Opioid Use Disorder

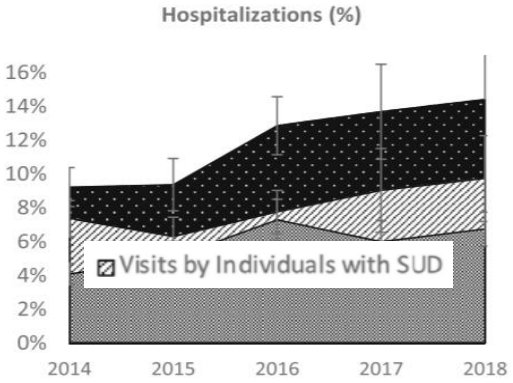
Rapid Clinical Updates
Society of Hospital Medicine

The OUD Endemic

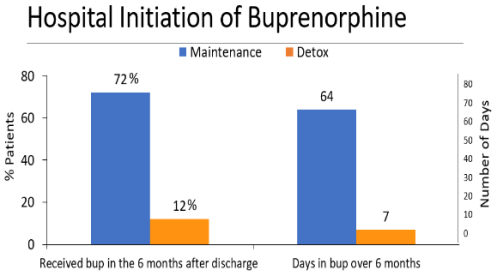
Context: Over 2/3 of drug overdoses involve opioids. This is worse than it has ever been. Prevalence of heroin down-trending while rates of synthetic opioids (fentanyl) rising.[1]

Current: OUD results in multiple admissions and is estimated to cost >$13B annually.[2] Patients with OUD experience longer LOS and worse outcomes.[3] Hospitalization is a "pivotal touch point" for these patients.[2]

Cutting Edge: SHM recommends all hospitalists obtain X-waivers and appropriately prescribe naloxone.



Buprenorphine



Context: Partial mu agonist that provides ceiling effect for opioid agonists. Inpatient initation of buprenorphien is dramatically better than opioid detoxification.[4]

Current: Typically opioid free period is required. Once mild withdrawal is present (COWS ≥8), 2-8mg dose is started. Max doses are 16mg on day 1, 24mg on day 2.

Cutting edge: Microdosing can avoid withdrawal symptoms and may be beneficial if regular use of fentanyl or long-acting opioids.

Methadone

Context: Higher retention than buprenorphine but requires daily visits and is heavily regulated.

Current: Peak effect is 3-4 hours but half-life is 24-36 hours so steady-state may not be achieved for 3-7 days.

Cutting edge: Although methadone cannot be prescribed at discharge if being used for OUD, it still has utility for intractable pain or other non-addiction indications.[5] Typical starting dose is 10-30mg daily.

	Methadone	Buprenorphine
Retention	Higher than buprenorphine	Increased at doses >16mg
Office visits	Daily(dispensed directly to patients)	Daily to monthly
Inpatient prescribing	**Any inpatient clinician during hospitalization**	**Any inpatient clinician during hospitalization**
Discharge prescribing	Only via Opioid Treatment Program	Any provider with X-waiver
Sedation	Yes if high doses, non-tolerant patients, or slow metabolizers	Minimal (ceiling effect for respiratory depression)
Initiation	Days-weeks to reach comfortable dose	Requires withdraw or microdosing

Acute/Perioperative Pain

Context: Therapies for treatment of OUD have historically been held during perioperative periods.

Current: Evidence is growing to suggest it is safe and effective to continue these medications throughout.[6]

Cutting Edge: Both buprenorphine and methadone can be split into BID or TID dosing for more effective analgesia and doses can be increased during hospitalization if needed for severe acute pain.[7]

References:

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