

Emergency department protocols for alcohol- and opioid-related presentations

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Alcohol intoxication

Assessment

- Examine for signs of trauma.
- Document number of standardized drinks consumed in past 12 hours.
- Document signs of intoxication: odour of alcohol, slurred speech, etc.
- Check finger-stick glucose.
- If blood work is drawn, consider adding blood alcohol level (BAL).
 - If BAL < 20 mmol/L, consider alternative diagnosis to explain ataxia, slurred speech, or altered level of consciousness (e.g., DT, Wernicke's, hepatic encephalopathy, subdural hematoma).
 - Note: BAL declines by 4–7 mmol/hour; therefore, a BAL of 40 mmol/L on admission will be around 15 mmol/L 5 hours later.

Treatment

- Thiamine 300mg PO/IV.
- Replace glucose if hypoglycemic.

Discharge and referral

- Discharge when patient is alert and ambulatory.
- **Refer to rapid access addiction medicine clinic.**
- Refer to withdrawal management services if:
 - Patient may go into withdrawal.
 - Patient does not have positive social supports or stable housing.
 - Patient is in crisis (e.g., their partner has threatened to leave them).
 - Patient wants to start treatment right away.
- Consider reporting to Ministry of Transportation.

Minimum criteria for reporting patient to Ministry of Transportation

- Patient drove to ED while intoxicated.
- BAL > 17 mmol/L at estimated time of driving (metabolized at 4–7 mmol/hour).
- Patient or family reports drinking and driving.
- Patient has had a seizure and drives.
- Patient has hepatic encephalopathy, cerebellar ataxia, alcohol-induced dementia, etc., and drives.
- Patient drinks throughout the day and regularly drives.

Alcohol withdrawal

Clinical features

- Severity increase with amount consumed; uncommon with < 6 drinks per day.
- Predictable pattern: patients with previous withdrawal seizures are at high risk for recurrence.
- Begins 6–12 hours after last drink.
- Usually resolves within 2–3 days, may last up to 7 days.
- Most reliable signs: sweating, postural or intention tremor (not resting).
- Other signs: tachycardia, reflexia, ataxia, disorientation.
- Symptoms: anxiety, nausea, headache, tactile/auditory/visual disturbances.

Baseline investigations

- CBC, electrolytes, magnesium, calcium, phosphorus
- Hepatic transaminases, bilirubin, albumin, INR
- BAL
- ECG

Clinical Institute Withdrawal Assessment for Alcohol, revised (CIWA-AR) scale

<p>NAUSEA AND VOMITING Ask “Do you feel sick to your stomach? Have you vomited?” Observation 0 no nausea and no vomiting 1 2 3 4 intermittent nausea with dry heaves 5 6 7 constant nausea, frequent dry heaves and vomiting</p>	<p>AGITATION Observation 0 normal activity 1 somewhat more than normal activity 2 3 4 moderately fidgety and restless 5 6 7 paces back and forth during most of the interview, or constantly thrashes about</p>
<p>TREMOR Arms extended and fingers spread apart Observation 0 no tremor 1 not visible, but can be felt fingertip to fingertip 2 3 4 moderate, with patient’s arms extended 5 6 7 severe, even with arms not extended</p>	<p>TACTILE DISTURBANCES Ask “Have you any itching, pins and needles sensations, any burning or numbness, or do you feel bugs crawling on your skin?” Observation 0 none 1 very mild itching, pins and needles, burning or numbness 2 mild itching, pins and needles, burning or numbness 3 moderate itching, pins and needles, burning or numbness 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>

<p>PAROXYSMAL SWEATS Observation 0 no sweat visible 1 barely perceptible sweating, palms moist 2 3 4 beads of sweat obvious on forehead 5 6 7 drenching sweats</p>	<p>AUDITORY DISTURBANCES Ask “Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?” Observation 0 not present 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness or ability to frighten 4 moderately severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>
<p>ANXIETY Ask “Do you feel nervous?” Observation 0 no anxiety, at ease 1 mildly anxious 2 3 4 moderately anxious, or guarded, so anxiety is inferred 5 6 7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</p>	<p>VISUAL DISTURBANCES Ask “Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?” Observation 0 not present 1 very mild sensitivity 2 mild sensitivity 3 moderate sensitivity 4 moderately severe sensitivity 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations</p>
<p>HEADACHE, FULLNESS IN HEAD Ask “Does your head feel different? Does it feel like there is a band around your head?” Do not rate for dizziness or light-headedness. Otherwise, rate severity. Observation 0 not present 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 very severe 7 extremely severe</p>	<p>ORIENTATION AND CLOUDING OF SENSORIUM Ask “What day is this? Where are you? Who am I?” Observation 0 oriented and can do serial additions 1 cannot do serial additions or is uncertain about date 2 disoriented for date by no more than 2 calendar days 3 disoriented for date by more than 2 calendar days 4 disoriented for place and/or person</p>

