THE CARLAT REPORT
ADDICTION TREATMENT

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CURRENT COVERAGE OF TOPICS IN ADDICTION MEDICINE

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IN THIS ISSUE

Focus of the Month:
Integrating Pharmacotherapy and Psychotherapy

Learning Objectives
After reading these articles, you should be able to:

1. Describe best practices for prescribing during the perioperative period for patients with opioid use disorder.
2. Assess and manage opioid withdrawal in emergency settings.
3. Identify the benefits of medications versus psychotherapy in patients with substance use disorders.

Perioperative Pain Management in Opioid Use Disorder

Rehan Aziz, MD. Associate Professor of Psychiatry and Neurology, Rutgers Robert Wood Johnson Medical School.

Dr. Aziz has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Highlights From This Issue

- Motivational interviewing and other strategies can steer clinicians toward the successful integration of medication treatment and psychotherapeutic approaches.
- New perioperative guidelines from the American Society of Addiction Medicine encourage continuation of medications for opioid use disorder through and after surgery.
- The emergency department is a key setting for addiction clinicians to advocate for initiating treatment and provision of harm reduction strategies to patients with unhealthy opioid use.

When your patients with opioid use disorder (OUD) develop pain due to medical illness or trauma, pain management can get tricky. When they seek pain control, they may be perceived as "drug seeking" in medical settings. Studies have shown that providing adequate pain management for these patients is a particular challenge (Department of Veterans Affairs, www.tinyurl.com/3cuzhpma; Koller G et al, *Exp Opin Pharm* 2019;20(16):1993–2005). Inadequate pain management, in turn, can cause various problems, including worsening substance use, mistrust of providers, and more post-surgical complications. This article will explore ways to manage pain effectively in patients with OUD, with a specific focus on the perioperative period. Some of these decisions will be made by your patients' surgeons or primary care doctors, but you

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Q&A With the Expert

Integrating Medication Prescribing and Psychotherapy
Carla Marienfeld, MD

Professor of Psychiatry, University of California, San Diego. Director of the UCSD Addiction Psychiatry Fellowship, co-editor of Motivational Interviewing for Clinical Practice, *and editor of* Absolute Addiction Psychiatry Review.

Dr. Marienfeld has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

CATR: Set the stage for us on how you approach psychotherapy in addiction treatment.
Dr. Marienfeld: I look at every interaction as a potential psychotherapeutic opportunity, whether it is "supposed" to be for psychotherapy or not. There is no strict separation when it comes to somebody with a substance use disorder. To begin with, I approach each conversation with the "spirit of motivational interviewing," a term coined by Bill Miller and Stephen Rollnick, the developers of motivational interviewing (MI). It describes the fundamental communication style inherent to an MI-consistent approach, and it colors every therapeutic interaction.

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Perioperative Pain Management in Opioid Use Disorder

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should be involved in advising them as they may not have much experience with this population.

Overall strategy

How should we manage OUD patients who are in acute pain related to surgery? In the past, the usual practice was to discontinue medication for addiction treatment (MAT), eg, discontinue buprenorphine (BUP) or methadone (MTD). The rationale for doing so was twofold. First, there was fear of overdosing patients who were already receiving opioids, and second, the presence of BUP or MTD could theoretically complicate anesthesia. However, faced with the growing opioid epidemic and the clear evidence supporting MAT, the American Society of Addiction Medicine (ASAM) issued an update to their guidelines and now recommend continuing MAT, and to supply additional analgesic treatment or alter MAT dosing, as indicated.

For pain management in OUD patients, ASAM recommends using opioids as needed, but emphasizes the use of non-opioid agents, like regional anesthesia, adjunctive non-opioid medications, and non-pharmacologic management. Typical non-opioid pain medications include acetaminophen, NSAIDs, gabapentinoids (eg, gabapentin and pregabalin), tricyclic antidepressants, serotonin-norepinephrine reuptake inhibitors, and ketamine (The ASAM National Practice Guideline for the Treatment of Opioid Use Disorder: 2020 Focused Update. *J Addict Med* 2020;14(2S):1–91). In my own practice, especially when a patient's anxiety and insomnia are worsening pain perception, I favor the use of gabapentinoids, as well as hydroxyzine as needed. For insomnia, melatonin (3–9 mg), trazodone (50–100 mg), or low-dose doxepin (3–6 mg) are reasonable options. Remember, though these drugs are safer than opioids, they are not benign either; gabapentinoids have a risk of misuse (Evoy KE et al, *Drugs* 2021;81:125–156) and can increase the risk of opioid overdose (Bykov K et al, *JAMA Netw Open* 2020;3(12):e2031647). Tricyclics can increase the risk of cardiac arrhythmia.

