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Opioid Withdrawal Management in the Acute Care Setting: Quick Treatment Tips

Heroin and prescription opioid addiction is a major public health problem in the United States.

Emergency department (E.D.) and urgent care healthcare providers often call The Poison Control Center to receive guidance related to the management of opioid withdrawal due to substance abuse. The management of drug withdrawal is complex, and healthcare providers are encouraged to develop and use their own institution's protocols. In the absence of such protocols, The Poison Control Center offers the following guidance.

Therapy for acute opioid withdrawal presenting to the E.D. or to an urgent care center should be based upon the current goals of therapy, which should be discussed with the patient:

A. To Eliminate Withdrawal Symptoms So that Other Medical Illness Can Be Evaluated and Treated

The simplest way to eliminate opioid withdrawal symptoms is to administer an opioid.

IV morphine can be titrated to produce rapid alleviation of withdrawal symptoms; alternatively, SL buprenorphine (adult dose: 4 mg, repeat in 15 minutes if necessary) can be effective, but should only be used if moderate to severe withdrawal symptoms* are clearly evident as buprenorphine can also precipitate withdrawal.

B. To Assist the Addicted Patient with Symptoms During "Cold Turkey" Detoxification (off-label)

Opioid withdrawal creates great discomfort with dehydration, nausea and vomiting, and over-stimulation. Decrease stimulation (limit noise, dim lights) where possible.

Dehydration should be treated, if present.

Clonidine decreases sympathetic outflow and may help with stimulatory symptoms.

Anti-nausea/anti-vomiting medications may provide comfort and allow oral medication dosing.

Bismuth subsalicylate or loperamide may help with diarrhea. Dicyclomine may help with peristaltic pains.

Some patients may benefit from a sedative medication such as gabapentin.

Withdrawal symptoms typically peak at 24 to 48 hours after onset, but may last days to weeks.

Appropriate psychosocial supports should be put in place.

C. To Assist the Addicted Patient with Opioid-substitution Detoxification

Contact information for local treatment programs can be found at www.samhsa.gov/find-help, and local social work or psychiatry services may be able to assist the patient in gaining access to available programs.

If a patient wants to enter a program, a single dose of methadone might ameliorate withdrawal symptoms until the patient can report to a treatment facility.

*Of note: Practitioners must be licensed to use methadone for addiction therapy, but it might be administered by acute care healthcare providers to treat acute withdrawal or pain.***

Methadone or buprenorphine are used in "maintenance therapy" detoxification programs.

If a patient "withdraws" because he/she has missed a dose of methadone or buprenorphine, an equivalent dose can be given (typically it is best to verify with the outpatient detox program).

*A "Clinical Opiate Withdrawal Scale" can be used to quantify a patient's withdrawal symptoms. One such scale is available at www.naabt.org/documents/cows_induction_flow_sheet.pdf.

**Title 42 of the Code of Federal Regulations provides extensive guidance regarding the use of methadone by registered opioid treatment programs. However, it also contains an exemption to these rules for hospitals treating patients with emergent medical needs (21 CFR § 1306.07) allowing physicians "to maintain or detoxify a person as an incidental adjunct to medical or surgical treatment of conditions other than addiction." Therefore, hospital-based providers do not require specialized training or certification to prescribe methadone and buprenorphine for use in the hospital when a patient is being treated for other medical conditions.

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