Outpatient Detox: Alcohol, Opioids and Benzodiazipines

Jennifer Morris

Edmond Psychiatric Associates

Disclaimer

This presentation is informational only and is not intended to substitute for treatment evaluation or decisions, etc..

Alcohol

- Appropriateness for outpatient detox
- Methods
- Boundaries

Initial Assessment

- UDS: polysubstance
- Other health conditions
- Social support

Contra-indications and risk considerations

- Pregnancy
- Seizures
- Diminished Capacity
- Previous course (long term refractory may not be ideal)
- Social support
- Age
- Marked autonomic hyperactivity at presentation
- Comorbid illnesses

Previous detox history

- History of complicated withdrawal or DT’s?

Withdrawal Stages

Stage 1 (mild)	Anxiety, tremor, insomnia, headache, palpitations, GI disturbances
Stage 2 (moderate)	Mild symptoms + diaphoresis, increased systolic blood pressure, tachypnea, tachycardia, confusion, mild hyperthermia
Stage 3 (Delirium tremens):	Moderate symptoms + disorientation, impaired attention, visual and/or auditory hallucinations, seizures

PLEASE NOTE

- Stages can progress quickly
- Onset as soon as 6 hours

Diagnosis of Alcohol Withdrawal Syndrome

- Central nervous system impact
- Autonomic nervous system impact
- Cognitive function impact

AWS

- Autonomic hyperactivity (sweating, tachycardia)
- Increased hand tremor
- Insomnia
- Nausea/vomiting
- Transient visual, tactile, auditory hallucinations or illusions
- Psychomotor agitation
- Anxiety
- Tonic-clonic seizures

Failure to treat AWS can lead to Delirium Tremens

Delirium Tremens

s

Severe hyperadrenergic state

- Hyperthermia
- Diaphoresis
- Tachypnea,
- Tachycardia
- Disorientation
- Impaired attention and consciousness
- Visual and/or auditory hallucinations

Risks for DT

- Sustained heavy drinking
- Age older than 30
- Increased days since last alcohol intake
- History of DT

CIWA

- Validated--to assess AWS severity
- Can aid in determining level of care
- Mild to moderate AWS—outpatient treatment may be appropriate, if no contra-indications

CIWA-continued

People who have not had alcohol in 5 days may also receive outpatient treatment

CIWA-Ar

Clinical Institute Withdrawal Assessment of Alcohol Scale - Revised

Date:

Name:

NAUSEA AND VOMITING
Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

0 No nausea and no vomiting
1 Mild nausea with no vomiting
2
3
4 Intermittent nausea with dry heaves
5
6
7 Constant nausea, frequent dry heaves and vomiting

TREMOR
Arms extended and fingers spread apart. Observation.

0 No tremor
1 Not visible, but can be felt fingertip to fingertip
2
3
4 Moderate, with patient's arms extended
5
6
7 Severe, even with arms not extended

PAROXYSMAL SWEATS
Observation.

0 No sweat visible
1 Barely perceptible sweating, palms moist
2
3
4 Beads of sweat obvious on forehead
5
6
7 Drenching sweats

ANXIETY
Ask "Do you feel nervous?" Observation.

0 No anxiety, at ease
1 Mild anxious
2
3
4 Moderately anxious, or guarded, so anxiety is inferred
5
6
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION
Observation.

0 Normal activity
1 Somewhat more than normal activity
2
3
4 Moderately fidgety and restless
5
6
7 Paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES
Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.

0 None
1 Very mild itching, pins and needles, burning or numbness
2 Mild itching, pins and needles, burning or numbness
3 Moderate itching, pins and needles, burning or numbness
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

AUDITORY DISTURBANCES
Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

0 Not present
1 Very mild harshness or ability to frighten
2 Mild harshness or ability to frighten
3 Moderate harshness or ability to frighten
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

VISUAL DISTURBANCES
Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

0 Not present
1 Very mild sensitivity
2 Mild sensitivity
3 Moderate sensitivity
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

HEADACHE, FULLNESS IN HEAD
Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 Not present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM
Ask "What day is this? Where are you? Who am I?"

