Pain Management and Addiction Medicine Section
Meeting Minutes

October 1st 2022, 3pm PT.

The meeting was called to order by Dr. Don Stader at 3pm PT.
Dr. Stader briefly discussed resolutions submitted to the Council by our Section. Dr. Eric Ketcham and Dr. Stater ran from one reference committee room to another and spoke eloquently in support of the resolutions. All the resolutions passed as amended. More on the resolutions in an upcoming newsletter. The resolutions submitted by the section and others relevant to the section were:

- 2022 Council Resolution 29: Buprenorphine is an Essential Medicine and Should be Stocked in Every ED
- 2022 Council Resolution 32: Supervised Consumption Facilities/Safe Injection Sites
- 2022 Council Resolution 33: Telehealth Bridge Model for the Treatment of Opioid Use Disorder
- 2022 Council Resolution 41: Addressing Stigma in the Emergency Department
- 2022 Council Resolution 43: Endorsing ED Resident Competency in Buprenorphine Initiation

Next Dr. Reuben Strayer gave a presentation on updates in alcohol use disorder (AUD), opioid use disorder (OUD) and Harm Reduction. This was a cutting-edge discussion on a wide range of topics with input from those attending the meeting. Dr. Strayer challenged the medical profession and us in particular to do better with alcohol use disorder. There are still 140,000 deaths per year from this illness in the US.

- Dr. Strayer's presentation can be found in the following attachment.

Dr. Andrew Herring gave another cutting-edge talk on pain. Again, this was a wide-ranging talk with lots of audience participation. There was discussion of difficult pain management cases.

Dr. Kathryn Hawk accepted the Innovation & Excellence in Behavioral Health and Addiction Medicine Award on behalf of Dr. Gail D'Onofrio at the Council Luncheon. Dr. Hawk made a brief presentation about Dr. D'Onofrio, a section member, at our meeting. This is the first time this award has been given, and the section is proud of the pioneering work of Dr. D'Onofrio in OUD. Several members of the section, as well as others, worked to initiate this award a couple of years ago.

Dr. Ryan Stanton. our board liaison, made a presentation about ACEP Board goals and ACEP's Strategic Plan. He also discussed progress in his home state of Kentucky in addiction medicine, specifically the roll out of needle exchange programs.

Jeff Davis, ACEP's Director of Regulatory and External Affairs, went over all the regulatory and legislative areas where ACEP is pursuing legislation and regulation pertinent to our section. These include:

- X-waiver
- G-Code for MAT in the ED
- Three Day Rule
- Proposed CDC Clinical Practice Guideline for Prescribing Opioids
- Draft Model Legislation: Substance Use Disorder Treatment in Emergency Settings Act
- Naloxone
- Telehealth

Mr. Davis's presentation can be found in the following attachment.

An aspirational goal from Dr. Stader: The outcomes for those with SUD should evolve from a predictable tragedy to a predictable miracle.

Respectively submitted,
John Bibb, MD, FACEP

emergency addiction updates

reuben j. strayer
emupdates.com

alcohol use disorder

opioid overdose crisis

↓

emergency medicine responds:

tons of OUD programming

lots of EPs gain addiction expertise

we see the impact of this programming and expertise

alcohol use disorder

opioid overdose crisis

↓

emergency medicine responds:

tons of OUD programming

lots of EPs gain addiction expertise

we see the impact of this programming and expertise

↓

what about alcohol?

a "new" opportunity to respond

alcohol use disorder

COVID escalation of use and mortality

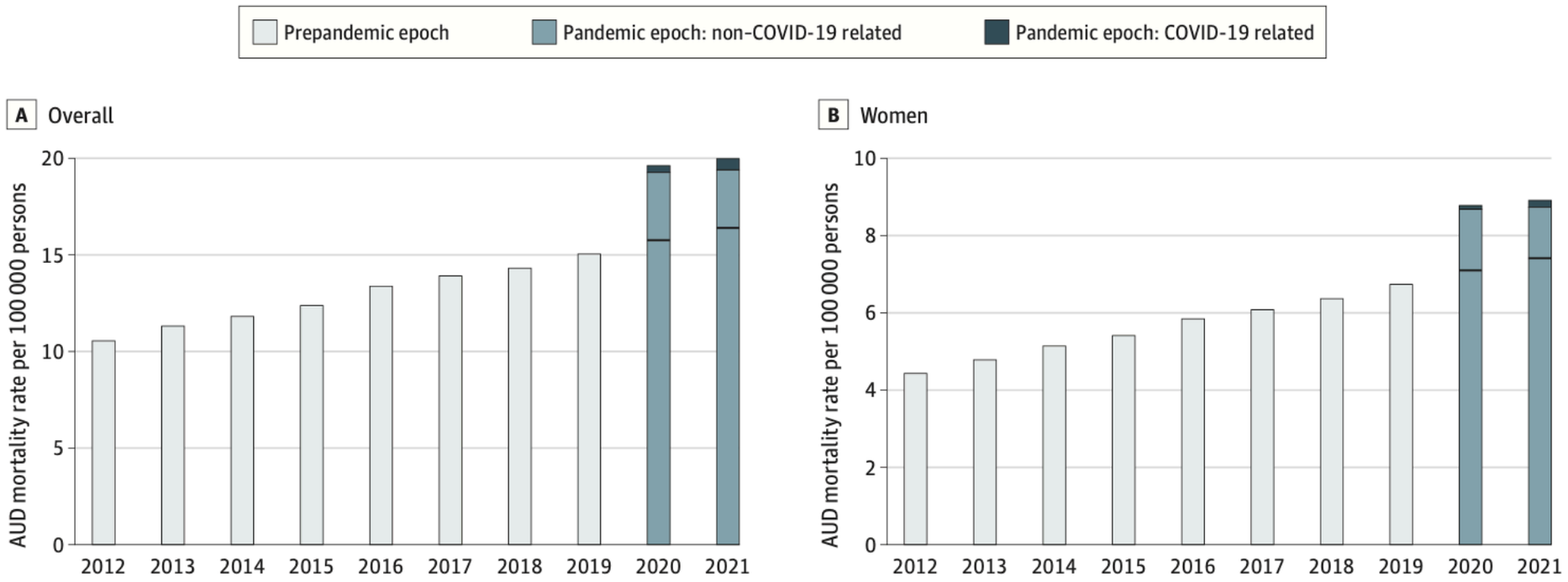
JAMA Network | Open™

Research Letter | Public Health

Evaluation of Trends in Alcohol Use Disorder–Related Mortality in the US Before and During the COVID-19 Pandemic

Yee Hui Yeo, MD, MSc; Xinyuan He, MD; Peng-Sheng Ting, MD; Jian Zu, PhD; Christopher V. Almario, MD; Brennan M. R. Spiegel, MD; Fanpu Ji, MD, PhD

Figure. Trends in Alcohol Use Disorder–Related Mortality Before and During the COVID-19 Pandemic, 2012 to 2021



alcohol use disorder

ascendance of phenobarbital for severe AWS

Alcohol 102 (2022) 59–65

Contents lists available at ScienceDirect

Alcohol

journal homepage: http://www.alcoholjournal.org/

A retrospective evaluation of phenobarbital versus benzodiazepines for treatment of alcohol withdrawal in a regional Canadian emergency department

Alexandra Pistore [a], Sarah Penney [a], Rhonda Bryce [b], Clinton Meyer [c], Braden Bouchard [a, c, *]

American Journal of Emergency Medicine 54 (2022) 263–266

Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.elsevier.com/locate/ajem

Phenobarbital and/or benzodiazepines for recurrent alcohol withdrawal: A self-controlled, retrospective cohort study

Alex Staidle, PharmD, BCPS, APh [a,b,*], Curtis Geier, PharmD, BCCCP [a]

[a] Department of Pharmacy, Zuckerberg San Francisco General Hospital, San Francisco, CA, USA
[b] Department of Pharmacy, Providence Santa Rosa Memorial Hospital, Santa Rosa, CA, USA

Journal of Medical Toxicology (2022) 18:4–10
https://doi.org/10.1007/s13181-021-00863-2

ORIGINAL ARTICLE

Return Encounters in Emergency Department Patients Treated with Phenobarbital Versus Benzodiazepines for Alcohol Withdrawal

