Novel Approaches to Address Opiate Addiction in Timmins

Pan Northern Clinical Rounds
Dr. Louisa Marion-Bellemare & Dr. Julie Samson
October 5, 2022.

DISCLOSURE OF FINANCIAL SUPPORT

- This program has received no financial support
- This program has received no in-kind support
- Potential for conflict(s) of interest: none

PRESENTER DISCLOSURE

- Relationship with financial sponsors
  - Speaker Honorarium:
    - Indivior CSAM Conference October 2021
    - Master Clinician Alliance Harley Street Talk: Nov 2021 & Feb 2022

MITIGATING POTENTIAL BIAS

- CONTENT REPORTS ON CLINICAL EXPERIENCE AND AS SUCH INCLUDES OFF-LABEL USES

LEARNING OBJECTIVES

Identify

- Identify treatment options for patients with opiate addiction.

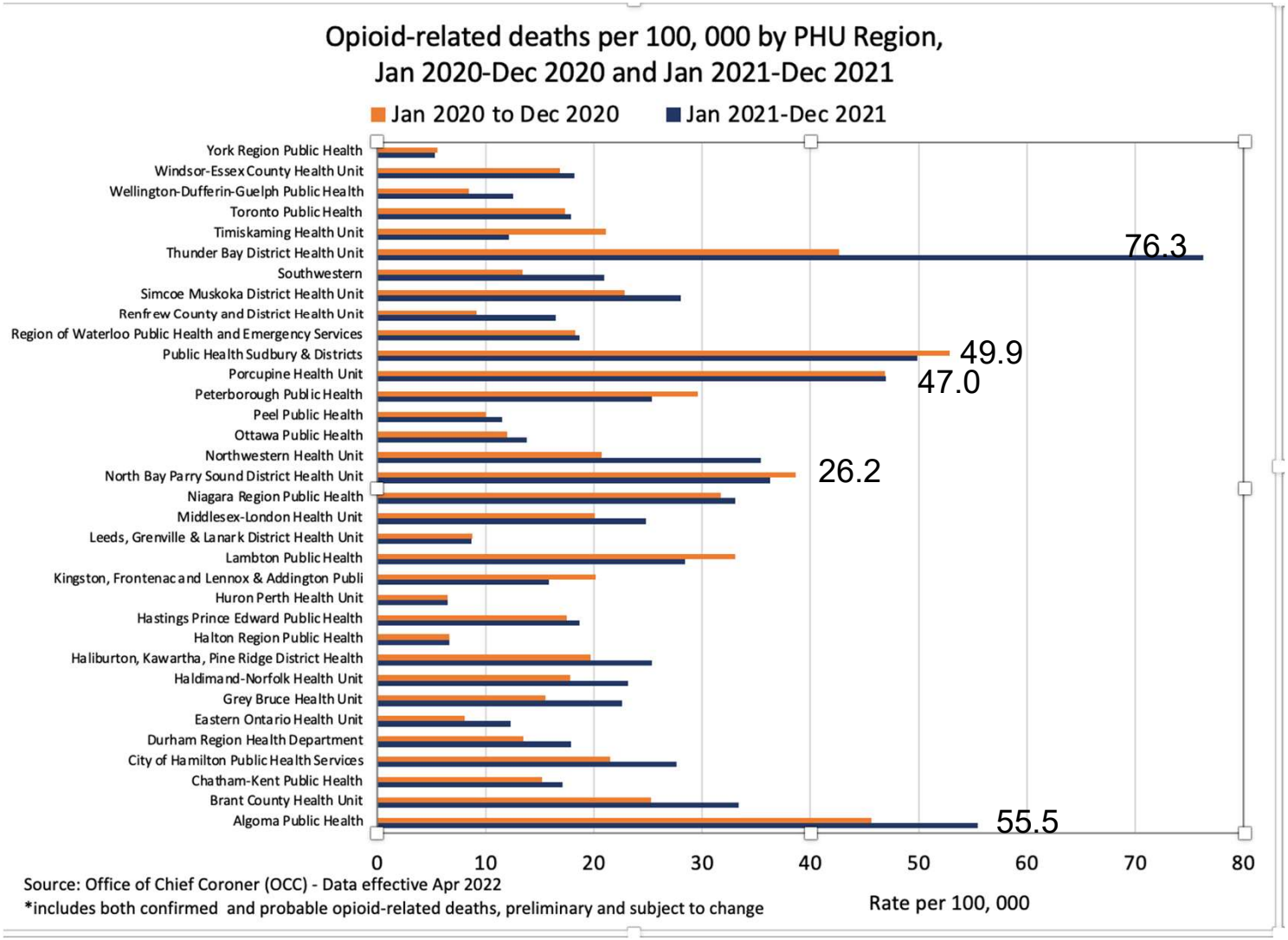
Discuss

- Discuss novel approaches to treat opiate addiction.

Explain

- Explain effective communication strategies to help those with an opiate addiction.

OUR CRISIS AND TIME FOR CHANGE

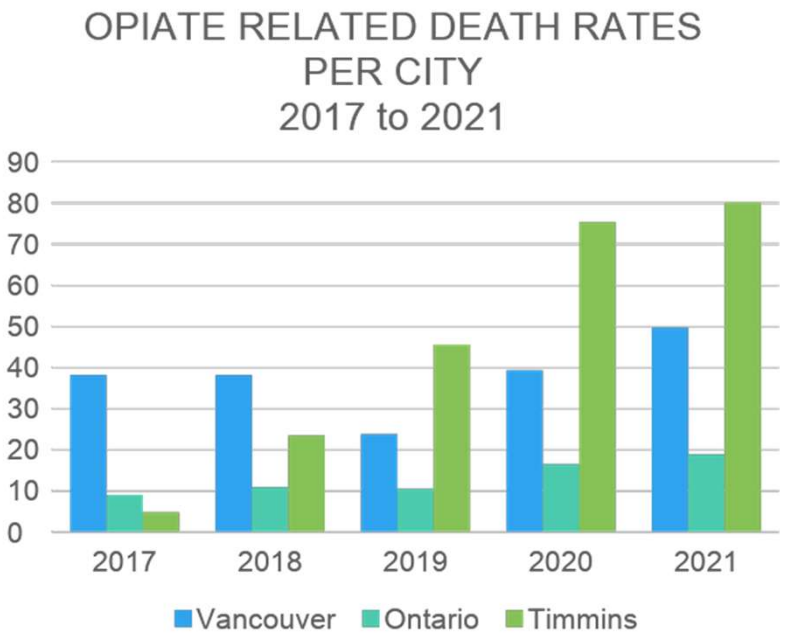


Source: Office of Chief Coroner (OCC) - Data effective Apr 2022

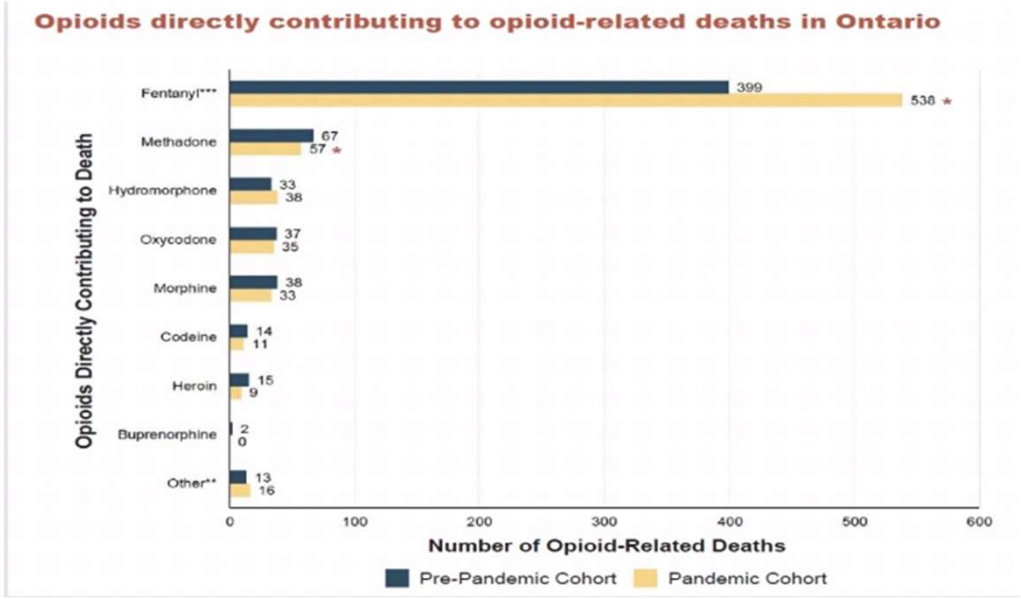
*includes both confirmed and probable opioid-related deaths, preliminary and subject to change

LOCAL CRISIS

- Data Source: https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool
- https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/statistical/illicit-drug.pd
- *2021rates are preliminary and subject to change



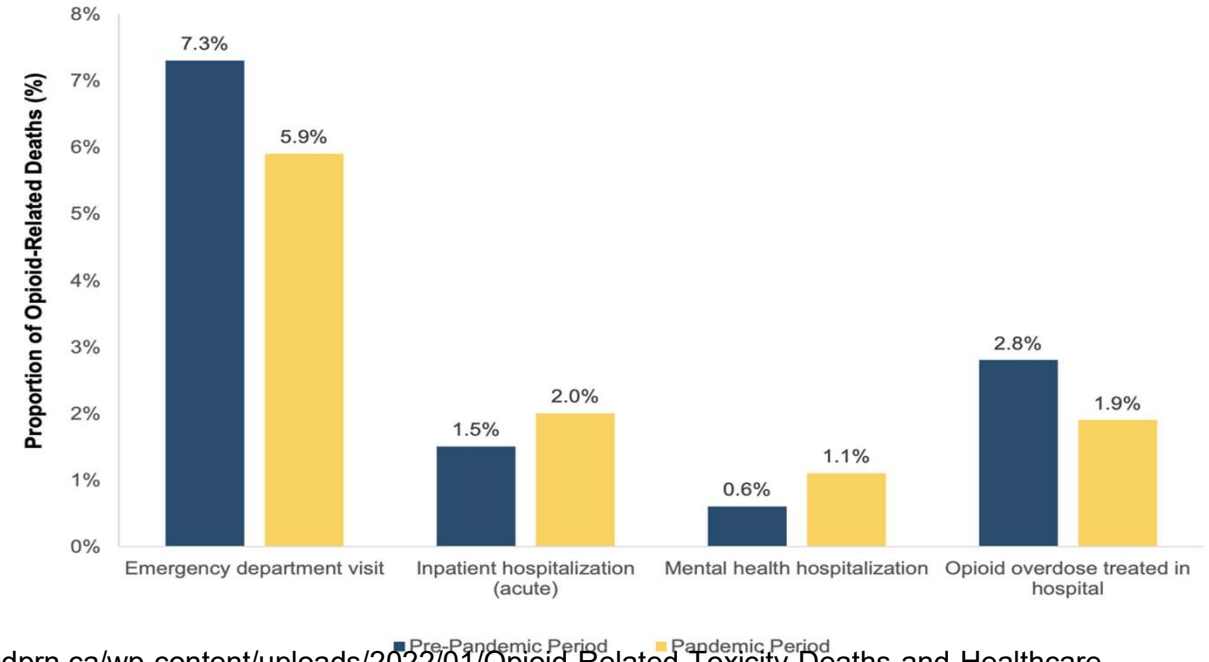
ONTARIO OPIOID RELATED DEATHS 2020



https://www.publichealthontario.ca/en/data-and-analysis/substance-use/interactive-opioid-tool

Healthcare Use among People who Died of Opioid-Related Toxicity During Pandemic- 2020

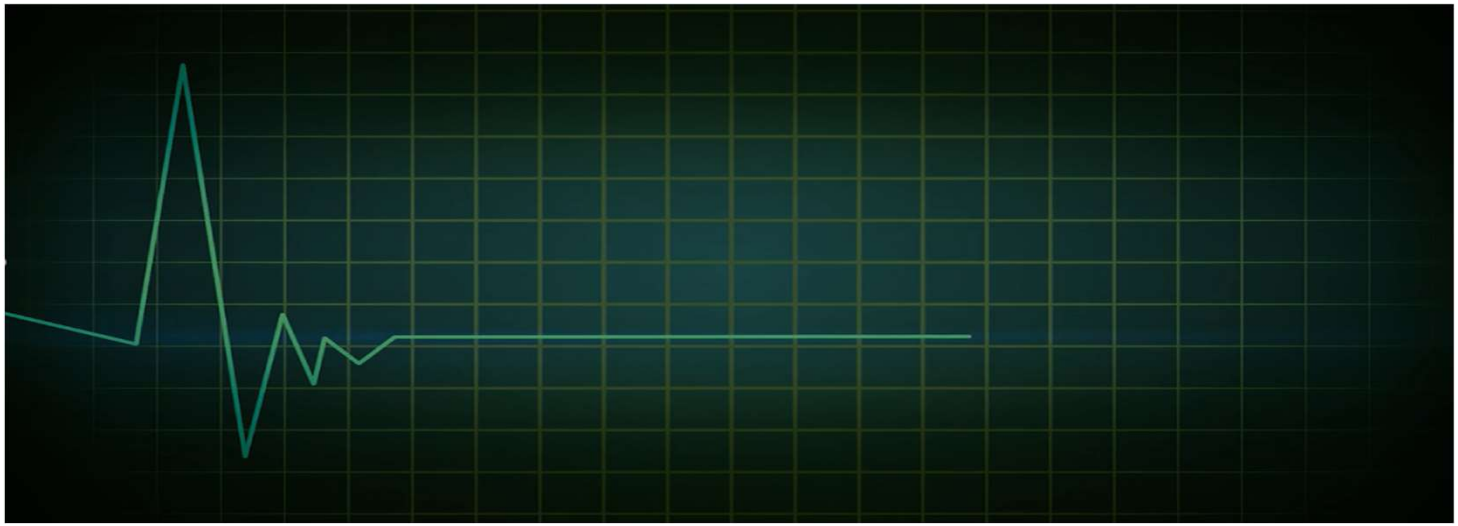
Figure 11: Recent hospital encounters in the seven days prior to opioid-related death in Ontario

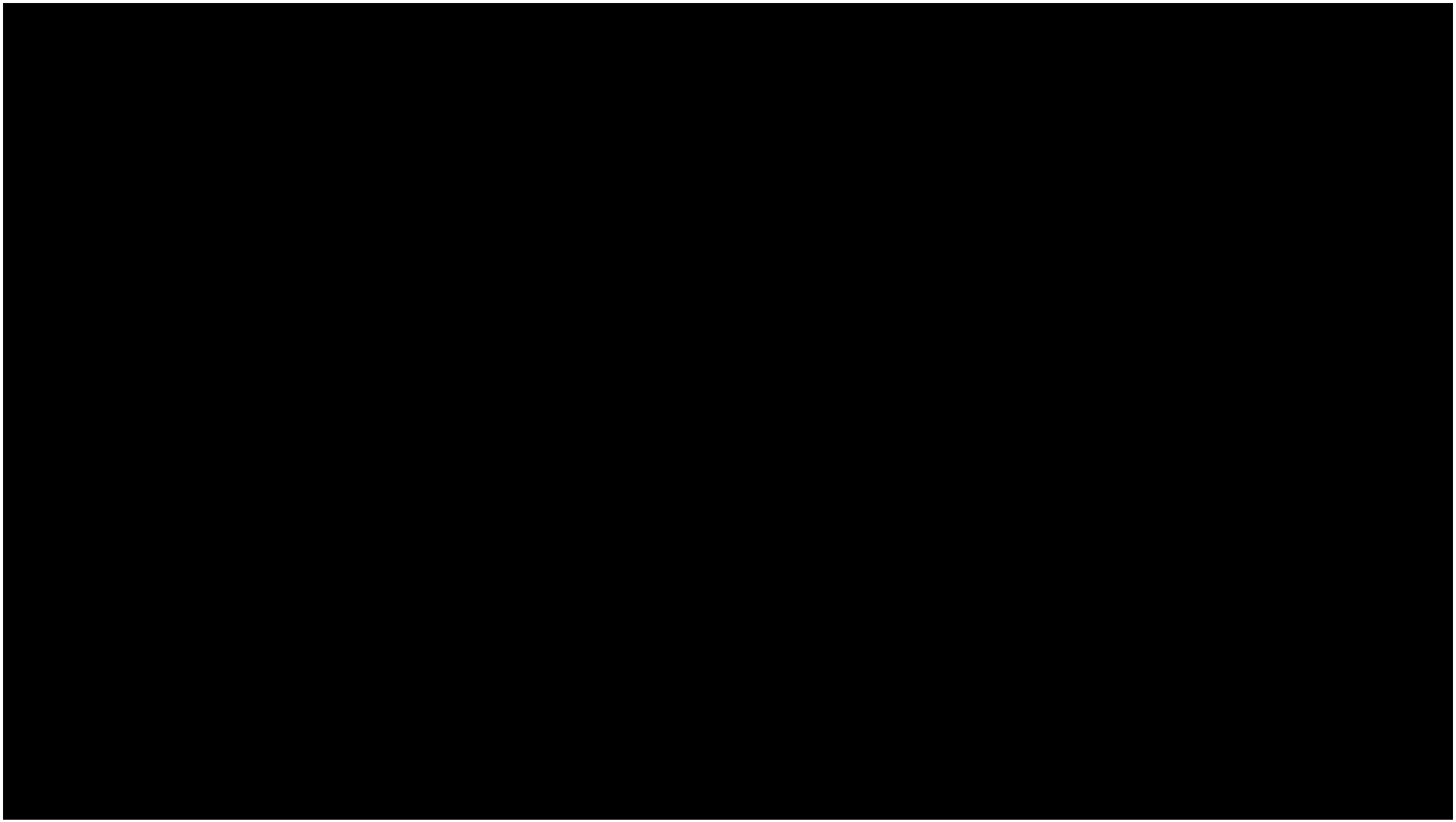


https://odprn.ca/wp-content/uploads/2022/01/Opioid-Related-Toxicity-Deaths-and-Healthcare-Use-Report.pdf

