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NONE OF OUR SPEAKERS HAVE ANY CONFLICTS OF INTEREST TO DISCLOSE
A 58-year-old M with opioid use disorder treated with 8/2 mg buprenorphine/naloxone two films/day is diagnosed with nephrolithiasis after an emergency trip to the hospital.
CASE 1: A LITTLE BIT OF PATIENT HISTORY

- The patient has a history of opioid, stimulant and alcohol use disorder. He has been a client in an outpatient treatment program for just under two years where he has monthly visits with a counselor and monthly meetings with an Xwaivered primary care provider, who has worked in the outpatient treatment program for years, and with him since he was transferred from a local detox, “on a bridge prescription.”

- He is prescribed 8/2 mg films of buprenorphine/naloxone SL BID which he’d initiated while in the ‘detox’ just under two years prior which he’d entered to stop using, “Vicodins and basically that’s it.”

- Prior to entering the detox center he’d had several unsuccessful attempts to stop using what he reported as primarily prescription opioids (though the urine drug testing company his current treatment program is utilizing is one that a prior treatment programs used and he had numerous, fentanyl, 6-MAM, morphine, codeine and cocaine analytes detected in the 1-2 years before entering his current program while in a different area program.

- About 6-7 years earlier he had struggled with alcohol but stopped after a “5th DWI,” and a period of incarceration. Upon release however he started using opiates and when he started using opiates he struggled until the detox initiated buprenorphine in 2018.
CASE 1

- **PMH:** The patient is generally healthy other than some chronic back pain.
- **SH:** He had worked as a car technician/mechanic and prior to his last DWI and at the time he owned a snow plowing business and repair shop had 20 years in “car industry” before quitting. He still has a business in reselling snow blowers and some plowing. He is divorced and has 1 son and a 4 year-old granddaughter that live in the area.
- Smokes cigarettes about 1 PPD. Lives in small apartment by self.
- **Medications:** buprenorphine/naloxone 8/2 mg films one SL BID, clonidine 0.1 mg PO TID (anxiety) and diphenhydramine 50 mg PO QID (allergies).
The patient was very anxious initially about social distancing and home isolation as the COVID-19 pandemic and state of emergency was announced but he maintained contact with his providers via telehealth (audio/video and phone combination).

About two weeks after his last telehealth encounter a pharmacy calls the program asking for instructions on, “what to do with the morphine that XX is trying to fill?” He has two prescriptions he is at the pharmacy picking up: one is the regular buprenorphine/naloxone 8/2 mg SL BID # 60, the other is morphine 15 mg IR #20.

The patient hasn’t called his provider or counselor. It is late in the afternoon (program closes 5:00).

**Question:** What do you say to the pharmacist? *The prescription is from a provider neither his regular provider or the Medical Director know. The patient’s phone goes to voice mail.*
The treatment providers ask the pharmacist to hold on dispensing the morphine but to release the buprenorphine/naloxone prescription. They also request the patient be asked to call and discuss the new prescription as he is dispensed the buprenorphine.

Shortly after this call the patient calls his counselor who notifies his provider, who calls him back. Apparently he’d had severe flank pain for 1-2 days. He’d delayed going to the ED due to COVID (it’s mid April in Upstate NY) but finally had to call an ambulance, “the pain was so bad.” He was diagnosed with nephrolithiasis and ultimately found to have a single 3 x 3 mm stone, “at the edge of the bladder.”

While in the ED he was first given morphine, “which didn’t do anything because of my ‘Suboxone’s’ and then, “they gave me Tora or ketora something and then Dilaudid and that really helped.” He reports that after a few hours his pain dissipated and he was sent home. It’s been 24 hours since he was in the ED and he wants to have the morphine, “on hand, just in case, I don’t want to have to go back to the ED again!”
No h/o kidney stones. Only single stone visualized on imaging in the ED.

In addition to the morphine he’d been prescribed tamsulosin and ibuprofen 800 mg PO TID (which he’d not needed to take).