If opioid analgesics are needed after surgery, choose short-acting full-agonist opioids like hydrocodone or oxycodone, prescribed for a limited time at the lowest effective dose. The CDC states that 3 days of opioid analgesics is usually sufficient, and the need for more than 7 days is rare for the treatment of non-chronic pain.

You should encourage your patients to keep in touch with community supports. A visiting nurse (or, in a pinch, a family member or friend) can help to secure and dispense prescribed opioid analgesics using a safe or locked pill box if necessary. If your patient has been actively using street drugs, be aware that hospital admissions will usually entail abstinence from illicit drugs. The potential hazard is that this forced abstinence can lead to decreased tolerance, and quickly returning to substance use after discharge can lead to overdose and death. Warn patients about the risk of overdose and give them a naloxone prescription.

Some anesthesiologists want patients to stop BUP or MTD before surgery if they anticipate the need for full-agonist opioids during the procedure. If the anesthesiologist requests this, you should stop the BUP or MTD the day before surgery. They can be resumed postoperatively when there is no longer a need for intravenous analgesia. Pre-surgery doses of these medications can be restarted if they were held for less than 2 to 3 days (Crotty K et al, *J Addict Med* 2020;14(2):99–112). Other anesthesiologists may advocate for continuing BUP at a reduced dose in order to balance intraoperative pain management with avoiding withdrawal and minimizing postoperative opioid agonists (Quay A and Zhang Y, *Pain Medicine* 2019;20(7):1395–1408). This is another reasonable approach, and the BUP dose can be lowered the day prior to surgery.

Patients with OUD on BUP or MTD

Your patients on BUP or MTD who have postoperative pain might receive add-on hydrocodone or oxycodone for management. Alternatively, you can choose to temporarily increase the dose of BUP or MTD. When you do this, you will probably have to increase the dosing frequency. Why? When used to prevent opioid cravings, both BUP and MTD are dosed once

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Expert Interview

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CATR: Can you explain the spirit of motivational interviewing?

Dr. Marienfeld: Miller and Rollnick break it down into four components with the acronym PACE: Partnership, Acceptance, Compassion, and Evocation.

The Spirit of Motivational Interviewing
• Partnership—work *with* or for a patient in order to provide treatment
• Acceptance—appreciate each patient's inherent strengths and vulnerabilities
• Compassion—promote patient welfare and prioritize their needs
• Evocation—find the knowledge patients have about themselves to change

"I look at every interaction as a potential psychotherapeutic opportunity, whether it is 'supposed' to be for psychotherapy or not. For some patients, I flip the traditional framework to conceptualize the psychiatrist as primarily providing psychotherapy with 'add-on medication management.'"

Carla Marienfeld, MD

The essence of the approach is that the best care happens when the patient is empowered to take advantage of their intrinsic strengths and resources. Rather than approaching the patient with the attitude, "I have the knowledge you need, and this appointment is about me imparting it to you," MI says that the patient has a lot of self-knowledge, and as the provider, it is our job to partner with them to uncover that knowledge together. It can be a subtle but meaningful frame shift.

CATR: Do you have advice about therapeutic approaches to patients during abbreviated medication management visits?

Dr. Marienfeld: Thus far, we have conceptualized the provider's role primarily as a prescriber and secondarily as someone who might do "add-on psychotherapy." But for some patients, I flip that framework to conceptualize the psychiatrist as primarily providing psychotherapy with "add-on medication management." Some patients undergo medication trials that are not particularly helpful, so visits primarily end up being for therapy. Alternatively, patients on a stable dose of buprenorphine may prefer to focus on therapy for co-occurring disorders.

CATR: What is a specific technique that can be utilized in brief medication management visits?

Dr. Marienfeld: A 30-minute appointment is ample time to deploy psychotherapy techniques. I often use a cognitive behavioral therapy (CBT) technique called "the 3 C's" or "Catch It, Check It, Change It" (see box at right). It is easy to run through examples in a relatively limited setting, and we can continue to revisit examples in subsequent visits. An advantage of the 3 C's is that the catchy name is easily remembered, and with practice, it can be incorporated into everyday life.