TOXIC TWINS

THE EYE OPENER FOR CHANGE



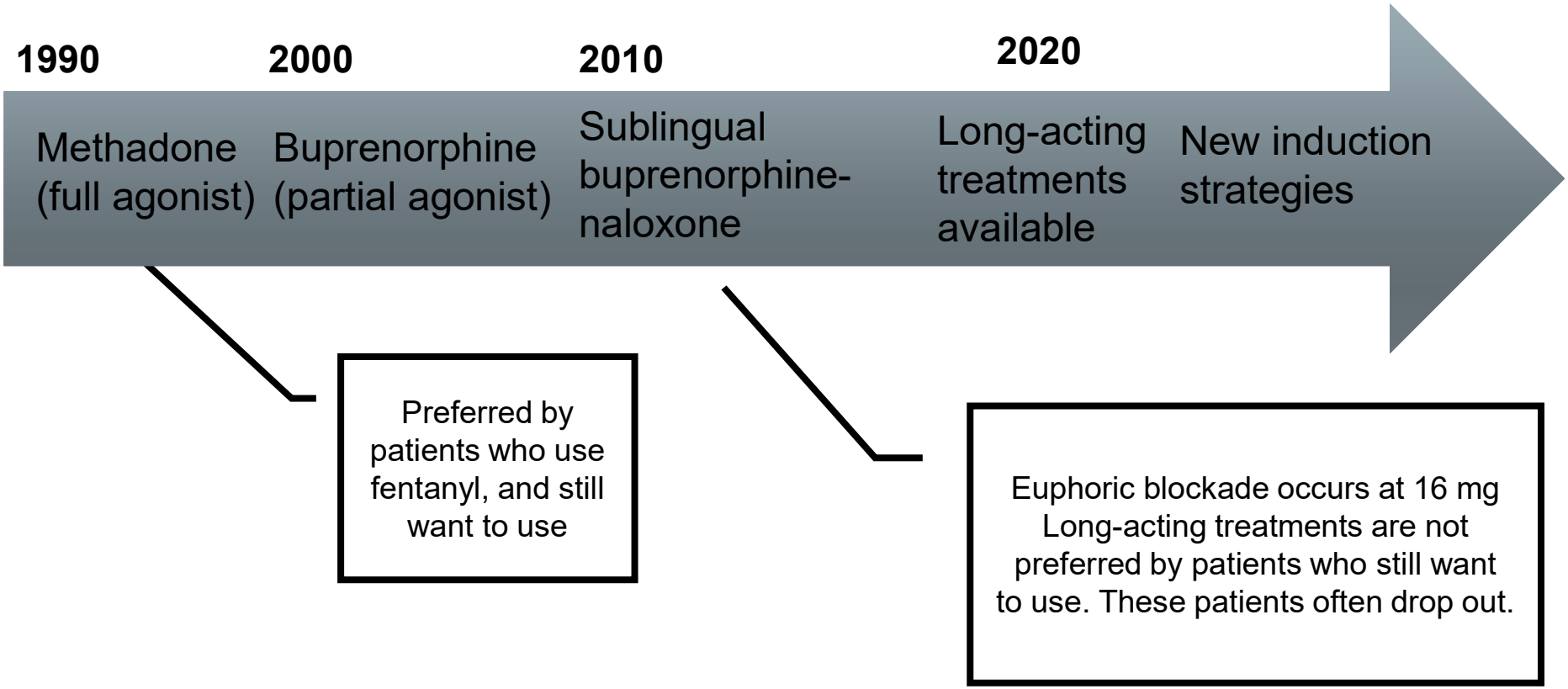


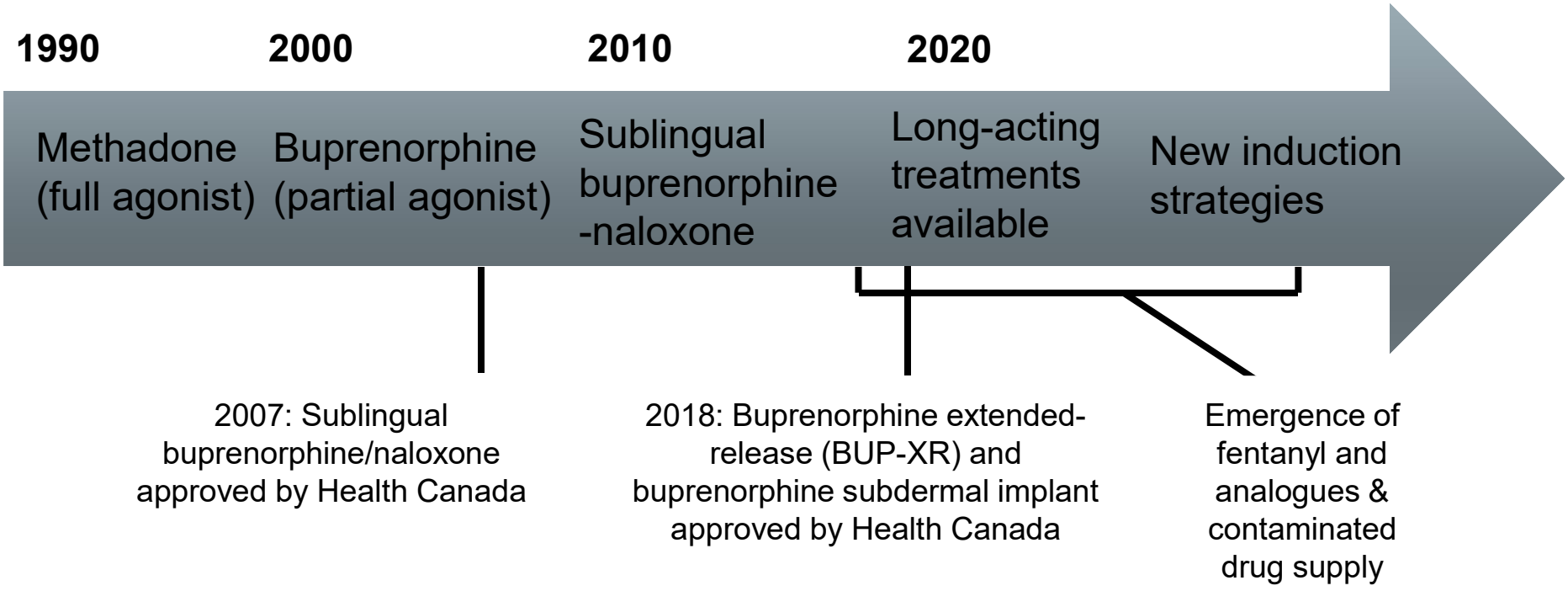
CASE PRESENTATIONS

34 yo female presenting to ER last used IV fentanyl 6 hrs ago asking for help with her opioid use (also uses IV Crystal Meth). Uses 0.5-1 g IV fentanyl daily x 5 yrs

25 yo male presenting to ER fully reversed with naloxone in severe withdrawals unsure if he wants help for his opioid use but wants to feel better immediately. Smokes fentanyl and crack x 2 years approximately 1-1.5 grams per day.

40 yo female in withdrawals and last used fentanyl 22 hours ago asking for help with her opioid use. Uses “a few points per day” of fentanyl, IV and smoked x 5 years. Use speed, cocaine, CM also IV and smoked.

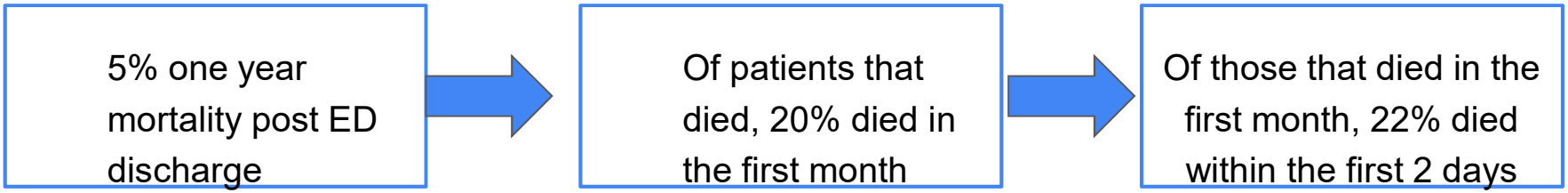

1990
2000
2010
2020
Methadone (full agonist)
Buprenorphine (partial agonist)
Sublingual buprenorphine-naloxone
Long-acting treatments available
New induction strategies
Preferred by patients who use fentanyl, and still want to use
Euphoric blockade occurs at 16 mg
Long-acting treatments are not preferred by patients who still want to use. These patients often drop out.



Canadian Agency for Drugs and Technologies in Health (CADTH). Buprenorphine/Naloxone Versus Methadone for the Treatment of Opioid Dependence: A Review of Comparative Clinical Effectiveness, Cost-Effectiveness and Guidelines [Internet]. Ottawa, ON; 2016 .

OVERDOSE & SHORT TERM MORTALITY

ED PATIENTS WITH NON FATAL OPIOID OVERDOSE:



Source: Weiner,Scott et al..One-Year Mortality of Patients After Emergency Department Treatment for Nonfatal Opioid Overdose. Annal of Emergency Medicine. April 2, 2019

PRACTICE GUIDELINES FOR TREATMENT OF OUD

For Mod & Severe Withdrawals Bup/Nal offered **WITHIN 2 HRS**
HQO Opioid Use Disorder Quality Statements 2018

First Line Treatment Option for Withdrawals & OUD: **BUP/NAL**
Management of OUD: A National Clinical Practice Guideline (CMAJ 2018)

If Not in Withdrawals but Requesting Treatment: should be offered within **MAX 3 DAYS (1st line BUP/NAL)** HQO Opioid Use Disorder Quality Statements /18

If a person enters an inpatient facility, OAT should be continued without disruption
HQO Opioid Use Disorder Quality Statements 2018

WHERE CAN WITHDRAWALS BE TREATED WITHIN 2 HOURS?

THE HOSPITAL

PRACTICE GUIDELINES FOR TREATMENT OF OUD

While on Treatment: Minimum **6 months** of concurrent psychosocial treatment, support & monitor

Management of OUD: A National Clinical Practice Guideline (CMAJ 2018)

Withdrawal Management alone **("Cold Turkey")** will be avoided because it is associated with increased rates of **relapse** (60-90%), morbidity & death

Management of OUD: A National Clinical Practice Guideline (CMAJ 2018)

Discussion about Harm Reduction Strategies offered (Naloxone, clean drug paraphernalia, SCS, never use alone, smoking better than IV etc.) Management of OUD: A National Clinical Practice Guideline (CMAJ 2018)

TREATING ADDICTIONS IN THE ER IS A STANDARD OF CARE

Expands opportunity for initiating treatment of OUD

Bup/Nal blocks craving & withdrawals symptoms

Bup/Nal prevents relapse & reduces OD & mortality

CAEP Position Statement: Emergency department management of people with opioid use disorder

October 2020

Justin J. Koh, MD, MPH[*]; Michelle Klaiman, MD[†‡]; Isabelle Miles, MD[§‖]; Jolene Cook, MD[**]; Thara Kumar, MD[††]; Hasan Sheikh, MD, MPA[‡‡§§]; Kathryn Dong, MD, MSc[‖‖***]; Aaron M. Orkin, MD, MSc, MPH[§§†††]; Samina Ali, MDCM[‖‖‡‡‡§§§]; Elizabeth Shouldice, MD, MPH[‖‖‖]

Managing Opioid Withdrawal in the Emergency Department With Buprenorphine

Andrew A. Herring, MD; Jeanmarie Perrone, MD; Lewis S. Nelson, MD*

*Corresponding Author. E-mail: lewis.nelson@rutgers.edu, Twitter: @LNelsonMD.

0196-0644/$-see front matter

https://doi.org/10.1016/j.annemergmed.2018.11.032

Untreated opioid withdrawal commonly results in return to high-consequence opioid use, with high risk of OD death after discharge from the ED

“ TREAT THEM AND STREET THEM” APPROACH IS NOT EFFECTIVE IN THE ER

- < 20% of patients in need of OAT with OUD presenting to ER were started on OAT despite its strong evidence
- When Bup/nal is administered in ER & continued via primary care 74% remain in treatment after 2 months
- No other setting replicates the all-hours access & wrap around services in EDs (access point for the most vulnerable) & availability of same day treatment of OUD

https://cabridge.org/wp-content/uploads/CA-Bridge-Impact-Report-2018-2021.pdf
https://www.healthaffairs.org/do/10.1377/forefront.20211208.799414/full/

ED improves access to OAT for many patients who would otherwise not seek help (levels the playing field)

Increase in ED visits coupled with the growing evidence for the effectiveness of bup/nal means addictions treatment cannot be a niche industry operating on the fringes of the fractured health care system

PRACTICE GUIDELINES FOR TREATMENT OF OUD

CFP·MFC

CANADIAN FAMILY PHYSICIAN • LE MÉDECIN DE FAMILLE CANADIEN

The official journal of the College of Family Physicians of Canada

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Treating opioid use disorder in primary care

Danielle Perry, Eliseo Orrantia and Scott Garrison

Canadian Family Physician February 2019, 65 (2) 117;

Article | eLetters | Info & Metrics | PDF

In this issue

Clinical question

How well is opioid agonist therapy (OAT) managed in primary care?

Bottom line

For patients dependent on opioids, receiving OAT in a primary care setting versus a specialized opioid treatment program resulted in an additional 1 in 6 patients retained in treatment and abstinent from street opioids at 42 weeks. Additionally, almost twice as many patients (77% vs 38%) reported being very satisfied with their care. All studies had supports and training available to their primary care teams.

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WHY BUPRENORPHINE/NALOXONE?

