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	• 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	• 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:	• 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.**

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.