Management

1. Replace electrolytes, glucose as needed
2. Administer IV fluids as needed
3. Benzodiazepines (see below)
4. Thiamine 300mg PO or 100mg IM

Diazepam	<p>Preferred agent due to long half-life. 10–20 mg PO q 1–2 H for CIWA-Ar \geq 10. If patient cannot take diazepam orally or if patient is in severe withdrawal, give diazepam 10–20 mg IV q 1–2H. In patients with clear signs and symptoms of alcohol withdrawal and a history of withdrawal seizures, minimum loading dose of diazepam 20 mg PO q 1H x 3, regardless of CIWA-Ar score. Avoid diazepam and use small doses (e.g., 0.5–2 mg) of lorazepam if:</p> <ul style="list-style-type: none"> • Intoxication (estimated BAC > 30-40 mmol/l) • Liver dysfunction and failure • Low serum albumin • Elderly • On opioids or methadone • Pneumonia or COPD
Lorazepam	<p>Second choice agent due to short half-life. 2–4 mg PO, SL, IM, IV q 1–2 H for CIWA-Ar \geq 10. In patients with clear signs and symptoms of alcohol withdrawal and a history of withdrawal seizures, minimum loading dose of lorazepam 4 mg PO q 1H x3, regardless of CIWA-Ar score.</p>
Indications for admission	<ul style="list-style-type: none"> • Marked tremor, sweating worsening/not improving despite 80 mg diazepam or 16 mg lorazepam • Two or more seizures • QT interval > 500 msec, not resolving • Repeated vomiting, dehydration, electrolyte imbalance • Impending or early DTs: confusion, disorientation, delusions, agitation • Suspected Wernicke’s encephalopathy: ophthalmoplegia, ataxia, confusion • Serious concurrent medical or psychiatric illness (e.g., pneumonia)

Discharge	<ul style="list-style-type: none"> • Treatment completed with CIWA-Ar < 8 on two consecutive measurements, with minimal tremor. • Thiamine 300 mg PO OD x 1 month. • Patient should not be discharged until their withdrawal has fully resolved. Discharging patient early reduces length of stay, but relapse is highly likely if patient leaves hospital still in withdrawal. Reduce length of stay by dispensing benzodiazepines every hour. • Benzodiazepines should not be prescribed on discharge: they are unnecessary if withdrawal is fully resolved, they increase risk of harm (e.g., aspiration, trauma) if patient relapses, and patients with alcohol use disorders are at high risk for developing benzodiazepine co-dependency. • Refer to rapid access addiction medicine clinic for treatment of alcohol use disorder. • Refer to withdrawal management services if withdrawal not fully resolved, lacks social supports, or in crisis. • See family doctor in 1–2 days.
Sample orders	<ul style="list-style-type: none"> • CBC, electrolytes, Ca, Mg, PO₄, BUN, creatinine, glucose, AST, ALT, GGT, albumin, bili, INR • ECG • CIWA-Ar q 1 H • Diazepam 20 mg PO q1–2 h if CIWA-Ar ≥ 10 • Hold if drowsy • D/C CIWA-Ar when score < 8 x 2, and patient has minimal tremor • Thiamine 300 mg PO or 100 mg IM

Complications of withdrawal

Seizures	Grand mal, non-focal, brief. Usually occurs 2–3 days after last drink.	Diazepam 20 mg PO q 1–2 H or lorazepam 2–4 mg SL/PO/IM/IV for at least 3 doses for patients with Hx of withdrawal seizures. Phenytoin ineffective Investigate if first seizure > 40 years; focal features; outside time frame; or head trauma
Tachyarrhythmia	Increased risk with age, cardiomyopathy, severe withdrawal, low K ⁺ , Mg ⁺ , cocaine use, other substances or conditions that prolong QT interval.	ECG in all patients with prolonged QT interval If QTc > 500 msec, consider monitored bed, or serial ECG measurement every 1–2 hours Treat withdrawal aggressively: diazepam 20 mg q 1H or lorazepam 4 mg q 1H until tremor and QT prolongation have resolved Correct electrolyte imbalance
Hallucinations without delirium	Usually tactile but may be auditory or visual. Patient oriented, knows hallucinations are unreal.	Continue benzodiazepine treatment per protocol Avoid antipsychotics – can prolong QT interval