Jacob A. Lebin[1] · Anita Mudan[1] · Charles E. Murphy IV[1] · Ralph C. Wang[1] · Craig G. Smollin[1]

high dose up front loading is very effective and self-tapering

alcohol use disorder

outpatient withdrawal management

Diazepam	Mild AWS: 10 mg PO q6h x 4 doses then prn* for 3-5 days (disp#20 10 mg tabs) Moderate AWS: 20 mg PO q2h x 3 doses, then prn for 3-5 days (disp#30 10 mg tabs)
Chlordiazepoxide	50-100 mg PO q6h prn for 1 week (disp#50 25 mg tabs)
Lorazepam	Mild AWS: 0.5-1 mg PO q6h as needed for 3-5 days (disp#20 0.5 mg tabs) Moderate AWS: 1-2 mg PO q2h as needed for 3-5 days (disp#30 1 mg tabs)
Carbamazepine	400 mg PO BID for 1 week (disp#14 400 mg tabs)
Valproic Acid	500 mg PO TID for 1 week (disp#21 500 mg tabs)
Gabapentin	Load with 1200 mg PO in ED, then 600 mg PO TID; may prescribe 1 week for detox or longer for maintenance treatment (disp#21 600 mg tabs)

alcohol use disorder

anti craving medications

Medication	Summary	Contraindications	Usual Dose	Tips
Naltrexone	First line agent from the ED (PO) Abstinence not required before initiation (only clinical sobriety for patient consent)	Opioid dependence Severe hepatic impairment Severe renal impairment	50 mg PO daily XR-NTX: 380 mg IM every 3-4 weeks.	Must inquire about current opioid dependence, including medications for opioid use disorder; if in doubt perform naloxone challenge Does not treat withdrawal –consider combining with gabapentin
Acamprosate	Renally cleared and can be used in severe liver disease More effective if initiated when patient abstinent (after detoxification)	Renal impairment (can decrease dose in mild/moderate renal impairment)	666 mg (two 333 mg tabs) PO TID	GI side effects are common; may have to be gradually increase to therapeutic dose May require prior authorization or be cost prohibitive
Gabapentin	Can be used to treat AWS and to decrease cravings Sobriety not required to initiate	Requires renal dose adjustment Caution in elderly or fall risk as medication is sedating	300-600 mg PO TID	Patients with AUD generally require high doses May be used as a single agent or adjunctively with NTX or AC
Topiramate	Dose needs to be titrated up to an effective dose (usually over a period of weeks) Only recommend to be initiated from the ED if prompt and reliable	Caution in patients with balance difficulty (fall risk)	Starting dose is 50 mg PO nightly Titrated to 50-300 mg PO daily, usually divided BID	Indicated for some forms of epilepsy, migraine, behavioral health conditions Adverse effects (tremor, disequilibrium, confusion) are common may prevent reaching a
Disulfiram	Not recommended for initiation from the ED Aversion therapy–does not reduce alcohol cravings.	Medically compromised patients Patients lacking observation or supervision	250 mg PO daily, may increase to 500 mg daily	Adherence is poor outside of an institutional or other daily supervised setting Can cause dangerous adverse effects

alcohol use disorder

anti craving medications

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alcohol use disorder

cancer risk / labeling

Updated Health Warnings for Alcohol — Informing Consumers and Reducing Harm

Anna H. Grummon, Ph.D., M.S.P.H., and Marissa G. Hall, Ph.D., M.S.P.H.

In April 2022, the Centers for Disease Control and Prevention (CDC) released new mortality statistics showing that alcohol consumption now accounts for more than 140,000 deaths per

Requiring new, well-designed warning labels on alcohol containers could be a commonsense strategy for providing information to consumers and reducing the burden of alcohol-related harm.

ing injuries caused by motor vehicle crashes), mounting research links longer-term alcohol consumption to chronic diseases including hypertensive heart disease, cirrhosis, and several types

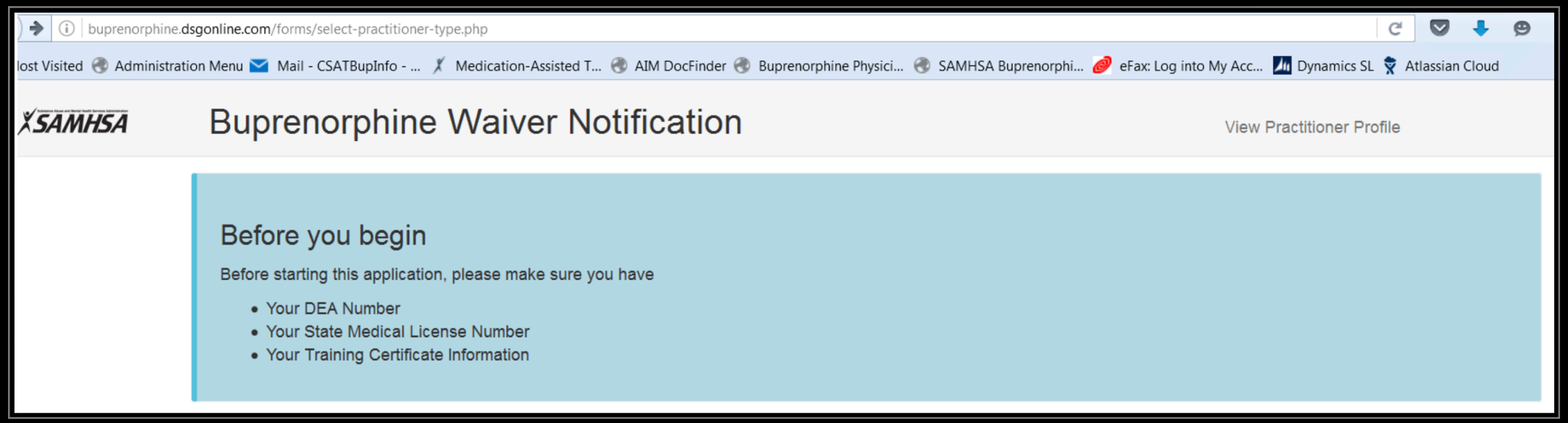
Current Warning

GOVERNMENT WARNING:
(1) According to the Surgeon General, women should not drink alcoholic beverages during pregnancy because of the risk of birth defects. (2) Consumption of alcoholic beverages impairs your ability to drive a car or operate machinery, and may cause health problems.

Potential New Warning

opioid use disorder

X-ing the X



HEALTH POLICY/EDITORIAL

Improve Access to Care for Opioid Use Disorder: A Call to Eliminate the X-Waiver Requirement Now

Gail D'Onofrio, MD, MS*; Edward R. Melnick, MD, MHS; Kathryn F. Hawk, MD, MHS

*Corresponding Author. E-mail: gail.donofrio@yale.edu.

0196-0644/$-see front matter

https://doi.org/10.1016/j.annemergmed.2021.03.023

opioid use disorder

X-ing the X

H.R.1384 - Mainstreaming Addiction Treatment Act of 2021

117th Congress (2021-2022) | Get alerts

BILL Hide Overview ✕

Sponsor: Rep. Tonko, Paul [D-NY-20] (Introduced 02/25/2021)

Committees: House - Energy and Commerce; Ways and Means; Judiciary

Latest Action: House - 04/28/2021 Referred to the Subcommittee on Crime, Terrorism, and Homeland Security. (All Actions)

Tracker: Introduced > Passed House > Passed Senate > To President > Became Law

S.445 - Mainstreaming Addiction Treatment Act of 2021

117th Congress (2021-2022) | Get alerts

BILL Hide Overview ✕

Sponsor: Sen. Hassan, Margaret Wood [D-NH] (Introduced 02/25/2021)