The 3 C's: Catch It, Check It, Change It	
Step 1: Catch It	Identify a situation in which a negative experience might be influenced by a cognitive distortion
Step 2: Check It	Examine the cognitive distortion as objectively as possible
Step 3: Change It	Substitute the cognitive distortion with a more rational and less emotionally charged interpretation of events

CATR: Walk us through an example of using the 3 C's.

Dr. Marienfeld: A classic example is feeling guilty after a slip to drinking alcohol. "Catch It" is about identifying the situation and any cognitive distortion that might be leading to the feeling. One expression of that feeling might be, "I'll never be able to stick with this!" "Check It" examines this statement for accuracy. The person might recognize that it is an overgeneralization or that it discounts the positive (two examples of cognitive distortions). Then, they can ask themselves if they've had any past successes that demonstrate they are capable of doing better. They might balance the reality of the slip with the recognition of the progress they had made beforehand. Then comes "Change It," in which you can work with the patient to evoke other interpretations of events that are more rational and less emotionally charged. Finally, revisit the emotion and examine how the new cognition decreased the affect (in this case, guilt). This model can be used for many negative cognitions common in mood and anxiety disorders. "I will always be lonely," "I will never be happy," and "I'll never be able to stay sober" are all examples to which the 3 C's can be applied.

CATR: What are other psychotherapeutic techniques that our readers might find useful?

Dr. Marienfeld: Behavioral activation, another technique with CBT grounding, is a go-to, especially when patients have comorbid depression. Many patients with substance use disorders have disrupted sleep, and sedative hypnotics such as benzodiazepines and Z-drugs can be addictive. I try to minimize prescribing these in patients with substance use disorders. Therefore, I do a fair amount of CBT for insomnia, a manualized, time-limited treatment. As the name suggests, it is grounded in cognitive and behavioral techniques, as well as psychoeducation. There are resources and manuals available online.

DARN CATS: Identifying Change Talk
Desire: I want to make a change.
Ability: I can change.
Reason: I have a reason to change.
Need: I need to change.
Commitment: I will change.
Activation: I am prepared to change.
Talking **S**teps: I have taken specific steps toward change.

CATR: Your specific area of expertise is motivational interviewing. Can you provide our readers with specific MI tools they can use during brief appointments?

Dr. Marienfeld: When meeting with patients, I always try to 1) build a positive therapeutic alliance, and 2) increase the likelihood that my patient will make positive choices. During encounters, I actively listen for statements that we can classify as "change talk." The mnemonic to remember the types of statements that qualify as change talk is DARN CATS (see box at right). The opposite of "change talk" is called "sustain talk";

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Expert Interview

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these are statements made against making a positive change, or in favor of maintaining a status quo. For example, a change talk statement is one in which a patient describes why they want to stop drinking, and a sustain talk statement is one in which a patient says why stopping drinking is so challenging. If I am hearing change talk, then I know to continue on the same track with that patient in a given session. If I am hearing sustain talk, then I go back to the basic MI skill: reflections.

CATR: Can you describe the concept of reflections?

Dr. Marienfeld: A reflection is simply a statement, not a question, in which a provider essentially tries to capture what a patient has experienced or is expressing in their discourse. For example, if a patient describes being hospitalized for a detoxification, a reflective response might be, "You don't ever want to experience that again." Depending on the patient's tone, an appropriate simple reflection of the patient's feelings might be, "That hospitalization was really scary for you." Finally, again depending on the patient, you might offer a complex reflection like, "Avoiding more hospitalizations like the one you just had is one of the reasons you would like to maintain sobriety going forward." When used properly, reflections can be a great way to facilitate a natural flowing conversation that steers the patient toward change talk, which is exactly where we want the conversation to go.

CATR: Can't this lead to stilted conversations?

Dr. Marienfeld: As providers, we are very comfortable with directly questioning our patients, but if you think about the average conversation between friends or colleagues, these are not exchanges of sequential back-and-forth questioning. The typical flow of a conversation is the progression of alternating statements, each one containing a bit of a reflection and building upon what was previously said. When done well, a clinical encounter with a high frequency of reflections is a much more natural-sounding exchange than a typical doctor-patient interview; it helps facilitate a strong therapeutic alliance and is just as effective at gleaning useful information as direct questioning. Interested readers can familiarize themselves with some of the common simple and complex reflections (see box at right). Simple reflections are called "simple" because they do not add any meaning to the patient's original statements, whereas complex reflections do just that. Ideally, providers should offer complex reflections whenever they can. I would suggest practicing these frequently; providers are often surprised by how easily they can be adapted into practice.