Thrombolytics for STEMI

NNT 43

ASA for Acute Ischemic Stroke

NNT 79

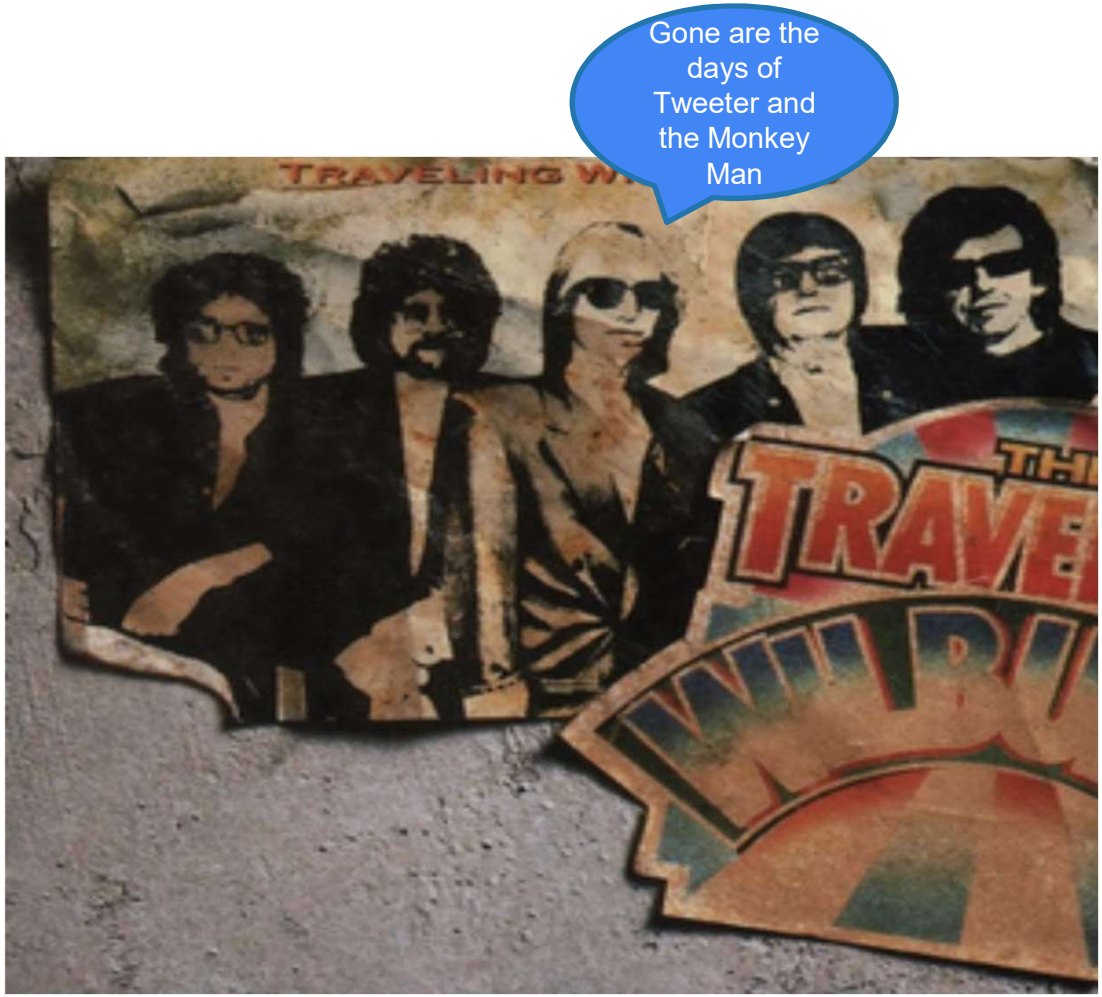
ASA for STEMI

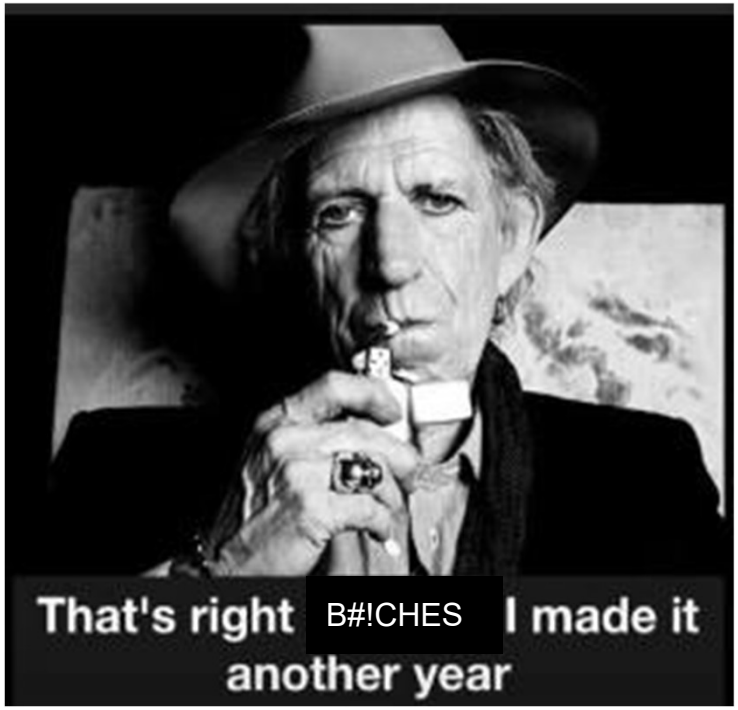
NNT 42

BUP/NAL (>16 mg)

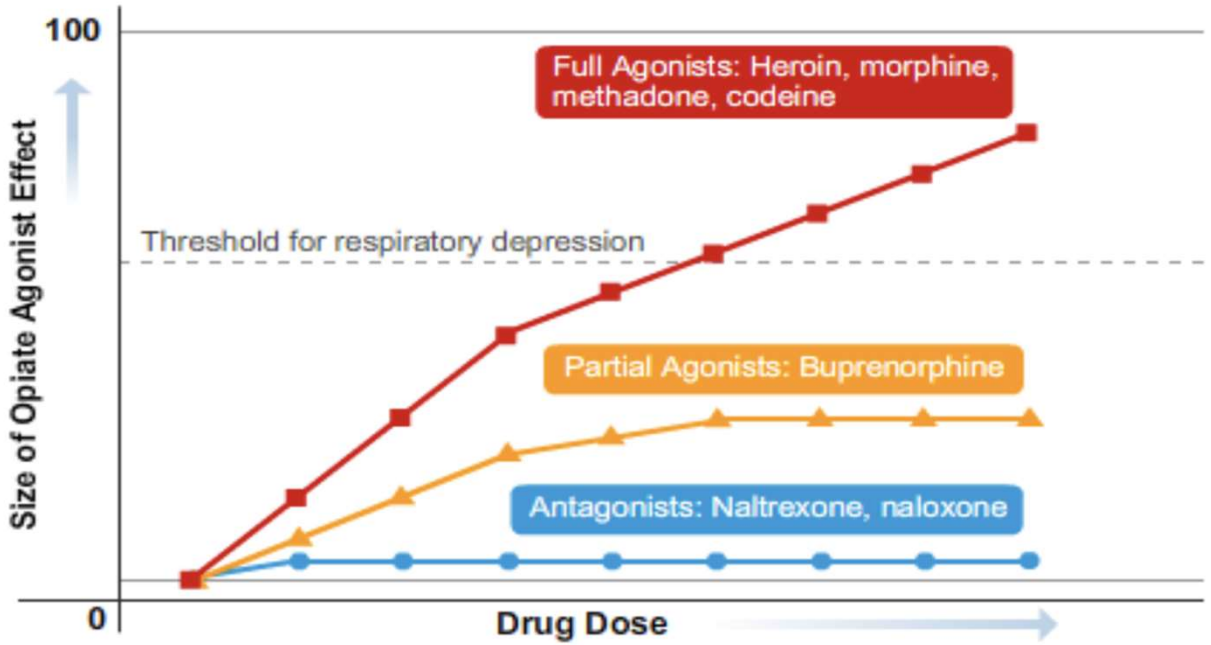
NNT 2

https://www.thennt.com


Gone are the days of Tweeter and the Monkey Man


That's right B#!CHES I made it
another year

HOW SAFE IS BUPRENORPHINE?

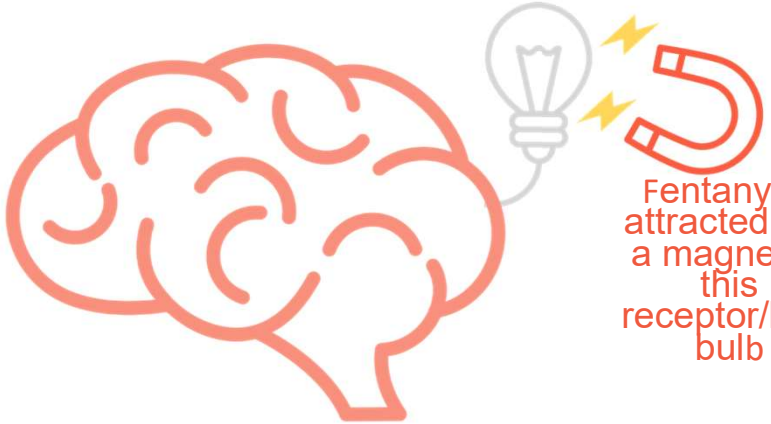


DURATION OF ACTION OF BUPRENORPHINE/NALOXONE

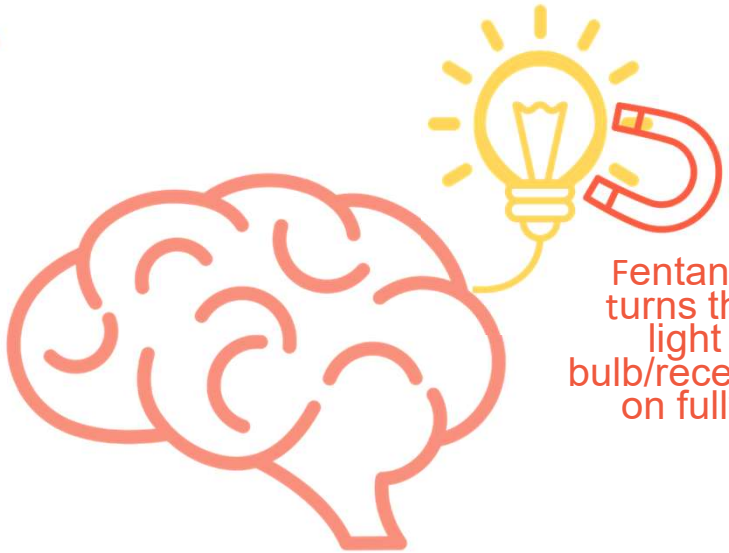
- DURATION OF ACTION IS DOSE DEPENDENT

Dose	Duration of action
4-6 mg SL	4-12 hours
8- 12mg SL	24 hours
> 16 mg SL	24-48 hours
Sublocade 300mg/100 mg (injection every 28 days)	2-6 weeks up to months after steady state

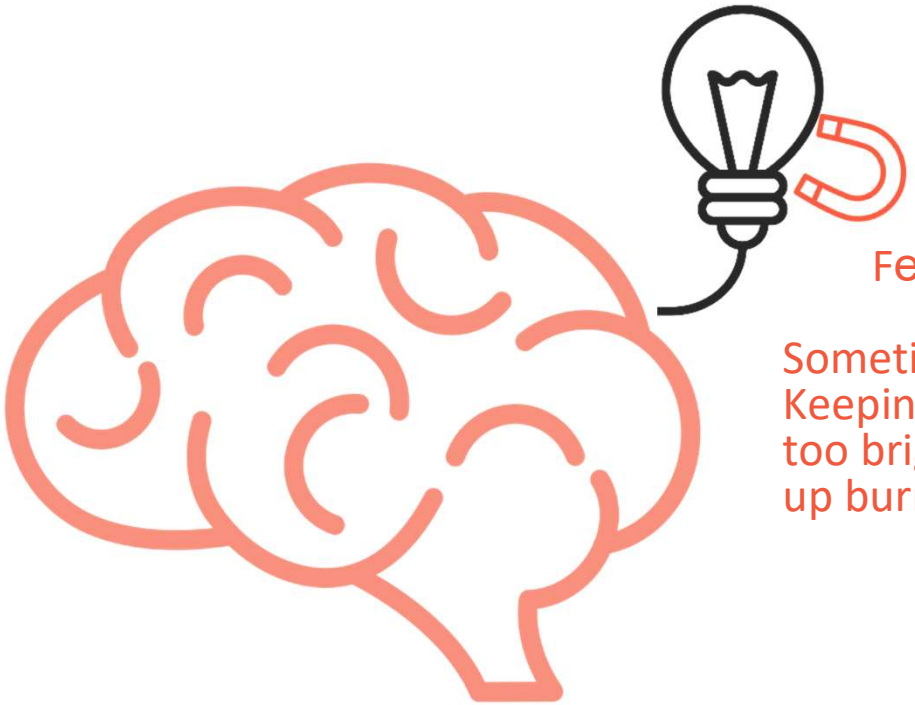
The light bulb is like an opioid receptor in your brain

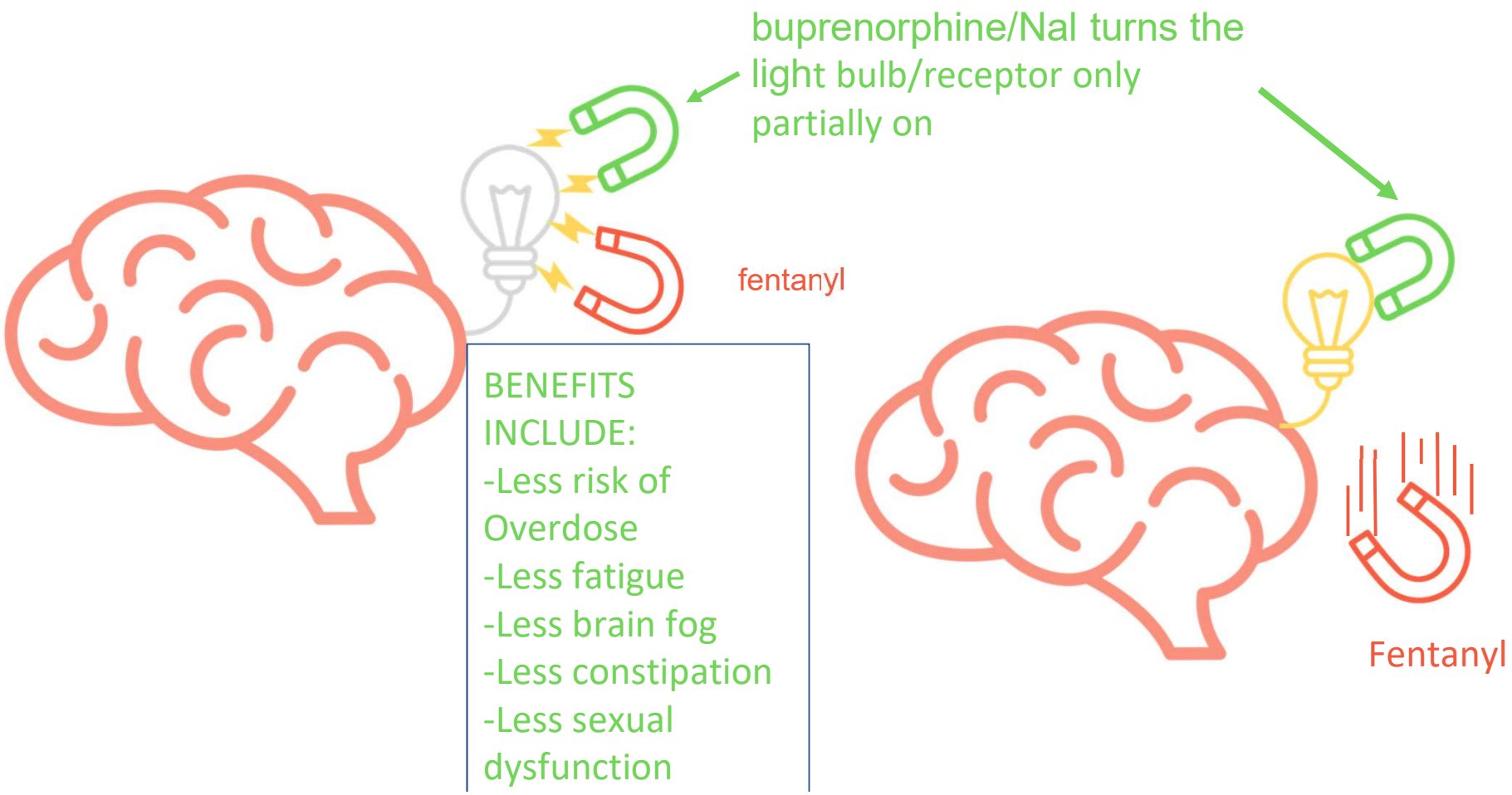


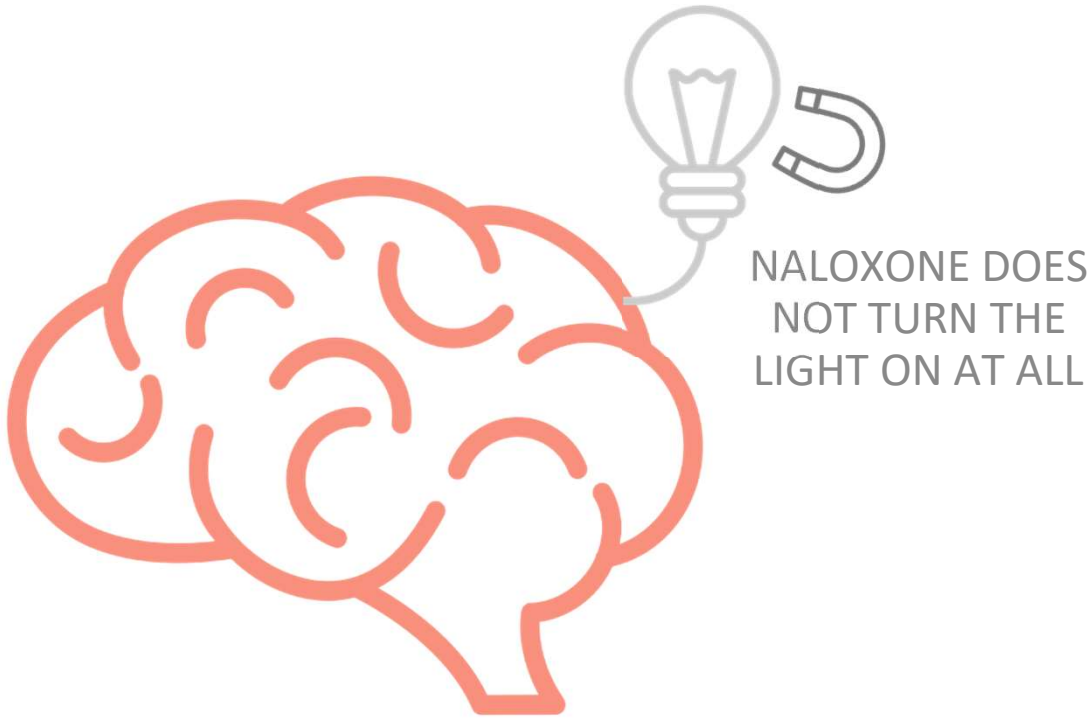
Fentanyl is attracted like a magnet to this receptor/light bulb