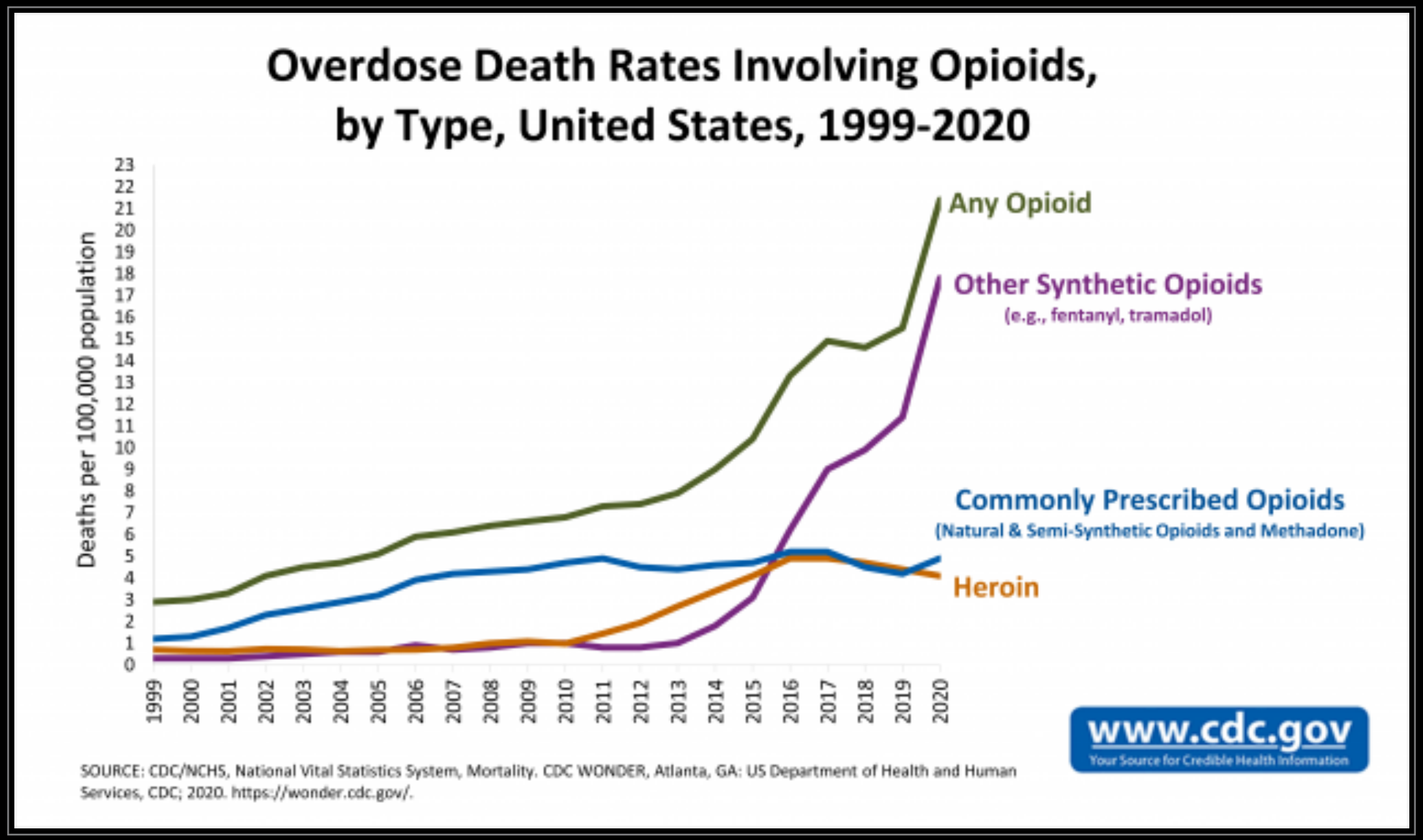
Committees: Senate - Health, Education, Labor, and Pensions

Latest Action: Senate - 02/25/2021 Referred to the Committee on Health, Education, Labor, and Pensions. (All Actions)

Tracker: Introduced > Passed Senate > Passed House > To President > Became Law

opioid use disorder

fentanyl and the pandemic mortality explosion



opioid use disorder

fentanyl and the pandemic mortality explosion

DRUG TYPE	(DEATHS 2021)	(DEATHS 2020)
Synthetic Opioids (fentanyl)	71,238	57,834
Psychostimulants (meth)	32,856	24,576
Cocaine	24,538	19,927
Natural/semi-synthetic (prescription)	13,503	13,722


the ONION

SATURDAY, JANUARY 10, 1998 AMERICA'S NEWS SOURCE ★★★ 75 CENTS

Drugs Win Drug War

WASHINGTON, DC—After nearly 30 years of combat, the U.S. has lost the drug war.

Drug Czar Barry McCaffrey delivered the U.S.'s unconditional surrender in a brief statement Friday. "Drugs, after a long, hard battle, you have defeated us," he said. "Despite all our efforts, the United States has proven no match for the awesome power of the illegal high."

"In retrospect," McCaffrey

Killer Robots Storm Home Of Bill Gates' Childhood Bully

SEATTLE, WA—Walter Conrad, a 46-year-old sporting-goods retail manager, was assaulted in his home by an army of killer Microsoft robots Friday.

opioid use disorder

harm reduction

The New York Times

Nation's First Supervised Drug-Injection Sites Open in New York

During the first official day in operation at the two Manhattan facilities, trained staff reversed two overdoses, officials said.

Give this article 281

People can use drugs in what is called a narcotic consumption booth inside the injection sites. David Dee Delgado for The New York Times

opioid use disorder

harm reduction

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved October 2015

Naloxone Prescriptions by Emergency Physicians

American College of Emergency Physicians®

ADVANCING EMERGENCY CARE

POLICY STATEMENT

Approved June 2016

Naloxone Access and Utilization for Suspected Opioid Overdoses

opioid use disorder

harm reduction

opioid use disorder

bup/nalox vs bup mono

The Naloxone Component of Buprenorphine/Naloxone: Discouraging Misuse, but at What Cost?

Jessica Gregg, PhD, MD, Jennifer Hartley, PhD, MD, David Lawrence, MD, Amanda Risser, MD, MPH, and Christopher Blazes, MD

Prescribing the Buprenorphine Monoproduct for Adverse Effects of Buprenorphine-Naloxone

Lucinda A. Grande, MD

Buprenorphine alone or with naloxone: Which is safer?

Erin Kelty[1,2], Craig Cumming[2,3], Lakhhina Troeung[2] and Gary Hulse[1,4]

Reconsidering the Usefulness of Adding Naloxone to Buprenorphine

Christopher K. Blazes[1] and Jonathan D. Morrow[1,2]*

opioid use disorder

buprenorphine initiation

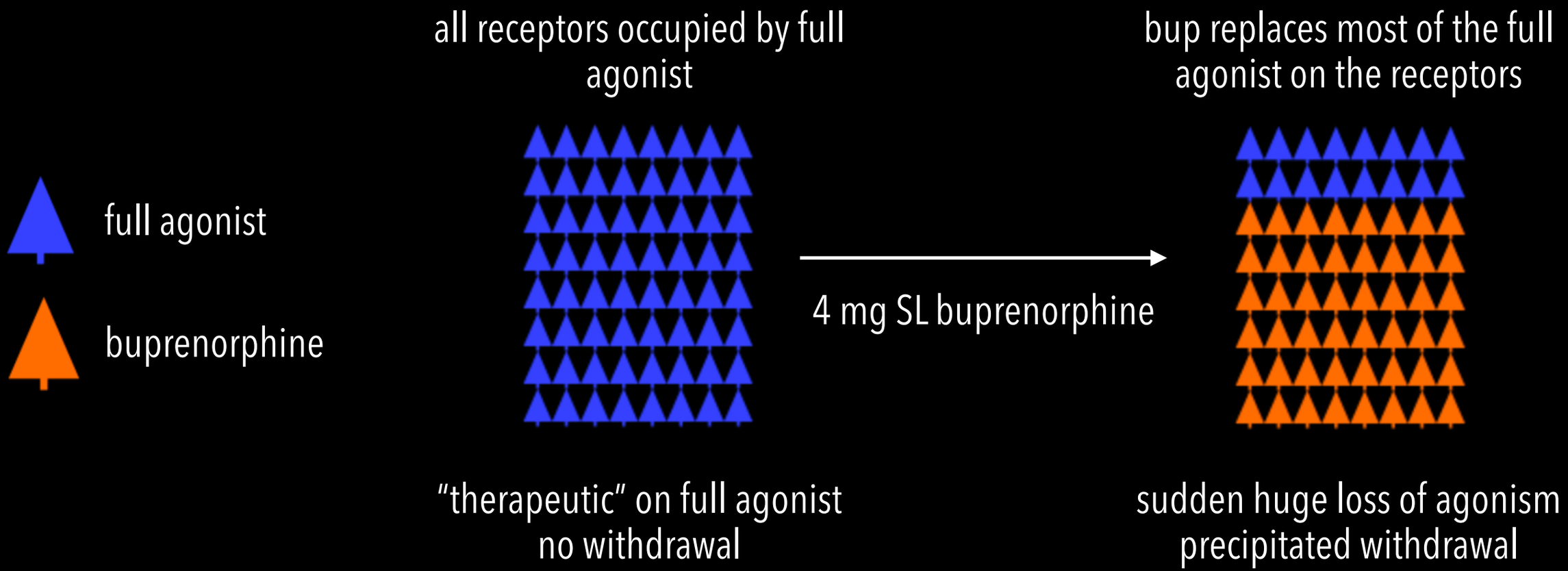
fentanyl

rise in buprenorphine-precipitated withdrawal

which sucks

opioid use disorder

buprenorphine initiation



opioid use disorder

buprenorphine initiation

spontaneous withdrawal strategies

home initiation

prescription vs. dispense, instructions, followup

observe in ED

do serial cardiac enzymes if it will make you feel better

admit or observation pathway

diagnose cellulitis or pneumonia if it will make you feel better

come back when you're sicker

opioid use disorder

buprenorphine initiation

alternative initiation strategies

intentional precipitation

macrodosing

microdosing

opioid use disorder

buprenorphine initiation

alternative initiation strategies

CASE REPORT

OPEN

Enhancing Patient Choice: Using Self-administered Intranasal Naloxone for Novel Rapid Buprenorphine Initiation