He would prefer to pick up the morphine to have, “on hand. Just in case”
CASE 1

- During a lengthy phone conversation the patient and Medical Director discuss risks/benefits of having morphine available at home – as well as the likelihood of having more pain given where the stone was and that he’d been doing well for > 24 hours. Ultimately he concedes he will call if he starts to have more pain. He has a f/u with the Urologist in a few days and has been taking the tamsulosin and drinking, “a lot of water.”

- **Question:** What is your approach to the treatment of pain in a patient that is treated with buprenorphine for opioid use disorder assuming it is acute or an emergency such as this?

- **Question:** What about if given more time to plan (e.g. upcoming surgery – TKA or hip replacement) and the patient is taking the same dose of buprenorphine?
The patient calls the next day and is irritable and c/o pain. He reports he hasn’t passed the stone and his friends are getting him worried about the pain and “the pain is back.” He hadn’t returned to the ED. The Urologist office is closed to contact that afternoon. But left message about a f/u CT scan scheduled in few weeks The patient reports he is taking both the buprenorphine and “crushing up 3 ibuprofen every few hours and drinking it in water.” He denies use of any opiates or other drugs (except tamsulosin).

**Question:** The provider wants to bring him in to do brief on site visit and UDS but the patient is hesitant due to “COVID” (but was running errands when he’d called). How often are providers meeting patients on site in clinics? How often is Urine Drug Screening (UDS) being done? What would you do in this case?

The morphine is still ‘at the pharmacy’ per patient (unclear if cancelled completely the PMP shows only buprenorphine/naloxone dispense > 1 year).
The patient agrees to come in for UDS and meeting but misses and isn’t answering his phone.

Two days later he calls and reports he is able to “come in now,” and when he does he is well appearing and pleasant. He says the pain hasn’t returned. He “got through it with an extra ‘Suboxone’” and he has f/u with the Urologist in 1-2 weeks.

His UDS returns a few days later -→
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Confirmation testing was performed. See confirmation test results.

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Valid - The specimen meets the requirements for normal urine.
Question: Is this result consistent with morphine only in the ED on 4/28? 2-4 mg apparently (and dose “Dilaudid®”) per patient.

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Buprenorphine and Pain Management

**Acute Pain Management**

As a partial mu-agonist, buprenorphine has analgesic properties. Temporarily increasing buprenorphine dosing and/or dividing the dose may be effective for acute pain management. As discussed above, this split dosing strategy better aligns the dosing with buprenorphine’s analgesic properties. The analgesic effects of buprenorphine last for approximately 6–8 hours while the withdrawal and craving suppressing properties last for approximately 24 hours. When moving to split dosing the clinician should ensure that the patient has not missed their last non-split dose. Increasing the daily dose of buprenorphine by 20–25% and splitting it into 3–4 doses can often adequately address acute pain.

Patients receiving buprenorphine for opioid use disorder who have acute pain refractory to other treatments and require additional opioid-based analgesia may also benefit from the addition of as-needed doses of buprenorphine. Adding a short-acting full agonist opioid to the patient’s regular dose of buprenorphine can also be effective for managing severe acute pain. The guideline committee recommends that this may be considered in supervised settings, such as during hospitalization. The dose of additional full agonist opioid analgesic prescribed is anticipated to be higher than the typical dose necessary to achieve adequate analgesia in opioid-naive individuals. Because of a lack of evidence, the committee was unable to come to consensus on whether this adjunct treatment can be safely prescribed in ambulatory care settings. An increased risk of relapse and overdose are the main concerns when prescribing a full opioid receptor agonist for acute pain care in individuals with opioid use disorder.
Make sure patient taking the buprenorphine to begin with then →

1.) Split the dose of buprenorphine (if dosed 8/2 mg SL BID → 4/1 mg SL QID)

2.) Add an additional dose either PRN or increase the dose (8/2 mg SL BID → 8/2 mg SL TID or + 2/0.5 mg SL q 12 hours PRN).

3.) Add short-acting full agonist on top of the buprenorphine e.g. 10-15 mg oxycodone IR PO q 4 hours PRN moderate – severe pain.

