Opioid Use Disorder: Providing Care across the treatment spectrum.

Focus on Primary Care

Dr. Greg Carfagnini MD CCFP(EM)(AM)

Conflict of Interest: Nothing to Disclose

Speaker:
Dr. Greg Carfagnini

Presentation:
Opioid Use Disorder: Providing Care across the treatment spectrum

I have no financial or personal relationship related to this presentation to disclose.

Conflict of Interest

Speaker: Dr. Greg Carfagnini

Relationships with commercial interests:

- No payment for this presentation
- No investments in Pharmaceuticals
- No investment in Addiction Clinics
- I did receive and Honorarium from University of Toronto for work on www.machealth.ca Opioid Primer.

My Work Biases

- I am a Salaried physician at SJCG.
- I do fee for service addictions medicine at various locations in Thunder Bay and in Nipigon.
- I provide on call services for private addiction treatment centres.

My Personal Biases

- I believe all drug use should be decriminalized.
- I feel strongly that drug use is not a moral failing.
- I empathise strongly with people who use drugs and their struggles.

Outline

Introduction to Addictions, and OUD

- Scope of the problem
- How and Why of OUD
- Trauma's role
- Methadone/Buprenorphine

Providing OUD Care

- Primary care buprenorphine start
- Case Discussion
- Conclusion
- Questions

OUD, Scope of the Problem

Opioid Use and Impacts in THUNDER BAY DISTRICT

Prepared by the Situational Assessment Working Group
of the Opioid Surveillance and Response Task Force

THUNDER BAY
Drug Strategy

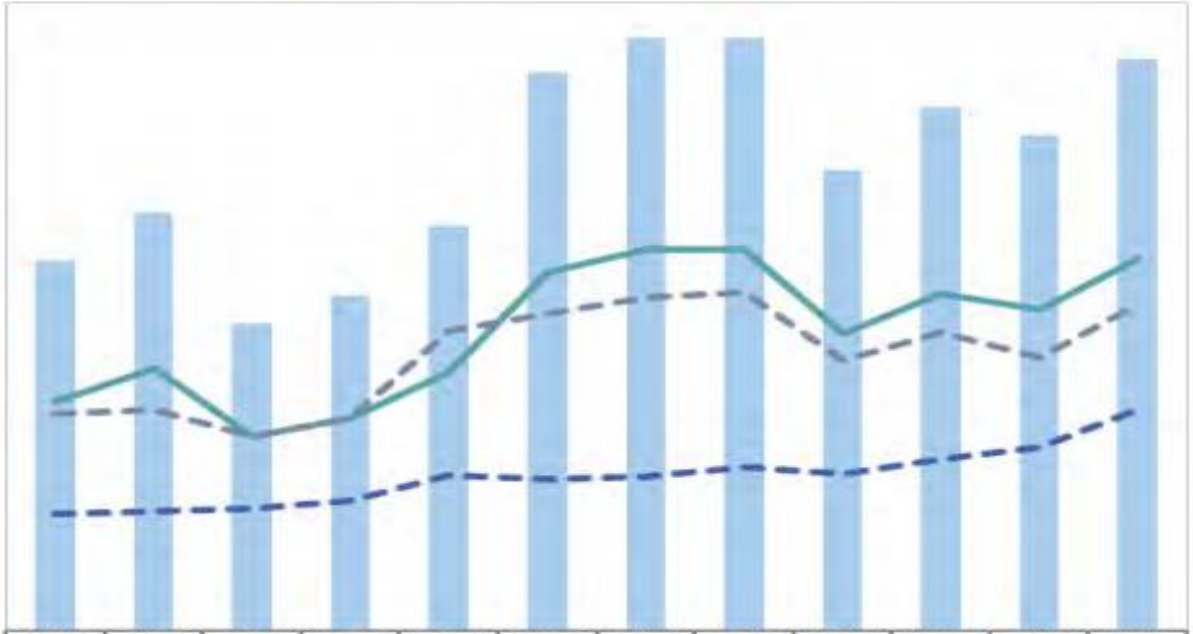
Thunder Bay District
Health Unit

The crude rate of hospitalization for opioid overdose in TBDHU was approximately 1.5 times higher than the Ontario rate for 2016 (13.6 per 100,000).

Over the last five full years of data from 2012-2016, TBDHU's crude rate of emergency department visits for opioid overdose remained almost double that of the Ontario rate.

Over the past 12 years, 220 deaths attributed to opioid overdose occurred in TBDHU. During these years, TBDHU had higher crude rates of deaths from opioid overdose than Ontario.

Figure 9. Emergency department visits for opioid overdose, 2005-2016



	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
TBDHU cases	53	60	44	48	58	80	85	85	66	75	71	82
TBDHU rate per 100,000	32.9	37.5	27.9	30.6	37.1	51.4	54.6	54.6	42.5	48.4	46.0	53.4
NWLHIN rate per 100,000	31.1	31.7	27.9	30.6	42.9	45.5	47.7	48.5	38.8	42.7	39.1	46.8
Ontario rate per 100,000	16.7	17.0	17.5	18.7	22.2	21.6	22.1	23.5	22.5	24.5	26.3	31.7

Source: National Ambulatory Care Reporting System (NACRS), 2005-2016, Ontario Ministry of Health and Long-Term Care, IntelliHealth Ontario, extracted 2017 June 1

Citation: Ontario Agency for Health Protection and Promotion (Public Health Ontario). Interactive Opioid Tool. Toronto, ON: Queen's Printer for Ontario; 2017. Available from: http://www.publichealthontario.ca/en/DataAndAnalytics/Opioids/Opioids.aspx

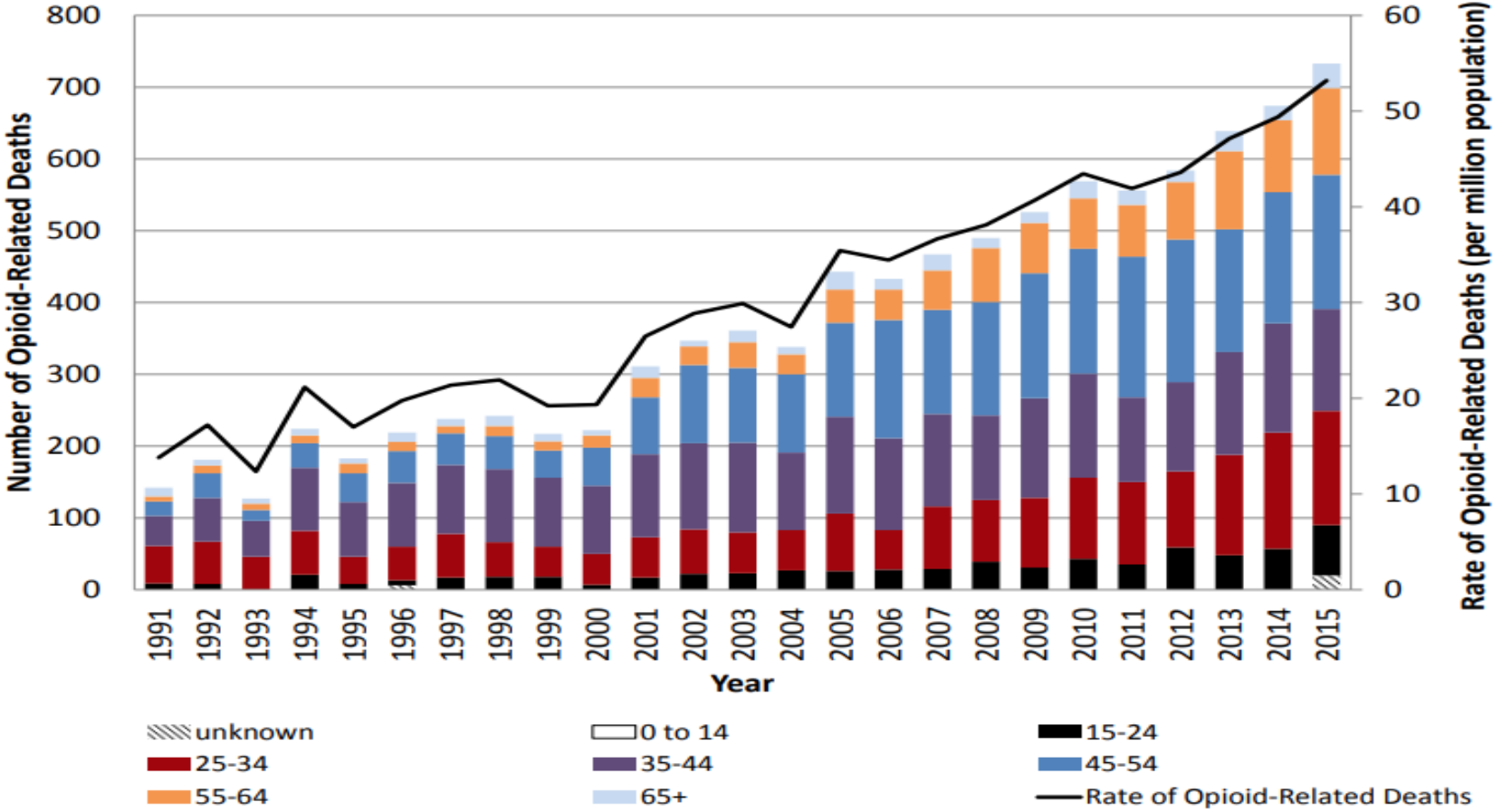
Latest Trends in Opioid-Related Deaths in Ontario

1991 to 2015

The Ontario Drug Policy Research Network
April 2017

ODPRN ONTARIO DRUG POLICY RESEARCH NETWORK

Figure 1: Trends in Opioid-Related Deaths by Year and Age Groups in Ontario, 1991 to 2015



In 2015, 734 people died of an opioid-related cause, averaging to approximately 2 people every day. The rate of opioid-related deaths has increased almost 4-fold (285%) over the past 25 years.