Co-occurring conditions

Decompensated cirrhosis	Firm liver, spider nevae. History of ascites, portal hypertension, esophageal varices. High bilirubin, low albumin, high INR.	Benzodiazepines can trigger hepatic encephalopathy Do not treat mild withdrawal Use lorazepam 0.5–1 mg for moderate withdrawal DC treatment when tremor improved May require hospital admission
On methadone or opioids	Benzodiazepines can cause sedation and respiratory depression, even if patient is on stable methadone/opioid dose.	Use lorazepam 0.5-1mg DC treatment when tremor improved

Alcohol withdrawal delirium (delirium tremens)

Clinical features	<p>More common with acute medical illness (e.g., pneumonia, post-surgery). Starts day 3–5, preceded by severe withdrawal symptoms, including seizures. Autonomic hyperactivity with agitation, sweating, tremor, tachycardia, fever. Disorientation, delusions, vivid hallucinations. Often marked sundowning. Death can occur from QT prolongation and fatal arrhythmias. Also risk of flight and violence.</p>
Non-medication orders	<p>Telemetry or serial ECGs, especially if QT interval prolonged. Daily CBC, Na⁺, K⁺, CO₂, creatinine, magnesium. O₂ sat monitoring. Restraints, sitter as needed.</p>
Lorazepam load	<p>Early and aggressive use of lorazepam will shorten duration and intensity of DTs. CIWA-Ar protocol is not useful.</p> <ul style="list-style-type: none"> • Lorazepam 4 mg SL/PO q ½ H x 4, then reassess. • Continue 4-dose lorazepam cycle until symptoms resolve. Then continue lorazepam 2 mg q 2 H as standing order, taper dose over next few days. <p>Consider more gradual load (e.g., lorazepam 0.5–1 mg q 1 H) if:</p> <ul style="list-style-type: none"> • Liver failure with ascites, etc. • Methadone patients • The frail elderly • Active pneumonia • COPD with compromised respiratory function
Phenobarbital	<p>Consider in patients in severe DTs who are not responding to high doses of lorazepam.</p>
Antipsychotics	<p>Both typical and atypical antipsychotics should be avoided during DTs as they can prolong QT interval. Manage agitation with benzodiazepines, phenobarbital.</p>
Indications for ICU admission and propofol, midazolam	<p>Patient remains agitated and delirious despite 48 mg of lorazepam over six hours, OR aggressive loading contraindicated.</p>

Other alcohol-related presentations

Alcohol-induced anxiety, depression, and suicidal ideation

Management	<p>If patient is intoxicated and suicidal, observe patient in ED until intoxication resolves. Even if suicidal ideation resolves when sober, refer patient to psychiatry if:</p> <ul style="list-style-type: none">• Patient has recently attempted suicide.• Patient remains severely depressed.• Patient has frequent alcohol binges and major risk factors for suicide (e.g., recent loss, has feasible suicide plan). <p>If suicidal ideation does not resolve, refer to psychiatry and place on Form 1 if indicated.</p>
Discharge advice and referral	<p>Heavy drinking can cause or worsen depression and anxiety. Abstinence or reduced drinking usually improves mood within weeks.</p> <p>Refer patient to rapid access addiction medicine clinic and to community addiction treatment upon discharge.</p>

Trauma caused by alcohol intoxication

General discharge and referral	<p>Screen for alcohol use disorder.</p> <p>Inform patient that risk of trauma dramatically increases with each drink.</p> <p>Advise patient on harm-reduction strategies (see below).</p> <p>Offer all patients referral to rapid access addiction medicine clinic.</p>
Advice on preventing alcohol-related accidents and violence	<p><i>Avoid intoxication:</i></p> <ul style="list-style-type: none">• No more than one drink per hour.• Sip rather than gulp.• Avoid unmeasured drinks (especially vodka and other spirits).• Alternate alcoholic drinks with non-alcoholic drinks.• Eat before and while drinking. <p><i>Avoid dangerous situations:</i></p> <ul style="list-style-type: none">• Do not drive a car or boat after drinking.• Do not get in a car or boat with people who have been drinking.• Do not engage in arguments with intoxicated people.• Leave a social event if uninvited strangers arrive, and/or if heavy drinking and aggressive behaviour takes place.• Have a non-drinking friend accompany you and take you home.