0 Oriented and can do serial additions
1 Cannot do serial additions or is uncertain about date
2 Disoriented for date by no more than 2 calendar days
3 Disoriented for date by more than 2 calendar days
4 Disoriented for place/or person

Withdrawal scales were developed to assist the monitoring and management of withdrawal symptoms. It is important to note that withdrawal scales are not diagnostic tools.

Interpretation of scores. The maximum score is 67. Patients scoring less than 10 do not usually need additional medication for withdrawal.

Total CIWA-Ar Score:

Source: Sulivan JT, Sykora K, Schneiderman J, Naranjo CA, Sellers EM. Assessment of alcohol withdrawal: The Revised Clinical Institute Withdrawal Assessment for Alcohol scale (CIWA-Ar). British Journal of Addiction to Alcohol and Other Drugs. 1989;84(11):1353-7. doi: 10.1111/j.1360-0443.1989.tb00737.x

insight
Centre for alcohol and other drug training and workforce development

CIWA SCORE

- </=8 Absent or very mild
- 9-14 mild
- 15-20 moderate
- >20 severe

	Appropriate	Neutral/Uncertain	Inappropriate	Appropriate	Neutral/Uncertain	Inappropriate
Withdrawal severity	Mild (e.g., CIWA-Ar <10).	Moderate (e.g., CIWA-Ar 10–18).	Severe or complicated (e.g., CIWA-Ar ≥ 19).	Mild or moderate (e.g., CIWA-Ar <18).	Severe but not complicated (e.g., CIWA-Ar ≥ 19).	Complicated (e.g., CIWA-Ar ≥ 19).
Concurrent withdrawal or physiological dependence		Withdrawing from other substance(s). Physiological dependence on opioids or OUD.	Physiological dependence on BZDs or BZD use disorder.	Physiological dependence on opioids or OUD.	Withdrawing from other substance(s). Physiological dependence on BZDs or BZD use disorder.	
Recent alcohol consumption		Consumes > 8 standard drinks per day.			Consumes > 8 standard drinks per day.	
Alcohol withdrawal history		Previous severe withdrawal episode. Complicated withdrawal > 1 year ago.	Recent complicated withdrawal episode.	Severe withdrawal > 1 year ago.	Previous complicated withdrawal episode. Recent severe withdrawal episode.	
Treatment history		Previous failure to benefit from ambulatory-WM.			Previous failure to benefit from ambulatory-WM.	
Other inpatient need			Medical or psychiatric condition that needs inpatient treatment.			Medical or psychiatric condition that needs inpatient treatment.
Biomedical conditions and complications		Older age. History of epilepsy. History of non-alcohol related seizure. Clinically significant abnormal lab results.	Moderate, active, and potentially destabilizing medical problem. Moderate to severe active and potentially destabilizing medical problem, including unstable chronic condition. Suspected head injury. Unable to take oral medications.	Older age. History of epilepsy.	Moderate, active, and potentially destabilizing medical problem. History of non-alcohol related seizure. Clinically significant abnormal lab results. Suspected head injury.	Moderate to severe active and potentially destabilizing medical problem including unstable chronic condition. Unable to take oral medications.
Emotional, behavioral, or cognitive conditions and complications	Mild/stable psychiatric symptoms.	Active psychiatric symptoms. Mild cognitive impairment.	Moderate or severe psychiatric symptoms. Moderate or severe cognitive impairment.	Mild/stable psychiatric sypmtoms.	Active or moderate psychiatric symptoms. Mild or moderate cognitive impairment.	Severe psychiatric symptoms. Severe cognitive impairment.
Symptom monitoring		Absence of reliable caregiver. Communication barrier (e.g., language, hearing, speech).			Absence of reliable caregiver. Communication barrier (e.g., language, hearing, speech).	
Recovery/ living environment		Absence of reliable support network. Unable to come to treatment setting daily.	Unable to obtain transportation or housing. Family/friends not supportive of WM process.		Absence of reliable support network. Unable to come to treatment setting daily. Family/friends not supportive of WM process.	Unable to obtain transportation or housing.
Risk of harm			Commitment not high, cooperation and reliability questionable. Imminent risk of harm – not cooperative or reliable. Significant risk of imminent relapse.		Commitment not high, cooperation and reliability questionable. Significant risk of imminent relapse.	Imminent risk of harm – not cooperative or reliable.