The Fallout

Johnson & Johnson Ordered to Pay $572 Million in Landmark Opioid Trial

Oklahoma pursued the first case against a drug manufactur
for the national public health disaster, and the ruling may
point to what lies ahead in 2,000 more lawsuits.

Mike Hunter, the Oklahoma attorney general, and Sabrina Strong, a lawyer for Johnson & John
questions after a judge ordered the company to pay the state $572 million for the destruction w
prescription painkillers. Pool photo by Chris Landsberger

By Jan Hoffman

Published Aug. 26, 2019 Updated Aug. 30, 2019

OxyContin maker offers up to $12bn to settle more than 2,000 opioid claims

Purdue Pharma stands accused of fueling US opioid epidemic that has cost the lives of more than 400,000 people across the US

▲ Protesters earlier in August outside court in Boston. Massachusetts is among several states that have brought civil lawsuits against Purdue and others. Photograph: Nic Antaya/Boston Globe via Getty Images

Purdue Pharma and members of the multi-billionaire Sackler family, who own the company that makes the prescription painkiller OxyContin, have offered to settle more than 2,000 lawsuits from US states and cities for between $10bn and $12bn.

Opioid crisis kills addicts, ruins career of a compassionate Windsor doctor

Only Ontario doctor disciplined for over-prescribing opioids agrees to give up his licence

KELLY GRANT › HEALTH REPORTER
TORONTO
PUBLISHED MARCH 26, 2018

Measuring the impact of the opioid overdose epidemic on life expectancy at birth in Canada

Table 1. Impact of accidental substance-related deaths on life expectancy at birth between 2000 and 2016 [*]

Measure	Overall	Males	Females
Life expectancy at birth 2000	79.27	76.63	81.80
Life expectancy at birth 2016	82.25	80.12	84.31
Gain in life expectancy between 2000 and 2016	2.99	3.48	2.52
Negative impact of increase in accidental substance-related deaths on life expectancy	-0.16	-0.23	-0.09
Potential gain to life expectancy if increase in accidental substance-related deaths had not occurred between 2000 and 2016	3.15	3.71	2.61
Potential life expectancy if increase in accidental substance-related deaths had not occurred between 2000 and 2016	82.41	80.35	84.40

[*] Estimates are rounded to two decimal places; as such, estimates may not add to totals.

Whose Fault is it?

- Physician’s?
- Pharmaceutical companies?
- Legal system?
- Poverty?
- The Drug user?

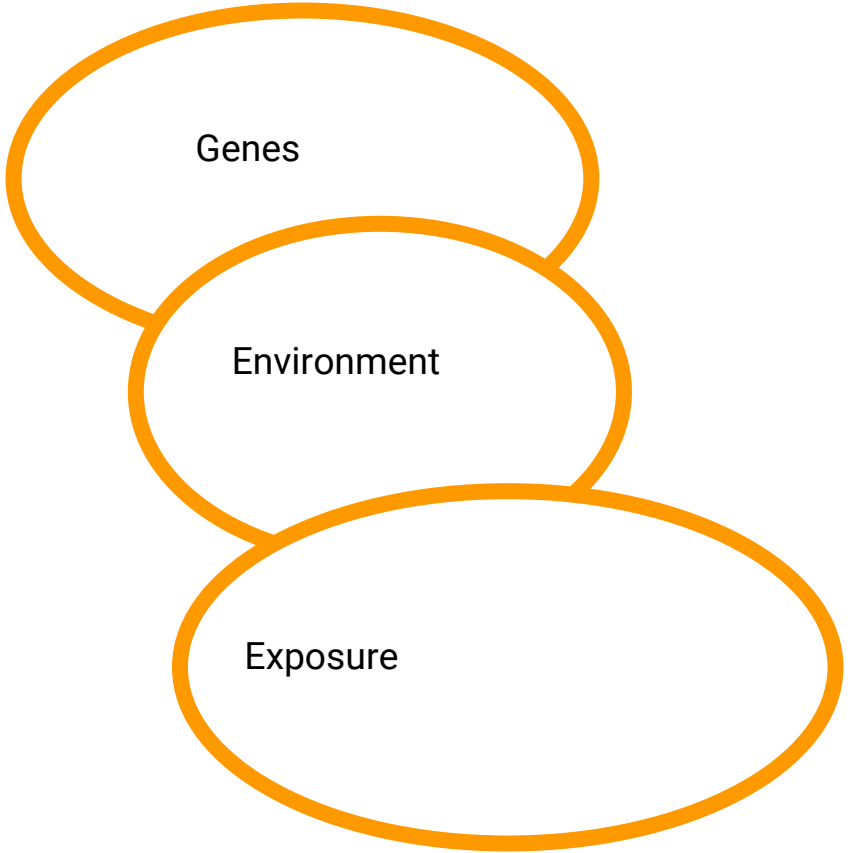
Everyone’s !

Moving Forward

- What can the Medical community do?
- Seems too big to tackle.
- We should begin with examining the factors that lead to opioid addiction.

OUD, How and Why?

Triple Threat



Genetics of OUD

It's Complicated !!!

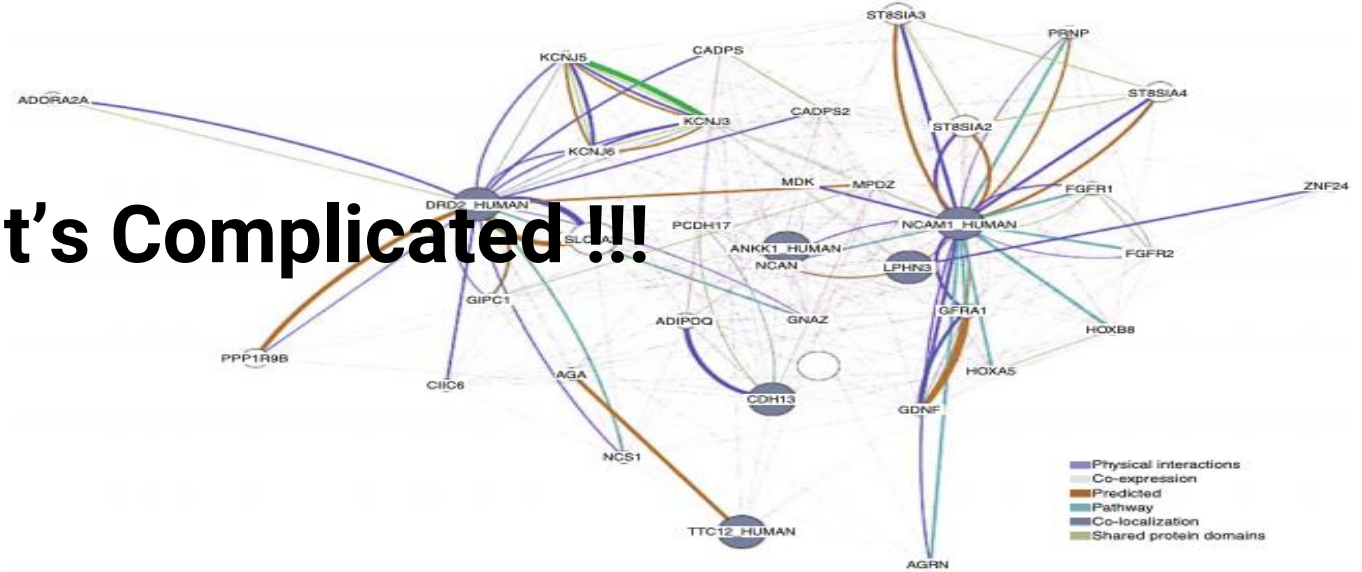


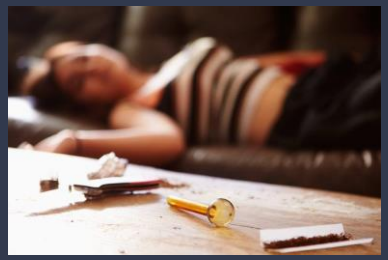
Fig. 7 Results from a formal network analysis using the *ANKK1*, *TTC12*, *DRD2*, *NCAM1*, *LPHN3*, and *CDH13* genes in order to detect significantly enriched gene categories for protein and genetic interactions, pathways, co-expression, co-localization and protein domain similarity. These selected genes were significantly replicated as being either associated and/or linked to ADHD, disruptive behaviors and SUD. Networks related to pathways involved in processes such as axon guidance, regulation of synaptic transmission and regulation of transmission of nerve impulse were overrepresented. For more information see Tables 2 and 3

Arcos-Burgos et. al. Hum genet (2012) 131:917-929

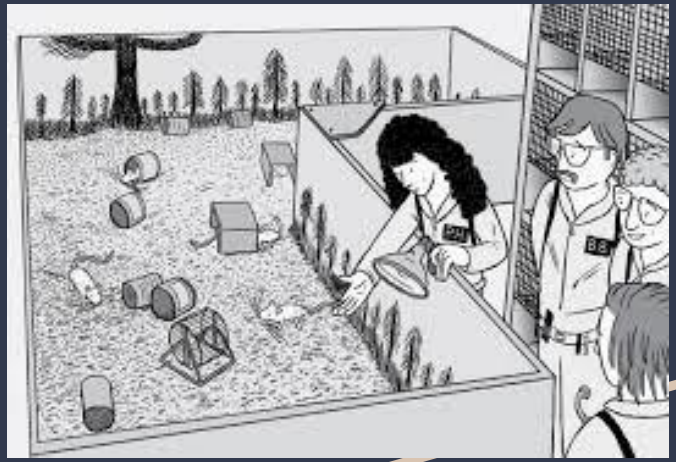
Genetics of OUD

- Multimodal gene
- No single “addiction gene”
- Research now looking at genetics of common behaviour types.
- Arcos-Burgos et. al.
    - “We provide compiled evidence of complex networks of genotypes underlying a wide phenotype that involves SUD and externalizing disorders”

The Environment



Rat Park



- An example of environmental effects on addictive behaviour.
- Served as a key study to support the biopsychosocial model of addiction.
- Only partially reproduced in follow-up studies
- Several other studies have added to the body of evidence to support the concept of environment as a key factor in addiction.

