Managing Opioid Withdrawal in the Inpatient Setting

Who Is Likely to Experience Withdrawal Symptoms?

- Risk group: Anyone consistently taking opioids for ≥2 weeks.
- Predictors of severe withdrawal: Daily use, high dosage, and use of short-acting opioids.

Common Symptoms of Opioid Withdrawal

- **FLU OPRS** mnemonic:
  - **F**lu-like: Fever, sweating, chills.
  - **L**eg movements: Restlessness, kicking.
  - **U**nwell: General malaise.
  - **O**veractive reflexes: Twitches, spasms.
  - **P**ain: Muscles, stomach, bones.
  - **R**uns: Diarrhea.
  - **S**leep: Insomnia.

Withdrawal Time Course

- Fentanyl: onset 3–12 hours, peak 12–36 hours, duration 5–7 days
- Heroin: onset 8–24 hours, peak 36–72 hours, duration 7–10 days
- Short-acting analgesics (eg, hydrocodone, oxycodone): onset 6–12 hours, peak 12–36 hours, duration 5–7 days
- Long-acting analgesics (eg, morphine): onset 8–24 hours, peak 36–72 hours, duration 7–10 days
- Methadone: onset 1–3 days, peak 4–7 days, duration 2–4 weeks

Severity Measurement

- *Clinical Opiate Withdrawal Scale (COWS)*: Clinician-administered (see page 25).

Management of Withdrawal Symptoms

- Opioid-assisted: Can use either buprenorphine or methadone (though buprenorphine is most common)
  - Buprenorphine
    - Start when patient is in mild/moderate withdrawal (COWS score of 8–12).
    - Prescribe 4 mg SL, then reevaluate your patient after 30–45 minutes to assess withdrawal symptoms and determine if redosing of another 4 mg SL buprenorphine is necessary.
    - Reevaluate your patient after another 30–45 minutes and administer another 4 mg SL buprenorphine if the patient still has a COWS score of 8–12.
    - A total of 8–12 mg SL buprenorphine is usually sufficient to prevent physiologic withdrawal symptoms in the first 24 hours.
    - Titrate the daily dose by 8 mg/day to a maximum of 24 mg daily with the goal of eliminating opioid cravings. Most patients will need 16–24 mg to eliminate cravings completely.
    - Once a maintenance dose is determined, administer it daily, or divided BID or TID.
    - Encourage patients to remain on buprenorphine long term, as they'll otherwise face a high risk of returning to use after discharge. Remember to refer them for outpatient buprenorphine treatment.
  - Methadone
    - Some patients have difficulty tolerating buprenorphine and seem to be prone to experiencing precipitated withdrawal. Consider using methadone for these patients instead.
    - Start with 20–30 mg of methadone as an initial dose. Reassess your patient after two to four hours and administer another 5–10 mg if they are still experiencing withdrawal symptoms.
    - A dose of 40 mg should be sufficient to prevent physiologic withdrawal symptoms in the first 24 hours.
    - Any patient receiving methadone for OUD for more than 72 hours needs to be connected to a federally regulated opioid treatment program (OTP). Contact local programs and ensure that the patient has follow-up if you plan on continuing methadone.
    - Collaborate with the OTP on dosing. Typical titration rates are 5–10 mg every few days with the goal of eliminating cravings. Doses may need to be as high as 120 mg or above.
    - Once the patient is stable, administer the total daily dose once daily.

- Symptom-based treatment—when opioid withdrawal management with buprenorphine or methadone is not available
  - Autonomic symptoms (GI distress, anxiety, sweating, cramping): clonidine 0.1–0.2 mg Qhr; max 0.8 mg/day. Check blood pressure before each dose.
  - Nausea: Ondansetron 4 mg Q4–6hrs; max 16 mg/day.
  - Anxiety: Lorazepam 1 mg Q4–6hrs; max 4 mg/day.
  - Diarrhea: Loperamide 4 mg, then 2 mg after each loose stool; max 16 mg/day.
  - Cramps: Dicyclomine: 10–20 mg Q6hrs.
  - Muscle spasm: Methocarbamol: 750–1500 mg Q8hrs or cyclobenzaprine: 5–10 mg Q6hrs; max 30 mg/day.