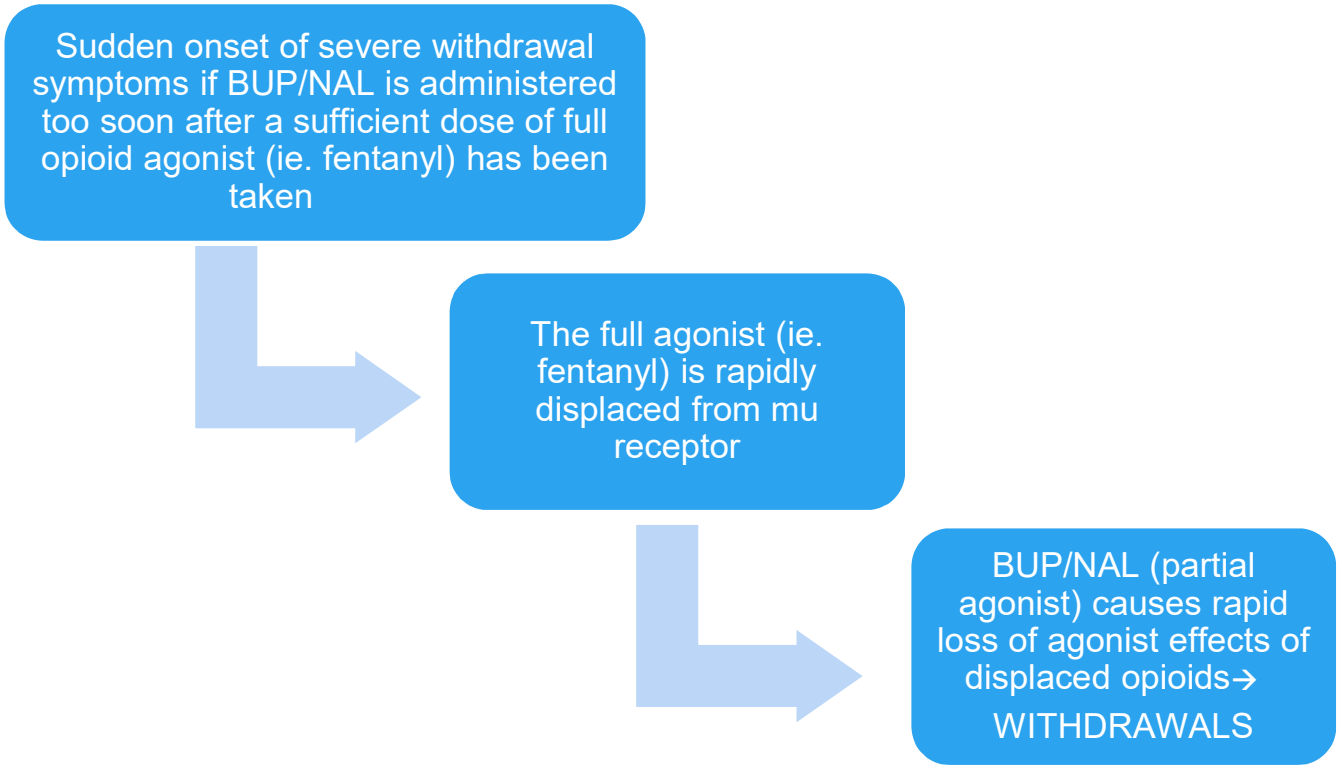
Fentanyl turns the light bulb/receptor on fully


Fentanyl
Sometimes
Keeping a light
too bright ends
up burning it out

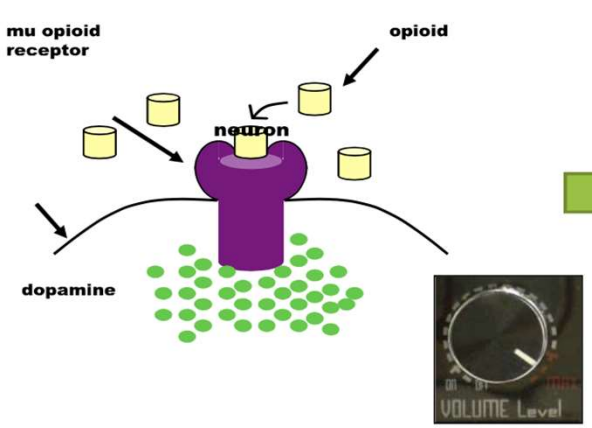

buprenorphine/Nal turns the light bulb/receptor only partially on
fentanyl
BENEFITS INCLUDE:
-Less risk of Overdose
-Less fatigue
-Less brain fog
-Less constipation
-Less sexual dysfunction
Fentanyl


NALOXONE DOES
NOT TURN THE
LIGHT ON AT ALL

WHAT IS BUP/NAL INDUCED PRECIPITATED WITHDRAWAL?



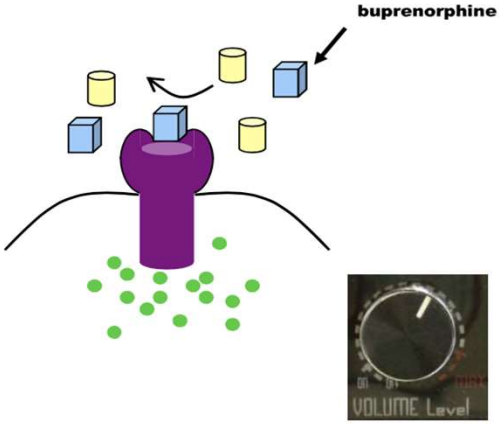
PRECIPITATED WITHDRAWAL FROM BUP/NAL



Intoxication

Significant amount of opioid bound to receptors

"Volume" on max



Buprenorphine

Binds preferentially to receptors

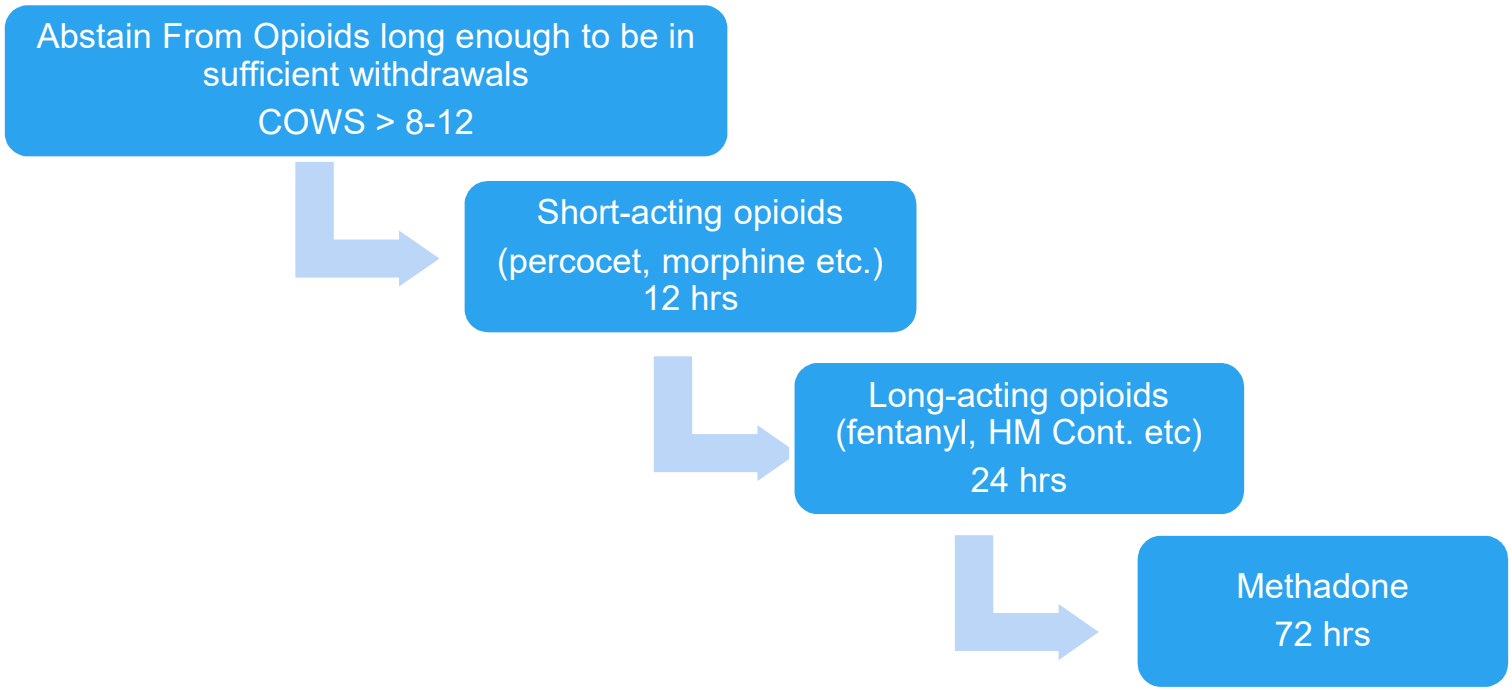
"Volume" on medium

Precipitated Withdrawal:

Relative to intoxication, Buprenorphine "turns on" receptors less so patients feel withdrawal

Graphics adapted from NAABT, Inc. (naabt.org)

PREVENTING PRECIPITATED WITHDRAWAL



TREATMENT OF PRECIPITATED WITHDRAWAL

- FIRST LINE
  - Continue with BUP/NAL induction (may need doses > 32 mg until stabilized)
  - For short-term symptomatic relief consider clonidine, Seroquel, Imodium, Zofran, NSAIDS
  - Also consider for severe agitation Ketamine, Haldol or Olanzapine (or statex)

CAbridge.org

OUD & BUP/NA IN PREGNANCY

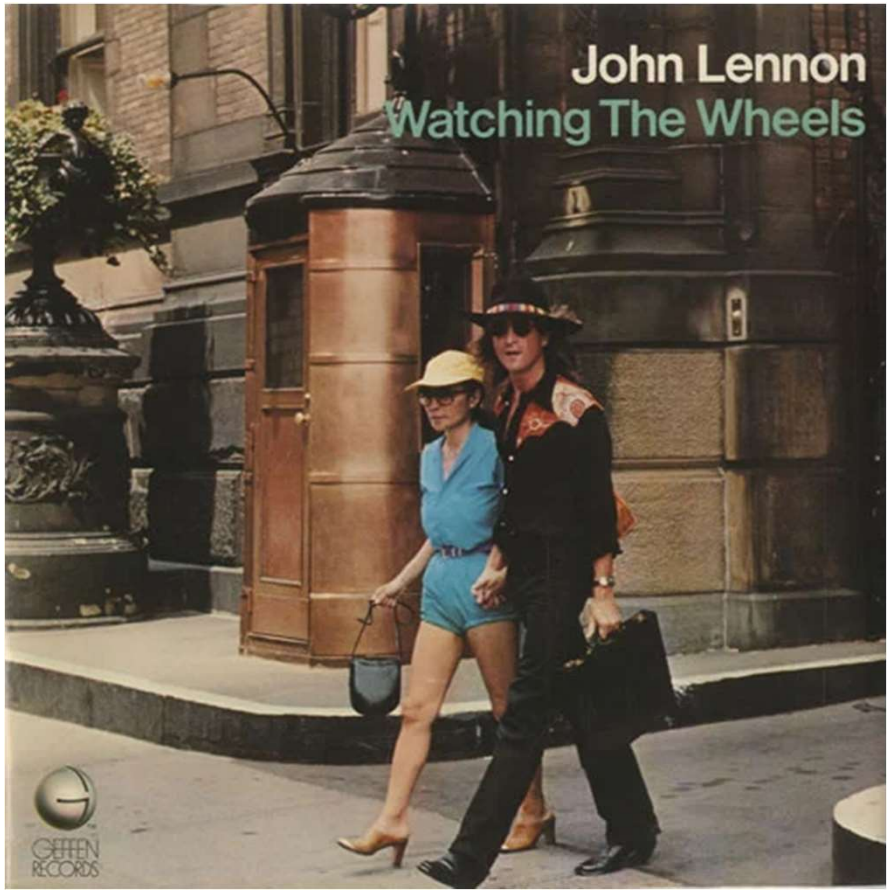
SAFE IN PREGNANCY

People askin' questions

Lost in confusion

Well, I tell them there's no problem

Only solutions



BREAKING DOWN BARRIERS: OUR INNOVATIVE APPROACH TO SYSTEM CHANGE

- BREAKING DOWN SILOS AMONGST COMMUNITY ORGANIZATIONS & IMPROVING PARTNERSHIPS
- OFFERING IMMEDIATE CARE AT HOSPITAL FOR THOSE REQUESTING TREATMENT FOR OUD
- SEAMLESS ACCESS TO THE FULL CONTINUUM OF ADDICTIONS TREATMENT
- DEVELOPING A PROGRAM TO MEET THE NEEDS OF OUR PATIENTS

Known as the whistleblowers

INNOVATION AND IMAGINATION AT THE HOSPITAL

HOSPITAL IS A KEY PLAYER IN SYSTEM CHANGE

- FIRST CHANGING HOSPITAL CULTURE, REDUCING STIGMA, AND IMPROVING COMFORT LEVELS (including ED)
- PROVIDING IMMEDIATE TREATMENT FOR THOSE PRESENTING TO ER REQUESTING HELP
- OPENING OF MEDICAL WITHDRAWAL MANAGEMENT BEDS
- EDUCATION TO COLLEAGUES & STAFF
- IMPLEMENTING AMCS & CWMS TEAMS
- PROVIDING WRAPAROUND CARE

TIMMINS AND DISTRICT HOSPITAL
L'HÔPITAL DE TIMMINS ET DU DISTRICT

OUR TEAM

- COMMUNITY WITHDRAWAL MANAGEMENT SERVICE
- ACUTE MEDICINE CONSULT SERVICE
- TIMMINS POLICE SERVICE COMMUNITY OUTREACH SAFETY PROGRAM
- AND WE WORK VERY CLOSELY WITH MOBILE CRISIS

WITHDRAWAL MANAGEMENT BEDS

TIMMINS AND DISTRICT HOSPITAL

- WiMU (Acute Withdrawal Management Unit) 7 BED UNIT LOCATED IN OUR HOSPITAL
  - Initially started as 2 beds(Dec 2020) in the ICU
  - STAFFED BY RNs
  - AMCT RN AND HOSPITAL SW
- PHYSICIAN ON CALL 7 DAYS A WEEK

OUTPATIENT COMMUNITY WITHDRAWAL MANAGEMENT SERVICES

- RN
- NP
- SW

INITIAL INPATIENT BUP/NALX INDUCTION PROTOCOLS

- THE "EARLY" DAYS OF BUPRENORPHINE DOSING:
  - SLOW TITRATION OF SUBLINGUAL BUPRENORPHINE-NALOXONE
  - LONG-ACTING BUPRENORPHINE GIVEN ON DAY 7 (AFTER HOSPITAL DISCHARGE)

Max Daily Dosing:

Day 1:
- Dose #1:4 mg
- Dose #2: 2-4 mg
- Subsequent dosing : 2 mg q1h prn

Max:
- Day 1: 12 mg
- Day 2: 16 mg
- Day 3: 20 mg
- Day 4: 24 mg

PROBLEMS:

- 7 days of inpatient stabilization on BUP/NAL > 8mg as per product monograph was too long
  - Patients would just leave
- Discharged patients wouldn't return for long-acting buprenorphine at 7 days
- Risk of OD and death was greater than risk of early injection
- **We had to change this protocol almost immediately**

WE USE TA GIVE A LITTLE BUT A LITTLE WOULDN'T DO IT SO THE LITTLE GOT MORE AND MORE……

GAME CHANGER: MACRODOSING, HERE WE COME!