Adam Randall, DNP, FNP-C, Ilana Hull, MD, MSc, and Stephen A. Martin, MD, EdM, FASAM, FAAFP

opioid use disorder

buprenorphine initiation

alternative initiation strategies

opioid use disorder

buprenorphine initiation

alternative initiation strategies

	Microdose	Low Dose	High Dose	QuickStart
Time since last use	None	1-2 days	12 hours	None
Initiation period	One week +	2 days +	2-3 hours	30 minutes
Is tapering required?	Yes	No	No	No
Expected withdrawal	None, but withdrawal can still occur	Must be in moderately severe withdrawal to start	Must be in moderate withdrawal to start	Short, but moderately severe once the process has begun (<30min)
Total transition time	On average, 8–14 days	2 days +	~15 hours	1 hour

opioid use disorder

buprenorphine initiation

alternative initiation strategies

buprenorphine macrodosing

macrodose less likely to precipitate withdrawal

macrodose prolongs duration of action/protection

should we be initiating with doses of ≥32 mg?

EDITORIAL

ADDICTION SSA

Low- and very low-dose buprenorphine induction: new(ish) uses for an old(ish) medication?

Low-dose buprenorphine initiation is increasingly necessary and is the most accurate and appropriate term to describe the overlapping initiation of buprenorphine with full agonist opioids.

NEED FOR NON-TRADITIONAL BUPRENORPHINE INITIATION TECHNIQUES

Ms C is a 32-year-old female who presented to the hospital with fever and chest pain who was found to have tricuspid valve infective endocarditis. Injection marks were noted on her forearms and she was observed to have opioid withdrawal. Her medical team discussed treatment options for opioid use disorder (OUD) and initiated methadone. She underwent successful cardiac surgery, but on post-operative day 2 she developed torsade de pointes. Her surgeons requested that methadone be transitioned to buprenorphine. The patient has acute post-operative pain and is receiving immediate-release hydromorphone. She is receptive to transitioning to buprenorphine but does not feel that she can abruptly stop full agonist opioids (FAO) and fears precipitated withdrawal.

TRADITIONAL BUPRENORPHINE INITIATION

Buprenorphine is a partial opioid agonist with formulations indicated for chronic pain or OUD. Unlike FAO (heroin, fentanyl, methadone, etc.) the partial opioid agonism of buprenorphine necessitates initiation consideration in people taking FAO. International buprenorphine initiation guidelines advise against starting buprenorphine until FAO have been stopped for 8–36 hours to prevent precipitated withdrawal and an initial buprenorphine dose of 2–4 mg [1–4]. This technique is generally well tolerated and successful in patients using heroin and other short-acting opioids; however, clinical realities such as acute buprenorphine allows the partial agonist opioid to slowly displace the FAO from the opioid receptor, thus minimizing symptoms of precipitated opioid withdrawal.

HISTORY OF LOW-DOSE BUPRENORPHINE INDUCTIONS

Studies with buprenorphine conducted in the 1980s and 1990s demonstrated that doses of up to 2 mg of sublingual liquid (equivalent to 3–4 mg of current buprenorphine tablet/film formulations) did not precipitate opioid withdrawal when provided to patients receiving methadone [5]. This mirrored data obtained from intramuscular and intravenous buprenorphine in patients receiving morphine [6]. The onset of buprenorphine-precipitated withdrawal was dependent upon the dose of the agonist, time since last agonist administration, and the dose of buprenorphine, and induction guidelines recommended optimizing these parameters [6]. The first case-series to further describe therapeutic low-dose buprenorphine initiation in patients receiving FAO was carried out in 2010 in Bern, Switzerland [7]. Since then, there have been 26 case reports or case-series of low-dose and very low-dose techniques. Reports use different low-dose initiation strategies, generally using buccal, intravenous, transdermal or sublingual buprenorphine in doses 25–50% lower than traditional initiation techniques. Most published cases describe successful initiations, raising the specter of publication bias. Several large academic institutions have sought approval from their institutional therapeutics' committees for the low-dose initiation approach.

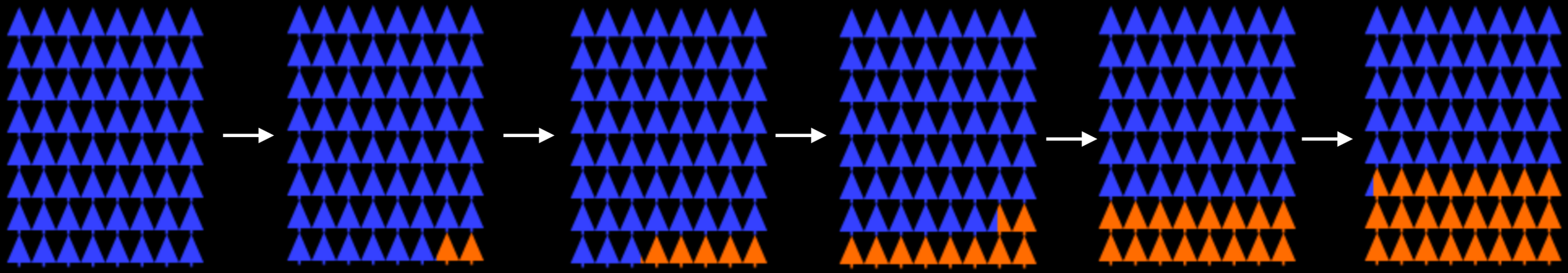
'MICRODOSE' IS AN INACCURATE AND LOADED TERM

The process of using low or very low doses of buprenorphine to assist with the transition from FAO to buprenorphine has been

opioid use disorder

buprenorphine microdosing initiation

once therapeutic dose of bup achieved
can discontinue full agonist
now patient therapeutic on bup
no withdrawal
can titrate up bup as needed to suppress cravings



Day 1
0.25 mg bup

Day 2
0.5 mg bup

Day 3
1 mg bup

Day 4
2 mg bup

Day 5
3 mg bup

continue full agonist

opioid use disorder

buprenorphine microdosing initiation

takes time- the slower you go, the less likely you'll accidentally precipitate withdrawal but the longer the period to fail initiation

ongoing injection of street drugs during subtherapeutic bup dosing is dangerous

opioid use disorder

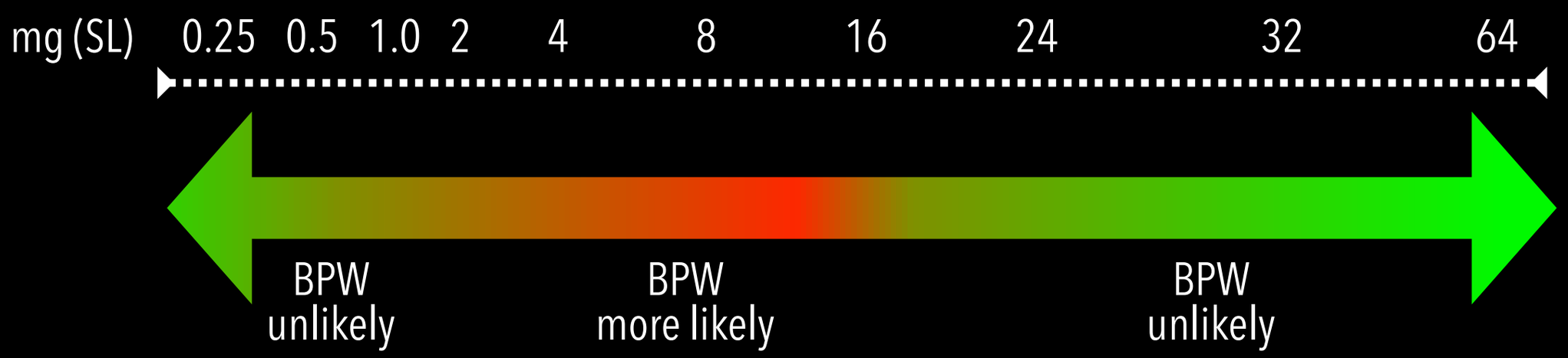
buprenorphine microdosing initiation

administering tiny doses of bup is tricky

cutting buprenorphine strips or tabs into very small pieces
transdermal buprenorphine
buccal bup (for pain) available in small doses
intravenous buprenorphine bolus
intravenous buprenorphine infusion
IV bup given sublingually or ingested
ingest sublingual bup to reduce absorbed dose
depot/extended-release buprenorphine

opioid use disorder

buprenorphine microdosing initiation



opioid use disorder

treating BPW

more bup, then more bup, then more bup

conventional non-agonists

full agonists

ketamine

opioid use disorder

treating BPW*

bup 8-16 mg

↓

precipitated withdrawal (oops)