Preceding chart:

The ASAM Clinical Practice Guideline on Alcohol Withdrawal Management. *Journal of Addiction Medicine* 14(3s):p1-72, May/June 2020.

Contra-indications to outpatient treatment

- Abnormal lab results (eg thiamine deficiency, coagulopathy)
- Absence of support network
- Acute illness-pneumonia, pancreatitis

Contra cont

- History of delirium tremens
- History of a withdrawal seizure
- Long-term intake of large amounts of alcohol

More contra

- Poorly controlled medical conditions (diabetes, CHF)
- Serious comorbid psychiatry concerns (SI, psychosis)
- Severe alcohol withdrawal sx

continued

- Polysubstance
- Seizure disorder or a brain-based illness (hx stroke)

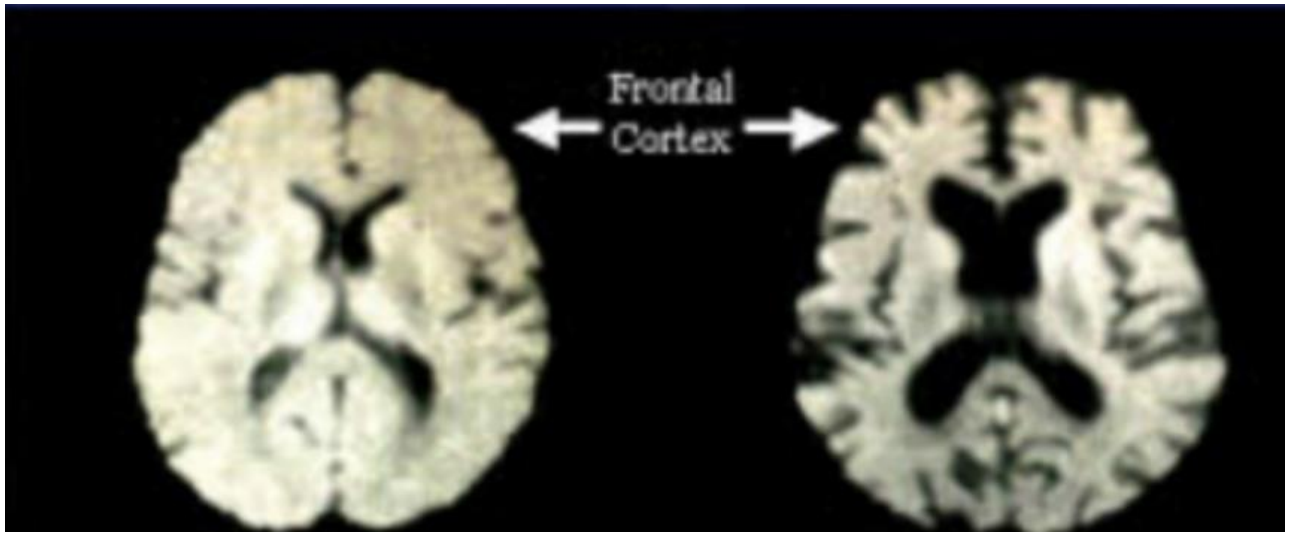
Our requirements for outpatient detox

- Lab: cbc, cmp (inc hepatic panel), B vitamins esp. thiamine, UDS
- Support system including dedicated family member to stay w/ patient and administer medicine

Treatment

- Thiamine 100 mg daily
- Folic acid 1 mg daily (or methylated)
- Benzodiazapines

Why Thiamine?



Impact of alcohol on brain neurons and structures

Preferred benzos

- Classic and preferred: Librium
- Ativan if liver is compromised

More on benzos

- Librium and Ativan have very different half life qualities and are dosed very differently…don’t screw this up!