- MAXIMUM DAILY DOSING: 32 MG BUP/NAL

Sometimes higher during stabilization

- RAPID TITRATION WITH MACRODOSING BUP/NAL

Day 1: COWS>12 + no fentanyl use >24 hrs
Dosing: **24mg then 8 mg q1h prn X1**
Total dose over 1-2 hours= 32mg

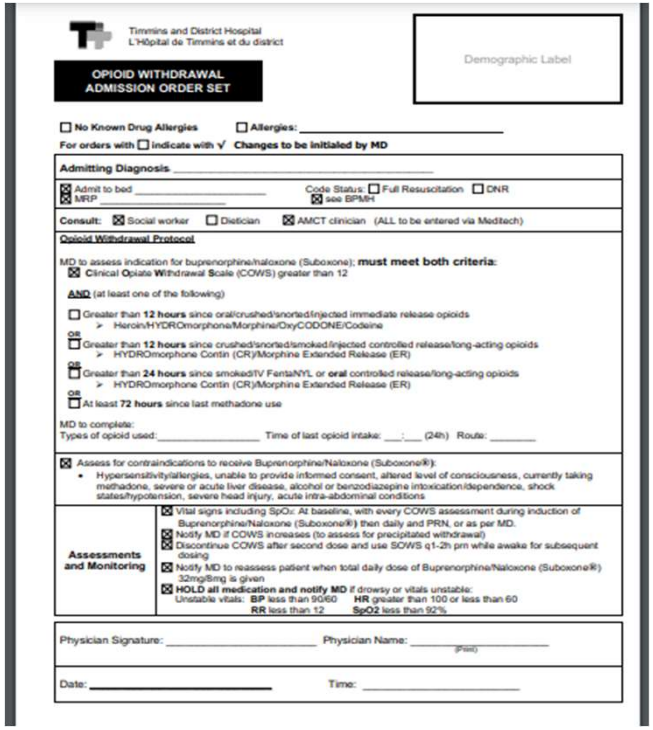
** PEOPLE WHO USE FENTANYL**

Within 1-3 hours most patients are comfortable and feeling ***no withdrawal symptoms***

1. JACOBS P ET AL. *AM J ADDICT* 2015;24:667-75.
2. CARROLL GG ET AL. *PREHOSP EMERG CARE* 2021;25:289-93.
3. HERRING AA ET AL. *JAMA NETW OPEN*. 2021;4:E2117128.

4.https://cabridge.ca
5.Mariani JJ et al. Am J addict.2021;1-7
6.Korownyk et al, Canadian Family Physician;2018:321-33

UPDATED ORDER SETS



Timmins and District Hospital
L'Hôpital de Timmins et du district

OPIOID WITHDRAWAL ADMISSION ORDER SET

Demographic Label

☐ **No Known Drug Allergies** ☐ **Allergies:** _____

For orders with ☐ **indicate with √ Changes to be initialed by MD**

Admitting Diagnosis _____

☒ Admit to bed _____ Code Status: ☐ Full Resuscitation ☐ DNR
☒ MRP _____ ☒ see BPMH

Consult: ☒ Social worker ☐ Dietician ☒ AMCT clinician (ALL to be entered via Meditech)

Opioid Withdrawal Protocol

MD to assess indication for buprenorphine/naloxone (Suboxone); **must meet both criteria:**
☒ **C**linical **O**piate **W**ithdrawal **S**cale (COWS) greater than 12

AND (at least one of the following)

☐ Greater than **12 hours** since oral/crushed/snorted/injected immediate release opioids
- Heroin/HYDROmorphone/Morphine/OxyCODONE/Codeine

OR
☐ Greater than **12 hours** since crushed/snorted/smoked/injected controlled release/long-acting opioids
- HYDROmorphone Contin (CR)/Morphine Extended Release (ER)

OR
☐ Greater than **24 hours** since smoked/IV Fentanyl or **oral** controlled release/long-acting opioids
- HYDROmorphone Contin (CR)/Morphine Extended Release (ER)

OR
☐ At least **72 hours** since last methadone use

MD to complete:
Types of opioid used:_____ Time of last opioid intake: ___:___ (24h) Route: _____

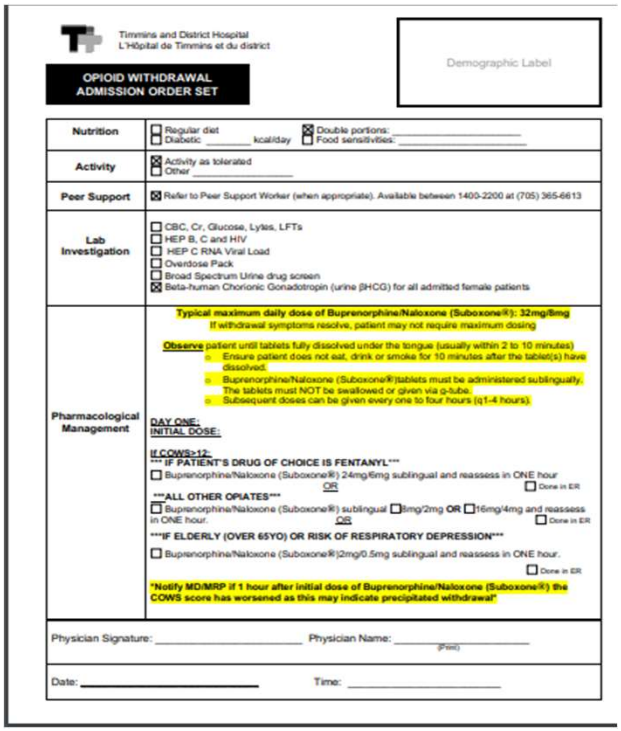
☒ Assess for contraindications to receive Buprenorphine/Naloxone (Suboxone®):
- Hypersensitivity/allergies, unable to provide informed consent, altered level of consciousness, currently taking methadone, severe or acute liver disease, alcohol or benzodiazepine intoxication/dependence, shock states/hypotension, severe head injury, acute intra-abdominal conditions

Assessments and Monitoring

☒ Vital signs including SpO_2: At baseline, with every COWS assessment during induction of Buprenorphine/Naloxone (Suboxone®) then daily and PRN, or as per MD.
☒ Notify MD if COWS increases (to assess for precipitated withdrawal)
☒ Discontinue COWS after second dose and use SOWS q1-2h prn while awake for subsequent dosing
☒ Notify MD to reassess patient when total daily dose of Buprenorphine/Naloxone (Suboxone®) 32mg/8mg is given
☒ **HOLD all medication and notify MD** if drowsy or vitals unstable:
Unstable vitals: **BP** less than 90/60 **HR** greater than 100 or less than 60
RR less than 12 **SpO2** less than 92%

Physician Signature: _____ Physician Name: _____ (Print)

Date: _____ Time: _____



Timmins and District Hospital
L'Hôpital de Timmins et du district

OPIOID WITHDRAWAL ADMISSION ORDER SET

Demographic Label

Nutrition	☐ Regular diet ☒ Double portions: _____ ☐ Diabetic _____ kcal/day ☐ Food sensitivities: _____
Activity	☒ Activity as tolerated ☐ Other _____
Peer Support	☒ Refer to Peer Support Worker (when appropriate). Available between 1400-2200 at (705) 365-6613
Lab Investigation	☐ CBC, Cr, Glucose, Lytes, LFTs ☐ HEP B, C and HIV ☐ HEP C RNA Viral Load ☐ Overdose Pack ☐ Broad Spectrum Urine drug screen ☒ Beta-human Chorionic Gonadotropin (urine βHCG) for all admitted female patients
Pharmacological Management	**Typical maximum daily dose of Buprenorphine/Naloxone (Suboxone®): 32mg/8mg** If withdrawal symptoms resolve, patient may not require maximum dosing **Observe** patient until tablets fully dissolved under the tongue (usually within 2 to 10 minutes) a. Ensure patient does not eat, drink or smoke for 10 minutes after the tablet(s) have dissolved. b. Buprenorphine/Naloxone (Suboxone®)tablets must be administered sublingually. The tablets must NOT be swallowed or given via g-tube. c. Subsequent doses can be given every one to four hours (q1-4 hours). **DAY ONE:** **INITIAL DOSE:** **If COWS>12:** ***** IF PATIENT'S DRUG OF CHOICE IS FENTANYL***** ☐ Buprenorphine/Naloxone (Suboxone®) 24mg/6mg sublingual and reassess in ONE hour ☐ Done in ER OR *****ALL OTHER OPIATES***** ☐ Buprenorphine/Naloxone (Suboxone®) sublingual ☐8mg/2mg **OR** ☐16mg/4mg and reassess in ONE hour. ☐ Done in ER OR *****IF ELDERLY (OVER 65YO) OR RISK OF RESPIRATORY DEPRESSION***** ☐ Buprenorphine/Naloxone (Suboxone®)2mg/0.5mg sublingual and reassess in ONE hour. ☐ Done in ER ***Notify MD/MRP if 1 hour after initial dose of Buprenorphine/Naloxone (Suboxone®) the COWS score has worsened as this may indicate precipitated withdrawal***

Physician Signature: _____ Physician Name: _____ (Print)

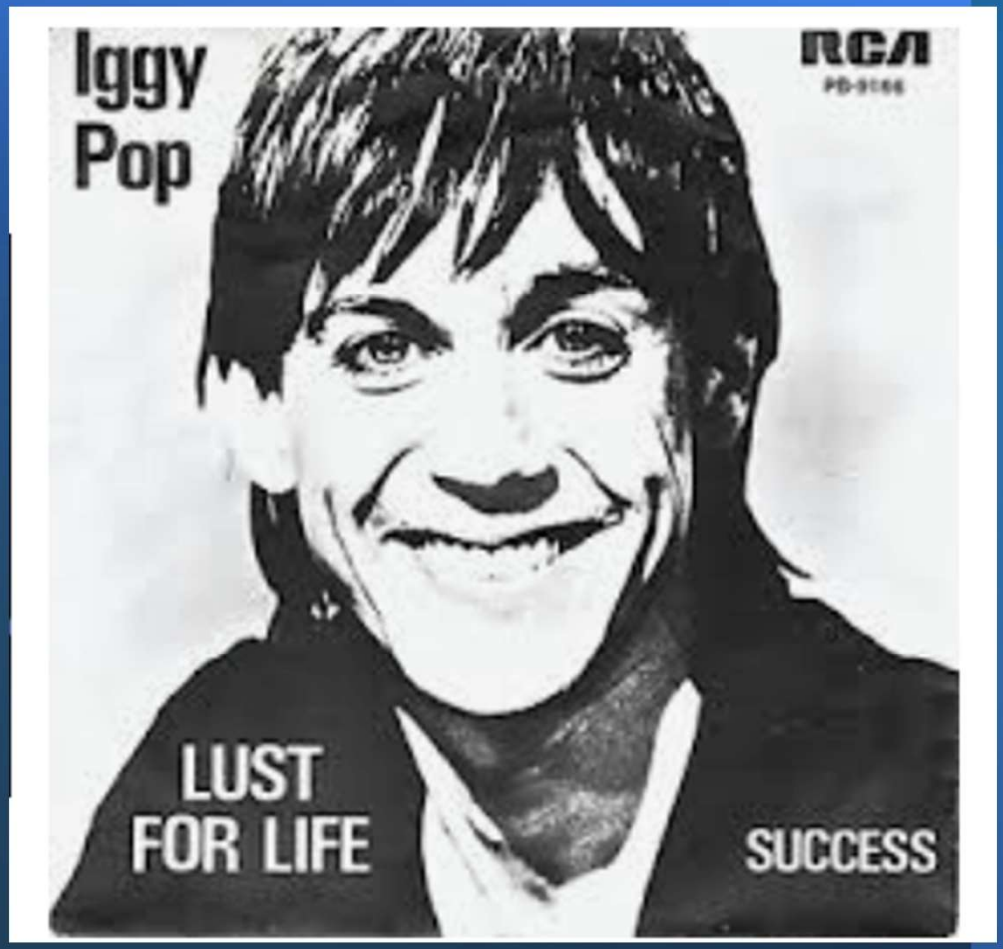
Date: _____ Time: _____

CLINICAL OBSERVATIONS SUPPORT MACRODOSING

- WE OBSERVED NO AES AFTER TREATING OVER 180 PEOPLE USING THIS PROTOCOL
- **WE HAVE NEVER GIVEN TOO MUCH SUBLINGUAL BUPRENORPHINE-NALOXONE, BUT WE HAVE GIVEN TOO LITTLE**
  - THIS MAY RESULT IN THE PATIENT LEAVING

Urgency of this crisis supports practiced-based evidence
AND REMEMBER:
Medicine makes evidence

Macrodosing can potentially circumvent precipitated withdrawal


Iggy
Pop
RCA
LUST
FOR LIFE
SUCCESS

EVIDENCE FOR MACRODOSING

Original Investigation | Substance Use and Addiction

High-Dose Buprenorphine Induction in the Emergency Department for Treatment of Opioid Use Disorder

Andrew A. Herring, MD; Aidan A. Vosooghi, MS; Joshua Luftig, PA; Erik S. Anderson, MD; Xiwen Zhao, MS; James Dziura, PhD; Kathryn F. Hawk, MD, MHS; Ryan P. McCormack, MD, MS; Andrew Saxon, MD; Gail D'Onofrio, MD, MS

JAMA Network Open. 2021;4(7):e2117128.

High Dose BUP/NAL (28-32 mg) is safe, well tolerated and may impart substantial OD protection & is effective in blunting the euphoric & reinforcing effects of any opioids used in the high-risk window following ED discharge

Therapeutic dose of BUP/NAL was achieved in < 3 hrs of ED stay & low acuity treatment areas

EVIDENCE FOR MACRODOSING

Single high-dose buprenorphine for opioid craving during withdrawal

Jamshid Ahmadi[1*], Mina Sefidfard Jahromi[1], Dara Ghahremani[2] and Edythe D. London[2,3,4]

Ahmadi et al. Trials (2018) 19:675

Single Doses of BUP/NAL up to 96 mg were safe and did not cause respiratory depression & adequately treat cravings and withdrawals

EVIDENCE FOR MACRODOSING

Am J Addict. 2015 October ; 24(7): 667–675. doi:10.1111/ajad.12288.

