THE TREATMENT OF SUBSTANCE USE DISORDERS AND ADDICTION DURING COVID-19

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CONFLICT OF INTEREST

NONE OF OUR SPEAKERS HAVE ANY CONFLICTS OF INTEREST TO DISCLOSE
Case 1: Alcohol Withdrawal During COVID19

- A 47-year-old M furloughed during COVID19 has been drinking heavier since his furlough and after trying to ‘self-detox’ presents to the ED with tachycardia, hypertension, tremors and hallucinations.
The patient had been working on a contracting crew that ‘downsized’ and he’s been home for about 4 weeks. Prior to his furlough he drank heavily, primarily whiskey, when getting home from work. “It was maybe half of a bottle each night but I started drinking in the morning and before I knew it I was drinking all day and had to drink at night because I was waking up drenched in sweats and in a panic!”
CASE 1

- Patient has family in area but hasn’t seen them during COVID19 (occasional phone calls).
- Has PCP, who he sees intermittently, prescribed a brief course of lorazepam, “for anxiety,” about 2 weeks into his escalating drinking. The patient reports he told PCP he had anxiety and insomnia related to furlough and COVID but, “I started taking the prescription (lorazepam 0.5 mg PO TID PRN 30 tabs) and realized it helped my shakes and was still drinking anyway. When I ran out it was terrible and I tried to stop.”
- Not taking other meds but has been on antihypertensive in past (not currently).
- Smokes about ½ PPD no other substance use. No previous treatment attempts. No history of detox.
- Has been drinking increasingly heavily at night for 6 months prior (separated from wife about 6-7 months ago) then 4 weeks about 1.5- 2 bottles 45-50% alcohol (whiskey) daily and the 30 x 0.5 mg tabs lorazepam over about 5 days (10 day Rx). The lorazepam Rx ended about 5 days before patient presented.
CASE 1

- Patient has had about 2 bottles whiskey/day x 3 days after the preceding history then didn’t purchase anymore because he wanted to stop. He told one of his sons he was, “stopping drinking,” and 2 days later when his son called, and he didn’t answer, he drove over to his father’s house and finds him, “sick, shaking, not looking good at all.

- Son brings him in to ED and patient traverses intake process (screening for COVID risk/symptoms) his initial vitals include HR 120 bpm. BP 160/95 mmHg, RR 20 breaths-minute and his temperature is 99 F.

- Patient is tremulous. Hadn’t slept in 48 hours. Able to provide some history but intermittently confused and tangential (mistakes dates and not able to describe how he arrived to ED).

- Pertinent labs: EtOH < 10 mg/dL. Na 138, K 3.3, Cl 104, HCO3 17, BUN 21, Cr 0.9, glucose 110 AST 210, ALT 145. EtG positive (subsequently returned) UDS negative for amph/meth, cocaine, THC, opiates. UDS is pos BZD (confirmation pending).


**CASE 1 QUESTIONS**

- **Question:** What is your perspective on alcohol use and the increase in complications related to excessive drinking during the COVID19 pandemic?
- **Question:** Has it impacted your ED, hospital or clinic practice?
- **Question:** What is your approach to this patient who has had escalating heavy alcohol use along with brief Rx of BZD (which he overtook while continuing to drinking) with delirium, autonomic hyperactivity and other sequellae of his heavy alcohol use now 48 hours since last drink (approx) presenting to the ED?
The patient is given 2 mg lorazepam IV with minimal improvement. 4 mg IV is given 30 min later with minimal improvement. IVF with thiamine and dextrose are started (along with KCl and Mg).

Despite the benzodiazepines (2 then 4 and a 2nd 4 mg 1 hour after 1st in first 4 hours) he remains tachycardic and hypertensive. He is intermittently sleeping early the AM of admission (presented late night) but only briefly then quite restless and wakes up ‘startling’ becoming agitated when nursing approaches or vital signs are taken.

Phenobarbital is administered after ED discusses with the hospitalist and toxicology CL team (10 mg/kg IV administration ‘load’ is ordered after which he improves but is still somewhat restless and HR remains at 100-110 bpm.

**Question:** Any changes to your alcohol withdrawal protocols or approach during COVID?
Hospitalist team calls for recommendations after the “load” as, “he was still pretty symptomatic usually they quiet down nicely.” Additional recs are given for PB 130 mg IV q 2 hours mild withdrawal or 260 mg IV q 2 hours moderate/severe withdrawal along with 50 mg quetiapine at HS if delirium/insomnia.

Additionally, clonidine 0.1 mg PO q 6 hours scheduled (hold if HR < 80) along with a 0.1 mg patch/week which had been placed as the patient was admitted.

After three additional doses of PB 260 mg IV the patient is sleeping, HR 70’s, BP 110’s/70’s. He wakes up with stimulation but falls back asleep. After the 3rd dose of 260 mg PB no further doses required. Oral clonidine is not needed the patch is continued (dc’d after week). Quetiapine is utilized on HD 1 and 2 but not after.

