Opioid Use Disorder Primary Care Pathway

PEER PATIENTS EXPERIENCE EVIDENCE RESEARCH

Consider Prescription Opioid Misuse Index (POMI) if patient receives prescription opioids and OUD is suspected.

Yes to ≥2 means diagnosis is more likely. If not, it is less likely.

DO YOU EVER:

- ☐ Use your medication more often, (shorten the time between doses), than prescribed?
- ☐ Use more of your medication, (take a higher doses) than prescribed?
- ☐ Need early refills for your pain medications?
- ☐ Feel high or get a buzz after using your pain medication?
- ☐ Take your pain medication because you are upset, to relieve or cope with problems other than pain?
- ☐ Go to multiple physicians /emergency room doctors, seeking more of your pain medication?

OUD
(Patient willing to start treatment and may benefit from OAT)

Buprenorphine /Naloxone
(Suboxone™)

- Patient must be in withdrawal (12-24-hours opioid-free)
- Sublingual tablet (~10 minutes to dissolve)
- Naloxone prevents IV diversion
- May be started in office or at home

RETENTION IN TREATMENT*

64% versus **39%** with placebo
NNT‡ = 4

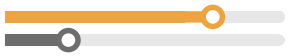
If one fails, consider the other.
Additional agents available.†

Methadone

- Prescribing restrictions in most provinces
- Can be started immediately
- Requires more observation and time for dose adjustment
- Liquid formulation

RETENTION IN TREATMENT

73% versus **22%** with no methadone
NNT = 2



Are psychosocial supports available?

Yes,
Offer to patient on OAT

RETENTION IN TREATMENT

74% with counselling versus **62%** no counselling
NNT = 8

No,
Opioid Agonist Therapy (OAT) alone is still effective

RETENTION IN TREATMENT

66% with OAT alone versus **22%** on wait list for OAT NNT = 3

OAT is intended for long-term management. Optimal length of therapy is unknown.

PRACTICE PEARLS

- Naloxone kits should be provided to all patients who are prescribed OAT.
- Avoid punitive measures. Continued drug use could suggest a need for treatment intensification.
- Stabilizing OUD may help with the management of chronic pain.

TREATMENT CONSIDERATIONS

Tailored to patient's needs and disease stability.

Treatment Agreement (Contract)
To outline patient and provider expectations.

Urine Drug Testing
May be required by provincial regulations.

* Most trials report on retention in OAT treatment. While RCT data is limited on patient oriented outcomes, observational data suggests retention in treatment is associated with reduction in mortality and improvement in quality of life.
† Eg. Injectable naltrexone (opioid antagonist that requires 7-10 day opioid free period) not currently available in Canada, slow release morphine.
‡ NNT = Number Needed to Treat

Korownyk C, Perry D, Ton J, Kolber MR, Garrison S, Thomas B, et al. Managing opioid use disorder in primary care. PEER simplified guideline. *Can Fam Physician* 2019;65:321-30.

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Buprenorphine/Naloxone (BUP/NLX) Induction Flow Diagram

PEER Patients Experience Evidence Research

Day 1

Patient Should be in Opioid Withdrawal

COWS Score >12
(~12-24 hours after last opioid dose)

Give BUP/NLX 4mg/1mg

WAIT 60 MIN.

Withdrawal Symptoms Gone?

Yes

Day 1 Dose: _____

No

Give BUP/NLX 2mg/0.5mg or 4mg/1mg*

DO NOT EXCEED BUP/NLX 12mg/3mg on Day 1

Wait 1-3 hours

Significantly Worse
(Only after first dose)

Possible Precipitated Withdrawal

1. Patient can stop and try induction again tomorrow.
2. Patient can continue induction.
3. Clinicians may treat withdrawal symptoms with medications.

*Can send patient home with 2-4 tablets (2mg/0.5mg) to finish induction.

Day 2 and onwards

Withdrawal symptoms present before dose?

Yes

May increase dose by a maximum of 4mg/1mg each day

(Do not exceed a total of 24mg/6mg per day)

No

Take the same dose as yesterday

Clinical Opiate Withdrawal Scale (COWS) Score (0-48)†

Category (Points), Clinician Administered

	WORSE →					
Resting Pulse Rate	0	1	2		4	
Sweating	0	1	2	3	4	
Observed Restlessness	0	1		3		5
Pupil Size	0	1	2			5
Bone or Joint Aches	0	1	2		4	
Runny Nose or Tearing	0	1	2		4	
Gastrointestinal Upset	0	1	2	3		5
Observed Tremor of Outreached Hands	0	1	2		4	
Observed Yawning	0	1	2		4	
Anxiety or Irritability	0	1	2		4	
Gooseflesh Skin	0		2	3	4	
TOTAL SCORE						

Agents for Management of Withdrawal Symptoms (Including precipitated withdrawal)

Symptom ▸ Agent	DIRECTIONS
Anxiety ▸ Clonidine	0.1mg PO Q4H PRN
Anxiety ▸ Quetiapine	25mg PO QHS PRN
Sleep ▸ Trazodone	50-100mg PO QHS PRN
Pain ▸ Ibuprofen	600mg PO Q6H PRN
Nausea ▸ Dimenhydrinate	50mg PO Q6H PRN
Nausea ▸ Ondanestron	4mg PO Q6H PRN
Diarrhea ▸ Loperamide	4mg, followed by 2mg after each loose stool (max:16mg/day)

† Full COWS Scoring Available at: https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf
For home induction, use patient administered Subjective Opiate Withdrawal Scale (SOWS) scoring available at: http://www.bccsu.ca/wp-content/uploads/2017/08/SOWS.pdf

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