↓

bup 16 mg

↓

improved?

yes → great

↓ no

am I missing anything?

line, labs, monitor

↓

bup 16 mg SL vs. IV bup

↓

improved?

yes → great

↓ no

non-agonists, especially **ketamine**

alcohol or benzodiazepine withdrawal, thyrotoxicosis, DKA, sepsis, ICH, etc

*scant evidence, YMMV

opioid use disorder

buprenorphine for naloxone precipitated withdrawal

Postoverdose Initiation of Buprenorphine After Naloxone-Precipitated Withdrawal Is Encouraged as a Standard Practice in the California Bridge Network of Hospitals

To the Editor:

Recently, one of my patients described surviving a heroin overdose. After being found unconscious by

Contents lists available at ScienceDirect

American Journal of Emergency Medicine

journal homepage: www.elsevier.com/locate/ajem

Treatment of acute naloxone-precipitated opioid withdrawal with buprenorphine

Neeraj Chhabra [a,*], Steven E. Aks [b]

[a] Cook County Health, Department of Emergency Medicine, Division of Medical Toxicology, 1950 West Polk Street, 7th floor, cubicle 85, Chicago, IL 60612, United States
[b] Cook County Health, Department of Emergency Medicine, Division of Medical Toxicology, Chicago, IL, United States

Buprenorphine Field Initiation of ReScue Treatment by Emergency Medical Services (Bupe FIRST EMS): A Case Series

Gerard G. Carroll, MD FAAEM EMT-P, Deena D. Wasserman, MD FAWM, Aman A. Shah, MD, Matthew S. Salzman, MD, Kaitlan E. Baston, MD MSc DFASAM, Rick A. Rohrbach, BSN CFRN CCRN-K MICP, Iris L. Jones, MA LPC, LCADC, Rachel Haroz, MD, FAACT

opioid use disorder

buprenorphine for naloxone precipitated withdrawal

ELSEVIER

Annals of Emergency Medicine

Available online 1 October 2022

In Press, Corrected Proof

Emergency Medical Services/Original Research

Impact of Administering Buprenorphine to Overdose Survivors Using Emergency Medical Services

Gerard Carroll MD [a], Keisha T. Solomon PhD [c], Jessica Heil MS [b], Brendan Saloner PhD [c], Elizabeth A. Stuart PhD [c], Esita Y. Patel PhD [c], Noah Greifer PhD [d], Matthew Salzman MD [a], Emily Murphy MD [a], Kaitlan Baston MD [b], Rachel Haroz MD [a]

Show more

https://doi.org/10.1016/j.annemergmed.2022.07.006

Study objective

To evaluate the efficacy and safety of utilizing emergency medical services units to administer high dose buprenorphine after an overdose to treat withdrawal

opioid use disorder

buprenorphine for naloxone precipitated withdrawal

Heroin or Fentanyl* overdose reversed with naloxone
*or other short-acting opioid

Are any patient exclusion criteria present?

- Benzodiazepine, other sedative or intoxicant suspected
- Altered mental status, depressed level of consciousness, or delirium
- Unable to comprehend potential risks and benefits for any reason
- Severe medical illness such as sepsis, respiratory distress, organ failure present or suspected
- Report of methadone use
- Not a candidate for buprenophine maintenance treatment for any reason

NO TO ALL

YES TO ANY

Is the patient awake with signs of opioid withdrawal? (i.e. COWS >4)

NO → **Provide supportive care, observe and reevaluate**

YES

Is the patient agreeable to treatment with buprenorphine?

NO → **Provide supportive care, observe and reevaluate**

YES

16mg SL Buprenorphine

Administered as a single dose or in divided doses over 1-2 hours.
(Start with 0.3mg IV if unable to tolerate SL.)

Observe in ED until patient shows no clinical signs of excessive sedation or withdrawal (typically 2 hours).

OK to administer additional doses of Bup up to 32mg.
Engage, use motivational interviewing, and link to ongoing care.

CA BRIDGE
TREATMENT STARTS HERE

@gemmeverdi

Cannabis

overdose deaths

are now equal to

the # of people

gored by

unicorns

#earl the unicorn

emergency addiction updates

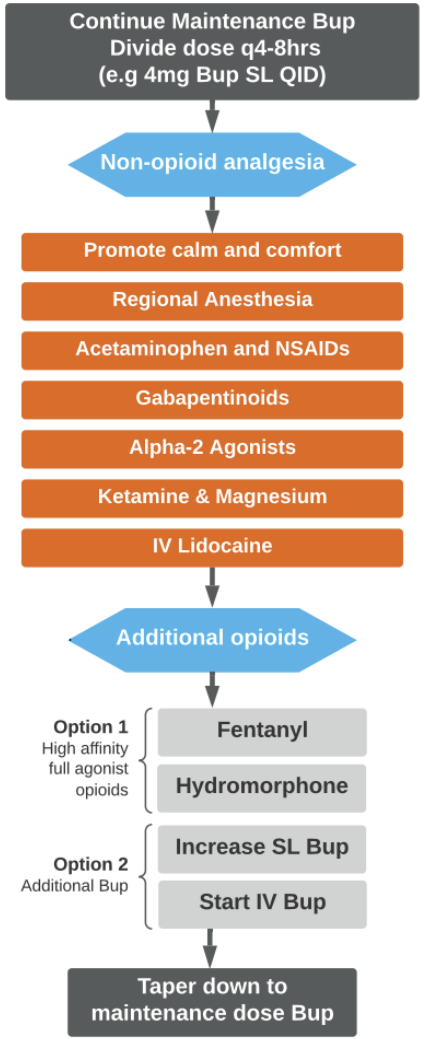
phenobarbital for severe AWS
outpatient treatment of mild-moderate AWS (chlordiazepoxide, gabapentin)
anti-craving medications for AUD (naltrexone, gabapentin)
bup-nalox vs. bup mono
buprenorphine initiation (microdosing, macrodosing)
buprenorphine-precipitated withdrawal
buprenorphine treatment of naloxone-precipitated withdrawal

buprenorphine for acute pain in opioid-naive patients
acute severe/perioperative pain in bup-maintained patients
methadone in the ED
treatment of tobacco use disorder in the ED
cannabis, methamphetamine, novel drugs of abuse

ACEP Pain and Addiction

Section meeting 2022

Andrew Herring MD



Promote calm and comfort

Anxiety, fear, depression are common: Instill sense of control, provide education on self-management techniques such as mindfulness meditation. Reduce noise, uncertainty, confusion.
Positioning, splinting, and physical comfort should be maximized. Minimize unnecessary NPO status.
TREAT UNPLEASANT SYMPTOMS:
Diphenhydramine 25-50mg PO q8h prn insomnia/anxiety
Tizanidine 2-4mg q6h prn muscle spasms
Ondansetron 4mg PO q6h prn nausea
Trazadone 50mg PO qhs prn insomnia
Melatonin 3mg PO qhs prn insomnia
Lorazepam 0.5-1mg PO prn anxiety
Antipsychotics prn psychotic disorder symptom control
Nicotine replacement prn tobacco dependence

Regional Anesthesia

Peripheral nerve blocks: superficial cervical plexus, brachial plexus, radial/median/ulnar, PECS, erratus plane, TAP, femoral, sciatic, posterior tibial.
Spinal and Epidural anesthesia

Acetaminophen and NSAIDs

Acetaminophen and **NSAIDs,** when not contraindicated, should are the foundation of a multimodal analgesic strategy.