Reflections

Simple	Complex
Echo	Paraphrase
Rephrase	Continuation
	Reflection of feeling
	Double sided
	Amplification

CATR: Can you suggest another MI tool that would apply to caring for patients with opioid use disorder?

Dr. Marienfeld: I use the "Ask-Tell-Ask" feedback model, also called the "Elicit-Provide-Elicit" model—another quick go-to therapeutic intervention for short encounters. This is especially useful to gauge a patient's understanding of a diagnosis or intervention. In this model, you begin by asking a patient about their understanding of the proposed intervention (the first Ask). For example, if I am talking to a patient about the use of buprenorphine as a treatment for opioid use disorder, I might begin by simply asking, "What do you know about buprenorphine?" Once the patient answers, I would be able to establish what they already know and what deficits remain. I would then provide any missing or misunderstood information (the Tell), and end by requesting that the patient repeat back the information or describe what they think about what I've said (the second Ask) to ensure proper understanding. For instance, I might say, "Given the discussion we just had, could you tell me what you have learned about buprenorphine so I can make sure we are both on the same page?" I find this model especially useful for informed consent as it applies to medication management encounters.

CATR: Many providers refer patients to separate psychotherapy providers. Do you have any tips on how best to collaborate with these providers?

Dr. Marienfeld: Get releases of information up front whenever possible; it is important to be informed if there are any significant status changes. It is useful to have a sense of the material being covered and the therapeutic modality being utilized. For example, I might be able to reinforce or build upon an ongoing CBT approach during a focused medication visit. Likewise, if a patient is undergoing cognitive processing therapy for PTSD, I might know that the patient could be experiencing heightened levels of anxiety. Keep in mind that the flow of information should go both ways. For example, as an addiction psychiatrist, I always try to keep other providers aware if a patient has returned to using substances or is not participating in treatment.

CATR: Do you have any specific resources to recommend?

Dr. Marienfeld: I think the 3rd edition of Bill Miller and Stephen Rollnick's book, *Motivational Interviewing: Helping People Change,* which came out in 2013 (New York: The Guilford Press), is a great resource. It is a textbook, but it's very enjoyable to read and isn't too dense. There is also a paper by Bill Miller and Terry Moyers called "Eight Stages in Learning Motivational Interviewing" that is a really nice read (*Journal of Teaching in the Addictions* 2006;5(1):3–17). It reviews both how to learn effective MI skills and how to build them into your practice. Finally, there are many shorter MI books, including one that I co-edited called *Motivational Interviewing for Clinical Practice* (Levounis P, Arnaout B, Marienfeld C, eds. Arlington, VA: American Psychiatric Association Publishing; 2017).

CATR: Thank you for your time, Dr. Marienfeld.

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Management of Opioid Withdrawal in the Emergency Setting

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Dr. Aziz has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

Opioid withdrawal is being seen more frequently in emergency settings. From 2005 to 2014, it is estimated that the rate of US emergency department (ED) visits due to opioids doubled from 89.1 per 100,000 people to 177.7 per 100,000 (Agency for Healthcare Research and Quality, www.tinyurl.com/2xr8hp8h). For many patients, the ED is their only contact with the health care system. Successful medically monitored withdrawal management can facilitate patient engagement in treatment, or at the very least avoid alienating them from future medical care. This article will help you assess and manage opioid withdrawal in emergency settings and advocate for your patients' care if they end up in the ED.

Assessment

Most patients in opioid withdrawal will tell you right off the bat that they are withdrawing, or that they are "dope sick." Nonetheless, you should document the signs and symptoms of withdrawal (see below) as treatment decisions depend on its severity and time course.