Treatment Outcomes in Opioid Dependent Patients With Different Buprenorphine/Naloxone Induction Dosing Patterns and Trajectories

Petra Jacobs, MD[1], Alfonso Ang, PhD[2], Maureen P. Hillhouse, PhD[2], Andrew J. Saxon, MD[3], Suzanne Nielsen, PhD[4], Paul G. Wakim, PhD[5], Barbara E. Mai, PhD[6], Larissa J. Mooney, MD[2], Jennifer S. Potter, PhD[7], and Jack D. Blaine, MD[1]

Higher doses (16&32 mg) with quicker titration
-less drop out rates at 7 days
-No major AEs

Rapid Heroin Detoxification Using a Single High Dose of Buprenorphine

Ilan Kutz & Victor Reznik

To cite this article: Ilan Kutz & Victor Reznik (2001) Rapid Heroin Detoxification Using a Single High Dose of Buprenorphine, Journal of Psychoactive Drugs, 33:2, 191-193, DOI: 10.1080/02791072.2001.10400484

32 mg induction dose
All Abstinent at 7days
No major AEs

EVIDENCE OF MACRODOSING

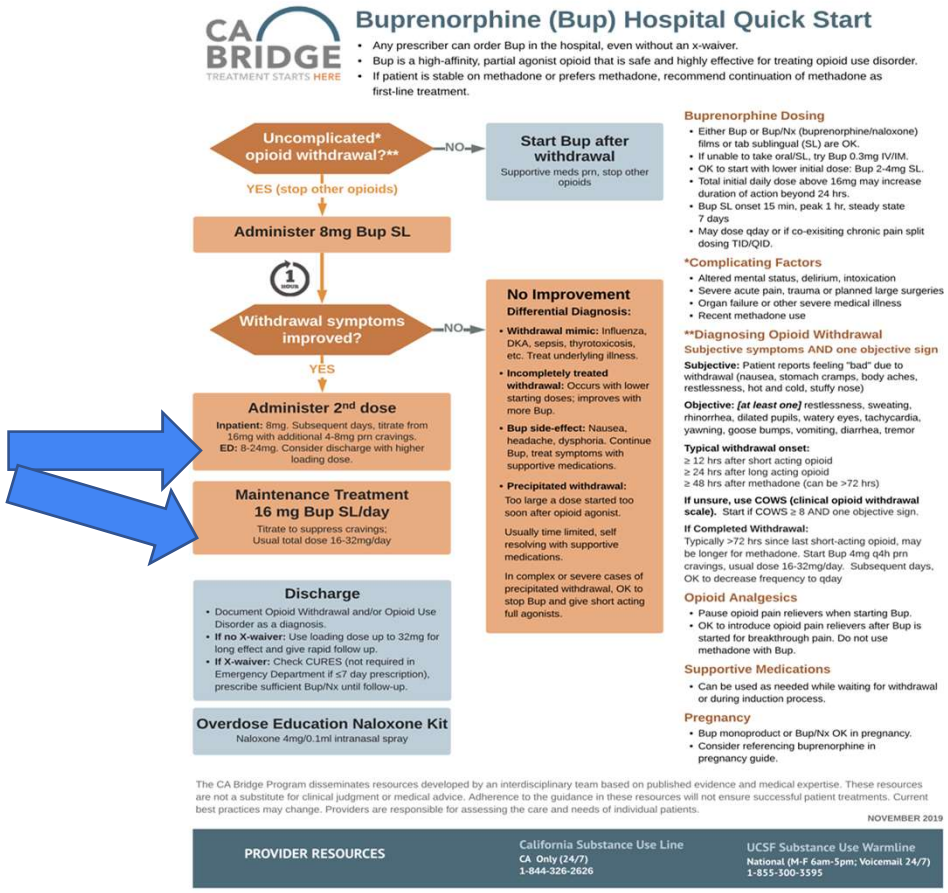
BUPRENORPHINE FIELD INITIATION OF RESCUE TREATMENT BY EMERGENCY MEDICAL SERVICES (BUPE FIRST EMS): A CASE SERIES

Gerard G. Carroll, MD FAAEM EMT-P, Deena D. Wasserman, MD FAWM, Aman A. Shah, MD, Matthew S. Salzman, MD, Kaitlan E. Baston, MD MSc DFASAM, Rick A. Rohrbach, BSN CFRN CCRN-K MICP, Iris L. Jones, MA LPC, LCADC, Rachel Haroz, MD, FAACT

Prehospital Emergency Care March/April 2021 Volume 25, Number 2

PROTOCOLS FOR MACRODOSING

8-24 mg
May need higher loading dose 32 mg



CA BRIDGE
TREATMENT STARTS HERE

Buprenorphine (Bup) Hospital Quick Start

- Any prescriber can order Bup in the hospital, even without an x-waiver.
- Bup is a high-affinity, partial agonist opioid that is safe and highly effective for treating opioid use disorder.
- If patient is stable on methadone or prefers methadone, recommend continuation of methadone as first-line treatment.

Uncomplicated* opioid withdrawal?**
NO → **Start Bup after withdrawal**
Supportive meds prn, stop other opioids

YES (stop other opioids)

Administer 8mg Bup SL

1 hour

Withdrawal symptoms improved?
NO → **No Improvement**

Differential Diagnosis:

- **Withdrawal mimic:** Influenza, DKA, sepsis, thyrotoxicosis, etc. Treat underlying illness.
- **Incompletely treated withdrawal:** Occurs with lower starting doses; improves with more Bup.
- **Bup side-effect:** Nausea, headache, dysphoria. Continue Bup, treat symptoms with supportive medications.
- **Precipitated withdrawal:** Too large a dose started too soon after opioid agonist.

Usually time limited, self resolving with supportive medications.

In complex or severe cases of precipitated withdrawal, OK to stop Bup and give short acting full agonists.

YES

Administer 2nd dose
Inpatient: 8mg. Subsequent days, titrate from 16mg with additional 4-8mg prn cravings.
ED: 8-24mg. Consider discharge with higher loading dose.

Maintenance Treatment 16 mg Bup SL/day
Titrate to suppress cravings;
Usual total dose 16-32mg/day

Discharge

- Document Opioid Withdrawal and/or Opioid Use Disorder as a diagnosis.
- **If no X-waiver:** Use loading dose up to 32mg for long effect and give rapid follow up.
- **If X-waiver:** Check CURES (not required in Emergency Department if ≤7 day prescription), prescribe sufficient Bup/Nx until follow-up.

Overdose Education Naloxone Kit
Naloxone 4mg/0.1ml intranasal spray

Buprenorphine Dosing

- Either Bup or Bup/Nx (buprenorphine/naloxone) films or tab sublingual (SL) are OK.
- If unable to take oral/SL, try Bup 0.3mg IV/IM.
- OK to start with lower initial dose: Bup 2-4mg SL.
- Total initial daily dose above 16mg may increase duration of action beyond 24 hrs.
- Bup SL onset 15 min, peak 1 hr, steady state 7 days
- May dose qday or if co-exisiting chronic pain split dosing TID/QID.

*Complicating Factors

- Altered mental status, delirium, intoxication
- Severe acute pain, trauma or planned large surgeries
- Organ failure or other severe medical illness
- Recent methadone use

**Diagnosing Opioid Withdrawal

Subjective symptoms AND one objective sign

Subjective: Patient reports feeling "bad" due to withdrawal (nausea, stomach cramps, body aches, restlessness, hot and cold, stuffy nose)

Objective: ***[at least one]*** restlessness, sweating, rhinorrhea, dilated pupils, watery eyes, tachycardia, yawning, goose bumps, vomiting, diarrhea, tremor

Typical withdrawal onset:
≥ 12 hrs after short acting opioid
≥ 24 hrs after long acting opioid
≥ 48 hrs after methadone (can be >72 hrs)

If unsure, use COWS (clinical opioid withdrawal scale). Start if COWS ≥ 8 AND one objective sign.

If Completed Withdrawal:
Typically >72 hrs since last short-acting opioid, may be longer for methadone. Start Bup 4mg q4h prn cravings, usual dose 16-32mg/day. Subsequent days, OK to decrease frequency to qday

Opioid Analgesics

- Pause opioid pain relievers when starting Bup.
- OK to introduce opioid pain relievers after Bup is started for breakthrough pain. Do not use methadone with Bup.

Supportive Medications

- Can be used as needed while waiting for withdrawal or during induction process.

Pregnancy

- Bup monoproduct or Bup/Nx OK in pregnancy.
- Consider referencing buprenorphine in pregnancy guide.

The CA Bridge Program disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

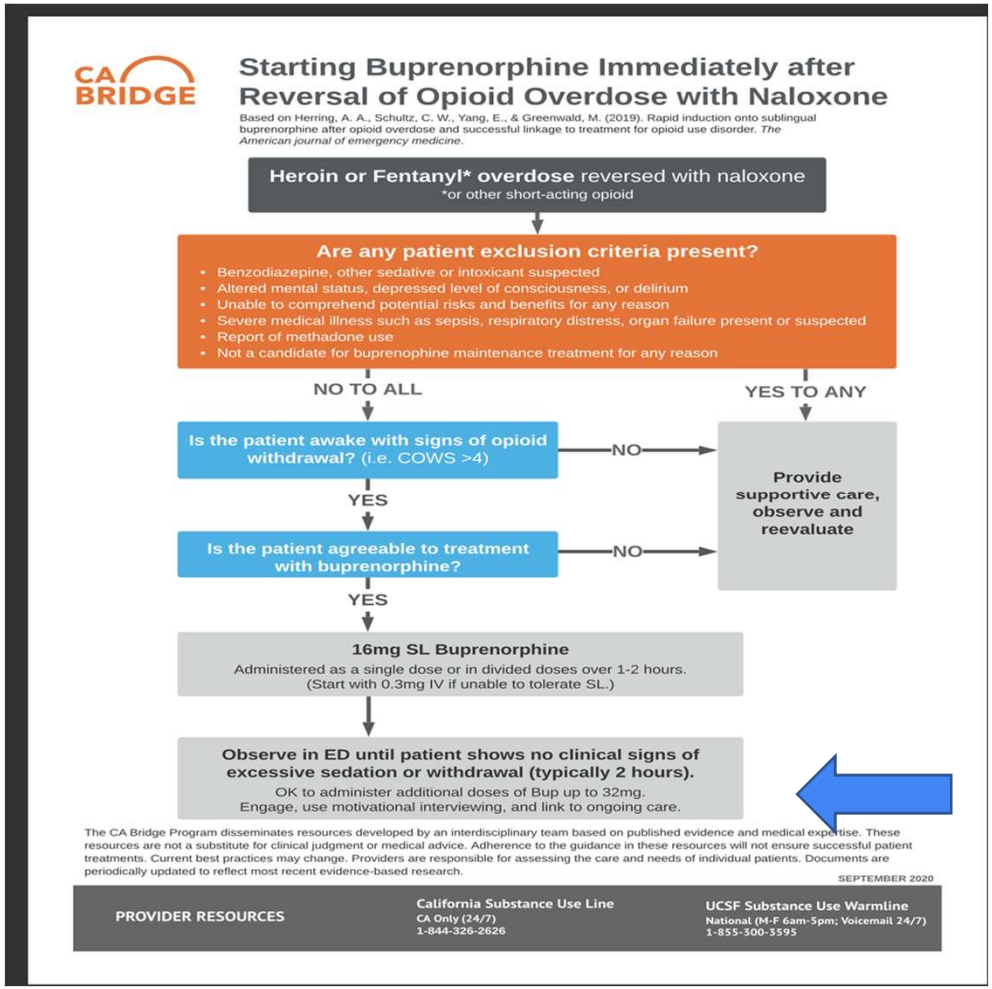
NOVEMBER 2019

PROVIDER RESOURCES

California Substance Use Line
CA Only (24/7)
1-844-326-2626

UCSF Substance Use Warmline
National (M-F 6am-5pm; Voicemail 24/7)
1-855-300-3595

PROTOCOLS FOR MACRODOSING



Up to 32 mg

Buprenorphine Macrodosing Initiation

Contact ED substance use navigator/hospital to home coordinator if available.

Macrodosing is an alternative approach to initiating buprenorphine for patients who do not meet traditional criteria and for whom delays in treatment pose significant risk. Macrodosing should be reserved for people with high opioid tolerance. Higher initial and total Day 1 doses are off-label but have been shown to be effective in achieving therapeutic levels of buprenorphine.[1]

Indications:

- **Patients in withdrawal from fentanyl use, or**
- **Patients who have had full naloxone reversal of an opioid overdose** (i.e., naloxone-induced withdrawal)

Are any exclusion criteria to buprenorphine macrodosing present?

- Allergy or hypersensitivity to buprenorphine or naloxone
- Reported methadone use in the last 72 hours
- Unable to provide informed consent
- Altered mental status, depressed level of consciousness, or delirium
- Acute intoxication
- Severe medical illness such as sepsis, respiratory distress, severe liver dysfunction
- Concurrent withdrawal from alcohol or benzodiazepines
- Elderly

YES → Provide supportive care and re-evaluate.

OPTIONS:

- ☐ Consult addiction medicine if available; patient may be a candidate for **methadone** or **SROM**
- ☐ Offer RAAM referral/harm reduction resources
- ☐ Provide naloxone kit

NO →

Is patient awake with COWS ≥ 13
Has at least 18 hours elapsed since last fentanyl use? (not necessary post-naloxone reversal)

NO →

OPTIONS:

- ☐ Offer home buprenorphine start
- ☐ Offer microinduction buprenorphine start
- ☐ Offer return to ED when in withdrawal for buprenorphine treatment
- ☐ Patient handouts about buprenorphine treatment, home start, microdosing
- ☐ Provide naloxone kit

YES →

Explain:

- Goal is to achieve full treatment dose within a matter of hours
- May experience transient worsening of withdrawal symptoms before relief
- For patients in naloxone-induced withdrawal macrodosing should be started as soon as possible

Provide 16mg buprenorphine SL as 2x8mg tablets → **Reassess in one hour**

Repeat buprenorphine 8–16mg q1–2h until withdrawal is resolved or sedation (recommended Day 1 maximum is 32mg)

- Discharge with prescription for total dose dispensed in the ED as daily observed dose until planned follow-up (max 7 days)
- Refer to RAAM/community clinic
- Dispense naloxone kit
- Buprenorphine handout
- Harm Reduction Info Sheet

- See High-Dose Buprenorphine Initiation ("Macrodosing") Reference Guide for ED Providers
- See Buprenorphine Reference Guide for further information

[1] https://cabridge.org/resource/starting-buprenorphine-immediately-after-reversal-of-opioid-overdose-with-naloxone/

METAPHI
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EARLY DEPO-BUP CONSIDERATIONS

WHY CAN'T WE GIVE DEPO-BUP EARLY-DAY 1-3?

Why do I have to wait 7 days for my injection (Patient)

WHAT IS THE DIFFERENCE BETWEEN

- 8 MG FOR 1-3 DAYS VS 7 DAYS?
- 7 DAYS X8 MG VS 2 DAYS X32 MG

EVIDENCE FOR EARLY DEPO-BUP ADMINISTRATION

ClinicalTrials.gov

Find Studies ▾ About Studies ▾

Home > Search Results > Study Record Detail

Trial record **1 of 393** for: Sublocade |

Previous Study | Return to List |

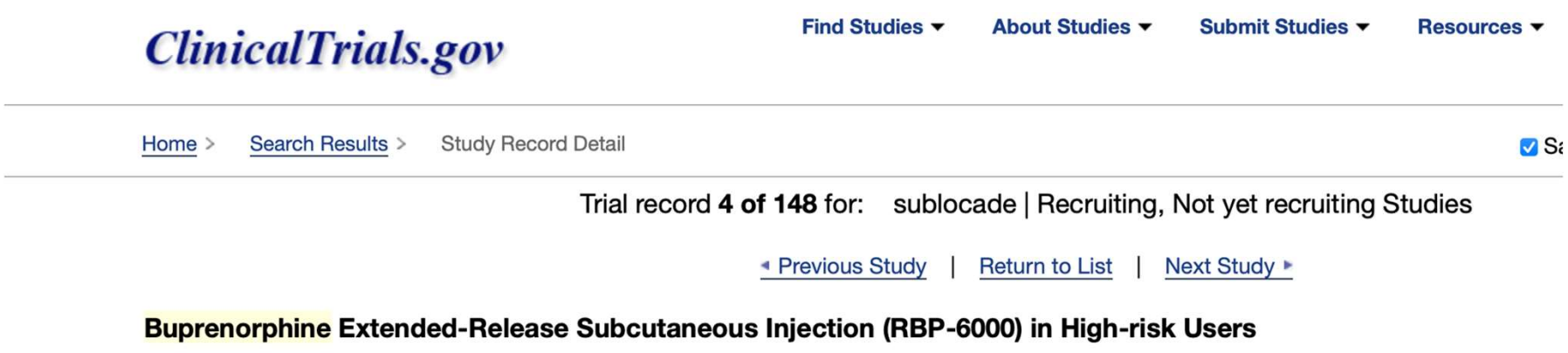
An Open-Label Pilot Study of Sublocade as Treatment for Opiate Use Disorder

EVIDENCE FOR EARLY DEPO-BUP ADMINISTRATION

Open-label trial of a single-day induction onto buprenorphine extended-release injection for users of heroin and fentanyl

John J. Mariani MD[1,2] | Amy L. Mahony LMHC[1] | Samuel C. Podell BS[3] | Daniel J. Brooks LCSW[1] | Christina Brezing MD[1,2] | Sean X. Luo MD, PhD[1,2] | Nasir H. Naqvi MD, PhD[1,2] | Frances R. Levin MD[1,2]

EVIDENCE FOR EARLY DEPO-BUP ADMINISTRATION



EVIDENCE FOR EARLY DEPO-BUP ADMINISTRATION

Initiating Monthly Buprenorphine Injection After Single Dose of Sublingual Buprenorphine

Katharina Wiest[1] | Stephanie Strafford[2] | Sunita Shinde[2] | Amy Heath[2] | Robert Dobbins[2] | Howard Hassman[3] | 1. Pacific Vascular Specialists, Portland, OR | 2. Indivior, Inc., Richmond, VA 3. Hassman Research Institute LLC, Marlton, NJ

Aims

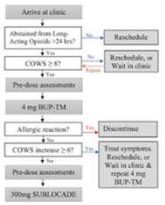
Buprenorphine extended-release injection (SUBLOCADE) is indicated for treatment of moderate/severe opioid use disorder (OUD) in patients who have initiated treatment with transmucosal buprenorphine (BUP-TM), followed by dose adjustment for a minimum of 7 days.[1] In the current medical climate, there is great interest in initiating a depot formulation as rapidly as possible, increasing the likelihood of patient adherence to treatment from the outset, and reducing the need to provide take-home transmucosal (TM) buprenorphine for outpatient use.[2,3] We evaluated withdrawal symptoms, safety and tolerability of initiating SUBLOCADE one hour after administering a single dose of 4 mg BUP-TM.