4.) transition to parenteral opioids if IR (on top of buprenorphine) not sufficient (PCA 0.5 mg hydromorphone q 15 min demand post-operative)

5.) Also consider regional anesthesia/multimodal therapy/nerve blocks

6.) ketamine analgesia

All of the above steps assume non-opioid agents maximized (acetaminophen, NSAID (if able), lidocaine/patch…)


CASE 2

A 60-year-old F who, under normal circumstances, receives 2 weeks Rx but since the COVID-19 pandemic has received 30 days RX to minimize travel and contact with the pharmacy. She calls 8 days early reporting she is "out."
CASE 2

- The patient normally takes 8 mg SL TID of the buprenorphine mono product—she’d started on this in an area inpatient program and was transitioned to the outpatient treatment program on this due to, “nausea and allergies with the naloxone one.” She has vague reasons as to why she took extra doses, “tooth pain, joint pain, arthritis…”

- She has two UDS screens from prior to on site service being limited which are positive for buprenorphine metabolites, THC and diazepam metabolites (protocol medication from the treatment program). She’s had only phone encounters since on site services stopped (no ‘smart phone’ or computer).

- H/o heroin/fentanyl, cocaine, THC, intermittent benzodiazepine/gabapentin abuse.

- Unstable housing—family or sig other (both h/o substance use—limited information) has erratic contact initially and throughout but did have contact with the program.

- She is asking to fill the prescription early or she will, “return to heroin use!” It is 8 days early.

**Question:** What do you do?
CASE 2 - BACKGROUND

- She is relatively new to the outpatient clinic having only been attending the program 2-3 weeks prior to when COVID-19 interrupted on site care in March.
- Long history of opioid and other substance use in variety of treatment programs typically for brief periods before disengaging –she has 11 different prescribers of buprenorphine this past year according to the PMP (of various durations) usually several short Rx’s.
- A couple of longer prescriptions are followed by what appear to be ‘detox protocol’ prescription orders (e.g. 84 buprenorphine and 14 days later a new Rx from local detox provider).
The patient initially states she is not going to come in to get testing and meet with the provider but the next day calls stating, “on the way in,” groceries from a pantry were offered and she requested these be ready.

**Question:** How often are UDS being done? On site dip/send outs what would your process be during COVID19? How do you see drug testing changing/evolving after COVID19?
CASE 2

- The patient is surprised that the screen is ‘dipped’ on site before she is given a prescription:
- UDS dip: oxycodone, THC, MTD, BZD, cocaine, buprenorphine (3 weeks ago only bup, diazepam and THC after the detox/inpatient).
- **Question:** She doesn’t have any more buprenorphine. How do you proceed?
CASE 2

- The provider confirms a bed at the local detox is open and offers to facilitate admission, which she declines. She is vague about any use/last use and not in withdrawal at the in-person visit. She confirms she isn’t able to arrange video conferencing and doesn’t want to come in to the clinic to do, “another drug test with covid around.”

- Ultimately the patient leaves with the open offer to help get into detox but not with a new prescription.

- Her UDS confirmation returns: norbup-cr levels 20’s ng/mg Cr (from 400 ng/mg Cr), MTD, alprazolam and diazepam metabolites confirmed, gabapentin, oxycodone and THC confirmed.

- **Question:** How do you interpret the urine results?

- **Question:** How do you leverage telehealth and other support for ‘challenging’ patients such as this?
A 22-year-old F with alcohol use disorder, who has increased her drinking since the COVID-19 pandemic, reaches out for help.
The patient has increased her drinking since the “stay at home” order went out. She starts in the AM, “unless my kids are with me,” and then continues until, “blackout usually,” in the evening.

She has two young kids that are with her half time and being sober around them is her main reason for reaching out for help and motivation to stop. “Bad things have happened when I’ve blacked out.”

The patient is adamant about not entering a detoxification setting due to COVID-19 and child care needs.

Other than THC use she denies other substances.

All visits to this point have been via phone and one direct audio/video medical screen.

She is interested in getting help while she is at home, “for the withdrawals and shakes and my anxiety.” No history of seizures or delirium/hallucinations. Only the one hospital visit for intoxication/suicidality.
In New York liquor stores were considered “essential services” and remained open during the emergency stay at home orders. Food delivery could also include liquor/alcohol. In other states (PA) the state-run stores closed.