Librium—reduce frequency

- Day 1: 25 or 50 mg every 6 hours
- Day 2: 25 or 50 mg every 8 hours
- Day 3: 25 or 50 mg every 12 hours
- Day 4-5: 25 or 50 mg q 24 hours or bedtime

Ativan Dosing—reduce dose

- Day 1: 2 mg every 8 hours
- Day 2: 1.5 mg every 8 hours
- Day 3: 1 mg every 8 hours
- Day 4: 0.5 mg every 8 hours
- Day 5: 0.25 mg every 8 hours

Adjuntive medicine

- Beta blockers, clonidine
- NOT: barbituates, phenothiazines
- NOT: dilantin (not effective)
- Not: baclofen—increased mortality

monitoring

- Ideally, daily until symptoms are decreased and medicine dose is reduced
- Checking blood pressure/pulse daily
- CIWA daily, ideally score progresses to below 10
- Patients who resume drinking or miss appointments should be referred to inpatient

Questions about outpatient alcohol detox?

Outpatient Opioid Detox

- Contra for polysubstance (esp with benzos or other sedatives)
- Poor social support

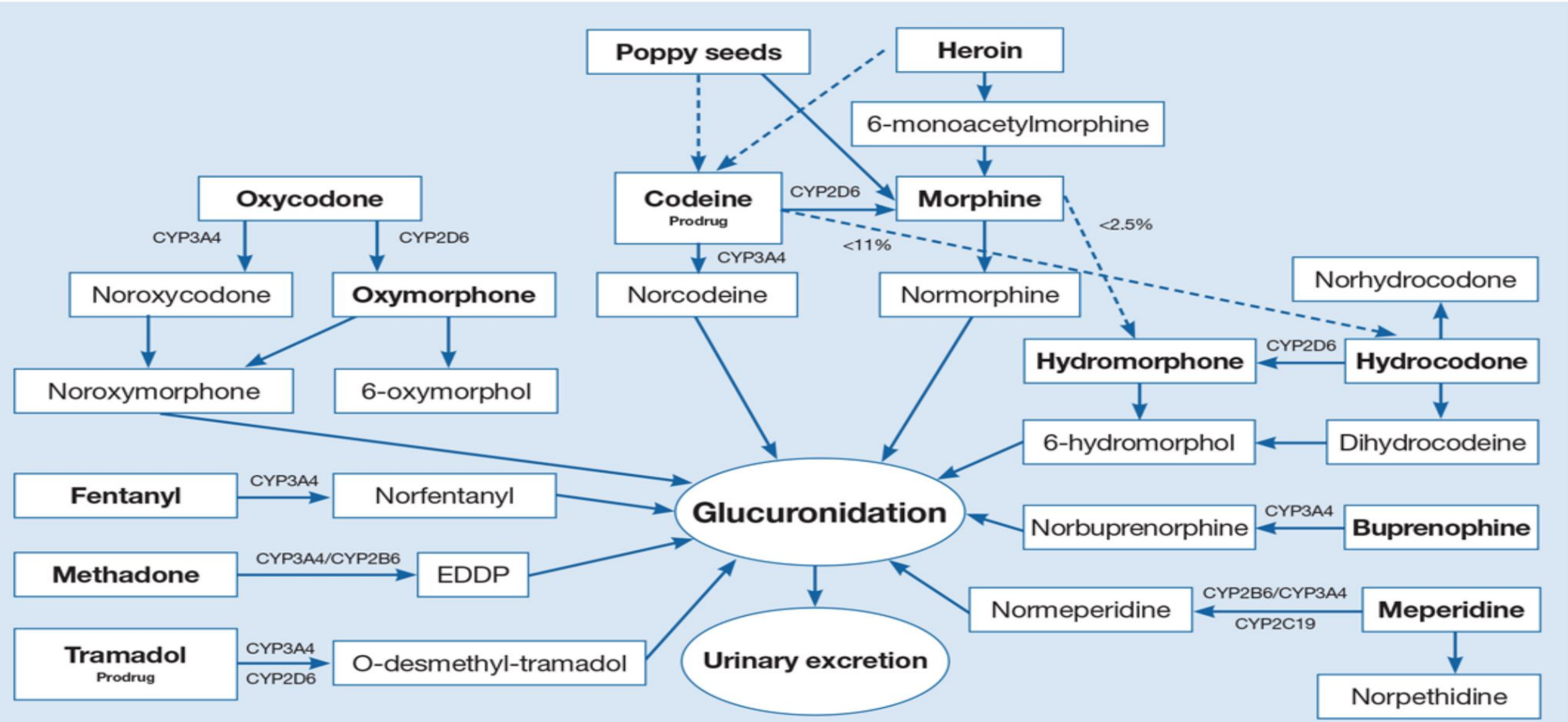
Opioid vs opiate?

