Opioid Withdrawal Management

Introduction

Getting patients with opioid use disorder (OUD) completely off opioids, so-called "detox," is generally not advisable. Very few patients with OUD are able to completely stop opioids and remain abstinent for any length of time without further treatment. Moreover, taking patients off opioids completely can lower tolerance and paradoxically *increase* risk of overdose in the long run. The only situation in which medically supervised withdrawal is a sensible approach is if the patient plans to receive intramuscular naltrexone immediately afterwards, but even this approach can be tough outside of controlled inpatient settings.

Nonetheless, some patients will insist on getting off all opioids. For these patients, a medically supervised opioid withdrawal is preferable to no care at all. Contrary to popular belief, the vomiting, diarrhea, and autonomic instability that patients experience during opioid withdrawal can be fatal for those with underlying medical conditions that impact their ability to regulate fluid balance or those who are at risk of developing cardiac arrhythmias. Opioid withdrawal can be especially risky in pregnant patients since it can lead to fetal demise. Finally, easing the symptoms of withdrawal at the very least can help keep your patient engaged with treatment. Be sure to provide these patients with naloxone in the likely event they return to use, and make sure they know how to get treatment if they change their mind.

There are two general approaches. Opioid-assisted withdrawal management, with buprenorphine or methadone, is preferable because withdrawal is less severe (Meader N, *Drug Alcohol Depend* 2010;108(1–2):110–114). Symptom-based treatment with alpha-2 agonists and adjunctive medications should be used only when opioid medications are not available.

Inpatient vs Outpatient

Good Candidates for Outpatient	Candidates Who Need Inpatient*
Medically healthy	Medical comorbidities
Good social supports	Living alone, unhoused, or otherwise isolated
Reliable	History of poor follow-up
Cognitively intact	Cognitively impaired
Access to transportation	No reliable transportation
No active psychiatric illness	Unstable major mental illness
Buprenorphine or symptom-based protocol	Methadone protocol
	Pregnant

*See "Managing Opioid Withdrawal in the Inpatient Setting" fact sheet for more details

Opioid-Assisted Withdrawal Management

Buprenorphine has less risk of overdose and is therefore preferred over methadone. Remember, buprenorphine can worsen withdrawal if given too early, and methadone can stack with other opioids in the patient's system. Therefore, start treatment once the patient is in moderate withdrawal (a score of around 8 on the Clinical Opiate Withdrawal Scale [COWS] or a score of about 10 on the Subjective Opiate Withdrawal Scale [SOWS]). Give just enough medication to control withdrawal symptoms and taper over five days or so. Here are sample protocols, which should be adjusted based upon patient response.

	Buprenorphine	Methadone
Day 1	4 mg BID	5–10 mg Q2hrs up to 40 mg
Day 2	4 mg BID	30 mg daily
Day 3	3 mg BID	20 mg daily
Day 4	2 mg BID	10 mg daily
Day 5	1 mg BID	5 mg daily

Symptom-Based Treatment

Alpha-2 agonists can relieve autonomic symptoms of opioid withdrawal like GI distress, anxiety, sweating, and cramping. They cause hypotension as a side effect, so be sure to check blood pressure before each dose and hold

the dose if SBP<90 or DBP<60. If outpatient, have patients check blood pressure before taking a dose. Consider the following adjunctive medications as well:

Symptom	Medication	Notes
Autonomic symptoms	Clonidine: 0.1–0.2 mg Q1hr; max 0.8 mg/day Lofexidine: 0.54 mg Q6hrs; max 2.88 mg/day	Give 0.1 mg if COWS or SOWS<12 Give 0.2 mg if COWS or SOWS>12 Take total dose in the first 24 hours; give in divided doses QID for several days; taper 0.1–0.2 mg/day until discontinuation (slow taper avoids rebound hypertension)
Anxiety	Hydroxyzine: 25–50 mg Q6hrs; max 200 mg/day Lorazepam: 1 mg Q4–6hrs; max 4 mg/day	Reserve benzos for inpatient Avoid benzos if patient takes other CNS depressants
Nausea/vomiting	Ondansetron: 4 mg Q4–6hrs; max 16 mg/day Prochlorperazine: 5 mg QID; max 20 mg/day	Prochlorperazine is an antipsychotic and can help relieve anxiety, though risks akathisia as well
Diarrhea	Loperamide: 4 mg first, then 2 mg after each loose stool; max 16 mg/day	
Abdominal cramps	Dicyclomine: 10–20 mg Q6hrs	
Pain and muscle aches	Ibuprofen: 400–600 mg Q6hrs; max 2400 mg/day Acetaminophen: 650–1000 mg Q8hrs; max 3000 mg/day Naproxen: 500 mg BID	Steer clear of opioid analgesics, including tramadol
Insomnia	Trazodone: 25–100 mg QHS Quetiapine: 25–100 mg QHS	Reserve benzos and z-drugs for inpatient
Muscle spasm	Methocarbamol: 750–1500 mg Q8hrs Cyclobenzaprine: 5–10 mg Q6hrs; max 30 mg/day	

Patients receiving opioid-assisted withdrawal management may also benefit from the addition of adjunctive medications for symptom-based treatment as "comfort meds."