**Question:** Any comments to the adjunctive agent use or other EtOH w/d regimens and impact from COVID? How frequently is ambulatory detox performed in your area? Would this patient have been candidate from the start (with history as reported)?
CASE 1

- The patient recovers remarkably after the additional PB – despite remaining on CIWA he is not scoring enough to receive additional doses. He is appreciative and recounts the history which was provided (corroborates initial info). States he wants help to avoid, “going back to that again.”

- Question: What additional options are there to treat patients with alcohol use disorder after initial withdrawal management in the hospital setting?
The patient’s PCP was contacted and “wasn’t aware” that alcohol had been as much of an issue. Appreciates contact from hospital. Agrees with plan to refer to outpatient CD treatment. Will f/u one week “telemedicine” contact,” and no longer prescribe lorazepam.

The patient agrees to try naltrexone and gabapentin (started at 600 mg PO TID while in the hospital 24 hours after last PB dose) and a first dose of 25 mg naltrexone is given and tolerated well –he is dc’d with 50 mg/day with f/u at an area outpatient treatment program that is doing ‘on site’ XR naltrexone injections.

Given info about Internet AA meetings and local meetings. Also shown how to download PDF of AA book while in hospital.
CASE 1

- Any additional comments?
CASE 1 – EXAMPLE PB FOR AWS PROTOCOLS (HOSPITAL)*

- Hendy GW et al – ED dosing 260 mg IV followed by 130 mg if needed (based on CIWA-Ar assessment)
- Rosenson et al Single 10 mg/kg IV PB dose + concomitant BZD (lorazepam) infusion in ICU patients if needed.
- Ibarra F. Jr a single 130 or 260 mg IV slow push in ED after patients that received > 4 mg lorazepam as adjunctive to the BZD ED dosing to start.
- Tidwell WP et al – ICU dosing based on severity:
  - Active DTs → 260 mg IV x 1 followed by 97.2 mg PO TID x 6 doses → 64.8 mg PO TID x 6 doses → 32.4 mg PO TID x 6 doses
  - History of DTs → 97.2 mg PO TID x 6 doses → 64.8 mg PO TID x 6 doses → 32.4 mg PO TID x 6 doses.
  - No history of DT → 64.8 mg PO TID x 6 doses → 32.4 mg PO TID x 6 doses
- All above plus lorazepam 1 mg IV q 4 hours PRN for agitation.


Case 2: Iatrogenic Dependence and Withdrawal

An Intensivist asks if there is utility in using buprenorphine and some ‘other’ techniques for some of the severe, critically ill, COVID-19 patients that often require prolonged sedation and analgesia.
A 40 year-old M had been hospitalized with COVID19 and ended up requiring intubation due to hypoxia and respiratory failure. Has been in the ICU for > 2 weeks requiring “very high” doses of sedatives and opioids in order to control symptoms (and minimize need to interact with patient –less sedation wean apparently).

Medications: midazolam 8-10 mg/hour and fentanyl 300 micrograms/hour infusion -14 days in –weans are associated with agitation. Not tolerating pressure support.

**Question:** How has COVID-19 changed sedation and analgesia protocols or use in the ICU during COVID (in particular if patient has ICU admission/intubation/support related to COVID infection?)

**Question:** Has iatrogenic dependence and complications with sedation weans become a problem for any of your COVID19 ICU admissions?

**Question:** When patients with opioid and/or sedative dependence are hospitalized and require ICU care with intubation is there any particular adjustment to the sedation wean or protocol? What is your practice?
For the patient mentioned we discussed incremental ‘loading’ using phenobarbital while reducing midazolam (e.g. 260 mg IV PB for 20% reduction in midazolam titrating up with PB). Dexmedetomidine (sympatholytic) was suggested adjunctively) and if fentanyl wean remained challenging either maintaining the other sedation for 8-10 hour ‘wash out’ with bup induction vs ‘micro induction’ if not tolerating fentanyl wean.

The team used IV PB had to switch to hydromorphone (shortages in IV fentanyl infusions) but decided not to use buprenorphine. The sedation wean was complicated and prolonged (aspiration PNA), delirium, etc. Discussion on protocols for PB, bup and other regimens initiated with some of the ICU teams after this case. “We have a lot of success if the patient is opioid dependent and we start buprenorphine/Suboxone® and use some of the other strategies for the patients tox/addiction CL consults on.
Case 3: Struggling While Hospitalized for IVDU-Associated Infective Endocarditis
A 29-year-old F with opioid and stimulant use disorder and IVDU-associated severe aortic valve endocarditis with perforation and severe aortic regurgitation is hospitalized during COVID19 – she is not complying with treatments/regimens critical to success with valve replacement.
CASE 3 – STIGMATA OF AORTIC VALVE ENDOCARDITIS - EMBOLI
CASE 3

