Clinical Pathways for Withdrawal Management (Detoxification)
West Virginia ODCP Presentation

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Learning Objectives

- DSM Diagnosis of SUD
- Importance of Accurate Diagnosis of Opioid SUD
- Treatment Planning for OUD
- FDA Approved Medications for SUD
- Specific SUD & OUD Withdrawal Management Protocols
- Life Long Management of SUD

DSM Diagnosis Of SUD

- There is formal DSM criteria (4 most common)
- Continued use in face of adverse consequences
- Development of Tolerance
- Withdrawal Phenomena upon cessation
- Behavioral Abnormalities (addiction vs. Physiological dependence)

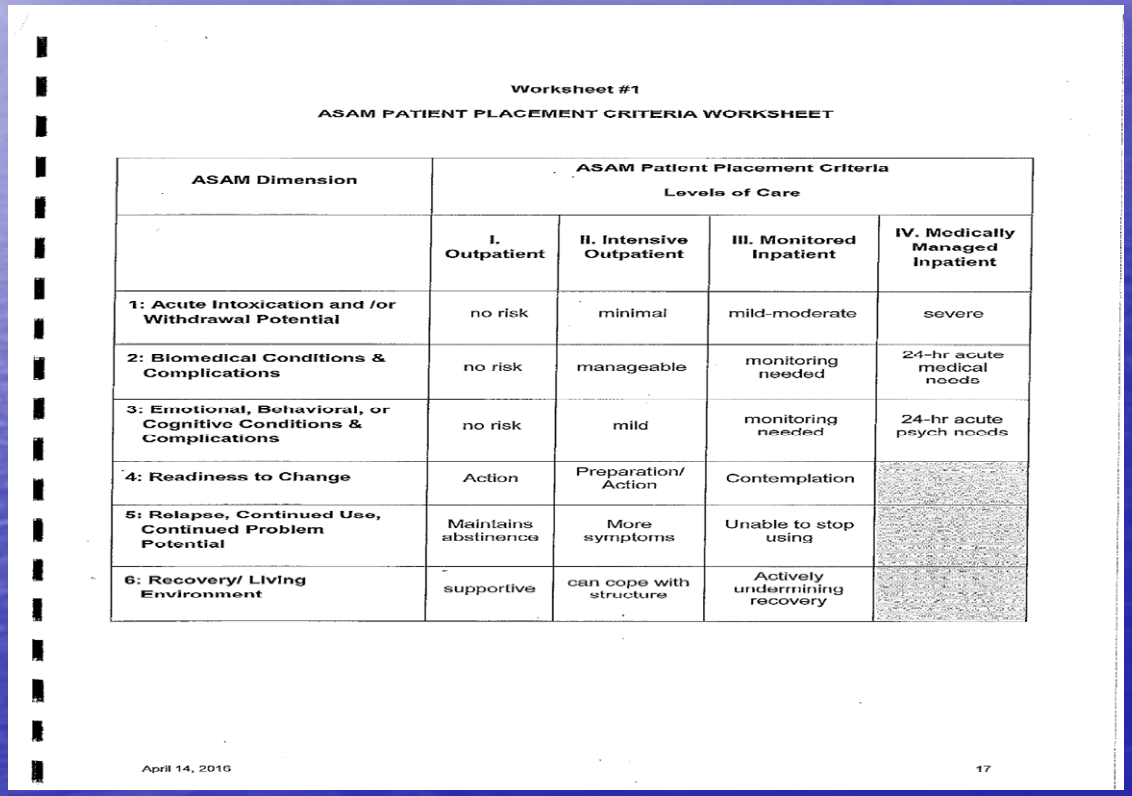
Importance of Accurate Diagnosis of SUD

- Must distinguish between "Addiction vs. Dependence"
- Addiction requires a "full treatment experience" beyond withdrawal management
- Physiological Dependence only requires withdrawal management
- The distinction saves resources, leads to appropriate treatment planning, better treatment outcomes

Treatment Planning for OUD (Addiction)

- "Full Treatment Experience"
- Withdrawal Management (detoxification)
- Rehabilitation Counseling (ASAM Criteria)
- ASAM Criteria – Levels 0.5, I, II, III, IV
- *It is essential that patients are in appropriate level of care*
- Ongoing maintenance (12 Step or other Support groups, and MAT when appropriate)
- Chronic Medical care of a Chronic Medical Disease