Gage, Sumnali. Rat Park: How a rat paradise changed the narrative of addiction. Addiction, 114, 917-922

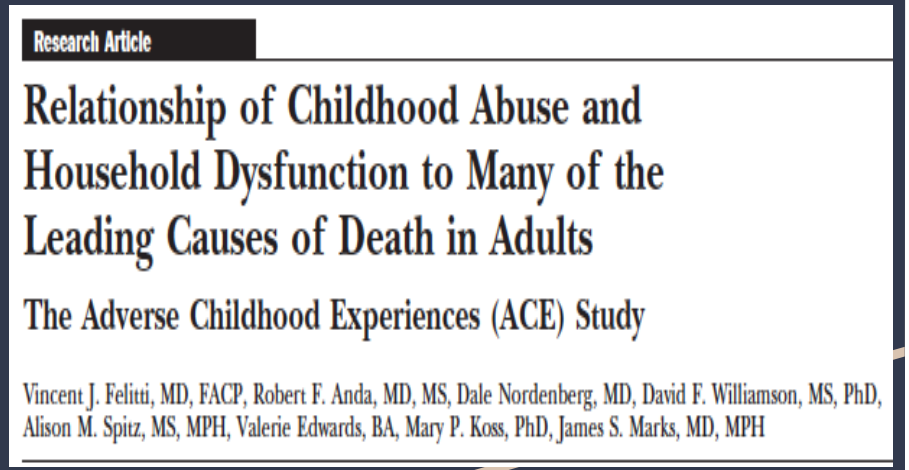
The Environment

- The other key factor studied that supports the environmental risk for addiction is:

Adverse Childhood Events

- Abuse, emotional, sexual, physical.
- Neglect, emotional and physical.
- Household Dysfunction.

ACE's
The ACE Study



Research Article

Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults

The Adverse Childhood Experiences (ACE) Study

Vincent J. Felitti, MD, FACP, Robert F. Anda, MD, MS, Dale Nordenberg, MD, David F. Williamson, MS, PhD, Alison M. Spitz, MS, MPH, Valerie Edwards, BA, Mary P. Koss, PhD, James S. Marks, MD, MPH

- 13,494 Americans studied.
- Graded relationship between the number of ACE's and adverse health outcomes.
- 4 or more ACE's resulted in 4-12 fold increase risk for alcoholism, drug abuse, depression and suicide.
- Some staggering statistics on health effects of ACE's

ACE's

- **Dube et al. Pediatrics 2003**
  - Each ACE increased the likelihood for early initiation of drug use by 2-4 fold.
  - Compared with people with 0 ACEs those with 5 or more ACE's were 7-10 fold more likely to report illicit drug use.

ACE's

- **Quinn et. al. Drug Alcohol Depend. 2016**
  - AOR for adulthood PPRM:
    - One trauma, 1.46 (1.12, 1.91)
    - Five + trauma, 3.09 (1.52, 6.30)
  - Injection Drug use
    - 4-5+ trauma's showed 5-7x the odds.

Social exclusion and traumatic events are strongly predictive of future drug use.

The Exposure

The Exposure

“..in the absence of drug exposure, itself an environmental factor, the specific addiction phenotype would remain hidden, even in the presence of an overwhelming genetic load”

Nora D. Volkow

Volkow ND. The genetics of addiction. Hum Genet (2012) 131: 773-777

The Exposure

- 20% of the population has chronic pain.
- 5.5% of patients with no pre-existing substance use disorder or psychiatric disorder will develop addiction to opioids prescribed for chronic pain.
- 8.9% for those patients with active substance use disorder.

The Exposure: Hot off the Press!

JAMA Network Open

Original Investigation | Anesthesiology

Opioid Prescribing After Surgery in the United States, Canada, and Sweden

Karim S. Ladha, MD, MSc; Mark D. Neuman, MD, MSc; Gabriella Broms, MD, PhD; Jennifer Bethell, PhD; Brian T. Bateman, MD, MSc; Duminda N. Wijeysundera, MD, PhD; Max Bell, MD, PhD; Linn Hallqvist, MD; Tobias Svensson, MSc; Craig W. Newcomb, MS; Colleen M. Brensinger, MS; Lakisha J. Gaskins, MHS; Hannah Wunsch, MD, MSc

Conclusions and Relevance The findings indicate that the United States and Canada have a 7-fold higher rate of opioid prescriptions filled in the immediate postoperative period compared with Sweden. Of the 3 countries examined, the mean dose of opioids for most surgical procedures was highest in the United States.

Key Points

Question Do rates of opioid prescriptions dispensed after surgical procedures differ among countries?

Findings In this cohort study, more than 70% of surgical patients in the United States and Canada filled opioid prescriptions after 4 surgical procedures compared with only 11% in Sweden. Of the 3 countries examined, the United States had the highest average dose of opioid prescriptions for most surgical procedures.

Meaning There is very large variability in the use of opioids after surgery in different countries, suggesting the potential to reevaluate prescribing practices.

Avoiding OUD

- Be aware of the factors that lead to addiction, i.e. remember the triple threat of addiction.
- Reduce exposure to opioids, look to other analgesia first.
- If choosing opioids, prescribe small amounts and short intervals.
- Include a risk screening tool in your chart prior to starting opioids.

Risk Screening Tools

- There are many tools available.
- Many are questionnaires for patients to fill on their own.
- Questions surrounding mental health conditions, family history of substance abuse and personal history of abuse can be triggering…. Proceed with Caution!

Opioid Risk Tool

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Scoring:
3 or less are low risk
4-7 moderate risk
8 or higher are high risk

Validity in an actual OUD population is unknown.
Must be used in a trauma informed manner.

Risk tools, Risk tools, Risk tools!

Table 1. Examples of Instruments Assessing Opioid and Nonopioid Risk

Category	Items, No.	Administered By
Patients considered for long-term opioid therapy:		
ORT: Opioid Risk Tool[7]	5	Patient
SOAPP®: Screener and Opioid Assessment for Patients with Pain[8]	24, 14, and 5	Patient
SISAP: Screening Instrument for Substance Abuse Potential[9]	5	Patient
DIRE: Diagnosis, Intractability, Risk, and Efficacy Score[10]	7	Clinician
Assess misuse once opioid treatment initiated:		
PDUQ-p: Prescription Drug Use Questionnaire-patient[11]	31	Patient
COMM: Current Opioid Misuse Measure[13]	17	Patient
PMQ: Pain Medication Questionnaire[14]	26	Patient
PADT: Pain Assessment and Documentation Tool[15]	41	Clinician
ABC: Addiction Behavior Checklist[16]	20	Clinician

https://www.practicalpainmanagement.com/

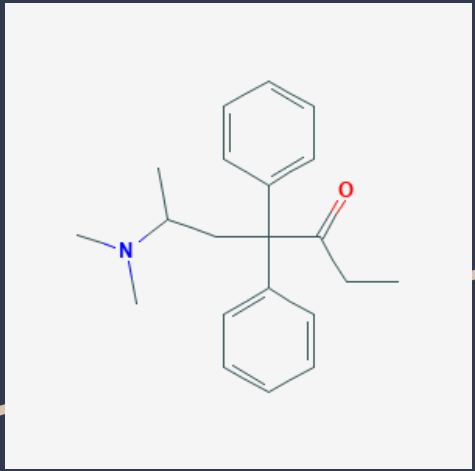
Practical Point

Reduce the occurrence of OUD by minimizing the exposure to opioids, and carefully selecting the patients to whom you prescribe opioids….. Assess the Risk!

Opioid Assisted Treatment:
Methadone and Buprenorphine

Methadone

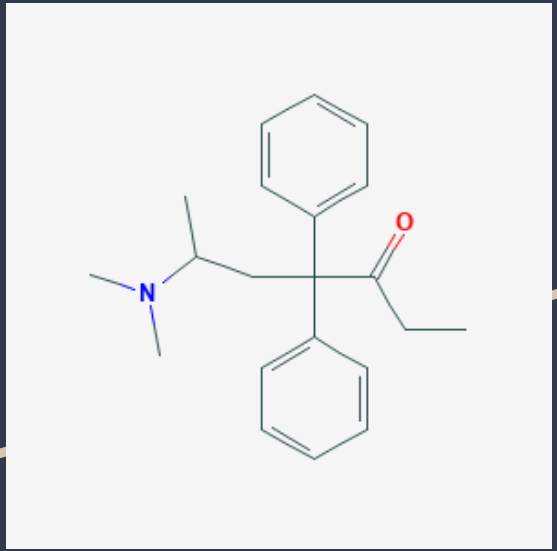
Pros



- Large body of evidence.
- Can begin treatment without withdrawal.
- Liquid form helps reduce diversion of observed doses.
- Can titrate in small amounts.