Methods

Study Design

This open-label, post-approval study was registered as NCT03993392. Qualitative and quantitative urine drug screens, self-reported drug use, and the clinical opiate withdrawal scale (COWS) were completed before buprenorphine administration. If COWS score was ≥8, staff administered 4 mg BUP-TM. If the participant did not exhibit hypersensitivity, symptoms of precipitated withdrawal (PW), or sedation within 1h, 300 mg of SUBLOCADE was administered and clinical assessments were completed inpatient for 48 hours and outpatient up to 28 days post-injection. Rescue medications and supplemental BUP-TM were permitted to treat withdrawal and recommended psychosocial counselling was provided to all participants. Endpoints were: 1) COWS score increase of ≥6 and 2) independent adjudication of PW.

Figure 1 Schematic Diagram Depicting Rapid Induction Procedure



BUP=buprenorphine; COWS=Clinical Opiate Withdrawal Scale; TM=transmucosal

Supported by funding from Indivior, Inc.

Participants

- ≥18 years of age
- Documented history of moderate or severe OUD as defined by Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5)
- Seeking buprenorphine-assisted treatment for OUD
- Abstained from short-acting opioids for at least 6 hours and long-acting opioids for 24 hours before arriving at the clinic on the morning of Day 1

Table 1 Demographic and Opioid Use Disorder Characteristics at Screening of Enrolled Participants

Parameter	Transmucosal Buprenorphine Enrolled Population (N=26)	SUBLOCADE 300 mg Safety Analysis Set (N=24)
Age (Years)	41.4±14.05	40.0±13.45
Sex		
Male	14 (53.8%)	12 (50.0%)
Female	12 (46.2%)	12 (50.0%)
Race		
African American	11 (42.3%)	9 (37.5%)
White	13 (50.0%)	13 (54.2%)
Other	2 (7.7%)	2 (8.3%)
Ethnicity		
Not Hispanic or Latino	24 (92.3%)	22 (91.7%)
Not Reported	2 (7.7%)	2 (8.3%)
BMI (kg/m²)	22.61±3.954	22.60±4.058
Opioid Use		
Opioids – Lifetime Use (years)	15.80±15.114	13.88±13.542
Opioids – Last 30 days (days)	28.96±3.693	28.88±3.837
Opioids – Intravenous Route	7 (26.9%)	6 (25.0%)
Day 1 Drug Screen		
Opioids		5 (20.8%)
Morphine		5 (20.8%)
Methadone		1 (4.2%)
Fentanyl		17 (70.8%)
Oxycodone		3 (12.5%)

Values are mean±SD or Number of participants (%)

Results

- 26 participants received BUP-TM, 24 proceeded to SUBLOCADE injection (Table 1), and 20 completed the study.
- After SUBLOCADE injection, mean±SD COWS scores decreased from a pre-SUBLOCADE baseline of 12.6±4.1 to 6.9±4.1 at 6h and to 4.2±3.2 at 24h (Figure 2). 15 participants (62.5%) had maximum COWS score pre-injection.
- 2 participants had a COWS score increase of ≥6 from the pre-injection value (events occurred at 1h and 2h post-injection). No participants had severe withdrawal and one participant had moderately severe withdrawal (maximum COWS score=27 at 2h post-injection). (Table 2)
- By independent adjudication, 2/24 participants experienced PW. There was concordance between the protocol definition and adjudication assessment of precipitated withdrawal for 25 (97%) of the participants post BUP-TM and 22 (92%) of the participants post-SUBLOCADE.
- The mean opioid craving score fell by 24.4 points at 12 hours post-SUBLOCADE and continued to decrease through completion of the study.

Figure 2 Mean (±SD) Clinical Opiate Withdrawal Scale (COWS) Scores Before and Following Administration of SUBLOCADE

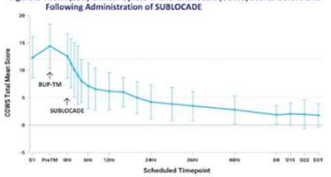
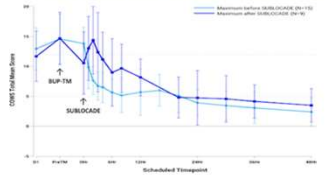


Table 2 COWS Scores by Severity and Timing of Maximum Severity Occurrence and Increase of ≥6 [Number of participants (%)]

	Participants Receiving SUBLOCADE (N=24)	
	Maximum Severity	Increase of ≥6
Pre-SUBLOCADE	15 (62.5%)	1 (4.2%)
Mild	6	0
Moderate	9	1
1 hour post-SUBLOCADE	2 (8.3%)	1 (4.2%)
Mild	1	1
Moderate	1	0
2 hour post-SUBLOCADE	5 (20.8%)	1 (4.2%)
Mild	2	0
Moderate	2	0
Moderately Severe	1	1
3 hour post-SUBLOCADE	2 (8.3%)	
Mild	1	0
Moderate	1	0

Figure 3 Mean (±SD) Clinical Opiate Withdrawal Scale (COWS) Scores by Maximum Severity Occurrence Before or After Administration of SUBLOCADE



Safety Results

Table 3 Summary of Treatment-Emergent Adverse Events (TEAEs)

Parameter	Participants Receiving SUBLOCADE (N=24)	
	All TEAEs	TEAEs within 48h
Any TEAE	20 (83.3%)	19 (79.2%)
Treatment Related TEAEs	5 (20.8%)	4 (16.7%)
Serious TEAEs	0 (0.0%)	0 (0.0%)
Treatment Related Serious TEAEs	0 (0.0%)	0 (0.0%)
Severe TEAEs	5 (20.8%)	5 (20.8%)
Injection site reaction TEAE	3(12.5%)	1 (4.2%)
TEAE resulting in study treatment withdrawal or interruption	0 (0.0%)	0 (0.0%)
TEAE resulting in death	0 (0.0%)	0 (0.0%)

- Irritability, anxiety, nausea, and pain were the most common treatment emergent adverse events (TEAEs).
- Most TEAEs were moderate or mild in intensity. Five participants reported a total of 8 severe TEAEs [irritability [n=4], pain [n=2], chills [n=1] and vomiting [n=1]), which all occurred within 48 hours of SUBLOCADE administration.
- Two participants received 4 mg BUP-TM after SUBLOCADE injection and 15 received other rescue medications.
- Rescue medications included ondansetron for nausea/vomiting (10 [41.7%], clonidine for anxiety/irritability (10 [41.7%]), ibuprofen for pain/body aches (9 [37.5%]) and trazadone for insomnia (5 [20.8%]).
- Potential limitations of this study include the small number of participants and the heterogeneous group of opioid-tolerant patients that might not fully represent the real-world population of patients with OUD.

Conclusions

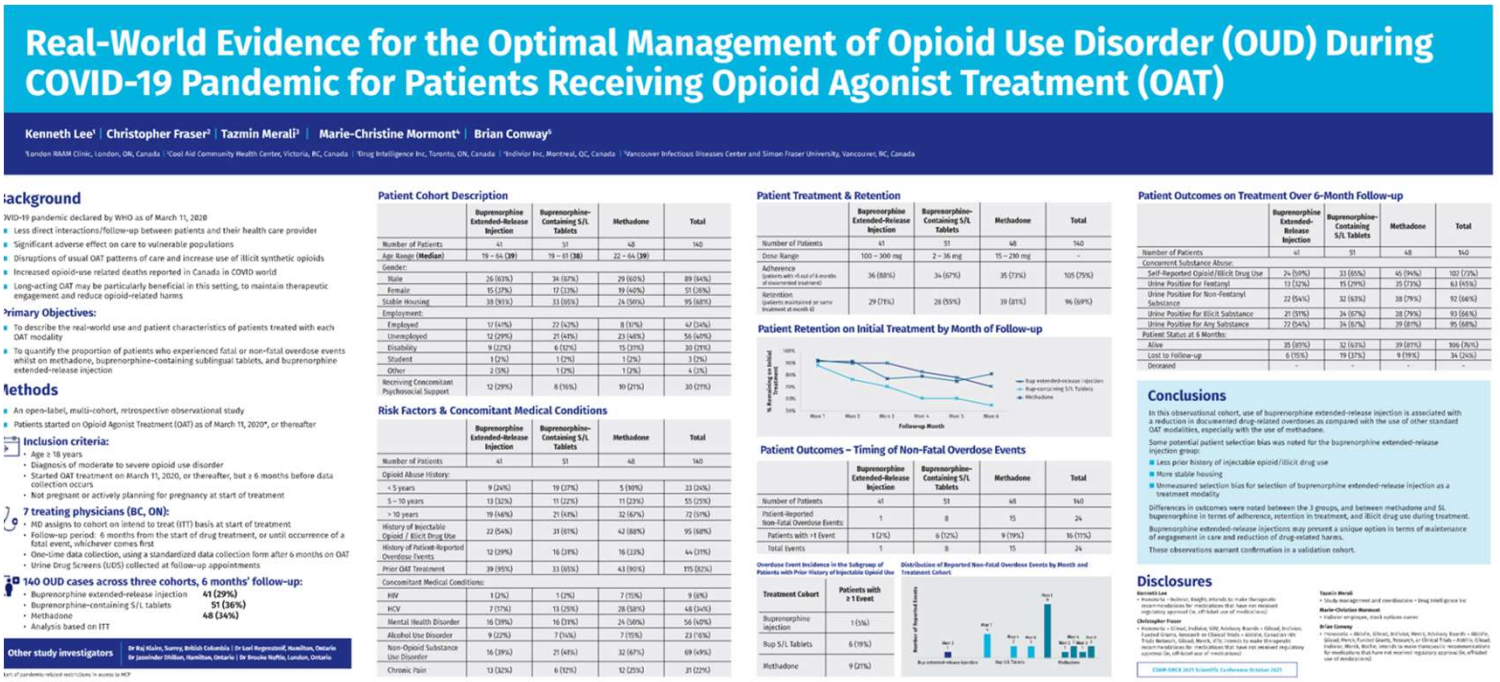
- Initiating SUBLOCADE 300 mg following a single 4 mg dose of BUP-TM indicated a safety profile similar to that observed with SUBLOCADE induction per current labeling.[1]
- After SUBLOCADE injection, withdrawal symptoms and opioid craving scores improved within 12h. Improvements were sustained for 4 weeks.

References

1. SUBLOCADE United States Prescribing Information, February 2020. https://www.accessdata.fda.gov/drugsatfda_docs/label/2020/022410s000lbl.pdf accessed October 30, 2020.
2. Dunlop A, Lukuge B, Masters D, et al. Challenges in maintaining treatment services for people who use drugs during the COVID-19 pandemic. Harm Reduct J. 2020;17:26.
3. Farhoudian A, Baldacchino A, Clark N, et al. COVID-19 and Substance Use Disorders: Recommendations to a Comprehensive Healthcare Response. An International Society of Addiction Medicine Practice and Policy Interest Group Position Paper. Basic Clin Neurosci. 2020;11:133.

PRESENTED VIRTUALLY AT THE ANNUAL MEETING OF THE COLLEGE ON PROBLEMS OF DRUG DEPENDENCE, 23 JUNE 2021 Virtual Poster Q&A Session III: Opiates/Opioids

SUBLOCADE OFFERS PROTECTION



Real-World Evidence for the Optimal Management of Opioid Use Disorder (OUD) During COVID-19 Pandemic for Patients Receiving Opioid Agonist Treatment (OAT)

Kenneth Lee[1] | Christopher Fraser[2] | Tazmin Merali[3] | Marie-Christine Mormont[4] | Brian Conway[5]

[1]London RAAM Clinic, London, ON, Canada | [2]Cool Aid Community Health Center, Victoria, BC, Canada | [3]Drug Intelligence Inc, Toronto, ON, Canada | [4]Indivior Inc, Montreal, QC, Canada | [5]Vancouver Infectious Diseases Center and Simon Fraser University, Vancouver, BC, Canada

ackground

VID-19 pandemic declared by WHO as of March 11, 2020

- Less direct interactions/follow-up between patients and their health care provider
- Significant adverse effect on care to vulnerable populations
- Disruptions of usual OAT patterns of care and increase use of illicit synthetic opioids
- Increased opioid-use related deaths reported in Canada in COVID world
- Long-acting OAT may be particularly beneficial in this setting, to maintain therapeutic engagement and reduce opioid-related harms

rimary Objectives:

- To describe the real-world use and patient characteristics of patients treated with each OAT modality
- To quantify the proportion of patients who experienced fatal or non-fatal overdose events whilst on methadone, buprenorphine-containing sublingual tablets, and buprenorphine extended-release injection

lethods

- An open-label, multi-cohort, retrospective observational study
- Patients started on Opioid Agonist Treatment (OAT) as of March 11, 2020*, or thereafter

Inclusion criteria:

- Age ≥ 18 years
- Diagnosis of moderate to severe opioid use disorder
- Started OAT treatment on March 11, 2020, or thereafter, but ≥ 6 months before data collection occurs
- Not pregnant or actively planning for pregnancy at start of treatment

7 treating physicians (BC, ON):

- MD assigns to cohort on intend to treat (ITT) basis at start of treatment
- Follow-up period: 6 months from the start of drug treatment, or until occurrence of a fatal event, whichever comes first
- One-time data collection, using a standardized data collection form after 6 months on OAT
- Urine Drug Screens (UDS) collected at follow-up appointments

140 OUD cases across three cohorts, 6 months' follow-up:

- Buprenorphine extended-release injection **41 (29%)**
- Buprenorphine-containing S/L tablets **51 (36%)**
- Methadone **48 (34%)**
- Analysis based on ITT

Other study investigators Dr Raj Kairy, Surrey, British Columbia | Dr Lori Regenstreif, Hamilton, Ontario | Dr Jasvinder Dhillon, Hamilton, Ontario | Dr Brooke Nuffle, London, Ontario

Patient Cohort Description

	Buprenorphine Extended-Release Injection	Buprenorphine-Containing S/L Tablets	Methadone	Total
Number of Patients	41	51	48	140
Age Range (**Median**)	19 – 64 (**39**)	19 – 61 (**38**)	22 – 64 (**39**)	
Gender:				
Male	26 (63%)	34 (67%)	29 (60%)	89 (64%)
Female	15 (37%)	17 (33%)	19 (40%)	51 (36%)
Stable Housing	38 (93%)	33 (65%)	24 (50%)	95 (68%)
Employment:				
Employed	17 (41%)	22 (43%)	8 (17%)	47 (34%)
Unemployed	12 (29%)	21 (41%)	23 (48%)	56 (40%)
Disability	9 (22%)	6 (12%)	15 (31%)	30 (21%)
Student	1 (2%)	1 (2%)	1 (2%)	3 (2%)
Other	2 (5%)	1 (2%)	1 (2%)	4 (3%)
Receiving Concomitant Psychosocial Support	12 (29%)	8 (16%)	10 (21%)	30 (21%)

Risk Factors & Concomitant Medical Conditions

	Buprenorphine Extended-Release Injection	Buprenorphine-Containing S/L Tablets	Methadone	Total
Number of Patients	41	51	48	140
Opioid Abuse History:				
< 5 years	9 (24%)	19 (37%)	5 (10%)	33 (24%)
5 – 10 years	13 (32%)	11 (22%)	11 (23%)	55 (25%)
> 10 years	19 (46%)	21 (41%)	32 (67%)	72 (51%)
History of Injectable Opioid / Illicit Drug Use	22 (54%)	31 (61%)	42 (88%)	95 (68%)
History of Patient-Reported Overdose Events	12 (29%)	16 (31%)	16 (33%)	44 (31%)
Prior OAT Treatment	39 (95%)	33 (65%)	43 (90%)	115 (82%)
Concomitant Medical Conditions:				
HIV	1 (2%)	1 (2%)	7 (15%)	9 (6%)
HCV	7 (17%)	13 (25%)	28 (58%)	48 (34%)
Mental Health Disorder	16 (39%)	16 (31%)	24 (50%)	56 (40%)
Alcohol Use Disorder	9 (22%)	7 (14%)	7 (15%)	23 (16%)
Non-Opioid Substance Use Disorder	16 (39%)	21 (41%)	32 (67%)	69 (49%)
Chronic Pain	13 (32%)	6 (12%)	12 (25%)	31 (22%)