ASAM Criteria – Short Version



Worksheet #1

ASAM PATIENT PLACEMENT CRITERIA WORKSHEET

ASAM Dimension	ASAM Patient Placement Criteria Levels of Care			
	I. Outpatient	II. Intensive Outpatient	III. Monitored Inpatient	IV. Medically Managed Inpatient
1: Acute Intoxication and /or Withdrawal Potential	no risk	minimal	mild-moderate	severe
2: Biomedical Conditions & Complications	no risk	manageable	monitoring needed	24-hr acute medical needs
3: Emotional, Behavioral, or Cognitive Conditions & Complications	no risk	mild	monitoring needed	24-hr acute psych needs
4: Readiness to Change	Action	Preparation/ Action	Contemplation	
5: Relapse, Continued Use, Continued Problem Potential	Maintains abstinence	More symptoms	Unable to stop using	
6: Recovery/ Living Environment	supportive	can cope with structure	Actively undermining recovery	

April 14, 2016 17

FDA Approved Medication for SUD

- **Naltrexone** – Oral and Injection AUD and OUD - maintenance
- **Acamprosate** – AUD - maintenance
- **Antabuse** – AUD –maintenance
- **Methadone** – OUD – W/D and maintenance
- **Buprenorphine** – W/D and maintenance
- **Lofexidine** – OUD - W/D only!

Withdrawal Management

- Withdrawal Management for all SUD
- Is a **two step process**! Stabilization and Tapering
- **Stabilization** – give enough medication to ameliorate all signs and symptoms of W/D
- **Tapering** – once patient has been stabilized, lower the dose slowly over next few days to zero, while not allowing W/D symptoms to return
- **Failure to follow** these two steps lead to **failure of W/D management.**

Medications for Detoxification

- **Librium** … Alcohol and Benzodiazepine Detoxification
- **Benzodiazepine & Phenobarbital …** Benzodiazepine detoxification
- **Suboxone (Subutex) & Methadone** …Opiate Detoxification
- **Clonidine & Naltrexone** …..Opiate detoxification
- **Bromocryptine & Amantadine** …Stimulant Detoxification
- **Welbutrin** … Cannabis Detoxification/Nicotine
- **Chantix & Nicotine products** … Nicotine

Suggested WM Guidelines for Alcohol

- **Librium** is recommended-most studied and stability with inactive metabolites … other medications can be used
- "Structured Scheduled Dosing" is preferable to "Symptom Triggered Dosing" as patients are ambulatory
- **Stabilization Taper Method-A**
- **Librium 25mg or 50mg q6hx24 hrs; then q8hrx24hs; then q12hrs x 24hrs; then once and then discontinue.**
- **Stabilization Method – B**
- **Librium 50mg q4h x 6 doses; q6h x 4 doses; q8h x 3 doses; q12h x2 doses; then once and then discontinue**
- ***Extra caution with pregnant patients …go slower.***

Suggested WM for Nicotine

- Nicotine replacement and WM medication
- Nicotine Replacement (patches, lozenges, and gum)
- Trans-dermal patches give slow release : daily use
- Lozenges and gums give faster release and may need to be used multiple times a day.
- Bupropion is an antidepressant that decreases craving and satisfaction (150mg qd x3 then bid 5-7wks)
- Varencline (partial agonist) 0.5 mg qd x 1wk then 1mg bid x 13wks reduces satisfaction
- Accupuncture & Hypnosis

Suggested WM for Sedative Hypnotics

- Very important to remember that WM is a two-step process!
- **Stabilization** of wd symptoms: and then **Tapering** the dose (10% of the stabilization daily)
- Tapering dose can be slowed if WM symptoms return
- **Librium**
- Day1: 100mg; 40mg; 35mg; 30mg; 25mg; 20mg; 15mg; 10mg; 5mg; and Day 10 discontinue
- Adjunctive Meds (buspirone, SSRIs, diphehydramine) prn

Suggested WM Guidelines for Opioids

- There are 3 approaches to Opioid WM: agonist substitution - maintenance; Agonist substitution and taper; and non-opioid WM therapy
- **Agonist Substitution-Methadone and Buprenorphine**
- **Methadone** started at 30mg (divided or single dose); once stabilized WD symptoms, reduce 5mg daily to zero.
- **Buprenorphine** Products 2mg – 32mg stabilization dose: once stabilized , dose can be reduced at 4mg increments to 8mg. Thereafter, reductions at 1mg intervals.
- **Non-Opiate WD Management (Non-FDA Approved)**
- Trans-dermal and oral **Clonidine;** oral dose 0.1-0.2 mg q4h for 72 hrs. Apply trans-dermal TTSI or II simultaneously and leave on for one week.
- **NSIADs and diphenhydramine** for agitation and insomnia
- **Lofexidine** 0.18mg iii po q6h with deceasing dose daily 7-14 days (FDA)
- **Naltrexone** is appropriate after WM is completed …