Methadone

Cons



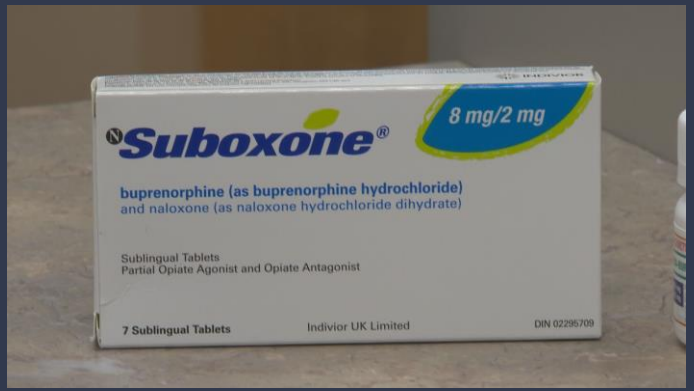
- Up until recently special CPSO requirements to prescribe.
- CPSO still recommends additional training, and will still likely scrutinize your practice.
- Takes longer to stabilize.
- Stigma.
- Has been used to create a business model.
- Narrow Therapeutic window.

The most common opioid reported on toxicological screen after death was methadone.

Cristen and Cory’s Story

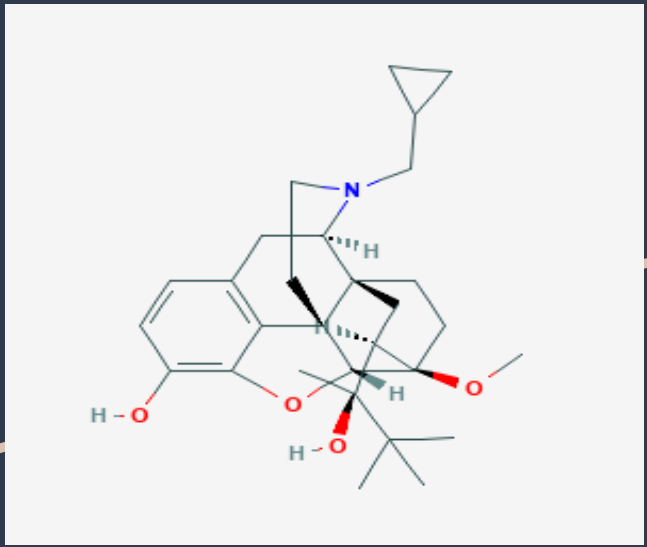
https://vimeo.com/333165345

For simplicity, I will refer to Buprenorphine/Naloxone as “Buprenorphine”

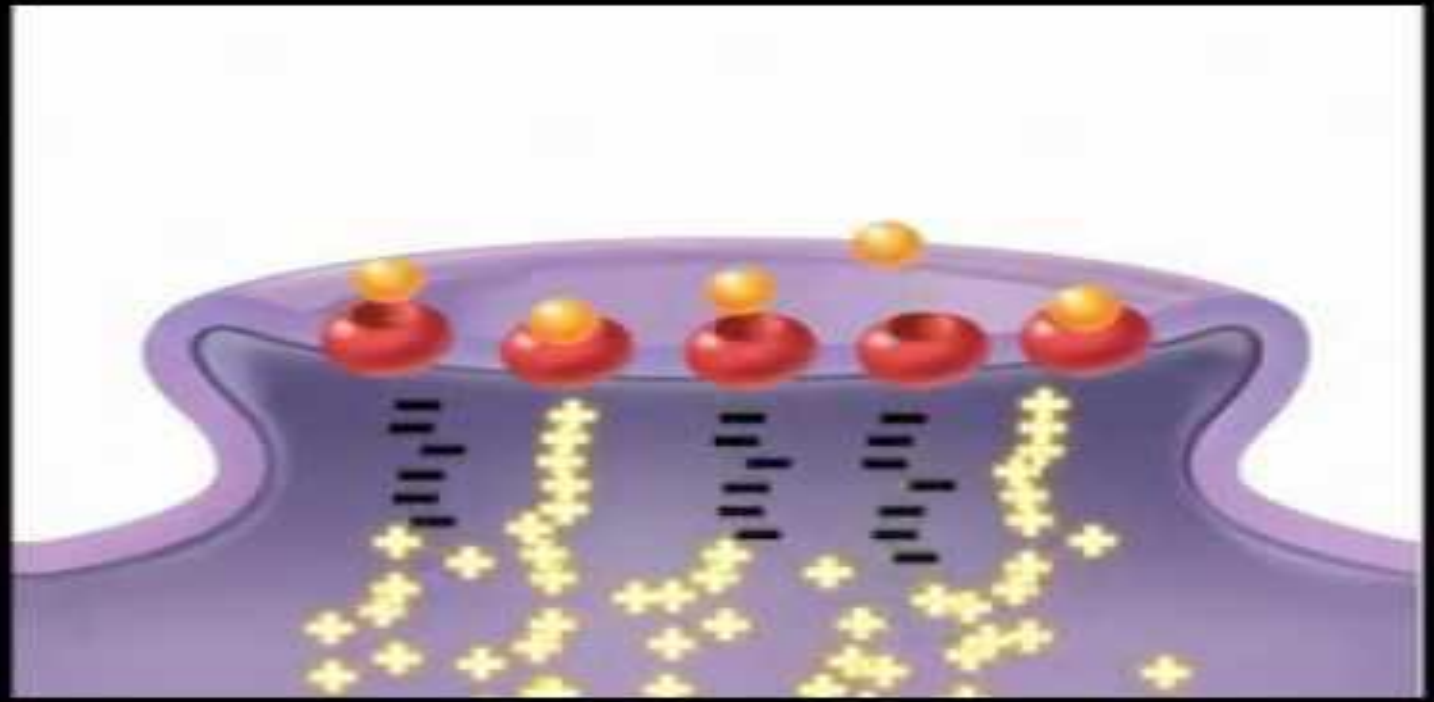


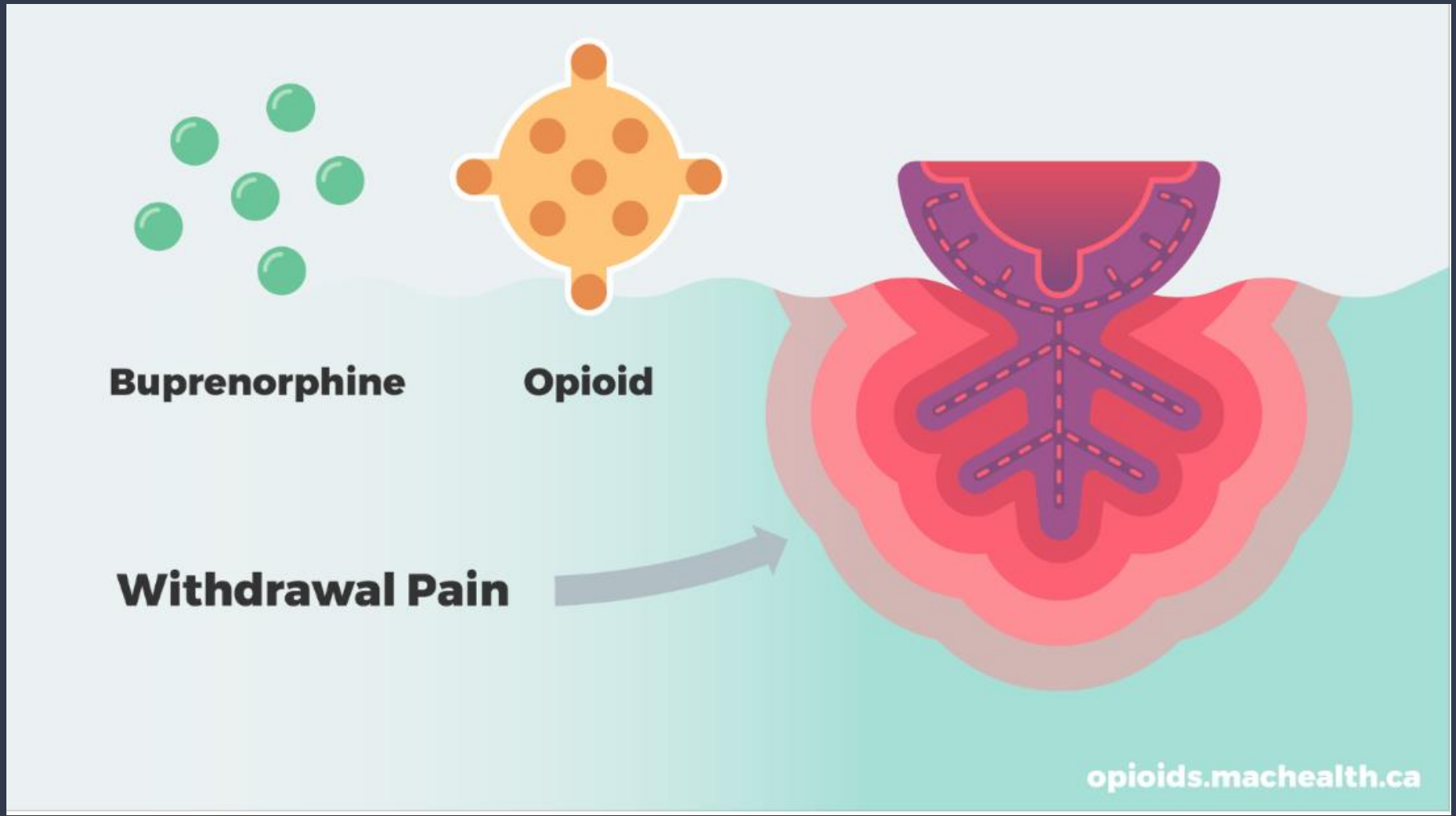
Buprenorphine

Pharmacology

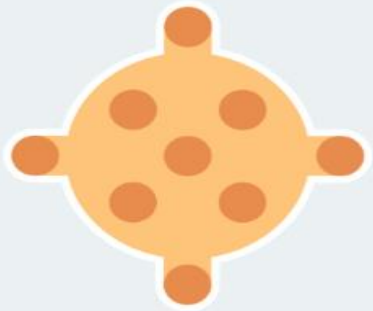


- High Mu affinity, ceiling effect, precipitated withdrawal.
- Buprenorphine/Naloxone has naloxone as deterrent for abuse, it is not active when taken sublingually.