Gabapentinoids

In opioid depenent patients, the calcium channel inhibitors, gabapentin and pregabalin reduce postoperative pain and reduce opioid consumption. Gabapentin 300-600mg PO TID.

Alpha-2 agonists

Clonidine and Dexmedetomidine are anxiolytic and analgesic with significant opioid sparing affects. e.g. **Clonidine** 0.1-0.3mg PO q6-8h prn pain or anxiety (NTE 1.2mg/day, hold if BP <100/70).

Ketamine & Magnesium (NMDAR antagonists)

Ketamine is the most potent non-opioid analgesic for opioid tolerant patients. A brief infusion of 0.3mg/kg IV over 15min is followed by 0.3-1mg/kg/hr as needed.
Magnesium is also an NMDAR with analgesic and opioid sparing effect. eg. 30-50mg/kg bolus followed by 10-mg/kg/hr.

IV Lidocaine (Na channel antagonist)

Opioid sparing analgesic. A bolus of 1-1.5mg/kg is followed by 1.5-3 mg/kg/h. Contraindications include cardiac dysrthymias. Must monitor serum levels after 24hrs.

High Affinity Full agonist Opioids

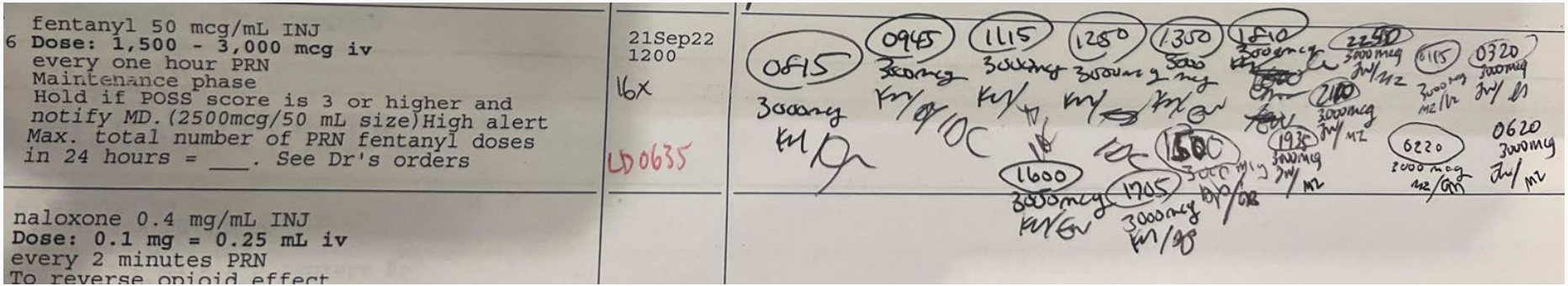
Hydromorphone, fentnayl, and sufentanil can be added to maintenance Bup to provide synergistic analgesia. Titrate to analgesia and side effects. This will NOT cause withdrawal.

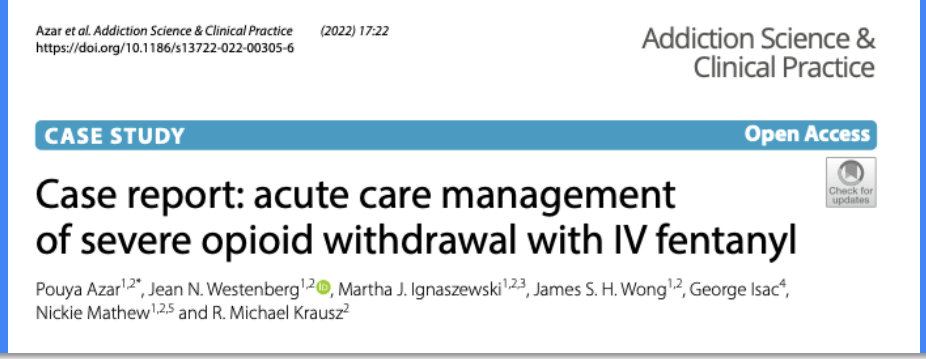
Additional Bup

There is no clinical ceiling on Bup analgesia. SL Bup can be given as frequently as q2h. IV Bup is a potent analgesic start at 0.3mg IV and titrate as needed. At higher doses respiratory depression does occur.

What is new?

what?


fentanyl 50 mcg/mL INJ
6 Dose: 1,500 - 3,000 mcg iv
every one hour PRN
Maintenance phase
Hold if POSS score is 3 or higher and
notify MD.(2500mcg/50 mL size)High alert
Max. total number of PRN fentanyl doses
in 24 hours = ___. See Dr's orders
21Sep22
1200
16x
LD 0635
naloxone 0.4 mg/mL INJ
Dose: 0.1 mg = 0.25 mL iv
every 2 minutes PRN
To reverse opioid effect
0615
0945
1115
1250
1350
1600
1705
1938
2110
2250
0115
0320
0620
0220


Azar et al. Addiction Science & Clinical Practice (2022) 17:22
https://doi.org/10.1186/s13722-022-00305-6

Addiction Science & Clinical Practice

CASE STUDY Open Access

Case report: acute care management of severe opioid withdrawal with IV fentanyl

Pouya Azar[1,2*], Jean N. Westenberg[1,2], Martha J. Ignaszewski[1,2,3], James S. H. Wong[1,2], George Isac[4], Nickie Mathew[1,2,5] and R. Michael Krausz[2]

Agonist dosing

Case: A 42-year-old female with a long history of injection opioid and crystal methamphetamine use was admitted to acute care for bilateral lower limb cellulitis.

Injectable Opioid Antagonist Treatment (iOAT)

- 200 mg IV diacetylmorphine (DAM) twice a day
- 12-h extended-release morphine (M-Eslon) 200 mg twice a day.

Table 2 Dosage regimen

Admission Timeline	Hydromorphone (IV)	Fentanyl (IV)			Monitoring
	Doses	Order	Dose	Cumulative daily	RASS (COWS)
Day 1	100 mg refused				
	100 mg				
	100 mg				
Day 2	100 mg refused				
	100 mg refused				
		100–200 mcg q5 min prn (induction)	200 mcg		0 (17)
			200 mcg		0
			200 mcg		0
			200 mcg	800 mcg	0 (2)
Day 3		300–400 mcg q1h prn (maintenance; consolidation)*	5 × 400 mcg	2000 mcg	— 1/0
Day 4			4 × 400 mcg; 1 × 300 mcg	1900 mcg	— 1/0
Day 5			3 × 400 mcg; 4 × 300 mcg	2400 mcg	— 1/0
Day 6			6 × 400 mcg	2400 mcg	— 1/0
Day 7			7 × 400 mcg	2800 mcg	— 1/0
Day 8			4 × 400 mcg	1600 mcg	— 1/0

q_mins: every_minutes; q_h: every_hour; prn: as needed; IV: intravenous; RASS: Richmond Agitation-Sedation Scale; COWS: Clinical Opiate Withdrawal Score; mg: milligram; mcg: microgram

* Patient self-selected for 300–400 mcg IV fentanyl every 3–4 h as it provided adequate sedation, pain relief and opioid effect

Table 1 Symptom-triggered IV fentanyl induction orders

Phases	Medication	Monitoring
Pre-induction	Discontinue all opioids	
Induction	Fentanyl 100–200 mcg IV q5min until patient satisfaction and RASS 0/−1	COWS before/after induction RASS, vitals* after each dose
Maintenance (0–24 h post-induction)	Fentanyl X mcg IV q1h PRN to maintain patient comfort and RASS 0/−1, where X is 50% of cumulative induction dose	RASS, vitals* q1h Continuous ECG and oxygen saturation monitoring
Consolidation (24 h + post-induction)	Reduced frequency of dosing on consecutive days to q2h, q3h, q4h PRN, where fentanyl dose is calculated using 24 h cumulative dose divided by dosing frequency	RASS, vitals* q1h Continuous ECG and oxygen saturation monitoring
Oversedation (RASS ≤ -2)	Naloxone 0.1 mg IV push q2min PRN until patient awakens	RASS, vitals* q1h Continuous ECG and oxygen saturation monitoring

q_mins: every_minutes; q_h: every_hour; prn: as needed; IV: intravenous; RASS: Richmond Agitation-Sedation Scale; COWS: Clinical Opiate Withdrawal Score; mg: milligram; mcg: microgram

