Opioid Use Disorder

A chronic treatable disease whose medications substantially reduce death · the admission is the reachable moment

The medication IS the treatment
detox alone raises overdose risk

⚠ TWO THINGS CHANGED THAT MOST OF US LEARNED WRONG

THE X-WAIVER IS GONE

Eliminated by the **Consolidated Appropriations Act of 2023**. **Any clinician whose DEA registration includes Schedule III authority may prescribe buprenorphine for OUD, with NO patient cap.** The separate waiver, the 8-hour prerequisite and the 30-patient limit are all history; a one-time training requirement attaches to DEA registration.

⚠ FENTANYL BROKE TRADITIONAL INDUCTION

Fentanyl is **highly lipophilic**, so with repeated use it **accumulates in peripheral fat and redistributes slowly**. Patients can precipitate withdrawal **even after 8-24 h of abstinence with a convincing COWS score**. "Wait for withdrawal, then give a standard dose" was reliable in the heroin era and no longer guarantees safety.

WHY THE ADMISSION MATTERS

Starting medication in hospital beats referral alone for still being in treatment weeks later. **Untreated withdrawal drives patients out of the building** -a leading, modifiable cause of discharge against advice. Treating it is not comfort care; it is what keeps someone present to finish 6 weeks of endocarditis antibiotics.

THE THREE MEDICATIONS

Drug	Mechanism	Practical points
Buprenorphine (usually w/ naloxone)	**PARTIAL** mu agonist, **very high affinity**	**Ceiling effect on respiratory depression is what makes it comparatively safe.** The same high affinity is why it **displaces full agonists and precipitates withdrawal if given too early.** Office-prescribable with a standard DEA registration. The naloxone component deters injection; it does not treat
Methadone	**FULL** mu agonist	**No ceiling, so respiratory depression remains possible.** Long, variable half-life → **accumulates over the first days, when overdose deaths cluster. Prolongs QT.** Ongoing OUD treatment must run through a licensed **opioid treatment program**, not an outpatient prescription
Naltrexone (XR injectable)	**ANTAGONIST**	Blocks rather than activates: **no withdrawal relief, no diversion value. ⚠ Needs ~7-10 OPIOID-FREE DAYS first** or it precipitates severe withdrawal -which is why it is hardest to start in those who need it most, and why many who intend to start never do. **Tolerance is lost while blocked**, so a lapsed injection is high-risk

Buprenorphine and methadone carry the strongest mortality evidence -either is a good answer. Patient preference predicts retention, and retention produces the survival benefit -a medication they will continue outperforms the one you would have picked

PRECIPITATED WITHDRAWAL & HOW TO START *iatrogenic, awful, and a reason patients refuse treatment forever*

Concept	Detail
The mechanism	Buprenorphine's affinity **exceeds** that of full agonists so it displaces them, but being only **partial**, it produces an **abrupt net DROP in receptor activation** → sudden severe withdrawal
Classic timing and its trap	Wait for **moderate withdrawal, COWS ~8-12** (graded from objective signs: pulse, sweating, pupils, aches, rhinorrhea, GI upset, tremor, yawning, gooseflesh), then give the first dose. **⚠ But COWS is not specific** -sepsis, alcohol withdrawal, thyrotoxicosis and pain all raise it. In endocarditis, calling a rising score "withdrawal" rather than worsening infection is a judgment, not a calculation
Low-dose initiation (micro-dosing / overlap)	**Small escalating doses WHILE the full agonist continues.** Each increment is too small to displace abruptly, so **the patient does NOT need to be in withdrawal to begin** -removing the requirement people find hardest to meet. Reaches therapeutic dosing over ~3-4 days
High-dose initiation	The opposite: larger initial doses to move rapidly through the vulnerable window. **ED studies in fentanyl-positive patients reported precipitated withdrawal in only ~1-5%.** Emerging as safe and efficient. **Involve addiction medicine early** rather than defaulting to a heroin-era induction

THE TWO ERRORS THAT DO REAL HARM

⚠ NEVER STOP MOUD TO TREAT ACUTE PAIN

The most frequent and most harmful inpatient error here. **The maintenance dose gives NO meaningful analgesia** at once-daily dosing, so stopping it does not unlock pain control -it **adds withdrawal to the pain** and destabilizes treatment that took months to build. **Continue the baseline drug and treat pain ON TOP**, expecting **higher full-agonist doses** to overcome receptor occupancy. Use multimodal and regional techniques.

⚠ DETOX WITHOUT MEDICATION IS NOT NEUTRAL

Tolerance falls faster than the drive to use returns, so the window after hospitalization, incarceration or supervised withdrawal is the **highest-risk period for fatal overdose.** Someone who completes a withdrawal-only admission and leaves without medication is at **HIGHER overdose risk than before they came in. Counseling or referral without medication is not equivalent** -the commonest well-intentioned mistake here.

METHADONE IN HOSPITAL · SCREENING · DISCHARGE

Task	What to do, and why
⚠ Verify the dose	Continue it -stopping causes withdrawal and jeopardizes the admission. **Confirm dose AND last dose directly with the dispensing program.** Do not rely on patient report alone: methadone accumulates, and an over-reported dose given to someone whose tolerance has lapsed can be fatal
The "72-hour rule"	A clinician **not** part of an opioid treatment program may **administer** (one day at a time, not prescribe) methadone for **up to 3 days** while arranging program linkage -a bridge whose value depends entirely on the linkage being made before it expires. For a patient admitted with another condition, methadone is part of hospital care
Screen, because this group is under-screened	**HIV and HCV** (HCV is curable, and **ongoing use is NOT a reason to withhold treatment**); **HBV with vaccination**, plus hep A and tetanus; **endocarditis** (low threshold for cultures and echo with fever plus injection use); **skin/soft tissue, osteomyelitis, epidural abscess -back pain with fever in someone who injects needs imaging**. Offer HIV PrEP
⚠ NOT reasons to withhold	**Concurrent benzodiazepine or alcohol use raises overdose risk but does NOT justify withholding buprenorphine or methadone.** In **pregnancy**, both are standard and **withdrawal management alone is not recommended**. Diagnosis is DSM-5 (**2-3 mild, 4-5 moderate, 6+ severe**), but **tolerance and withdrawal do NOT count when opioids are taken as prescribed** -dependence is not a use disorder
Discharge bundle	**Naloxone, and train the person who lives with them** -someone overdosing cannot dose themselves, so the bystander is the target. Counsel on **lost tolerance, "don't use alone"**, avoiding alcohol/benzodiazepines. **A BOOKED appointment, not a phone number.** Fentanyl and xylazine contaminate the supply unpredictably
Language is part of the treatment	**"Person with opioid use disorder", never "abuser"; toxicology "positive/negative", never "clean/dirty"; "medication for OUD", not "replacement".** Stigmatizing terms in the chart measurably change how the next clinician treats the same patient

References: Consolidated Appropriations Act of 2023 (removal of the DATA-waiver requirement) · SAMHSA and ASAM guidance on medications for opioid use disorder · published protocols and cohort data on low-dose and high-dose buprenorphine initiation in the fentanyl era · federal 72-hour rule for methadone administration outside an opioid treatment program.

Educational aid; verify against current guidance, local formulary, state regulation and patient factors.