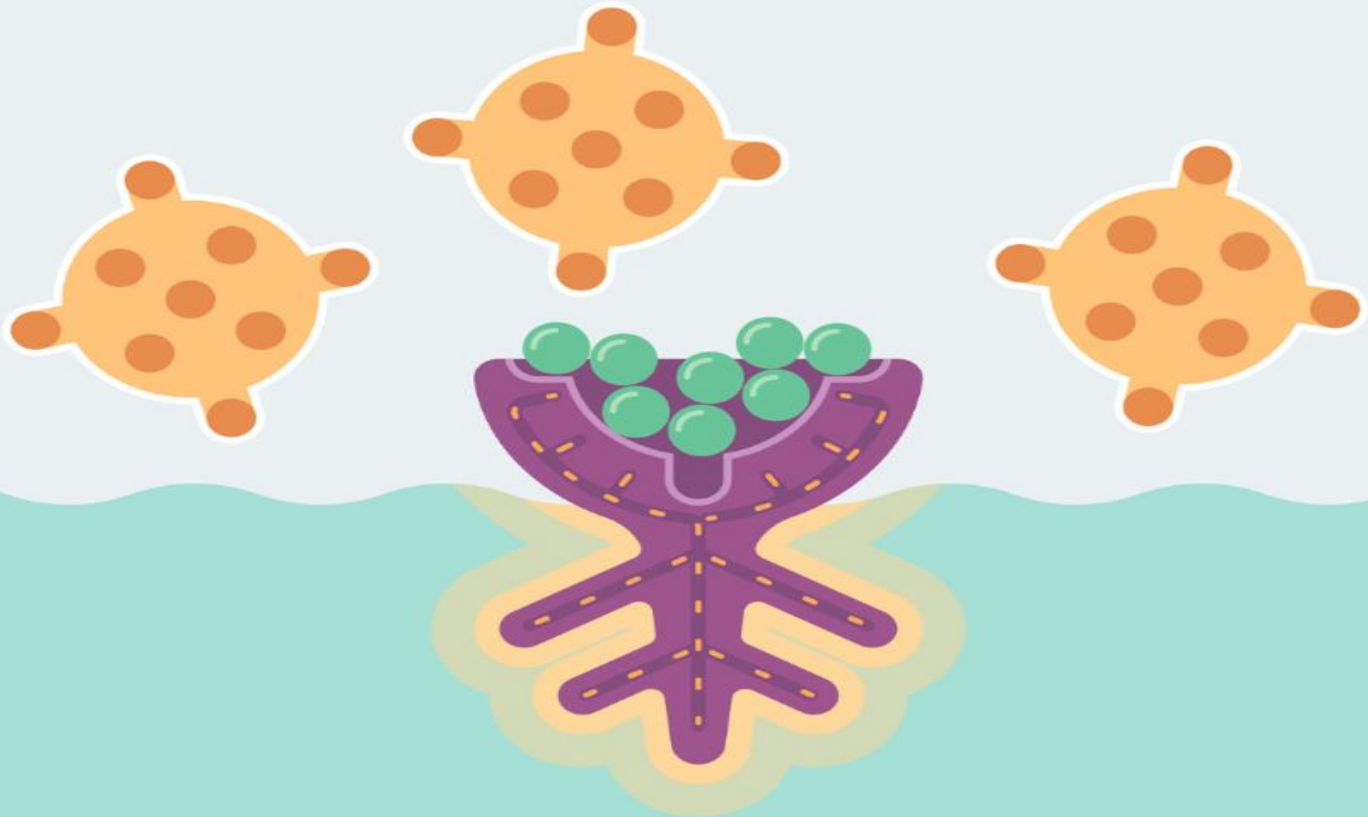


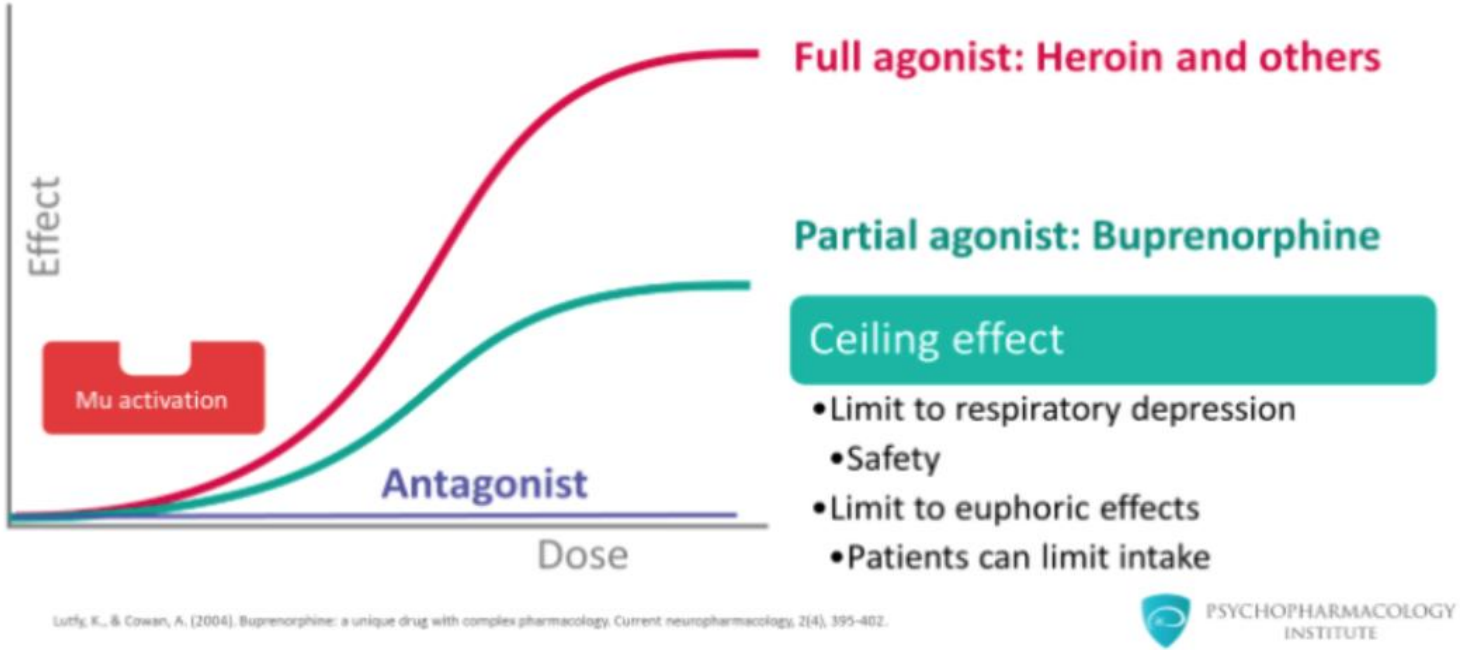

Buprenorphine
Opioid
Withdrawal Pain
opioids.machealth.ca

High Affinity



Partial Agonist

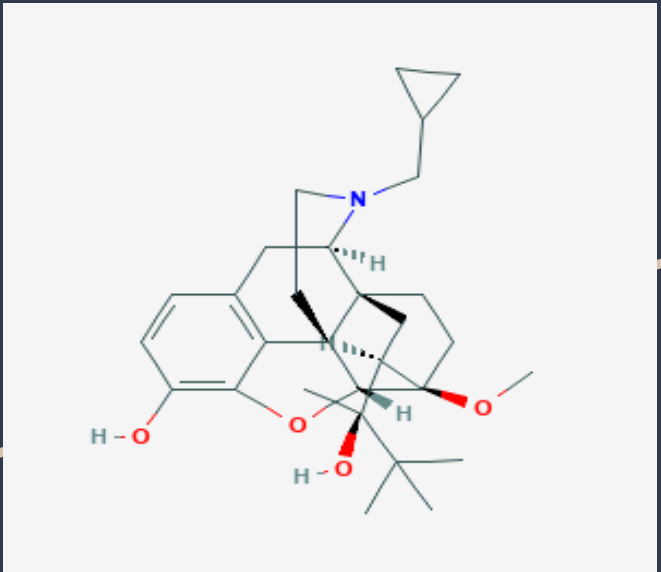




Source: Suzuki, J. Buprenorphine for Opioid Use Disorder: Mechanism of Action. Psychopharmacology Institute,2018.

Buprenorphine

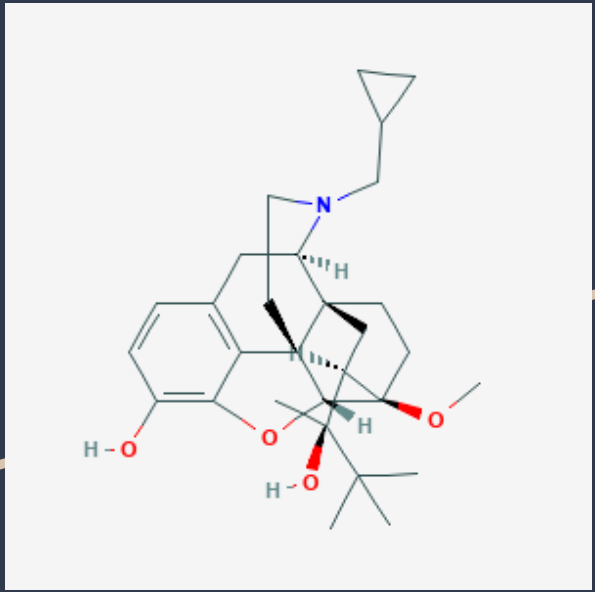
Pros



- Safe!
- You can prescribe in Primary care, ED, and the Hospital.
- Ceiling effect for Respiratory Depression.
- Prescribing guidelines are less stringent.
- Less stigmatized
- Protective against overdose.
- Newer formulations:
    - Probuphine, 6 month implant.
    - Monthly Depot soon to be released.

