Managing Opiate Withdrawal on the Inpatient Psych Unit

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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 hrs, Peak: 12–36 hrs, Duration 5–7 days.
- Heroin: Onset 8–24 hrs, Peak 36–72 hrs, Duration 7–10 days.
- Short-acting analgesics (e.g. hydrocodone, oxycodone): Onset 6–12 hrs, Peak 12–36 hrs, Duration 5–7 days.
- Long-acting analgesics (e.g. morphine) Onset 8–24 hrs, Peak 36–72 hrs, 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 XX).

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 8-12)
    - Prescribe 4 mg SL, re-evaluate your patient after 30-45 minutes to assess withdrawal symptoms and determine if redosing of another 4mg SL buprenorphine is necessary.
    - Re-evaluate your patient after another 30-45 minutes and administer another 4mg SL buprenorphine if the patient still has a COWS 8-12.
    - A total of 12mg SL buprenorphine is usually sufficient
    - Once you know the total dose needed, administer it once daily.
    - Encourage patients to remain on buprenorphine long-term, even after withdrawal symptoms subside, as they'll otherwise face a high risk of relapse/overdose after discharge. Remember to refer them for outpatient buprenorphine treatment.
  - Methadone
    - Methadone can also be used to treat opioid withdrawal. Consider methadone for patients who have difficulty tolerating the mild withdrawal symptoms needed for treatment with buprenorphine, or those who refuse buprenorphine.

        - Start with a single 20-30 mg dose of methadone. You can give small additional doses of 5-10mg at a time if the patient is still experiencing withdrawal symptoms. Maximum dose in 24 hours is 40mg.
        - Again, encourage patients to remain on methadone long term. Patients who elect to stay on methadone will need to be referred to a federally regulated Opioid Treatment Program (aka "methadone clinic"). Typical daily doses of methadone in these programs range from 40-120mg, though some patients may require higher doses.
        - For patients who refuse longer term treatment, maintain 40mg daily for 2-3 days, and then taper off as tolerated over the course of a week or so.

- Symptom-based treatment -- when opioid detox 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.
    - 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.