

# Emergency Care During an Opioid Addiction Epidemic

**in withdrawal**  
desires treatment for opioid addiction

exclusions from ED buprenorphine initiation  
on methadone  
on high dose (usually prescribed) opioids  
very intoxicated (with other substances)  
buprenorphine allergy

verifying adequate withdrawal is crucial  
*if inadequate withdrawal, buprenorphine will precipitate withdrawal*  
plug COWS into your favorite medical calculator  
COWS should be  $\geq 8$ , the higher the better

you do not need to be x-waivered to treat withdrawal with buprenorphine in the ED

buprenorphine 4-8 mg sublingual  
the higher the COWS, the larger the bup dose  
if unsure of withdrawal symptoms or borderline COWS, dose 2 mg q2h

observe in ED for 30-60 minutes  
provide sandwich

optional testing during buprenorphine initiation  
HCG, urine tox, LFTs, Hep C, HIV

if waived doc present, can d/c with prescription

if expected delay in accessing buprenorphine ( $\geq 24$ h), consider high dose initiation in consultation with addiction specialist

advise on dangers of etoh/benzo use while on bup

**refer to bup-capable provider/clinic**  
the smaller the ED buprenorphine dose, the tighter the followup has to be, esp if no Rx

**in withdrawal**  
does not desire treatment

consider buprenorphine initiation anyway  
alternative: methadone 10 mg IM  
can use non-opioid Rx but much less effective  
clonidine, NSAID, antiemetic, antidiarrheal  
haloperidol, ketamine

refer to ongoing addiction care

harm reduction (see box)

**not in withdrawal**  
does not desire treatment

engage, encourage to move to treatment

refer to ongoing addiction care

**Harm Reduction** for all opioid misusers

all patients at high risk for OD should receive take home naloxone

high risk for OD: prior OD, use of illicit opioids, high daily dose ( $>50$  MME), concurrent use of sedatives, recent period of abstinence, uses alone

if IVDU, encourage safe injection practices and refer to local needle exchange/safe injection site

Do you lick your needles?  
Do you cut your heroin with sterile water?  
Do you discard your cotton after every use?  
Do you inject with other people around?  
Do you do a tester shot to make sure a new batch isn't too strong?

open door policy: if unwilling to be treated for addiction now, return anytime, we're here 24/7

**not in withdrawal**  
desires treatment for opioid addiction

if waived doc present, can prescribe buprenorphine for home initiation

alternatives:  
return to ED when withdrawing  
hold in ED to await withdrawal

refer to bup-capable provider/clinic

**Priorities for Emergency Care**

**Prevent opioid-naive patients from becoming misusers by your prescription**

calculate benefit:harm whenever an opioid prescription is considered, and if opioid Rx, prescribe small # of low dose, lower-risk pills

Immediate Release Morphine Sulfate (MSIR)  
15 mg tabs, 1 tab q4-6h prn pain, disp #9

Willing: **"I have a problem, I need help"**  
aggressive move to treatment  
ED-initiated buprenorphine  
arranged speciality followup

Revealed, unwilling: **"I overdosed"**  
harm reduction (see box)  
supportive stance, open door

Partially revealed: **"I have chronic pain and need meds"**  
avoid opioids in ED or by prescription  
opioid alternatives for pain  
express concern that opioids are causing harm

Unrevealed: **"I have acute pain and need meds"**  
risk stratify with red & yellow flags  
PDMP - move positives to willingness  
if low risk, treat as opioid-naive  
if high risk, treat as partially revealed

**buprenorphine Rx**

buprenorphine/naloxone 8/2 mg sublingual tabs  
1 tab SL bid-can dispense 6 to 14 tabs

if concern for suboxone abuse/diversion, can skip Rx or  $\downarrow$ Rx (though suboxone safer than street opioids)

alternatively, **patient can return to ED** while awaiting followup: on days 2 and 3 dose 16 mg SL  
x-waiver not required to dose in ED on days 2&3  
however cannot continue beyond 3 days by law