Buprenorphine

Cons

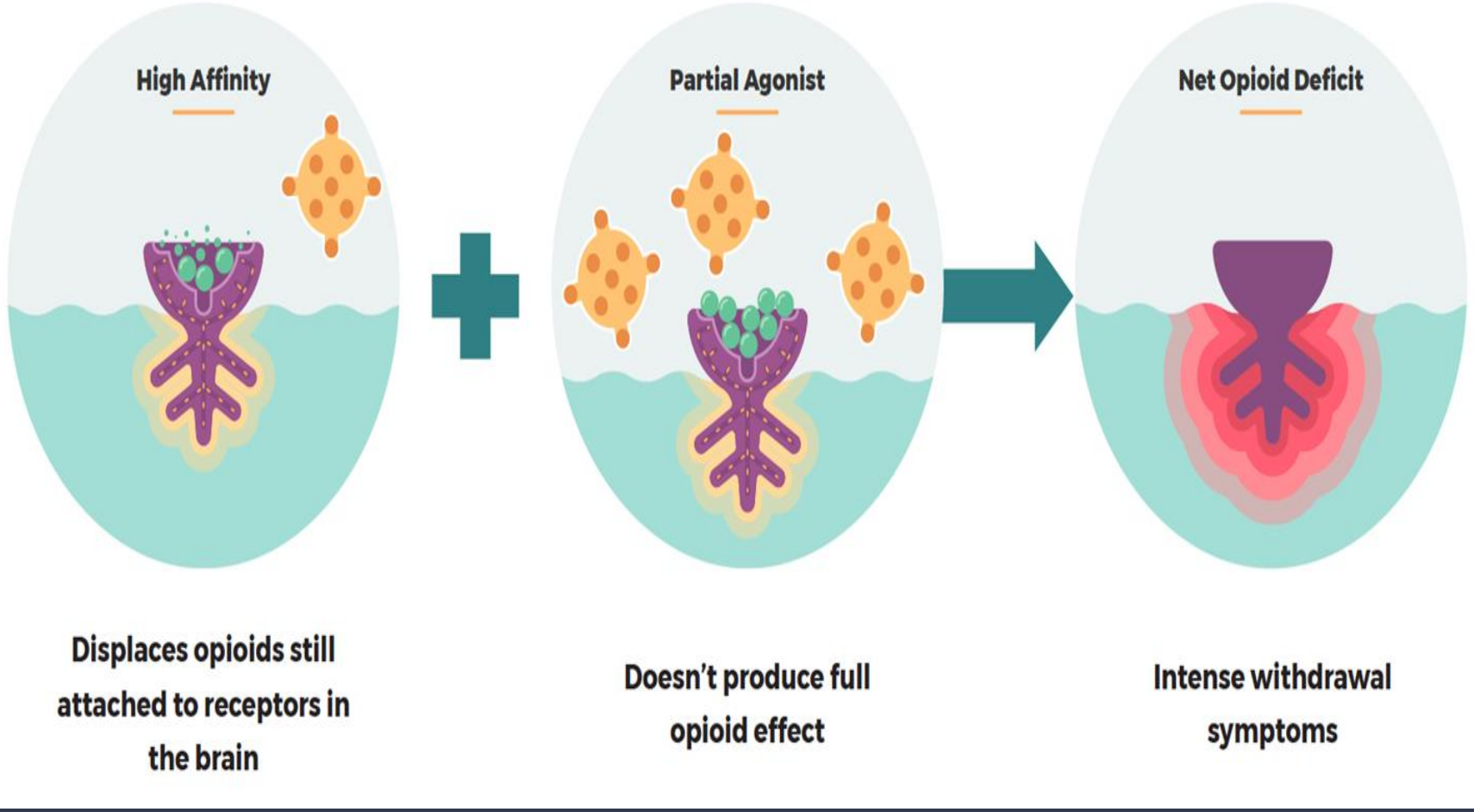


- Must be in moderate withdrawal to start to avoid precipitated withdrawal.
- Has a ceiling effect for analgesia and withdrawal relief.
- Some patients complain about taste.
- More Difficult to titrate at lower doses, smallest formulation is 2 mg tabs.
- Binds strongly to Mu receptor which can create some analgesia challenges.

PRECIPITATED WITHDRAWAL!!!

Precipitated withdrawal

- Very rare.
- Easily avoided in patients who are using short acting opioids.
- Communication to patients is the key.
  - Emphasize the level of discomfort.
  - Frankly, scare them a bit.
- In my entire career I have seen this twice.
- Can be more of an issue with those on LA opioid formulations, methadone and street Fentanyl products.


High Affinity
Partial Agonist
Net Opioid Deficit
Displaces opioids still attached to receptors in the brain
Doesn't produce full opioid effect
Intense withdrawal symptoms

Practical Point

Buprenorphine is an extremely safe opioid that can be prescribed without special exemption and can be protective against overdose.

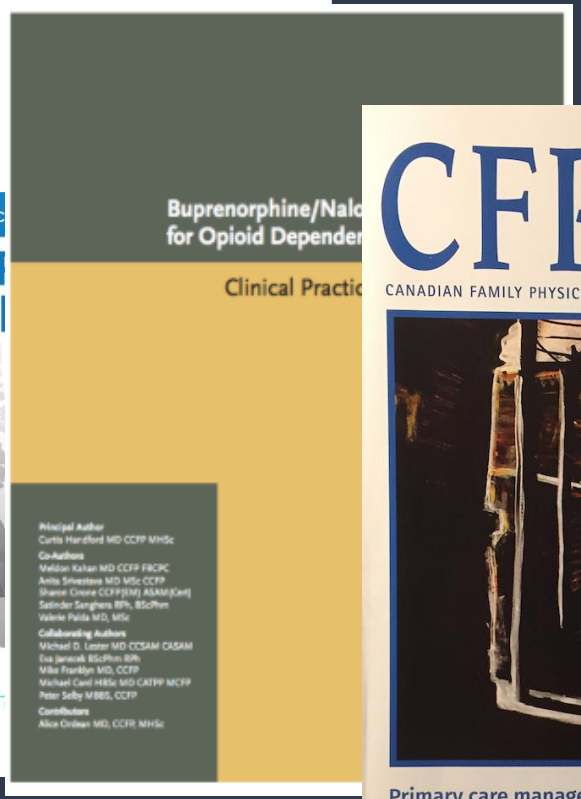
Practical Point

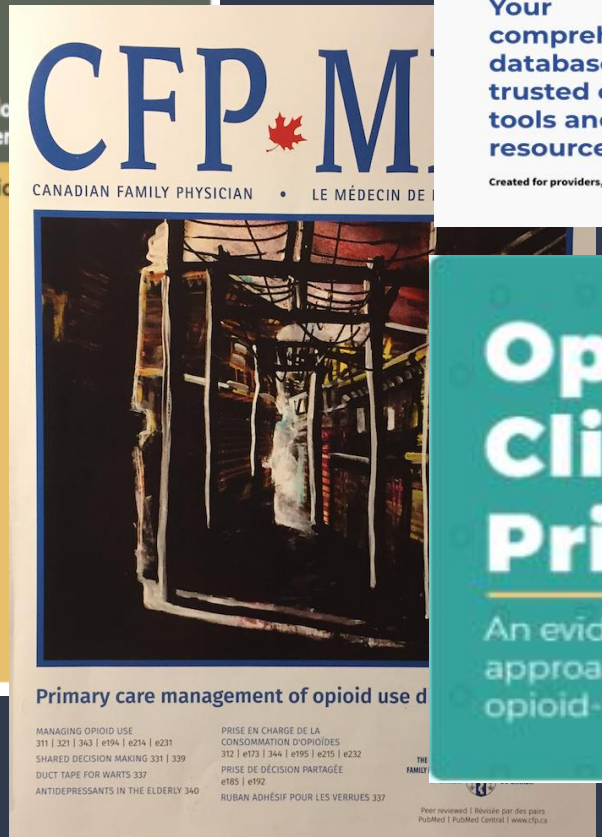
Buprenorphine Precipitated withdrawal should be respected but not feared (at least not by the prescriber).

Prescribers across the treatment spectrum can and should be comfortable treating OUD with Buprenorphine.

OUD, Providing Care

Guidelines, tutorials, websites, detailing!





How can physicians begin to treat OUD in their Practice?

- We all must become comfortable prescribing Buprenorphine!
- We must talk to patients, without judgement, about their drug use.
- We must avoid new OUD development by controlled prescribing with proper risk assessment.
- We must not refuse to prescribe opioids.
- We must not abruptly discontinue chronic opioids.

Buprenorphine in Primary care

Step 1

Prepare staff and clinic, and make friends with a pharmacist.

Step 2

Make the Diagnosis, prepare the patient.

Step 3

Start the medication.

Step 4

Follow up care.

Buprenorphine in Primary Care

Step 1

Preparing the Clinic

- Encourage non judgemental approach by frontline staff.
- Ensure easy urine sample drop off and testing.
- Best to have MD back-up for your prescriptions, do it as a team for best results.
- Be ready to see the new Buprenorphine start within 3-5 days, or be able to refer to someone who can.

Buprenorphine in Primary Care

Step 2

Make the Diagnosis

- DSM V criteria
- 4 C's of addiction
  - Craving
  - Loss of Control
  - Compulsive
  - Use despite Consequences
- Aberrant behaviour with opioids, including unexpected urines.
- Risk screening tool is elevated.
  - This may not necessarily "diagnose" OUD.