Patient Treatment & Retention

	Bupreonorphine Extended-Release Injection	Buprenorphine-Containing S/L Tablets	Methadone	Total
Number of Patients	41	51	48	140
Dose Range	100 – 300 mg	2 – 36 mg	15 – 230 mg	-
Adherence (patients with >5 out of 6 months of documented treatment)	36 (88%)	34 (67%)	35 (73%)	105 (75%)
Retention (patients maintained or same treatment at month 6)	29 (71%)	28 (55%)	39 (81%)	96 (69%)

Patient Retention on Initial Treatment by Month of Follow-up

Patient Outcomes – Timing of Non-Fatal Overdose Events

	Buprenorphine Extended-Release Injection	Buprenorphine-Containing S/L Tablets	Methadone	Total
Number of Patients	41	51	48	140
Patient-Reported Non-Fatal Overdose Events:	1	8	15	24
Patients with >1 Event	1 (2%)	6 (12%)	9 (19%)	16 (11%)
Total Events	1	8	15	24

Overdose Event Incidence in the Subgroup of Patients with Prior History of Injectable Opioid Use

Treatment Cohort	Patients with ≥ 1 Event
Buprenorphine injection	1 (5%)
Bup S/L Tablets	6 (19%)
Methadone	9 (21%)

Distribution of Reported Non-Fatal Overdose Events by Month and Treatment Cohort

Patient Outcomes on Treatment Over 6-Month Follow-up

	Buprenorphine Extended-Release Injection	Buprenorphine-Containing S/L Tablets	Methadone	Total
Number of Patients	41	51	48	140
Concurrent Substance Abuse:				
Self-Reported Opioid/Illicit Drug Use	24 (59%)	33 (65%)	45 (94%)	102 (73%)
Urine Positive for Fentanyl	13 (32%)	15 (29%)	35 (73%)	63 (45%)
Urine Positive for Non-Fentanyl Substance	22 (54%)	32 (63%)	38 (79%)	92 (66%)
Urine Positive for Illicit Substance	21 (51%)	34 (67%)	38 (79%)	93 (66%)
Urine Positive for Any Substance	22 (54%)	34 (67%)	39 (81%)	95 (68%)
Patient Status at 6 Months:				
Alive	35 (85%)	32 (63%)	39 (81%)	106 (76%)
Lost to Follow-up	6 (15%)	19 (37%)	9 (19%)	34 (24%)
Deceased	-	-	-	-

Conclusions

In this observational cohort, use of buprenorphine extended-release injection is associated with a reduction in documented drug-related overdoses as compared with the use of other standard OAT modalities, especially with the use of methadone.

Some potential patient selection bias was noted for the buprenorphine extended-release injection group:

- Less prior history of injectable opioid/illicit drug use
- More stable housing
- Unmeasured selection bias for selection of buprenorphine extended-release injection as a treatment modality

Differences in outcomes were noted between the 3 groups, and between methadone and SL buprenorphine in terms of adherence, retention in treatment, and illicit drug use during treatment.

Buprenorphine extended-release injections may present a unique option in terms of maintenance of engagement in care and reduction of drug-related harms.

These observations warrant confirmation in a validation cohort.

Disclosures

CSAM-SMCA 2021 Scientific Conference October 2021

GAME CHANGER: EARLY DEPOT-BUP HERE WE COME!

- MAXIMUM DAILY DOSING: 32 MG

  BUP/NAL

- RAPID TITRATION WITH MACRODOSING BUP/NAL
- EARLY DEPO-BUPRENORPHINE

Sometimes higher during stabilization

Day 1: COWS>12 + no fentanyl use >24 hrs
Dosing: **24mg then 8 mg q1h prn X1**
Total dose over 1-2 hours= 32mg

24-72 hours after first sublingual buprenorphine-naloxone dose

** PEOPLE WHO USE FENTANYL**

Within 1-2 days → patients receive depot-bup
no withdrawal symptoms

1. JACOBS P ET AL. *AM J ADDICT* 2015;24:667-75.
2. CARROLL GG ET AL. *PREHOSP EMERG CARE* 2021;25:289-93.
3. ERRING AA ET AL. *JAMA NETW OPEN*. 2021;4:E2117128.

4.https://cabridge.ca
5.Mariani JJ et al. Am J addict.2021;1-7
6.Korownyk et al, Canadian Family Physician;2018:321-33

Updates from TADH

2021 ACUTE WITHDRAWAL MANAGEMENT BEDS TIMMINS AND DISTRICT HOSPITAL

	Number of Admissions	Avg Occupancy	Avg LOS	Alcohol Use Disorder	Opiate Use Disorder	Polysubstance Use Disorder	Suboxone Starts	Sublocade
Dec-20	7	36%	2.3	3	4		4	1
Jan-21	11	50%	3.5	4	7		7	4
Feb-21	13	82%	3.6	3	10		10	6
Mar-21	13	79%	3.8	2	11		11	10
Apr-21	14	79%	3	3	11		10	6
May 1-22, 2021	13	65%	2.6	3	10		10	9
Jun-21	14	73%	2.9	1	13		11	11
Jul-21	13	42%	2.7	0	13		9	7
Aug-21	10	55%	3.1	1	8	1	8	7
Sep-21	16	82%	2.7	5	11		11	11
Oct-21	13	63%	3.1	2	10	1	10	7
Nov-21	16	62%	3	7	9		9	4
Dec-21	5	40%	5	0	4	0	4	4

TOTAL : 148
AUD:27 (18%)
OUD:121 (82%)

AVERAGE LOS
3.1

BUP/NLX START
FOR OUD
114/121(94%)

DEPO-BUP
START
87/114 (76%)

2021 DEPO-BUP AT TADH

DECEMBER 7TH,2020 – DECEMBER 31ST, 2021

TOTAL:

122 doses given

LOCATION:

87 doses : WMS beds
35 doses : Medical floor, Surgical floor, MHU

MARCH-JULY 2022

TOTAL: 121

OUD: 77 (64%)
AUD: 44 (36%)
LOS: 3.4 days

BUP STARTS:
60
78% OF OUD ADMISSIONS

DEPOT-BUP:
52
68% OF OUD ADMISSION
87% OF BUP START

COMMUNICATION STRATEGIES

- Listen to the patient
- Understand their language
- Understand where they are along the treatment continuum
- Show compassion and patience
- Discuss a variety of treatment options available with supporting pros and cons
- Involve the person in treatment decisions (they may change their mind many many many times)

CASE PRESENTATIONS

34 yo female presenting to ER last used IV fentanyl 6 hrs ago asking for help with her opioid use (also uses IV Crystal Meth). Uses 0.5-1 g IV fentanyl x 5 yrs

25 yo male presenting to ER fully reversed with naloxone in severe withdrawals unsure if he wants help for his opioid use but wants to feel better immediately. Smokes fentanyl and crack x 2 years approximately 1-1.5 grams per day.

40 to female in withdrawals and last used fentanyl 22 hours ago asking for help with her opioid use. Uses “a few points per day” of fentanyl, IV and smoked x 5 years. Use speed, cocaine, CM also IV and smoked.

REFLECTION ON PAST AND PRESENT SUCCESSES

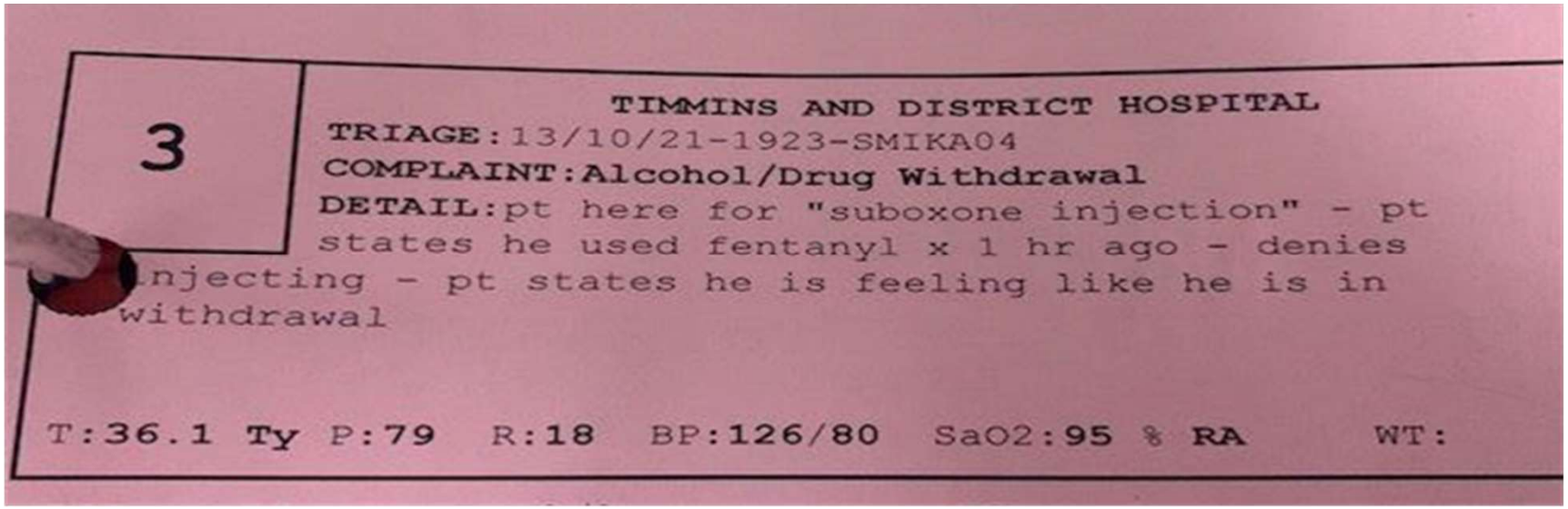
What did we do before? We were letting these patients down.
-RN ICU and physicians

We haven't seen J.S. in a long time in emerg.
-RN ER & physician

We no longer send people home if our beds are "full"
RN ER & physician

This is AMAZING, the change we are making for these patients.
-RN ICU

REFLECTION ON PAST AND PRESENT SUCCESSES



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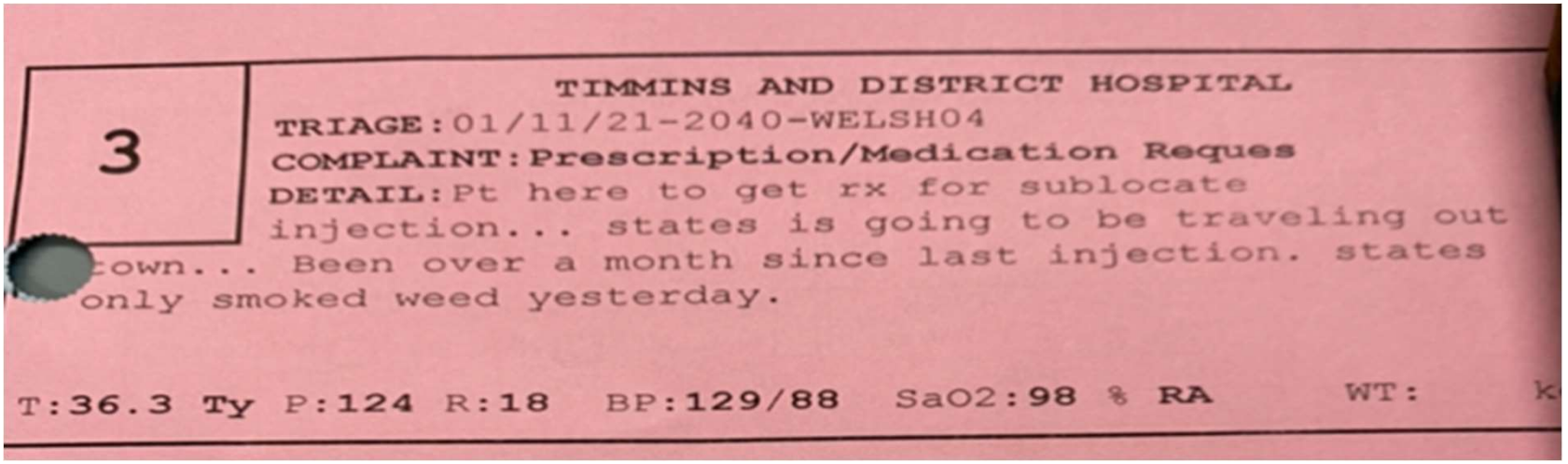
TIMMINS AND DISTRICT HOSPITAL

TRIAGE:13/10/21-1923-SMIKA04
COMPLAINT:Alcohol/Drug Withdrawal
DETAIL:pt here for "suboxone injection" - pt states he used fentanyl x 1 hr ago - denies injecting - pt states he is feeling like he is in withdrawal

T:36.1 Ty P:79 R:18 BP:126/80 SaO2:95 % RA WT:



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TIMMINS AND DISTRICT HOSPITAL

TRIAGE:01/11/21-2040-WELSH04
COMPLAINT:Prescription/Medication Reques
DETAIL:Pt here to get rx for sublocate injection... states is going to be traveling out town... Been over a month since last injection. states only smoked weed yesterday.

T:36.3 Ty P:124 R:18 BP:129/88 SaO2:98 % RA WT:

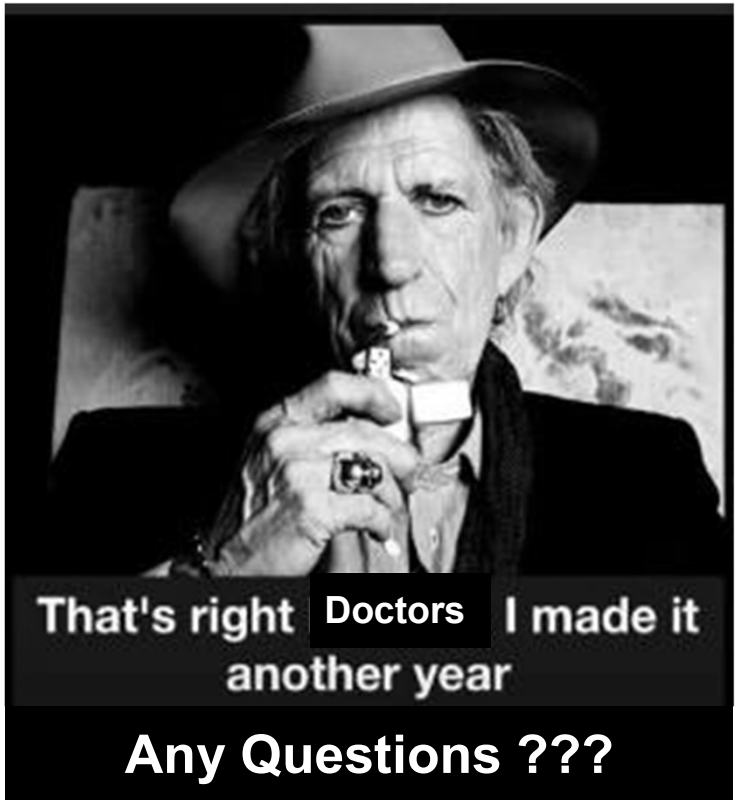
TAKE HOME MESSAGES

- LISTEN TO THE PATIENTS
- DON'T BE AFRAID TO PUSH LARGER "MACRODOSES" OF SL BUP/NLX FOR INDUCTION AND PW
- BUP/NLX NEEDS TO BE STANDARD OF CARE IN ER OF OUD
- CONSIDER GIVING EARLY DEPOT BUPRENORPHINE WITHIN 24 HRS OF INDUCTION
- THINK OUTSIDE THE BOX AND BE FLEXIBLE
- REDUCE STIGMA & BARRIERS ASSOCIATED WITH ADDICTIONS IN YOUR HEALTH CARE SETTING

TAKE HOME MESSAGES

- TREAT THEM AND STREET THEM CAN NO LONGER OCCUR
- PATIENTS CAN'T REMAIN ON TREATMENT IF THEY ARE NOT STARTED ON TREATMENT
- DON'T SETTLE FOR "WE CAN'T DO IT" … THE QUESTION SHOULD BE "HOW CAN WE DO IT"
- IT'S NOT A PATIENT PROBLEM… IT'S A SYSTEM PROBLEM

AND…..HAVE NO REGRETS



Any Questions ???

THANK YOU !!

- Julie Samson : jsamson5@me.com
- Louisa Marion-Bellemare: lmarionbellemare@nosm.ca