- Opioid: all inclusive
- Opiate: natural opioids eg heroin, morphine, codiene

Why these UDS results?

Immunoassay	Detected	Other drugs in class detected	Potential false positives	Potential false negatives
Buprenorphine	Buprenorphine	---	Morphine, methadone, codeine, tramadol	None known
Methadone	Methadone	---	Antipsychotics, verapamil, diphenhydramine	None known
Opioids	Morphine	Codiene, heroin, hydrocodone/ hydromorphone	Quinalones, naltrexone, diphenhydramine, rifampacin	Oxycodone/oxymorphone, fentanyl, methadone, buprenorphine, tramadol, meperidine
Oxycodone	Oxycodone	---	None known	None known

Metabolic pathways of commonly used opioids[a]



Dashed lines indicate minor pathways. Drugs in bold are commonly used opioids

CYP: cytochrome P450; EDDP: 2-ethylidene-1,5-dimethyl-3,3-diphenylpyrrolidine

Source: Reference 15

Goals

- Comfortable detox
- Reduce risk of relapse
- Prepare for long-term treatment

Brief word on pregnancy

Withdrawal in pregnancy can lead to miscarriage…we always treat abstinence symptoms in pregnancy with replacement

Medicines Used

- Comfort meds: Clonidine, Zofran, Vistaril,
- Replacement meds: Methadone, Buprenorphine

Methadone Vs buprenorphine

Methadone: no wait period to initiate

buprenorphine: usually 12 hours s/p short-acting opiate, 36 hours s/p methadone

Methadone converts at about 30 mg

Methadone

Full agonist
Only administered at specific clinics
18 and up
Pregnancy outcomes not as good
More challenging

methadone

Alleviates w/d sx and reduces cravings

Caution w: resp deficiency, acute alcohol dependence, head injury, treatment w/ MAOS, UC/Crohn’s, severe hepatic impairment

Methadone interactions

There are over 320 major medicine interactions with methadone

Buprenorphine

- Partial agonist
- Comes in pills, strips, injections
- Single or combination with naloxone (suboxone)

A word on naloxone

- Has negligible absorption when used sublingually
- Used to reduce risk of abuse or diversion
- We do NOT use this version in pregnancy though

Withdrawal management alone does not lead to long term abstinence

Environment mgmgt during w/d

Quiet and relaxing

Don’t force physical exercise (can make sx worse)

Reassurance

Don’t engage in therapy at this stage

Clinical Opiate Withdrawal Scale (COWS)

Flowsheet for measuring symptoms over a period of time during buprenorphine induction.

For each item, write in the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. *For example*: If heart rate is increased because the patient was jogging just prior to assessment, the increased pulse would not add to the score.

Patient name: _____ Date: _____ Buprenorphine Induction: _____ Enter scores at time zero, 30 minutes after first dose, 2 hours after first dose, etc.				
Times of Observation:				
Resting Pulse Rate: Record Beats per Minute				
Measured after patient is sitting or lying for one minute 0=pulse rate 80 or below 1=pulse rate 81-100 2=pulse rate 101-120 4=pulse rate greater than 120				
Sweating: Over Past ½ Hour Not Accounted for by Room Temperature or Patient Activity				
0=no report of chills or flushing 1=subjective report of chills or flushing 2=flushing or observable moistness on face 3=beads of sweat on brow or face 4=sweat streaming off face				
Restlessness Observation During Assessment				
0=able to sit still 1=reports difficulty sitting still, but is able to do so 3= frequent shifting or extraneous movements of legs/arms 5=unable to sit still for more than a few seconds				
Pupil Size				
0=pupils pinned or normal size for room light 1=mild diffuse discomfort 2=pupils moderately dilated 5=pupils so dilated that only the rim of the iris is visible				
Bone or Joint Aches if Patient was Having Pain Previously, only the Additional Component Attributed to Opiate Withdrawal is Scored				
0=not present 1=mild diffuse discomfort 2=patient reports severe diffuse aching of joints/muscles 4=patient is rubbing joints or muscles and is unable to sit still because of discomfort				
Runny Nose or Tearing Not Accounted for by Cold Symptoms or Allergies				
0=not present				