Signs and Symptoms of Opioid Withdrawal

Symptoms	Signs
Gastrointestinal Abdominal cramps Diarrhea Nausea Vomiting	**Vital signs** Increased heart rate Increased blood pressure
Head and neck Runny nose Tearing Yawning	**Gastrointestinal** Increased bowel sounds
Musculoskeletal Bone pain Joint pain Muscle cramps	**Ophthalmologic** Dilated pupils Tearing
Neuropsychiatric Anxiety Insomnia Low mood Restlessness Tremors	**Skin** Goosebumps Sweating

For short-acting opioids (eg, heroin, fentanyl, oxycodone), withdrawal typically begins 6 to 12 hours after the last dose, peaks within 24 to 48 hours, and can persist for several days. For those on longer-acting opioids like methadone or the partial agonist buprenorphine, the withdrawal symptoms probably won't be as intense, but the timeline will be significantly extended; in these cases, withdrawal starts a day or two after cessation, has a peak of a week or more, and can persist for as long as 2 to 3 weeks. Of course, withdrawal is precipitated almost immediately after administration of an opioid blocker like naloxone—which applies to many patients who end up in the ED.

The most common opioid withdrawal scale is the Clinical Opiate Withdrawal Scale (COWS). It grades withdrawal severity from 0 to 36 points on measures including pulse, pupillary size, restlessness, and yawning (Wesson DR and Ling W, *J Psychoactive Drugs* 2003;35(2):253–259); it is similar to the CIWA-Ar scale used for alcohol withdrawal, though the latter does not include vital signs. COWS is becoming more popular as many stable patients are sent home from the ED and instructed to monitor for their own opioid withdrawal symptoms.

Treatment strategies

The best way to treat opioid withdrawal in the ED is to use an opioid agonist or partial agonist as a bridge to long-term outpatient treatment. You can use buprenorphine/naloxone (bup/nx) or methadone, though bup/nx is usually preferred due to its less stringent regulations. Note that ED providers may use buprenorphine to manage withdrawal symptoms without additional waivers or specific training. See table on page 6 for dosing and treatment recommendations. For info on billing for the initiation of medication for ED treatment of OUD, including assessment, referral to ongoing care, and arranging access to supportive services, see: www.tinyurl.com/z57tshz4

Buprenorphine

Buprenorphine is an opioid receptor partial agonist. It causes minimal euphoria, and there's a ceiling effect on both sedation and respiratory depression. Because bup/nx has very high opioid receptor affinity, it can precipitate withdrawal in patients who are opioid-intoxicated or in very early withdrawal. Thus, don't start bup/nx until the COWS score has reached at least 8. Talk to patients about their preferences—most will have prior bup/nx experience and will have strong opinions on when it's safe for them to start it in order to avoid withdrawal.

In terms of dosing, I recommend starting with 2–4 mg followed by an additional 2–4 mg dose 2 hours later; most patients will achieve substantive relief by the time they receive 8 mg (Herring AA et al, *Ann Emerg Med* 2019;73:481–487). The FDA recommends that patients receive no more than 8 mg in the first day after last use, 16 mg on the second day, and then up to 24 mg daily thereafter. However, patients may need more than 8 mg in those first 24 hours. The most important goal is to keep them comfortable and engaged in treatment.

Methadone

Use methadone only if bup/nx isn't available or in patients who are withdrawing from methadone, especially if they plan to return to methadone treatment. Start with either 10 mg intramuscularly (in patients who are vomiting) or 20 mg orally. Titrate very slowly, especially if the patient has not been on methadone before. These doses are enough to significantly reduce COWS scores without causing significant sedation or respiratory depression—both of which are concerns at higher doses. If the patient is enrolled in a methadone maintenance clinic, call the clinic to confirm what their dosage was, when the patient last received a dose, and if they are able to return for dosing soon. Some patients may have to wait to return to a clinic—or even find another clinic—because of extended no-shows or violating program rules.

Clonidine and adjunctive symptomatic medications

In some settings, buprenorphine or methadone may not be available or a patient may not agree to take them. In these cases, treat withdrawal based on your patient's

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Management of Opioid Withdrawal in the Emergency Setting

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symptoms (see table on page 6 for some commonly used agents). Overall, this strategy doesn't work as well, but it's something to consider—especially for patients intending to initiate long-acting injectable naltrexone (Vivitrol), which requires first being opioid free for 7 to 10 days.

Transitioning from detoxification to treatment

Encourage patients to begin outpatient opioid use disorder treatment after detox, and ensure they have a reliable follow-up plan. If your ED has access to a recovery coach in house, arrange a meeting before discharge. If your patient declines a referral, stress that their risk for relapse and overdose will be high. Those who decline further treatment should have their medications tapered off prior to discharge. In contrast, patients who agree to treatment can have their dose gradually increased up to standard outpatient dosages (30–40 mg for methadone and 8–24 mg for bup/nx). For bup/nx, provide a prescription for a week or so, if possible, to cover them until they can see a certified outpatient provider. Supply a naloxone prescription or kit before they leave the ED, too.