* Vitals: heart rate, blood pressure, respiratory rate, oxygen saturation

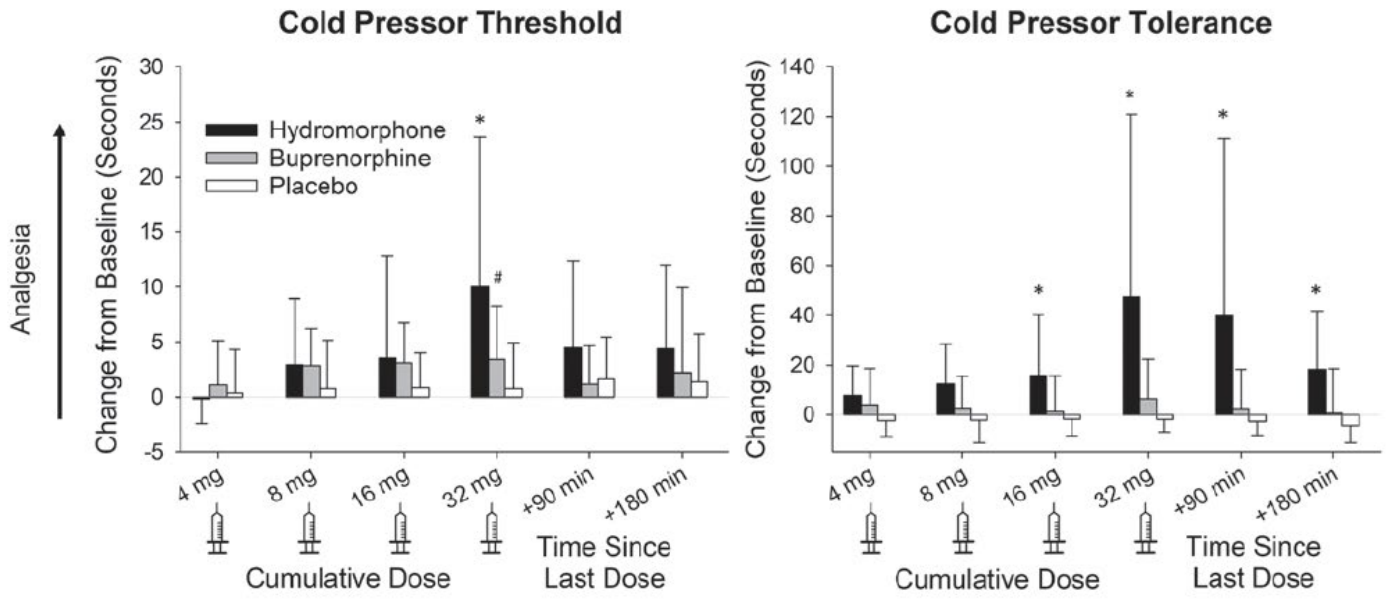
Pain management in patients on Bup

ANESTHESIOLOGY

Analgesic Effects of Hydromorphone *versus* Buprenorphine in Buprenorphine-maintained Individuals

Andrew S. Huhn, Ph.D., Eric C. Strain, M.D., George E. Bigelow, Ph.D., Michael T. Smith, Ph.D., Robert R. Edwards, Ph.D., D. Andrew Tompkins, M.D., M.H.S.