Opioid Dependent Pregnant Patients

- ***Should not undergo WM !!!***
- **Methadone Maintenance** is the treatment of choice (American College Obstetrics & Gynecology and American Society of Addiction Medicine)
- **Buprenorphine Maintenance** most used currently (With Pregnancy Category C waiver)
- Some data suggests less Neonatal Abstinence Syndrome with buprenorphine (NIDA Bulletin)

Poly-substance Withdrawal Management

- WM for **all substances** can occur ***simultaneously*** *… with good management*
- ***Poly-substance*** *abusing patients must be monitor for various class symptoms*
- *If the patient is abusing alcohol and BZD, the* ***BZD protocol*** *should be used (covers both) and Opioid medications as well*
- *N.B. The BZD W/D will take the longest (10 - 14 days) all others will be done!*

Medications for Maintenance

- **Buprenorphine** ….Opiate dependence
- **Methadone** …. Opiate Dependence
- **Acamprosate** …. Alcohol Dependence
- **Naltexone ….** Alcohol and Opiate dependence
- **Vivitrol** ……. Alcohol and Opiate Dependence
- **Disulfram** …. Alcohol Dependence
- **Nicotine Replacement** …Nicotine Dependence

Adjunctive Medications – Psychiatric Co-Morbidities

- **SSRIs** …… Affective Depressant Disorders
- **Buspar** ……. Anxiety Disorders
- **Benzodiazepines** (Oxazepam, Librium, Klonopin) … in *special psychiatric cases* (GAD, Panic Disorder, Agoraphobia)
- **Phenothiazines** … Affective Disorders (Schizophrenia)
- **Lithium** ……. Major Depression
- **Trazadone** ….. Insomnia
- **Cymbalta …** Depression and pain
- ***Other Medications for Medical Problems under medical supervision***

Patients with SUD and Pain

- **NSAIDs** …. at maximum dosages ATC
- **Methadone** …. In combination with NSAIDs
- **Buprenorphine** in combination with NSAIDs
- **Cymbalta** … in combination buprenorphine & NSAIDS
- **Neuroleptics** … in combination with other meds
- **SSRIs** …. Have been shown to be useful
- **Clonidine** … for neuropathic pain
- **Clonazepam** …. For lancinating pain
- **Baclofen** …..for central nervous system pain
- ***LONG Acting Narcotics …. Medical supervision***

OUD Withdrawal Protocols – FDA Approved Medications

- **Methadone** – dose up to 30mg until stable
- Then taper ~5mg daily to zero
- **Buprenorphine** – dose up to 32 mg until stable : then taper by ~4mg daily to 8mg dose : there after reduce 1mg to zero
- **Lofexidine** – 0.18mg 3 tabs qid with reducing amounts over next 5-7 days (up to 14 days)

Disadvantages of Medication Therapy

- ***"Use in lieu of"*** full treatment experience
- Burdensome **regimes** and **side-effects** may undermine commitment to recovery
- Poor **medication selection** … must patient needs
- **Premature discontinuation** of medications (need to match with patient's recovery status)

Chronic Medical Care for SUD Patients

- **SUD** is a **chronic** medical disorder like diabetes and hypertension. It is a brain disease.
- Chronic medical conditions need **chronic follow-up** to assure continuing recovery and remission.
- During the life course of a SUD patient, **situations arise** where adjustments in treatment plans may be needed. Surgery, injuries, life changes, death of a spouse all may occur.
- Development of psychological or psychiatric issues may require **addiction potential medications**
- Chronic medical follow-up helps to ensure **ongoing recovery and remission** of chronic disorders

Drug Testing In SUD Treatment

- Various modalities: **Urine, Oral Fluid, Hair, Sweat, Patches**
- **Urine is gold standard** – most valuable validity
- **POCT** – Oral fluid: liability of "false positives"
- **Hair** – not good for real time evaluation of use
- **Frequency of Urine testing**: twice weekly sufficiently covers use evaluation (72 hour detection window)
- **Positives Results** should indicate need for re-evaluation of treatment plan (Level of care), evaluation for psychiatric disorder, or change in medical diagnoses:
- ***Not discharge from care!***

SUMMARY

- SUD is a **chronic brain disease** that requires chronic medical care
- **Accurate** & complete **diagnosing** is essential to develop a successful treatment plan
- providing a **"Full Treatment Plan"** is essential (withdrawal / rehab counseling & continued care)
- **FDA approved medications** for w/d management and maintenance
- All will lead to better treatment outcomes and **sustained remissions**

Additional Best Practices Guidelines

- CSAT TIP # 8
- CSAT TIP # 19
- CSAT TIP # 45