Buprenorphine in Primary Care

Step 2

Prepare the patient

- Ensure they have proper ID for the pharmacy, photo health card preferred.
- Make them aware of Buprenorphine Risks and Side effects:
  - Prolonged withdrawal on discontinuation
  - Need for regular visits to pharmacy
  - Headache, dry mouth, constipation, low libido, sedation.
  - Potential risks with ETOH and Bzd.
- But generally much safer than other opioids
- Stable home/address preferred for take home doses.

Step 3..... Start the medication

Case Review

Buprenorphine in Primary Care

Case

67 YO Male, Chronic low back pain, greater trochanteric pain syndrome, and peripheral neuropathy. Had brief success with pain blocks, allergy to morphine, did not tolerate Lyrica, gabapentin, TCA's, could not swallow oxyneo, dilaudid caused skin to peel. Cannabis helps with sleep and mild pain relief. Only opioid that works for him is oxycontin or percocet?!

Buprenorphine in Primary care

Case

Extended period of care for chronic pain starting in 2015, including CPMC . During this time, he has some scattered UDS results that were unexpected. Cocaine, methadone, codeine would show up periodically. His pill counts remained accurate.

I had many frank discussions with him about drug misuse. He was mostly honest with me and we had good rapport. I never threatened him that I would cut off his medications. I always explained his opioid contract to him, and would tighten dispensing after unexpected results.

My final straw was a second UDS with methadone.

I reduce his percocet dose and dispensing interval over the phone.

Buprenorphine in Primary Care

Case

After the dose reduction and dispensing interval reduction his OUD became quite evident. He started to misuse street opioids with nasal use of oxycontin. His functioning had reduced significantly to the point that he could not get out of bed on most days.

Primary Care Buprenorphine

Case

SOAP note…. My Plan

“Long discussion regarding opioid options for him now. Given the several unexpected urines, his snorting of oxy, his overuse of the prescribed Percocet, his buying off the street, I feel comfortable stating he has opioid misuse/use disorder. Gave Bup home induction handout. Long discussion about PW, he seems to understand. F/U tomorrow”

Buprenorphine Primary Care

Case

Review

- Chronic pain patient, not doing well on Percocet 2 tabs TID, even worse with reduce dose and dispensing.
- UDS periodically unexpected.
- Admits to nasal use.
- Failed non-opioid treatments.

Buprenorphine Case Diagnosis

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

DSM-5 CLINICAL DIAGNOSTIC CRITERIA FOR OPIOID USE DISORDER[1]

To be eligible for methadone, buprenorphine/naloxone or slow release oral morphine agonist treatment, patients must meet DSM-5 criteria for opioid use disorder.

DSM-5 Criteria for Opioid Use Disorder		
1	Opioids are often taken in larger amounts or over a longer period than was intended	The presence of at least 2 of these symptoms indicates an Opioid Use Disorder (OUD) The severity of the OUD is defined as: MILD: The presence of 2 to 3 symptoms MODERATE: The presence of 4 to 5 symptoms SEVERE: The presence of 6 or more symptoms
2	There is a persistent desire or unsuccessful efforts to cut down or control opioid use	
3	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects	
4	Craving or a strong desire to use opioids	
5	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home	
6	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids	
7	Important social, occupational, or recreational activities are given up or reduced because of opioid use	
8	Recurrent opioid use in situations in which it is physically hazardous	
9	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.	
10	Tolerance,* as defined by either of the following: a) Need for markedly increased amounts of opioids to achieve intoxication or desired effect b) Markedly diminished effect with continued use of the same amount of opioid	
11	Withdrawal,* as manifested by either of the following: a) Characteristic opioid withdrawal syndrome b) Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms	

Score of 2-4, results in mild to moderate OUD

* Patients who are prescribed opioid medications for analgesia may exhibit these two criteria (withdrawal and tolerance), but would not necessarily be considered to have a substance use disorder.

Reference:
1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5™ 5th ed. Arlington, VA: American Psychiatric Publishing, Inc.

More information:
www.bccsu.ca

BRITISH COLUMBIA CENTRE for EXCELLENCE in HIV/AIDS · Providence HEALTH CARE · UBC · St Paul's FOUNDATION

Buprenorphine Case Starting Tx.

Home Start

- Reliable patient
- Safe home
- Good understanding of the Process
- Not for those at high risk

Office Start

- Unsafe home environment
- BZD or ETOH use/abuse
- Difficulty with comprehension

Most Primary Care Buprenorphine starts can be done at home.

It is common for opioid-related deaths to also involve other substances. Benzodiazepines were present in half, and cocaine was present in one-third of opioid-related deaths.

Buprenorphine Case Starting tx.

To me this patient satisfied my criteria for home buprenorphine start.

- **Stable address.**
- **No housemates using drugs.**
- **No Heavy/uncontrolled ETOH use.**
- **No bzd use.**
- **Mild to Moderate OUD by DSM.**
- **Motivated to get pain and withdrawal under control.**

Buprenorphine Case Home Start handout

Day 1 Starting Suboxone® (buprenorphine/naloxone)

Are you in withdrawal? Before starting Suboxone® (buprenorphine/naloxone) you need to be in withdrawal (dope-sick). Use the 'SOWS' withdrawal scale on the back page to determine how bad your withdrawal is. Wait until your withdrawal score is 17 or more to begin.

- **Do not take with alcohol or sedatives.**
- **Do not take more than 12 mg total on Day 1.**
- **Do not inject. You will be dope-sick if you inject.**

☐ My doctor/nurse practitioner and I agree on this treatment plan.

Contact Information

Patient Name _____

Provider Name _____

Provider Number _____

1st Dose — Take your 1st dose

- **Keep medication under your tongue until fully dissolved** (this can take up to 10 min) **or it will not work**. Do not chew or swallow.
- Do not eat, drink, or swallow while it is dissolving.
- Contact your provider to let them know you took your 1st dose.

My dose:
_____ mg
= _____ tablets
Time: _____

It usually takes 20-45 min for the medication to start to work. Wait 1-3 hours before your 2nd dose.

Notes

If you feel a lot worse → Contact your provider if your symptoms feel a LOT WORSE. This happens when you start before you are in enough withdrawal and is called "precipitated" withdrawal. Talk to your provider about managing symptoms and next steps.

2nd Dose — 1-3 hours after 1st dose

How do you feel?

- Still feeling withdrawal (dope-sick) symptoms → Take a 2nd dose (keep under tongue until fully dissolved).
- Better → Check in with yourself later.

My dose:
_____ mg
= _____ tablets
Time: _____

3rd Dose — 1-3 hours after 2nd dose or later in evening

How do you feel?

- Still feeling withdrawal (dope-sick) symptoms → Take a 3rd dose (keep under tongue until fully dissolved).
- Better → Check in with yourself later, you may not need another dose.

My dose:
_____ mg
= _____ tablets
Time: _____

Most people feel much better by the end of the first day. Contact your provider if you are still feeling bad withdrawal or feel like using and have taken the daily max of 12 mg.

How many doses did you take today?

	1st Dose	2nd Dose	3rd Dose	Total
Amount	mg	mg	mg	mg

The total for Day 1 is your starting dose for Day 2. Whether you started treatment at home or in the clinic, most providers will ask you to start Day 2 with a clinic visit. Take this sheet with you to your next appointment.

Next appointment info: Date: _____ Time: _____ Location: _____

Buprenorphine Case Home Start Handout

Additional Information for Starting Suboxone® (buprenorphine/naloxone)

Knowing when to start

Suboxone® (also known by generic name buprenorphine/naloxone) helps you manage opioid withdrawal symptoms and cravings.

You need to be in withdrawal (dope-sick) to start or your symptoms will get a lot worse – the more in withdrawal you are the better.

You know your symptoms. Wait until you are in moderate to severe withdrawal (dope-sick) before you begin. You can use the SOWS scale (below) to help you see if you are in enough withdrawal to start. You can also check your SOWS score throughout the day. You should feel better and see your SOWS withdrawal scores decrease throughout the day. If your SOWS withdrawal score increases and your symptoms get worse, contact your provider.

Subjective Opiate Withdrawal Scale (SOWS)[1]

Please score each of the statements according to how you feel right now on a scale of 1 to 4. Add up all your scores to get your total SOWS withdrawal score.

Scale: 0= Not at all 1= A little 2= Moderately 3= Quite a bit 4= Extremely

	Time:					
	Symptoms:	**Score**	**Score**	**Score**	**Score**	**Score**
	I feel anxious					
	I feel like yawning					
	I am perspiring					
	My eyes are teary					
	My nose is running					
	I have goosebumps					
	I am shaking					
	I have hot flushes					
	I have cold flushes					
	My bones and muscles ache					
	I feel restless					
	I feel nauseous					
	I feel like vomiting					
	My muscles twitch					
	I have stomach cramps					
	I feel like using now					
	My SOWS score (total score):					

If your SOWS withdrawal score is **17 or more** → You are ready to start, follow the instructions on page 1.
If your SOWS withdrawal score is **less than 17** → Check your score again in 1-3 hours.

[1] Handelsman L et al. Am J Drug Alcohol Abuse.1987.

Notes:

This handout is based on the *BC Guideline Opioid Use Disorder - Diagnosis and Management in Primary Care* available at BCGuidelines.ca

BRITISH COLUMBIA Ministry of Health | doctors of bc | BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

Buprenorphine Case
Home Start

- Pick a handout or make a handout that works for you.
- Estimate the effective dose.
- Have pharmacy dispense starting dose using 2 mg tabs for day 1.
- Following days observed at pharmacy.
- Quick Follow-up to assess need for dose increase.

Buprenorphine Case: The Rx

1) Suboxone 2 mg-0.5 mg tablet

Dispense: 4 Tab(s) **Refills:** 0

Instructions : Take 2 tabs under tongue when feeling moderate to severe withdrawal, and/ or greater then 24hours since last opioid use.
Repeat 2 tabs under tongue in 30 min if withdrawal symptoms persist.