Alcoholic cirrhosis

- If consent is provided, speak to patient with family members present.
- Patients with decompensated cirrhosis should be advised that treatment may be life-saving: 5-year survival rate of 60% with abstinence, 30% with continued drinking.
- **Refer all patients to the rapid access addiction medicine clinic.**
- Arrange follow-up with family physician and gastroenterologist for consideration of endoscopy, beta blockers for portal hypertension, low-salt diet, etc.

Alcohol use in the elderly: Falls, confusion, depression, problematic failure to cope

Identify alcohol problems in the elderly	Always ask about alcohol use in elderly patients presenting with falls, confusion, depression, problematic benzodiazepine use, or failure to cope. Obtain collateral from family if patient provides consent. Order CBC, LFTs including GGT, +/- BAL.
Discharge advice and referral	Explain to patient and family that the patient's problems (falls, confusion, etc.) are caused by alcohol. Involve social worker in addiction treatment planning; options may be limited in patients who are cognitively impaired or lack mobility. Refer to rapid access addiction medicine clinic. If applicable, send letter to family physician suggesting benzodiazepine taper. Discuss ways the family can assist (e.g., frequent supervision, limiting availability of alcohol in the home).

Opioid withdrawal

Clinical features

Time course	Symptoms start six hours after last use of short-acting opioid, peak at 2–3 days, and begin to resolve by 5–7 days (methadone withdrawal peaks on day 5, and buprenorphine/naloxone withdrawal peaks on day 7). Psychological symptoms can last for weeks.
Physical symptoms	Flu-like: Myalgias, chills, sweating, nausea and vomiting, abdominal cramps, diarrhea, rhinorrhea, lacrimation, piloerection.
Psychological symptoms	Insomnia, anxiety and irritability, restlessness, dysphoria, craving.
Complications	a. Suicide b. Overdose if opioids taken after a period of abstinence (loss of tolerance). c. Gastritis or peptic ulcer. d. Acute exacerbation of cardiorespiratory illnesses, e.g., asthma, angina. e. Exacerbation of psychiatric conditions: anxious patients may experience panic attacks, schizophrenic patients may experience psychosis, etc.

ED treatment

Protocol	<p>Administer buprenorphine/naloxone if:</p> <ul style="list-style-type: none">• Patient has not used any opioids for at least 12 hours (preferably 16).• Patient reports both physical and psychological symptoms of withdrawal.• COWS score > 12.• Patient is not on methadone or buprenorphine/naloxone <p>Initial dose: 2–4 mg SL (2 mg if elderly, on high benzodiazepine dose, or if not sure that patient is in withdrawal). Dose should be witnessed by nurse to ensure it is taken SL and fully dissolved.</p> <p>Reassess in 1–2 hours. Give another 2–4 mg SL if still in significant withdrawal.</p> <p>ED treatment completed when COWS score < 12.</p> <p>Max dose on first day: 12 mg</p>
Discharge	<p>Refer patient to rapid access addiction medicine clinic.</p> <p>Prescribe buprenorphine/naloxone total amount dispensed in the ED (max 12 mg) as a single daily dose:</p> <ul style="list-style-type: none">• Dispense daily under observation at a specific pharmacy.• Include start and end dates.• Prescription should last until next rapid access addiction medicine clinic. <p>Refer patient to withdrawal management if transient housing, lack of social supports, and/or high risk for relapse.</p> <p>Provide high-risk patients with take-home naloxone.</p>

Home treatment

Protocol	<p>Prescribe buprenorphine/naloxone for patient to take at home if:</p> <ul style="list-style-type: none">• Onset of withdrawal is still several hours away.• Patient refuses to stay in ED until withdrawal begins.• Patient is not on methadone or buprenorphine/naloxone. <p>Prescribe 4 mg SL, repeat in two hours if necessary, up to four 2 mg tabs (8 mg) over 24 hours, x 1–3 days (e.g., twelve 2 mg tabs all as take-home or 4 tabs daily dispensed for 3 days).</p>
Discharge	<p>Patient instructions:</p> <ul style="list-style-type: none">• Wait at least 12 hours after last opioid use and be in at least moderate withdrawal before taking first dose.• Take 2 mg x 2 tabs SL.• If still in withdrawal after 2 hours, take another 2 mg x 2 tabs SL.• Max dose: 8 mg in 24 hours <p>Refer patient to rapid access addiction medicine clinic for ongoing buprenorphine/naloxone treatment.</p> <p>Refer patient to withdrawal management if transient housing, lack of social supports, and/or high risk for relapse.</p> <p>Provide high-risk patients with take-home naloxone.</p>