COWS

Used to guide treatment decisions

Withdrawal symptoms

- Nausea/vomiting
- Anxiety
- Insomnia
- Hot and cold flushes
- Perspiration
- Muscle cramps
- Watery eyes/nose
- Diarrhea

buprenorphine

Opioid replacement

Alleviates w/d and reduces cravings

Only after w/d commences (use cows)

buprenorphine

Partial agonist (MU)
Ceiling effect on respiratory suppression
Analgesic plateau
Safer than methadone

buprenorphine

Poor bioavailability due to first pass

Sublingual, transdermal, depot

buprenorphine

Subject to 3a4 interations

Slow onset

Long duration of action

buprenorphine

Available comb w/ naloxone (SL)
Naloxone not abs orally,
Added to reduce abuse potential when injected
Can be prescribed outpt setting

Practical stuff

Pt in emergent w/d

Give 2-4 mg

Monitor 1-2 hours

Give 2-4 mg more if needed

Induces w/d: dose is too soon into w/d or too high: treat with clonidine and wait 6-8 hrs

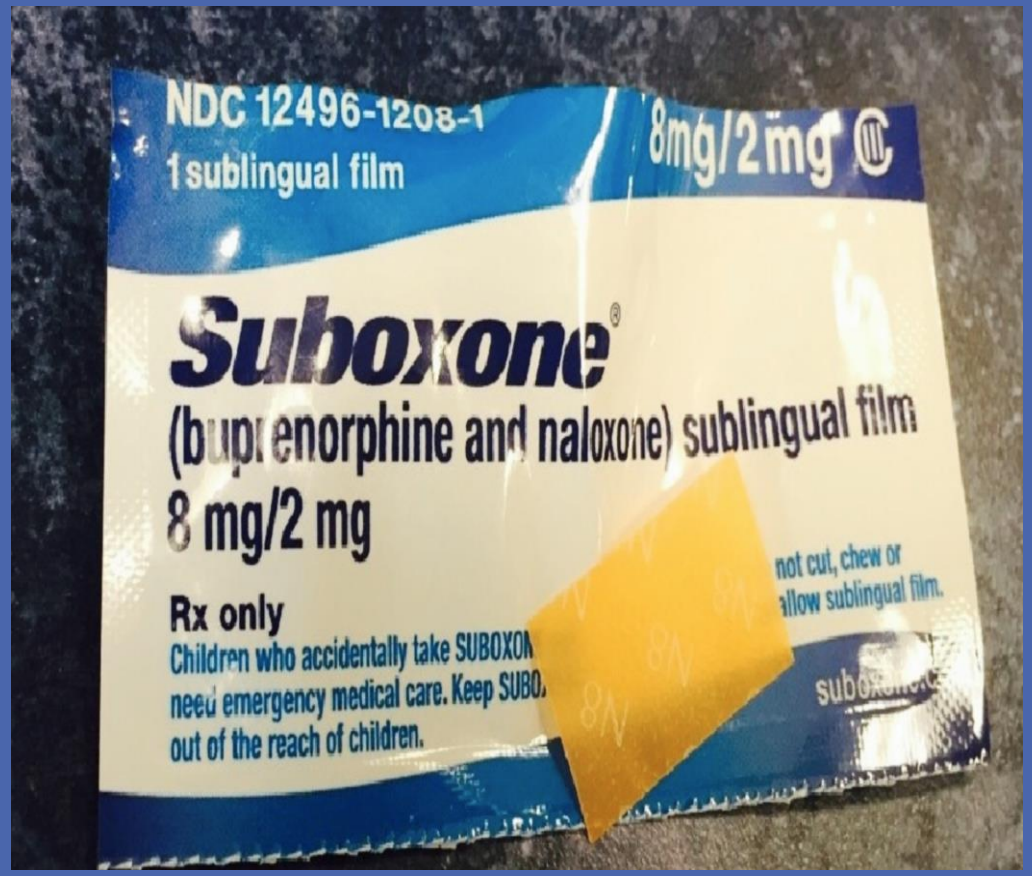
Fentanyl/ buprenorphine

Sometimes it just doesn’t work right

Buprenorphine cautions

Sole contra is allergic to buprenorphine

Relative: respiratory suppression, gi obstruction, diabetes


NDC 12496-1208-1
1 sublingual film
8mg/2mg
Suboxone®
(buprenorphine and naloxone) sublingual film
8 mg/2 mg
Rx only
not cut, chew or
allow sublingual film.
out of the reach of children.


BUPRENORPHINE
Hydrochloride Injection
0.2
0.3
0.4
0.5

½ lives

Short: codeine, hydrocodone, oxycodone, oxymorphone, morphine, heroin, fentanyl

Long: buprenorphine, extended release opiates,methadone, fentanyl patch

clonidine

Relieves sweating, diarrhea, vomiting, abdominal cramps, chills, anxiety, insomnia, tremor

