea
    - Imodium 2mg - 2 tabs at onset of diarrhea, then 1 tab after each loose stool, Max 8 tabs per day
- Headache, body aches, pain
    - Tylenol 975mg po q6h prn

    - Ibuprofen 400-600g po q8h prn OR Naproxen 250-500mg po q12h prn OR toradol 15mg iv q6h prn
- Insomnia
    - Trazodone 50-100mg qhs prn
- Shakes, chills, sweats, anxiety, restlessness
    - Clonidine 0.1mg - 1-2 tabs po q6h prn
    - If seeing in person, give a “test dose” of 1 tab and check BP before and 60min after to assess for hypotension (a known side effect). If managing remotely, tell the patient to take only 1 tab for the first dose, and discontinue if any postural dizziness occurs.

Loss of tolerance and overdose prevention:
Any patient who undergoes opioid “detox”, whether intentional or unintentional, should be warned about the loss of tolerance that occurs when they stop using (even for a short time) and the risk of overdose if they go back to using their usual amount. Ensure they are aware that if they restart using opioids they should start with a much smaller dose than usual. If possible, ensure the household has a naloxone kit and knows how to use it.