OPIOID ADDICTION – MANAGEMENT OF HOSPITAL IN-PATIENTS (PHA60)

This summary should only be used as part of the immediate assessment and management of patients.

During normal hours contact the Substance Misuse Service (SMS) - see next page.

**PATIENT HISTORY**
- Establish current opiate use:
  - What drug(s), amount, frequency, duration of use, last use, withdrawal symptoms and cautions / contra-indications to methadone prescribing.
  - Is the patient currently in possession of drug(s) or substitute medication?
- Enquire about other substance misuse especially alcohol and benzodiazepines
- Enquire about Hep C, Hep B and HIV status.

**EXAMINATION**
- Evidence of drug use (e.g. needle marks, thrombosed veins, cellulitis and old scars)
- Observe for signs of opioid intoxication or withdrawal (see next page)
- Urine dipsticks testing for opiates (morphine) and/or methadone if available
- Request ‘urine drugs of abuse screen’ from clinical biochemistry.
  (Note: Buprenorphine urine assays are not readily available at UCLH or RFH)

**Urine dipstick positive for opiates or methadone**
- Has the patient been on a regular methadone prescription administered within 3 days pre-admission?
  - Yes: Continue with previously prescribed dose if confirmed and clinically safe.
    - NB: Check when patient last had a dose of methadone / buprenorphine / illicit opiates.
    - If on methadone, initially give as divided dose
    - If on sublingual buprenorphine (Subutex®) give once daily
    - Cancel community prescription to avoid double scripting
    - Inform Substance Misuse Service (SMS)
    - Inform GP
  - No: Do not rely on patient’s answers – check with SMS and/or community pharmacy

**Urine dipstick negative for opiates**
- Has the patient been on a regular buprenorphine (Subutex®) script administered within 3 days pre-admission?
  - Yes: Do not rely on patient’s answers – check with SMS and/or community pharmacy
  - No: Has the patient been on a regular methadone prescription administered within 3 days pre-admission?
    - Yes: Methadone liquid (1mg/ml) 10mg up to QDS
      - Monitor for opiate toxicity for at least 2 hours after dose
      - Monitor for opiate withdrawal and assess 4 hourly
      - If withdrawing at 4 hours, prescribe 5-10mg STAT
      - Maximum of 40mg in first 24 hours in divided doses.
      - Once maintenance dose established give once daily
      - Always write on drug chart ‘Omit if sedated or intoxicated’
      - Divided doses of methadone should be TWICE a day or up to FOUR times a day. Avoid doses after 18.00hrs
      - Only prescribe methadone oral solution (1mg/ml) – do not prescribe tablets or injection
      - Prescribe all methadone and buprenorphine dose & frequency in WORDS & FIGURES
      - Ensure there is immediate access to Naloxone
      - Fatal respiratory depression can occur with methadone doses of 30mg or lower in non-tolerant individuals or if combined with other opiates, alcohol or benzodiazepines (e.g. chlordiazepoxide, diazepam). Buprenorphine can similarly cause respiratory depression if used with these agents.
    - No: Are there objective signs of opiate withdrawal? (see next page)

**Are there objective signs of opiate withdrawal?**
- Yes: Methadone liquid (1mg/ml) 10mg up to QDS
  - Monitor for opiate toxicity for at least 2 hours after dose
  - Monitor for opiate withdrawal and assess 4 hourly
  - If withdrawing at 4 hours, prescribe 5-10mg STAT
  - Maximum of 40mg in first 24 hours in divided doses.
  - Once maintenance dose established give once daily
- No: Do NOT PRESCRIBE OPIATES
  - Observe for withdrawals using Short Opiate Withdrawal Scale (page 3)
Notes on managing opioid addiction for hospital inpatients

General Management
The treatment of opioid addiction is a specialist area. Existing treatment regimens should be continued if clinically indicated. New treatment episodes should be initiated with specialist advice. In emergencies and out-of-hours the aim is to minimise withdrawal symptoms so that the primary health problem can be treated. Whenever possible get confirmation from the responsible prescriber and / or community pharmacist in relation to substitute opioid prescribing.

