

Opioid-related presentations

Opioid overdose

- Naloxone 0.4–2mg IV/IM/SQ q2min prn for RR < 12, consider infusion if suspect long-acting opioid.
- Provide respiratory support if needed.
- Monitor at least 6 hours after respiratory support discontinued (10 hours if methadone overdose).
- Resume respiratory support and consider naloxone infusion if patient shows slurred speech or nodding off, or if RR < 12.
- If patient experiences withdrawal after termination of naloxone, treat with buprenorphine/naloxone for symptom relief rather than other opioids.
- On discharge:
 - Give take-home naloxone kit.
 - Give harm reduction advice.
 - If patient is not yet in withdrawal, prescribe buprenorphine/naloxone to take at home.
 - **Refer to rapid access addiction medicine clinic.**
 - Refer to withdrawal management if transient housing, lack of social supports, and/or high risk for relapse.

Signs suggestive of an opioid use disorder

- Physical signs of opioid intoxication: meiosis, slurred speech, altered LOC, decreased respiratory rate.
- Physical signs of withdrawal: diaphoresis, restlessness, mydriasis, lacrimation, rhinorrhea, yawning, piloerection, vomiting.
- Signs of opioid use: track marks, abscesses.
- Check dispensing record for patients on Ontario Drug Benefits.
- If you suspect an opioid use disorder, ask patient about opioid use and withdrawal symptoms; patients will often disclose opioid use if they think you can help relieve withdrawal symptoms.
- **All patients with a suspected opioid use disorder should be offered buprenorphine/naloxone and referred to the rapid access addiction medicine clinic.**

Managing infections in opioid users

Oral antibiotics	<ul style="list-style-type: none">• Treat with oral antibiotics that cover staph and strep.• Ask about injection drug use and examine for signs (track marks, abscesses).• Refer to rapid access addiction medicine clinic.• Offer buprenorphine/naloxone to treat withdrawal with a bridging outpatient prescription to last until next rapid access addiction medicine clinic.• Offer advice on overdose prevention and consider providing take-home naloxone.
Parenteral antibiotics	<ul style="list-style-type: none">• Avoid PICC line.• Ask about injection drug use and examine for signs (track marks, abscesses).• Refer to rapid access addiction medicine clinic.• Offer buprenorphine/naloxone to treat withdrawal with a bridging outpatient prescription to last until next clinic.• If patient willing to try buprenorphine/naloxone, advise to abstain from opioids for 12 hours and initiate at follow-up ED visit for antibiotics, or give outpatient prescription to start at home.• Offer advice on overdose prevention and consider providing take-home naloxone.

Requests for refills of opioid prescriptions for chronic non-cancer pain

- Contact pharmacy or review ODB record to verify date and amount of last script.
- Write on the script: “Do not dispense if you receive an alert from Narcotic Monitoring System.”
- Prescribe dose that you are comfortable with, even if it is much lower than the usual prescription.
- Prescribe only enough until the next working day.
- Send a record of the visit to the family physician.

Drug seeking

When drug seeking is suspected:	<ul style="list-style-type: none">• Contact patient’s pharmacy and review ODB record.• Do not prescribe opioids.• Advise patient that opioids are harming them, and that addicted patients usually experience improved mood, function, and pain with treatment.• If patient is in opioid withdrawal, administer buprenorphine/naloxone and provide prescription to last until next rapid access addiction medicine clinic.• If not in withdrawal, prescribe buprenorphine/naloxone to take at home.• Refer to rapid access addiction medicine clinic.
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Depression and suicidal ideation

- Inform patient that treatment of opioid addiction usually improves mood.
- Administer buprenorphine/naloxone if in withdrawal and give bridging prescription on discharge.
- If not in withdrawal and not admitted, prescribe buprenorphine/naloxone to take at home.
- Refer patient to psychiatry if:
 - Patient has recently attempted suicide.
 - Patient refuses buprenorphine/naloxone treatment or remains severely depressed despite buprenorphine/naloxone treatment.
 - Patient has major risk factors for suicide (e.g., recent loss, has feasible suicide plan).
- **Refer to rapid access addiction medicine clinic.**

Managing acute pain in patients on methadone or buprenorphine/naloxone

- Maintain patient on their usual dose of methadone or buprenorphine/naloxone.
- Prescribe standard non-opioid analgesia.
- Prescribe opioids if patient's acute pain condition warrants it.
- Start with the dose you usually administer for that pain condition.
- Titrate rapidly; patients on methadone or buprenorphine/naloxone often need higher doses.
- On discharge, prescribe opioids for no more than 10 days; write "dispense with buprenorphine/naloxone" or "dispense with methadone" on prescription.
- Instruct patient to follow up with family physician and methadone or buprenorphine/naloxone provider.