- 29 y/o female with PMH of IV Heroin and cocaine abuse (for past 10 years) directly admitted from outside Hospital with AMS and fever. Patient greatly impaired/lethargic, falling asleep in mid conversation when asked questions.
- Unable to obtain significant history from patient. According to previous OSH chart review patient came down from current area (where she lives) 4 days ago to stay with a friend (XX). Has been weak, tired, and having diarrhea.
- In the ED patient has temp 38.3 C. HR 110 bpm. Is confused and intermittently pulling at IV, telemetry leads and trying to get out of bed. Reports of heavy cocaine use daily heroin (fentanyl) but “less” per ‘friend’. She injects into her chest and has an abscess/wound that has been intermittently treated/chronic changes (R chest wall).
- She reports last opiate use (fentanyl) before going to ‘friend’s’ had gotten some IV hydromorphone in ED both at OSH and current ED. 4 years ago was “on ‘Suboxone’s but I injected them… don’t want it…”
- Tox/Addiction CL consulted to help with dependence and stabilization. Concern for infective endocarditis as she has stigmata of peripheral emboli (hands/feet (see photo)).
- TTE is obtained.
- **Question:** What are options for this patient to help stabilize what appears to be opioid withdrawal (and/or other dependence) what types of supportive/adjunctive meds might you offer?
The patient is started on methadone 10 mg PO TID after an initial dose of 20 mg x one (with much improvement).

Topiramate 50 mg PO BID is started for ‘cocaine craving’.

TTE demonstrates: aortic valve vegetation, with severe regurgitation, and perforation.

Patient admitted for IV antibiotics and evaluation for valve replacement.

Course complicated by regular refusal of heparin, monitoring, other treatments.

Patient is upset her friend is unable to visit while in the hospital.

**Question:** What resources did you have available for patients with substance use disorders and addiction if hospitalized during COVID19?
Case 3

- Patient has long discussion with tox/addiction CL and is made aware of availability of Ipad® that she can use to FaceTime® (she didn’t have phone brought in).
- She is familiar with local peer (head of ‘Hopedealers BTC’) and agrees to have call with ‘peer’.
- Some books brought in (Raymond Carver – New Path to the Waterfall) and ‘home made’ face mask – she starts to engage more but intermittent refusal of cares and CT surgery gives ultimatum of “compliance for at least 3 days or no surgery”.
- **Question:** How do you best support patient struggling in this context?
Team meetings had (discussing medication use, plans, support available) patient would agree to certain treatments only followed by not doing so. She developed anasarca, SOB, her bacteremia cleared on IV abx and after 2 weeks in the hospital she signed out AMA because, “father just died of the same thing I have.”

About 2 weeks later re-presents – she’d taken an oral abx and reports only intermittent use of fentanyl (no cocaine) is admitted to complete day 38/42 of IV vancomycin.

Strategies utilized: methadone (split dosing for pain 10 mg PO TID) in hospital (she declined link to OTP at d/c), peers, counseling/MI, few small ‘gifts’ (books) to engage.

Due to compliance had not received valve replacement. Medically managed with info on link to ongoing treatment (has home – sig other alcohol use but not heroin/cocaine per patient). Not answering peer calls for apt on f/u.
Her AMA d/c 3 days into the 2nd hospitalization includes d/c with metoprolol 12.5 mg PO BID, torsemide 20 mg daily, topiramate 50 mg PO BID (‘off label’ cocaine craving) she declines referral/intake to OTP for ongoing methadone (declined link to outpatient for f/u SC buprenorphine (monthly injectable).
PCP contact/apt made and info for area treatment programs as well as peer organization/resources provided.
CASE 3 –DISCUSSION

- **Question:** COVID has dramatically altered hospital visitation policy (and other policy/procedures e.g. patients able to leave unit to smoke) how has this impacted patients with substance use disorders/addiction?
- Are there any particular PEARLS or suggestions that anyone would like to share?
- **Question:** What other community resources have been impacted by COVID-19 (see following two pages)?
COMMUNITY RESOURCES IMPACTED BY COVID-19

- 1,101 Naloxone kits distributed
- 127,987 needles picked up
- 10,135 lunches provided/handed out
- 168 Persons Who Use Drugs helped into Recovery – from street contact to detox/program/ongoing treatment
COMMUNITY RESOURCES IMPACTED BY COVID
‘virtual’ calendar of events
No other word will do. For that’s what it was.
Gravy.
Gravy, these past ten years.
Alive, sober, working, loving, and
being loved by a good woman. Eleven years
ago he was told he had six months to live
at the rate he was going. And he was going
nowhere but down. So he changed his ways
somehow. He quit drinking! And the rest?
After that it was all gravy, every minute
of it, up to and including when he was told about,
well, some things that were breaking down and
building up inside his head. “Don’t weep for me,”
he said to his friends. “I’m a lucky man.
I’ve had ten years longer than I or anyone
expected. Pure Gravy. And don’t forget it.

~Raymond Carver
Q&A