Side effects: drowsiness, dizziness, low bp

Use in conj w/ symptomatic txtmt NOT w/ opiod sub

Lofexidine

- Used for opioid w/d with less hypotension and sedation
- May be used with low-dose naloxone
- I use this when transitioning patients off suboxone

Rapid detox under anesthesia

Uses naltrexone, propofol, ondansetron, octreotide, clonidine

No long-term improved outcome at 1 and 3 mo

High rate of mortality, within 72 hours of procedure, frequently associated with pulmonary edema

VIVITROL

- Monthly injection
- Used to maintain abstinence-alcohol and opiates, gambling
- 7-14 days post opioid (much longer if sublocade)

Resources

Clinical Protocols*:

Naloxone (i.m.) Challenge Procedure

- Obtain baseline COWS, if 4 or less proceed with the challenge
- Administer naloxone 0.4 mg (1 cc) i.m. to deltoid and observe for 20 minutes.
- If no change in COWS administer additional 0.8 mg (2 cc) to the other deltoid and monitor for additional 20 minutes
- Test is considered positive if there is a COWS increase of 2 or more from the pre-injection score
- In case of positive challenge, do not administer XR-naltrexone, wait 1-2 days and repeat the challenge
- If the test is negative, proceed with the XR-Naltrexone injection.

Naltrexone (p.o.) Challenge Procedure

- Obtain baseline COWS; if 4 or less proceed with the challenge
- Administer naltrexone 25 mg p.o. and observe for 90 minutes, if COWS increase is less than 2 proceed with XR-naltrexone injection
- In case of positive challenge, treat withdrawal with adjunctive medications and reschedule injection for next day
- Administer XR-naltrexone (no need for repeated challenge the next day unless there was a new episode of use)