Basic harm reduction strategies

Before your patients leave your care, don't forget to mention harm reduction strategies. An ED visit allows you to review the following with your patients, especially if they receive the majority of their care emergently or decline follow-up treatment:

- Make sure patients know about local substance use treatment resources such as bup/nx providers and methadone clinics.
- Educate patients who use intravenously about bloodborne illness, the risks of needle sharing, and clean needle exchange programs.
- Order labs to check for pregnancy, HIV, hepatitis B, hepatitis C, and tuberculosis. Offer vaccinations for hepatitis A and B, tetanus, and pneumonia (Visconti AJ et al, *Am Fam Physician* 2019;99(2):109–116).
- If available, offer access to pre-exposure prophylaxis (commonly called PrEP): antiviral medications shown to reduce HIV spread from engaging in risky sexual behaviors or high-risk injection drug use (Owens DK et al, *JAMA* 2019;321(22):2203–2213).
- Discuss risks of opioid overdose. Provide education about naloxone and a prescription for it.

CATR VERDICT: The ED is a primary point of medical contact for individuals with unhealthy opioid use. Treat their withdrawal, preferably with bup/nx or methadone, and refer to treatment if willing. Don't forget to exercise harm reduction practices such as offering appropriate infection screening, vaccines, PrEP, and a naloxone prescription. Finally, provide a list of community substance use resources and make a warm handoff if you can.

Treatment Strategies for Opioid Withdrawal

	Medication	Dosing	Treatment Considerations
Opioid Agonist	Buprenorphine/naloxone	Up to 8 mg in divided doses day 1 Up to 16 mg day 2 Up to 24 mg day 3	Start at COWS ≥ 8
	Methadone	< 30 mg first dose, then up to 10 mg more	Patient must be alert Inpatient setting QTc prolongation
Symptomatic Treatment	Clonidine	0.1 mg q4h PRN Hold for SBP < 90, DBP < 60 Total: < 0.8 mg daily	Dysautonomia Check orthostatics Can use patch after 3 days Generic
	Lofexidine	0.2–0.4 mg q6–12h PRN	Dysautonomia Check orthostatics FDA approved for opioid withdrawal Expensive
	Loperamide	2 mg q2h PRN, NTE 16 mg/day	Diarrhea QTc prolongation
	Ondansetron	4–8 mg q4–6h PRN	Nausea QTc prolongation
	Dicyclomine	20 mg q6h PRN	Stomach cramps
	Methocarbamol	750 mg q6h PRN	Muscle cramps
	Ibuprofen	400–600 mg q8h PRN	Pain Caution in renal impairment
	Gabapentin	100–300 mg TID	Pain, anxiety Caution in renal impairment
	Chlordiazepoxide (or other benzos)	10–25 mg q6h PRN	Anxiety, agitation
	Hydroxyzine	12.5–50 mg TID PRN	Anxiety, agitation
	Trazodone	50–200 mg qHS PRN	Insomnia

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a day, because their craving-suppressant properties last for 24 to 36 hours. However, their analgesic effects typically only last for 6 to 8 hours. Therefore, dividing daily doses into 3 to 4 times daily can optimize their pain-relieving effect.

Another tricky aspect of BUP to remember is that it binds very strongly to opioid receptors—more strongly than most other opioids. Because of this, it can block opioid agonists from binding receptors, blunting their analgesic effects. If opioid agonists are already bound, the BUP can kick them off, sending the patient into opioid withdrawal. Therefore, you may need to discontinue BUP for a short time after surgery to allow for the

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These questions are intended as a study guide. Please complete the test online at www.carlataddictiontreatment.com. Learning objectives are listed on page 1.