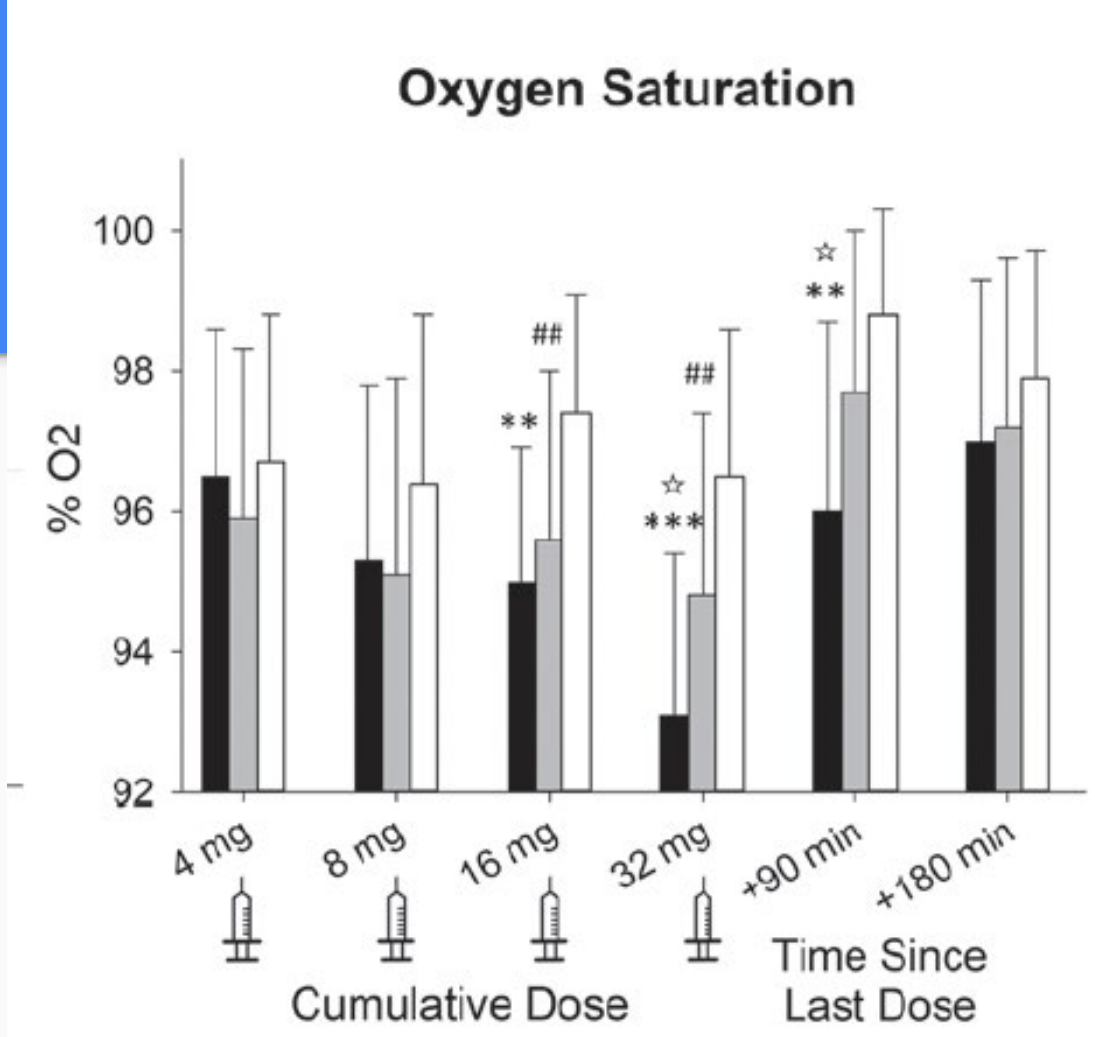
ANESTHESIOLOGY 2019; 130:131–41

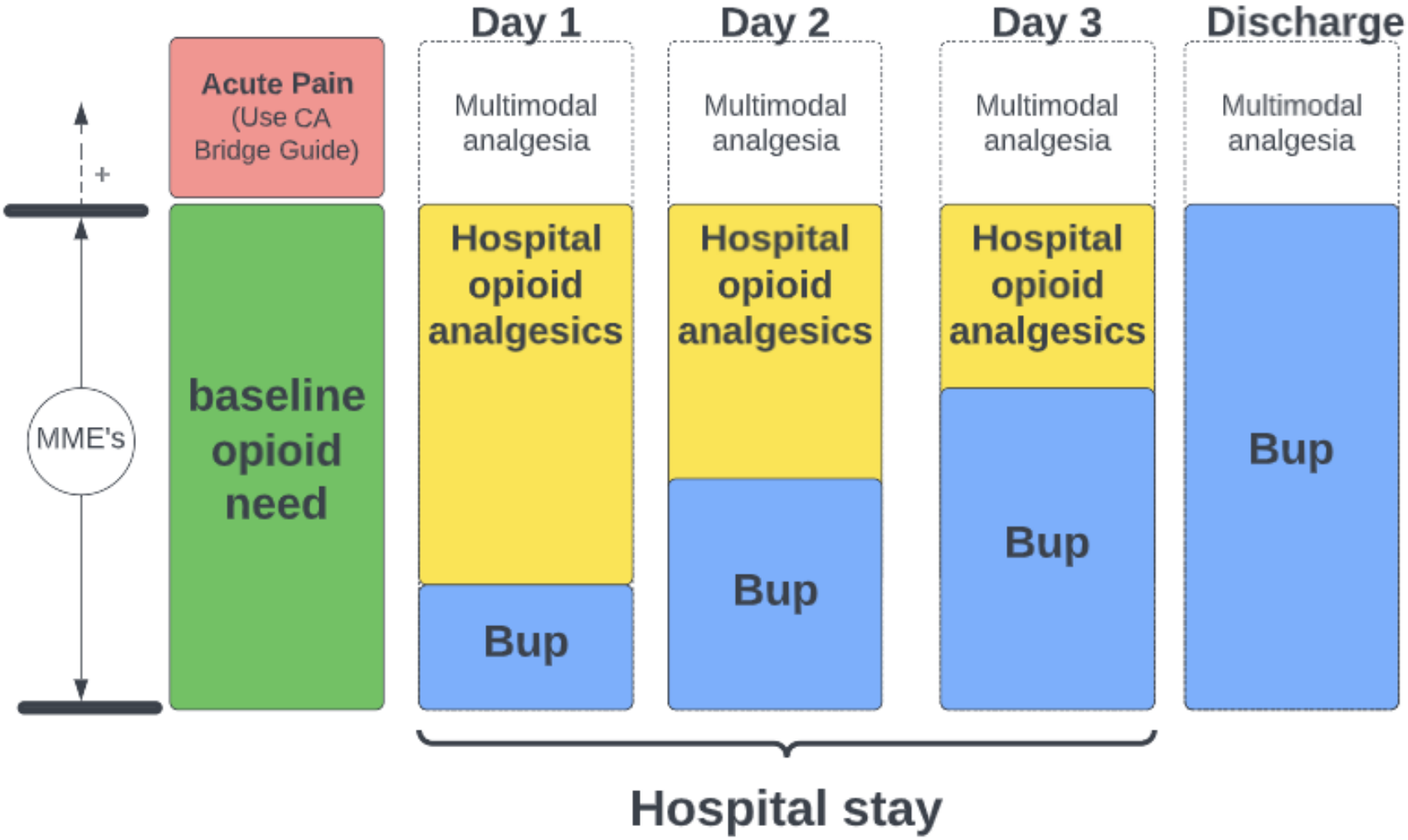


Very large doses

Buprenorphine IV

Hydromorphone IV




Day 1
Day 2
Day 3
Discharge
Acute Pain
(Use CA Bridge Guide)
Multimodal analgesia
Multimodal analgesia
Multimodal analgesia
Multimodal analgesia
+
MME's
baseline opioid need
Hospital opioid analgesics
Hospital opioid analgesics
Hospital opioid analgesics
Bup
Bup
Bup
Bup
Hospital stay

Federal Regulatory Updates for Pain Management and Addiction Medicine

Scientific Assembly SAN FRANCISCO 22

Federal Regulatory Updates for Pain Management and Addiction Medicine

Jeffrey Davis, Director of Regulatory and External Affairs

Overview

- X-Wavier
- G-Code for MAT in the ED
- Three Day Rule
- Proposed CDC Clinical Practice Guideline for Prescribing Opioids
- Draft Model Legislation: Substance Use Disorder Treatment in Emergency Settings Act
- Naloxone
- Telehealth

X-Wavier

- Mainstreaming Addiction Treatment (MAT) Act has passed in the U.S. House of Representatives
- Coalition partnership to ensure the coalition passes in Senate + is signed into law
  - May be able to get the legislation included in a year-end package

G-Code for MAT in ED

- 2021 Medicare PFS: Emergency physicians can be reimbursed by Medicare for MAT services delivered in ED
  - CMS finalized a proposal to create a new add-on code for MAT (G2213) that can be billed in addition to an ED evaluation and management (E/M) code during an ED visit.
  - Went into effect January 1, 2021
- What is your experience billing this add-on code?
  - MAT FAQs

Three Day Rule

- Exception to the requirements around prescribing buprenorphine and dispensing methadone without an X-wavier
  - Allows physicians without X-wavier and outside OTPs to administer, but not prescribe, “narcotic drugs” to a person “for the purpose of relieving acute withdrawal symptoms when necessary while arrangements are being made for referral treatment.”
  - Not more than one day’s medication may be administered to the person or for the person’s use at one time
  - Such emergency treatment may be carried out for not more than 3 days and may not be renewed or extended
- Easy MAT Act signed as part of short-term funding bill on December 11, 2020
  - Under this law, practitioners (not just physicians) will be allowed to dispense three-days’ worth of medication at one time, saving patients from having to make subsequent trips to the ED.
  - DEA had 6 months to issue the regulation – still not issued

Requests to DEA

- Practitioners who wish to dispense the full three days worth of medication to patients at one time can make a request to DEA
- The exception covers any DEA-registered practitioner working in a hospital, clinic, or emergency department, or any DEA-registered hospital/clinic that allows practitioners to operate under their registration number.
- Email template to apply for the exception found here.

Proposed CDC Clinical Practice Guideline for Prescribing Opioids

- February 2022: CDC releases Revised Draft Guideline of the 2016 Opioid Prescribing Guideline
- 12 recommendations across 4 broad categories
  - Determining Whether or Not to Initiate Opioids for Pain
  - Opioid Selection and Dosage
  - Opioid Duration and Follow-Up
  - Assessing Risk and Addressing Harms of Opioid Use
- In April 2022, ACEP and SAEM jointly responded to Proposed 2022 CDC Clinical Practice Guideline for Prescribing Opioids

Draft Model Legislation: Substance Use Disorder Treatment in Emergency Settings Act

- ACEP has been invited to comment on the draft model legislation that requires the initiation of MAT in EDs and hospitals. The draft model legislation:
  - requires the development of achievable, effective, and evidence-based protocols in emergency health settings, such that there will be a measurable improvement in health outcomes for those discharged from emergency departments following substance use-related emergencies.
  - Establishes oversight and enforcement mechanisms that would ensure consistent data collection and compliance assurance by state actors, thus ensuring constant improvement of health care delivery.
  - Creates and activates a variety of funding levers in order to promote improved protocols and dismantle barriers to improving quality of care
- The Legislative Analysis and Public Policy Association (LAPPA), in partnership with Georgetown Law Center and ONDCP, has worked on the model legislation, and Dr. Aimee Moulin provided initial input during a meeting on September 27.

Naloxone

- ACEP is working with the AMA and others on the AMA Substance Use and Pain Care Task Force.
  - Creating a paper on “Help save lives: Support community-based naloxone access, prescribe and distribute naloxone.” Will include language that we encourage states to create mechanisms for EDs to directly dispense naloxone to eligible patients and allow reimbursement by insurers for this.
- ACEP is part of coalition regarding how states should allocate opioid settlement funds from drug manufacturers.
  - Should we send resources to chapters? What is our wish list?

Telehealth

- At the beginning of the PHE, the DEA issued waivers to allow DEA-registered practitioners to prescribe controlled substances to their patients without having to interact in-person with their patients.
- Under the DEA's policy (which became effective on March 31, 2020), authorized practitioners can prescribe buprenorphine over the telephone to new or existing patients with OUD without having to first conduct an examination of the patient in person or via telehealth.
- The DEA also plans to issue two regulations regarding the use of telehealth to prescribe controlled substances. Both are being reviewed by the Office of Management and Budget, but it is unclear when they will be issued.

- The "Special Registration to Engage in the Practice of Telemedicine" rule relates to the Ryan Haight Online Pharmacy Consumer Protection Act of 2008, which required an in-person medical evaluation as a prerequisite to prescribing or dispensing controlled substances, except for practitioners engaged in the practice of telemedicine. The definition of the "practice of telemedicine" includes seven categories that involve circumstances in which the clinician might be unable to satisfy the Act's in-person medical evaluation requirement yet nonetheless has sufficient medical information to prescribe a controlled substance. One specific category includes a practitioner who has obtained a special registration from the DEA. This proposed rule would permit such a special registration.

- The "Audio-Only Telemedicine for Buprenorphine Initiation for Treatment of Opioid Use Disorder" rule would clarify the ability of clinicians with X waivers to prescribe buprenorphine to patients with OUD via an audio-only encounter (i.e., by telephone).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