Pharmacist : Start: Dec 18
Stop: Dec 18
D/C Percocet
Dispense as carries for home start

Buprenorphine Case

- The patient took 4 mg, followed by 2mg and then 2mg.
- He actually waited much longer then the 30 min… He was being quite cautious
- Withdrawal severity: 6/10
- Pain Severity: 8-9/10 (baseline 8/10)
- Denies somnolence, or headache
- Denies ETOH or bzd use
- First day total dose 8 mg

Buprenorphine Case

- Day 1:
- Home start a success!
- Now what?
- 8 mg dose still resulting in mid to late day withdrawal symptoms.
- Pain still at baseline, perhaps some mild relief a few hours after dose.
- Prescribe him 12 mg od for the next week

Buprenorphine Case Follow up

- I work to target withdrawal symptoms first.
- Was able to achieve 100% withdrawal symptom resolution with 12 mg dose.
- Secondly I target pain….. Split dosing
- He had improvement with 12 mg split TID, but still only at 7-8/10
- Increase dose to 6 mg TID to target pain.
- These changes occurred over visits space 1-2 weeks apart.

BUPRENORPHINE FOR CHRONIC PAIN IS STILL OFF LABEL USE.

Buprenorphine Case Results

- Final dose 6 mg TID.
- Pain score to target at 5/10.
- Functionality massively improved from bed ridden to enjoying life and getting ADL’s done.
- No reported side effects.
- No unexpected urines.
- Now time spent on chronic pain in visits is less allowing us to focus on other health concerns.

Buprenorphine

Step 4

Follow-up

- Urine Screening
  - Frequency depends on risk
  - Recommend starting with higher frequency and move towards reducing.
  - At least once/month to start.
  - At least 4x/year ongoing.
- Side effect monitoring
  - Headache, usually self limiting
  - Somnolence, rare
  - Dry mouth
  - Constipation
  - Check LE for those with Liver concerns

British Columbia OUD Guidelines, June 2017: http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

Buprenorphine

Step 4

Follow-up

- Dispensing interval
  - If high risk and ongoing Opioid abuse: daily dosing until stable
  - If quickly stabilizes with no concerns can increase to weekly
- Missed doses:
  - If 5 or less missed doses no need to alter dose
  - If 6 or more, suggest a visit to discuss, follow guidelines for re-start

Dose	Number of Missed Days	Suggested Dose Adjustment
2 mg/0.5 mg–4 mg/1 mg	≥ 6 days	No change
6 mg/1.5 mg–8 mg/2 mg	≥ 6 days	Restart at 4 mg/1 mg
> 8 mg/2 mg	6–7 days	Restart at 8 mg/2 mg
> 8 mg/2 mg	> 7 days	Restart at 4 mg/1 mg

British Columbia OUD Guidelines, June 2017: http://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

Conclusion

If we are truly going to curb the overdose epidemic or adequately treat those with addiction, we must take actions that will make a difference. These include building an addiction treatment ecosystem that looks like every other medical specialty, and make its response just as predictable and effective as the treatment for a heart attack.

Dr. R Corey Waller

- ”Treatment for Addiction should be like that for a heart attack: Swift, sure and standardize”
- USA TODAY, June 4, 2018

- Be aware of OUD risks
- Think about ACE’s in your patient population
- Reduce exposure to opioids
- Screen for OUD risk before writing the Rx.
- Become comfortable with Buprenorphine Rx.

Local Addiction Resources:

ACES Medical Group
Dr. Chung, Dr. Kibiuk, Dr. Carfagnini
MOHLTC focused practice designated

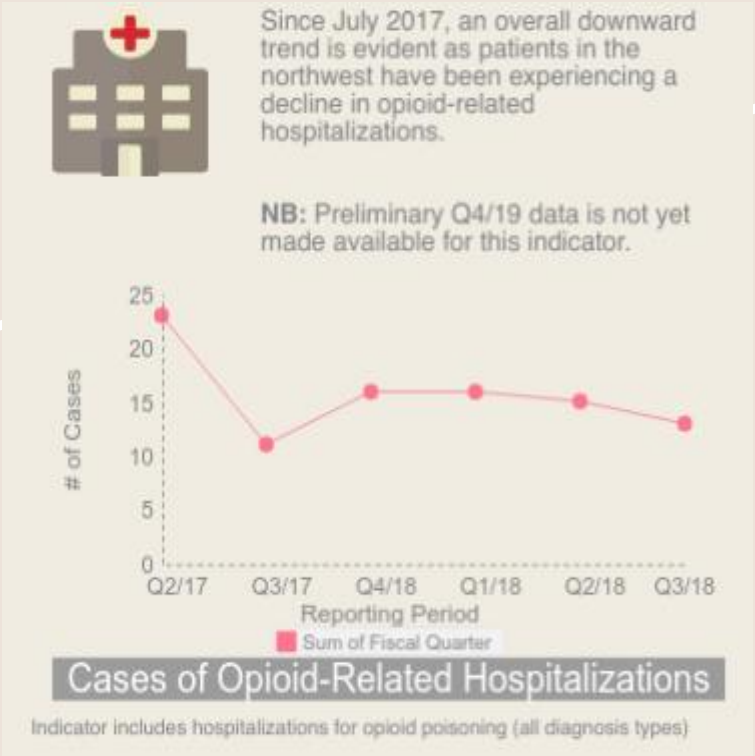
RAAM Thunder Bay
Dr. Denson, Tannice Fletcher-Stackhouse NP, Dr. Carfagnini

Nipigon Family Health Team Buprenorphine Program
Dr. Carfagnini

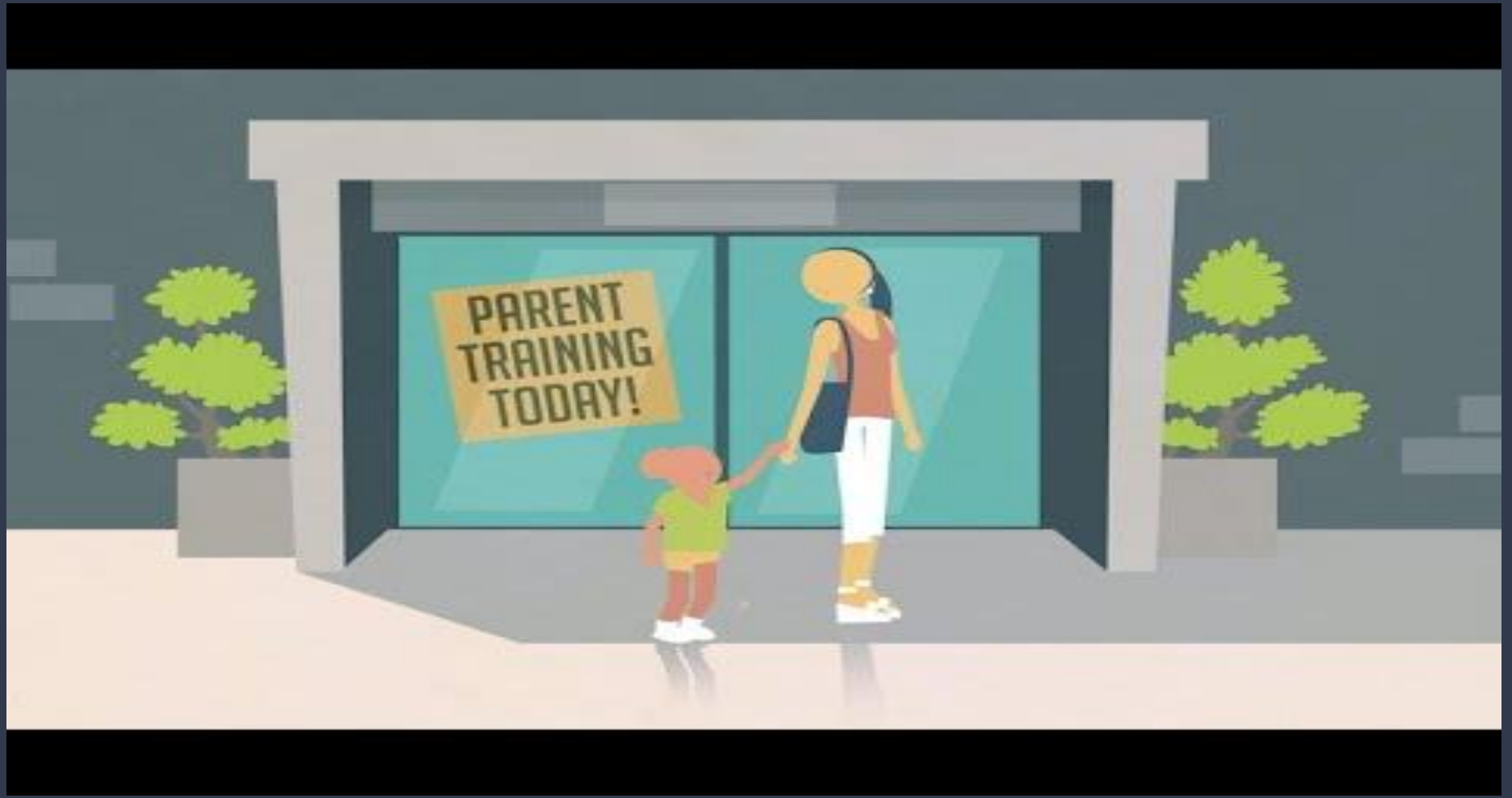
Marathon Family Health Team: HARMS Program
Dr. Ryan Patchett-Marble
Harmsprogram.ca

Some Emerging Good News on Opioids:

- Newest ODRP shows declining Opioid-related Hospitalizations and ED visits.
- Data is showing an increasing number of OAT providers.



Questions?


PARENT
TRAINING
TODAY!