**Question:** What are the pros/cons of the different ways the states have chosen to manage alcohol sales during the COVID emergency and what have you seen in New York as this has progressed (related to alcohol consumption)?
CASE 3

- The patient has been drinking heavily for about a year (prior to that binge drinking but not daily) her current significant other is a daily drinker but drinks hard at the end of work and going to bed –he’s still working during the emergency (some construction work). The COVID emergency and isolation led to dramatically more alcohol use.

- PMH: No recent hospitalizations. One emergency psychiatric visit “while drinking” that she was dc’d from as she sobered up.

- Medications: none

- PCP: No PCP

- Smokes “some black and tans 2-3 a day, “but not a full one each time.” 10 $ cannabis every-other-day.

- Alcohol is 4-5 of 24 oz. beers (and occasionally pint of Hennessey or other liquor or, “some shots.” daily less if with kids (concentrated after dinner/bed).
CASE 3 - PAWSS

- Screening patients for Ambulatory Detoxification – what information do you need to know?
  - Anyone else with patient?
  - Severity of alcohol use and other substance use
  - Medications available/prescribed? + ?

Prediction of Alcohol Withdrawal Severity Scale

Screens hospitalized patients for complicated alcohol withdrawal (seizures, delirium tremens).

INSTRUCTIONS
Use in patients ≥18 years old admitted to general floor, with or without history of alcohol abuse. Do not use in patients with active or uncontrolled seizure disorder.
**CASE 3:**

PAWSS –THRESHOLD IF YES THEN – SERIES OF 10 QUESTION

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<th>Ask the patient</th>
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<tr>
<td>Have you ever experienced previous episodes of alcohol withdrawal?</td>
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CASE 3 - PAWSS

MANAGEMENT
- Subjects at risk for alcohol withdrawal should be placed on symptom-triggered therapy.
- May be used to inform which patients may be appropriate candidates for the CIWA-Ar protocol.

CRITICAL ACTIONS
PAWSS Scores ≥4 suggest high risk for complicated AWS. Prophylaxis and/or treatment may be indicated.
The patient PAWSS is 3 (likelihood ratio of complicated or severe w/d 0.07)

The patient has a significant other at home. Takes no prescribed medications. She agrees to daily contact and one on site visit on a Friday (starting on a Tuesday).

**Question:** What medications would you use for this patient?
The patient is prescribed 600 mg of gabapentin to take every 6 hours (20 tabs) before she starts to feel any withdrawal.

She is also given clonidine 0.1 mg PO QID (20 tabs one refill) to take as needed for anxiety.

Two 5 mg tabs of diazepam are given for her the first night to take if she “can’t sleep or feels anxious” despite taking the gabapentin and clonidine.

She is taking a multivitamin and thiamine and encouraged to maintain hydration and drink juice, fluids.
Audio-video visits are set up for the first contact—which she states she’s doing fine, “a little tired but not having any shakes.” She reports, “setting my watch by the hour to make sure I don’t miss any doses.” She didn’t take the diazepam and is using 1-2 clonidine daily.

On the video call she appears fine but somewhat depressed, “my kids aren’t here this is when its hard.” Counselor and peer counselor are given her info and she is given info on Internet AA/women's’ group and other resources.

On day 2 (phone) she confirms no alcohol use sounds ok (no slurred speech) no use diazepam. No w/d.

On day 3 (phone) same as day 2. taking meds, 1-2 clonidine a day. Gabapentin, “making me hungry.”

Day 4 is in person visit. She is anxious but relaxes during the visit. UDS done. She admits to “one or two drinks just small beers” two days prior but, “nothing like I was doing.”

Naltrexone 50 mg is ordered (start ½ of it and then next day 50 mg/day).
On day 6 she switches to gabapentin 600 mg PO TID and is taking naltrexone 50 mg/day.

An SSRI had been started as well based on her report of depressive symptoms and interview.

At the end of week two she reports, “maybe a beer or two once this week,” says she isn’t noticing the gabapentin or naltrexone just taking them. Has attended several Internet AA meetings.