1. If a patient stops buprenorphine or methadone the day prior to surgery, pre-surgery doses of these medications can be restarted if they were withheld for how long (LO #1)?
   [ ] a. > 3 days [ ] b. < 2–3 days [ ] c. 3–4 days [ ] d. 5 days
2. Which of the following about the management of opioid withdrawal is true (LO #2)?
   [ ] a. Buprenorphine should only be started when the COWS score has reached at least 16
   [ ] b. The COWS does not include vital signs
   [ ] c. Methadone dosed at 10 mg intramuscularly or 20 mg orally is enough to significantly reduce COWS scores
   [ ] d. Buprenorphine should only be used if methadone is not available
3. According to Dr. Marienfeld, which of the following is the best example of "change talk" (LO #3)?
   [ ] a. "I need to drink to fall asleep."
   [ ] b. "I have a family history of alcohol use disorder, which is why I can't change."
   [ ] c. "I want to address my problems with alcohol use."
   [ ] d. "It's difficult to reduce my alcohol intake because of withdrawal symptoms."
4. During opioid withdrawal, most patients will experience substantive relief when they reach what dose of buprenorphine (LO #2)?
   [ ] a. 8 mg [ ] b. 4 mg [ ] c. 24 mg [ ] d. 2 mg
5. Patients who discontinue buprenorphine for a short time after surgery to allow for the use of full-agonist opioids are at a decreased risk of oversedation and respiratory depression (LO #1).
   [ ] a. True [ ] b. False

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use of full-agonist opioids. Be aware that as full agonists gradually displace BUP molecules from the mu receptor, there is an increased risk of oversedation and respiratory depression.

Patients with OUD on naltrexone

If your patient is taking oral naltrexone, make sure to stop the medication at least 72 hours before surgery to allow it to completely wash out. Injectable naltrexone should be stopped at least 4 weeks prior to surgery. These patients may switch to oral naltrexone, but they too should stop their medication 72 hours before surgery. It is important to keep in mind that patients on long-term naltrexone are at high risk for overdose once the naltrexone is stopped. This is because their opioid receptors have been starved of opioids for a long time and will be highly sensitive as a result. Monitor these patients closely for respiratory suppression and sedation when they start opioid agonists for pain. And don't forget what may be obvious—namely, that these patients should be off opioids for 3 to 7 days before resuming either oral or extended-release naltrexone (Ward E et al, *Anesth Analg* 2018;127(2):539–547).

Patients with OUD in remission without medication

Patients in remission who are not receiving BUP, MTD, or naltrexone are particularly vulnerable to relapse if they are started on opioids for pain. Have a frank discussion of the risks and benefits of postoperative pain management well in advance, before surgery is scheduled. If postoperative opioid analgesics will be necessary, suggest self-help groups and close outpatient follow-up. Remember that during the postoperative period, the patient will be at risk for returning to use. Therefore, it is important to discuss the possibility of starting treatment with BUP, MTD, or injectable naltrexone immediately after surgery. BUP and MTD in particular could help ease pain and manage rebound opioid cravings.

Collaborative care

Optimal care for patients with OUD during the perioperative period requires a multidisciplinary approach. First and foremost, it is essential to collaborate with these patients on a comprehensive treatment plan. Many of them are aware of the risk that surgery entails and are justifiably worried about returning to opioid use. A bit of extra time spent on psychoeducation and construction of a safety plan can go a long way. In addition, I always involve anesthesiology, surgery, and internal medicine as early as possible. I make sure my colleagues know that opioid agonists are the standard of care for OUD treatment and that they should be continued until right before surgery and restarted as soon as possible after surgery. Patients with OUD are likely to have lowered pain tolerance, increased sensitivity to pain, increased tolerance to opioids, and comorbid chronic pain conditions. They may require higher than

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Perioperative Pain Management in Opioid Use Disorder

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usual dosage and frequency of pain medications, and these expectations should be set as well.

CATR VERDICT: Make sure your OUD patients get the right treatment before, during, and after surgery. Keep them on their medication for addiction treatment, and encourage your medical colleagues to use opioids as needed for pain sparingly.

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In Brief

The Other Pandemic

Predictions that overdose mortality would worsen during the COVID-19 pandemic have unfortunately proven accurate. Recent data outlined in an alert by the CDC show that rates of overdose deaths from opioids and stimulants accelerated at an alarming rate between March and May 2020, the period coinciding with widespread lockdowns (www.tinyurl.com/4ductzzx). In fact, the 12-month period ending in May 2020 saw over 81,000 overdose deaths in the US, the largest number ever recorded for a one-year period (www.tinyurl.com/ekz6aw). Deaths have largely been driven by illicit fentanyl, but fatal overdoses from stimulants are rising rapidly as well. Yale's Addiction Medicine Program has produced free resources that review various harm reduction strategies for people who are using drugs during the COVID-19 pandemic. These resources can be found at Yale's website: www.medicine.yale.edu/intmed/genmed/addictionmedicine/