Naltrexone Challenge Source: vivitrol package insert

Benzo w/d brief

Can last for an extended period of time

Benzo ½ life

Short: oxazepam, alprazolam, temazepam

w/d 1-2 days s/p last dose, can cont 2-8 weeks

Benzo ½ life cont

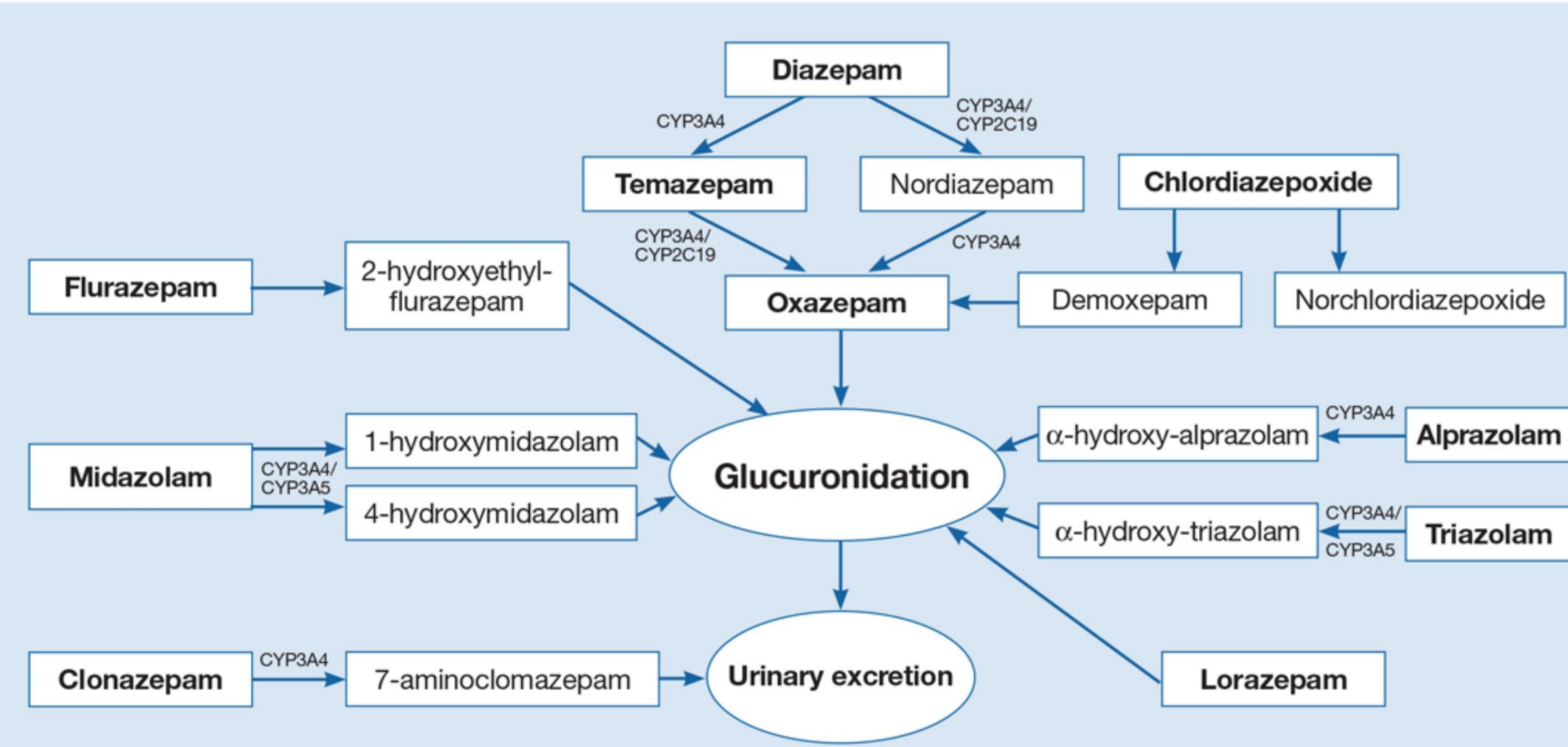
Long ½ life: diazepam, clonazepam

w/d 2-7 days s/p last dose, can cont 2-8 weeks or longer

Why these UDS results?

Immunoassay	Detected	Other drugs in class detected	Potential false positives	Potential false negatives
Benzodiazepines	Diazepam	Oxazepam, temazepam, flurazepam, chlordiazepoxide, midazolam, triazolam, lorazepam, alprazolam	Sertraline, oxaprozin, efavirenz	Clonazepam

Metabolic pathways of commonly used benzodiazepines[a]



w/d sx

Anxiety
Inosmnia
Restlessness
Aggitation/irritability
Poor conc/memory
Muscle tension/ha
May be subjective w/ few observable signs

Management for benzo w/d

Long ½ life benzo very slow taper

Diazepam or clonazepam

Immunoassays	Detecting drugs/ metabolites	Other drugs detected in the same class	Potential false positive[a]	Potential false negative[a]
Amphetamine[b]	Amphetamine	Dextroamphetamine, lisdexamphetamine	Bupropion, trazodone, desipramine, doxepin, labetalol, metformin, promethazine, ephedrine, pseudoephedrine, phentermine, atomoxetine, ranitidine	None known

stimulant UDS results

Notice what is missing? Methylphenidates will NOT show up on most point-of-care UDS tests..