Clinical Opioid Withdrawal Scale (COWS)

INTERVAL	0	30 mins	2 hours	4 hours
DATE: DD / MM / YYYY				
TIME				
Resting heart rate (measure after lying or sitting for 1 minute): 0 HR 80 or below 1 HR 81-100 2 HR 101-120 4 HR 121+				
Sweating (preceding 30 minutes and not related to room temp/activity): 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face				
Restlessness (observe during assessment) 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds				
Pupil size: 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible				
Bone or joint aches (not including existing joint pains): 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints/muscles plus unable to sit still due to discomfort				
Runny nose or tearing (not related to URTI or allergies): 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks				
GI upset (over last 30 minutes) 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of vomiting or diarrhea				
Tremor (observe outstretched hands): 0 no tremor 1 tremor can be felt but not observed 2 slight tremor observable 4 gross tremor or muscle twitching				
Yawning (observe during assessment) 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute				
Anxiety or irritability 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult				
Gooseflesh skin 0 skin is smooth 3 piloerection (goosebumps) can be felt or hairs standing up on arms 5 prominent piloerection				
SCORE INTERPRETATION 5-12 MILD WITHDRAWAL 13-24 MODERATE WITHDRAWAL 25-36 MODERATELY SEVERE WITHDRAWAL 37+ SEVERE WITHDRAWAL	TOTAL	TOTAL	TOTAL	TOTAL
	INITIALS	INITIALS	INITIALS	INITIALS

Sample buprenorphine/naloxone prescription

Hospital

Hospital address

Prescriber, MD
Hospital
Phone number
Fax number

Patient
Health card number
Date of birth

Pharmacy
Address
Fax number

Date

Buprenorphine/naloxone 8/2 mg 1 tab SL OD
Start date – end date inclusive
Dispense daily observed

Physician signature
CPSO number

Opioid overdose prevention

Patient advice

Patients in the following risk categories should receive advice on overdose prevention:

- Opioid-addicted patients who inject, smoke, or snort opioids.
- Recently abstinent opioid-addicted patients (e.g., patients discharged from a treatment program, withdrawal management, prison, or hospital).
- Patients on very high prescribed doses (> 400 mg MEQ)
- Patients on high opioid doses (> 200 mg MEQ) who also take benzodiazepines or drink heavily.

Advice for patients at risk for overdose

- Taking more than 200 MEQ a day is associated with increased risk of death.
- If you relapse after being recently abstinent, do not inject, and take a much smaller opioid dose than usual. You have lost tolerance and could die if you take your previous dose.
- Do not mix opioids with alcohol or benzodiazepines.
- Always have a friend with you if you inject or snort opioids.
- If a friend seems drowsy, has slurred speech, or is nodding off after taking opioids:
 - Shake them and keep talking to them to keep them awake.
 - **Do not let them fall asleep, even if someone watches them overnight.**
 - Call 911.
- The best way to avoid an overdose is to get treatment for your addiction. **Please attend the next rapid access addiction medicine clinic.**

Providing take-home naloxone to at-risk patients

Patients (or their friends/relatives) should be given take-home naloxone if they have the following risk factors:

- Started on methadone or buprenorphine/naloxone within the past two weeks.
- On methadone or buprenorphine but not stable.
- On high-dose opioids for chronic pain.
- Treated for an overdose in the emergency department, or reports a previous overdose.
- Injects, crushes, smokes, or snorts opioids (fentanyl, morphine, hydromorphone, oxycodone).
- Buys methadone or other opioids from the street.
- Recently discharged from an abstinence-based residential treatment program, withdrawal management service, hospital, or prison.
- Uses opioids in a binge pattern (i.e., does not use the same opioid dose every day).
- Uses opioids with benzodiazepines or alcohol.

Patient instructions for administering naloxone

- Shake the overdose victim and call their name.
- Call 911.
- Inject a full vial of naloxone into an arm or leg muscle.
- Start chest compressions.
- Inject another vial if they do not wake up in 3–4 minutes.