UDS returns from her in person visit:
### Custom Tox Profile HD

**Ordering Provider:** Timothy Wiegand  
**Status:** Final

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Confirmation testing was performed. See confirmation test results.

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**Valid:** The specimen meets the requirements for normal urine.

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**ETHYLGLUCURONIDE (500/100) W/CONFIRM**

**ORDERING PROVIDER:** TIMOTHY WIEGAND  
**STATUS:** FINAL  
**COLLECTED:** 2020-04-23 16:18  
**RECEIVED:** 2020-04-24 21:04

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Confirmation testing was performed. See confirmation test results.

**ALCOHOL METABOLITES CONFIRMATION**

**ORDERING PROVIDER:** TIMOTHY WIEGAND  
**STATUS:** FINAL  
**COLLECTED:** 2020-04-23 16:18  
**RECEIVED:** 2020-04-24 21:04

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CASE 3

- Patient continues with weekly check ins with physician, counselor, is participating in Internet meetings.
- Seems to be continuing to do well with the gabapentin, naltrexone and SSRI.
- Also referred to PCP

**Question:** What are the risks and what are the benefits to being able to provide ambulatory detox support to patients during COVID-19 (or in general).

**Question:** What degree of ‘risk’ do you tolerate for patients with ambulatory detox and limited contact (telephone/telehealth) minimal onsite (? None) and testing limitations...

---

**GABAPENTIN**

ORDERING PROVIDER: TIMOTHY WIEGAND

STATUS: FINAL

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COLLECTED: 2020-04-23 16:18
RECEIVED: 2020-04-24 21:04
IV. Ambulatory Management of Alcohol Withdrawal

This guideline divides recommendations on the management of alcohol withdrawal into two broad categories where withdrawal management services are provided: ambulatory and inpatient settings. While there are many differences in the services provided within these categories, and services should not ideally be tied to a specific setting, this organization follows a reasonable structure that seems to match how providers currently think about their practice context. The goal is that practitioners can reference one management section or the other. There are many shared service practices across categories, however, which creates a great deal of repetition across sections. This organization was intentional. As most readers do not read through an entire guideline, the goal was to ensure that each section stands on its own.

Within each section, differences between levels of care are highlighted. In ambulatory settings, Level 1-WM is ambulatory withdrawal management without extended on-site monitoring. This service can be carried out in a physician's office, by a home health care agency, or an addiction treatment facility. Level 2-WM is ambulatory withdrawal management with extended on-site monitoring. It can be carried out in structured outpatient settings such as a day hospital setting, a general health care or mental health facility, or an addiction treatment facility. Level 2-WM is an organized service with the capacity to provide regular medical assessments and monitor alcohol withdrawal progression. Level 2-WM settings may also provide access to psychological or psychiatric treatment (see The ASAM Criteria for additional details).

The following recommendations apply to both Level 1-WM and Level 2-WM settings unless otherwise specified. Additional recommendations specific to Primary Care settings are included in the section VII.A: Primary Care.

A. Monitoring

**Recommendation IV.1:** In ambulatory settings, arrange for patients to check in with a qualified health provider (e.g., medical assistant, nurse) daily for up to five days following cessation of (or reduction in) alcohol use. For some patients who are unable to attend daily in-person check-ins, alternating in-person visits with remote check-ins via phone or video call is an appropriate alternative.

**Recommendation IV.2:** Re-assessments should focus on the patient’s health since the last checkup. Clinicians should assess general physical condition, vital signs, hydration, orientation, sleep and emotional status including suicidal thoughts at each visit. Ask about alcohol and other substance use and, if available, measure Blood Alcohol Content (BAC) with a breathalyzer to detect recent alcohol use.
The patient continues to do well... Now 4 weeks in. Planning to schedule another in person visit.

- How do you schedule/prepare in-person visits at the office/treatment sites for patients with substance use disorders? PPE? Screening? Any other comments?
UPCOMING EVENT
ACMT & PARTNERS COVID19 WEBINAR SERIES

Mitigating the Intersection of COVID19 and Opioid Use Disorder

Wednesday, May 20, 2020
3:00 PM EDT

www.acmt.net/covid19web