- **Opiate withdrawal:** Opiate withdrawal symptoms are unpleasant and can be very uncomfortable but are not life-threatening. Mild or early features are often subjective: restless, agitation, subjective discomfort and muscle/joint aches and pains.
  - **Objective signs:** Sweating, yawning, running nose (rhinorhoea), runny eyes (lacrimation), feeling hot/cold, abdominal cramps, nausea, vomiting and diarrhoea, tremor, increased pulse rate (tachycardia), increased blood pressure (hypertension), gooseflesh (piloerection), dilated pupils (mydriasis) and increased bowel sounds.
  - The Short Opiate Withdrawal Scale can be used for assessment (see next page)

- **Opiate Intoxication:** signs and symptoms: Constricted pupils (miosis), drowsy, intermittent dozing off with eyes closing, orthostatic hypotension, loud snoring, leading to cyanosis and respiratory depression. The Short Opiate Intoxication Scale can be used for assessment (see next page)

- **POSITIVE urine result** for OPIATES means that heroin, morphine, codeine-based opiates and/or their metabolites have been identified (note: prescribed or OTC analgesics may contain opiates).
  **NEGATIVE urine result** means that it is unlikely that the patient has taken opiates recently. Note that buprenorphine is not tested for in the clinical biochemistry urine drug analysis, so the result will come back as negative. Specific urine dip sticks are available for buprenorphine.

- Methadone has a long half-life, so if discontinued withdrawal symptoms may not occur for up to 36hrs.

**Methadone oral solution (1mg/1ml)** is the medication of choice to manage opiate withdrawal. It should not be prescribed or administered to a patient who appears intoxicated, whether with drugs or alcohol. Do not prescribe it for patients who are usually on buprenorphine.

- Ingestion of methadone/buprenorphine should be observed. To avoid illicit drug use on the ward, be aware of visitors who may bring drugs or medication onto the ward (Refer to local drugs & alcohol policy). Regular urine drug screens should be undertaken.
- Ensure clear documentation of advice/recommendations; other staff may need to refer to your notes.
- Pain relief: Opiate dependent patients will be tolerant to their daily intake and may require additional opiates for pain relief, however, these should be prescribed only if clinically indicated and for short term. Consider referral to the local pain management team.

Discharge
- When planning discharge, the keyworker or duty worker from the local drug service must be contacted. They will be able to advice on management and link with follow-up agencies.
- **DO NOT prescribe methadone or buprenorphine as a TTA.**
- If necessary patients should return to the ward over the weekends to receive daily supervised doses of methadone/buprenorphine. During weekdays the drug treatment service will aim to pick up prescribing as soon as the patient is discharged. The hospital should make arrangements for the client to attend over the weekend if they are discharged after midday on Friday.

**Specialist Substance Misuse Service (SMS) Contact Details**
- Margarete Centre (Camden Specialist Drug Services) 108 Hampstead Rd, NW1 2LS Tel: 020 3317 6000
- Integrated Camden Alcohol Treatment Service (ICATS): Tel 020 3227 4950
- IDASS (Islington Drug & Alcohol Specialist Service), 592 Holloway Road, N7 6LB Tel: 020 3317 6420
- CGL (Change, Grow and Live) Camden Community Drug Service Tel: 0207 485 2722
- Islington Specialist Alcohol Treatment Service (ISATS) Tel: 020 3317 6650
# Short Opiate Withdrawal Scale

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**For completion by staff:**

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<th>Pulse (bpm)</th>
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**Short Opiate Withdrawal Scale (SOWS)**

Rate whether any of the following have been experienced in the last 24 hours: None = 0, Mild = 1, Moderate = 2, Severe = 3

- Feeling Sick
- Stomach Cramps
- Muscle spasms/Twitching
- Feelings of Coldness
- Heart Pounding
- Muscular Tension
- Aches and Pains
- Yawning
- Runny Eyes
- Insomnia/ problems sleeping

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**Short Opiate Intoxication Scale (SOIS)**

Rate whether any of the following have been experienced in the last 24 hours: None = 0, Mild = 1, Moderate = 2, Severe = 3

- Constricted pupils (miosis),
- Drowsy
- Intermittent dozing off with eyes closing
- Orthostatic hypotension
- Loud snoring