Other opioid-related presentations

Opioid overdose

- Naloxone 0.4–2mg IV/IM/SQ q2min prn for RR < 12, consider infusion if suspect long-acting opioid.
- Provide respiratory support if needed.
- Monitor at least 6 hours after respiratory support discontinued (10 hours if methadone overdose).
- Resume respiratory support and consider naloxone infusion if patient shows slurred speech or nodding off, or if RR < 12.
- If patient experiences [withdrawal](#) after termination of naloxone, [treat with buprenorphine/naloxone](#) for symptom relief rather than other opioids.
- On discharge:
 - [Give take-home naloxone kit.](#)
 - [Give harm reduction advice.](#)
 - If patient is not yet in withdrawal, prescribe [buprenorphine/naloxone to take at home.](#)
 - **Refer to rapid access addiction medicine clinic.**
 - Refer to withdrawal management if transient housing, lack of social supports, and/or high risk for relapse.

Signs suggestive of an opioid use disorder

- Physical signs of opioid intoxication: meiosis, slurred speech, altered LOC, decreased respiratory rate.
- Physical signs of withdrawal: diaphoresis, restlessness, mydriasis, lacrimation, rhinorrhea, yawning, piloerection, vomiting.
- Signs of opioid use: track marks, abscesses.
- Check dispensing record for patients on Ontario Drug Benefits.
- If you suspect an opioid use disorder, ask patient about opioid use and [withdrawal symptoms](#); patients will often disclose opioid use if they think you can help relieve withdrawal symptoms.
- **All patients with a suspected opioid use disorder should be [offered buprenorphine/naloxone](#) and referred to the rapid access addiction medicine clinic.**

Managing infections in opioid users

Oral antibiotics	<ul style="list-style-type: none">• Treat with oral antibiotics that cover staph and strep.• Ask about injection drug use and examine for signs (track marks, abscesses).• Refer to rapid access addiction medicine clinic.• Offer buprenorphine/naloxone to treat withdrawal with a bridging outpatient prescription to last until next rapid access addiction medicine clinic.• Offer advice on overdose prevention and consider providing take-home naloxone.
Parenteral antibiotics	<ul style="list-style-type: none">• Avoid PICC line.• Ask about injection drug use and examine for signs (track marks, abscesses).• Refer to rapid access addiction medicine clinic.• Offer buprenorphine/naloxone to treat withdrawal with a bridging outpatient prescription to last until next clinic.• If patient willing to try buprenorphine/naloxone, advise to abstain from opioids for 12 hours and initiate at follow-up ED visit for antibiotics, or give outpatient prescription to start at home.• Offer advice on overdose prevention and consider providing take-home naloxone.

Requests for refills of opioid prescriptions for chronic non-cancer pain

- Contact pharmacy or review ODB record to verify date and amount of last script.
- Write on the script: “Do not dispense if you receive an alert from Narcotic Monitoring System.”
- Prescribe dose that you are comfortable with, even if it is much lower than the usual prescription.
- Prescribe only enough until the next working day.
- Send a record of the visit to the family physician.

Drug seeking

When drug seeking is suspected:	<ul style="list-style-type: none">• Contact patient’s pharmacy and review ODB record.• Do not prescribe opioids.• Advise patient that opioids are harming them, and that addicted patients usually experience improved mood, function, and pain with treatment.• If patient is in opioid withdrawal, administer buprenorphine/naloxone and provide prescription to last until next rapid access addiction medicine clinic.• If not in withdrawal, prescribe buprenorphine/naloxone to take at home.• Refer to rapid access addiction medicine clinic.
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Depression and suicidal ideation

- Inform patient that treatment of opioid addiction usually improves mood.
- Administer [buprenorphine/naloxone](#) if in withdrawal and give [bridging prescription](#) on discharge.
- If not in withdrawal and not admitted, prescribe [buprenorphine/naloxone to take at home](#).
- Refer patient to psychiatry if:
 - Patient has recently attempted suicide.
 - Patient refuses buprenorphine/naloxone treatment or remains severely depressed despite buprenorphine/naloxone treatment.
 - Patient has major risk factors for suicide (e.g., recent loss, has feasible suicide plan).
- **Refer to rapid access addiction medicine clinic.**

Managing acute pain in patients on methadone or buprenorphine/naloxone

- Maintain patient on their usual dose of methadone or buprenorphine/naloxone.
- Prescribe standard non-opioid analgesia.
- Prescribe opioids if patient's acute pain condition warrants it.
- Start with the dose you usually administer for that pain condition.
- Titrate rapidly; patients on methadone or buprenorphine/naloxone often need higher doses.
- On discharge, prescribe opioids for no more than 10 days; write "dispense with buprenorphine/naloxone" or "dispense with methadone" on prescription.
- Instruct patient to follow up with family physician and methadone or buprenorphine/naloxone provider.