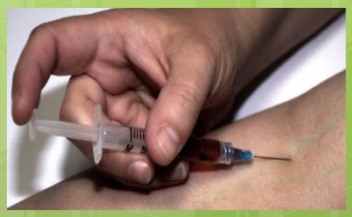
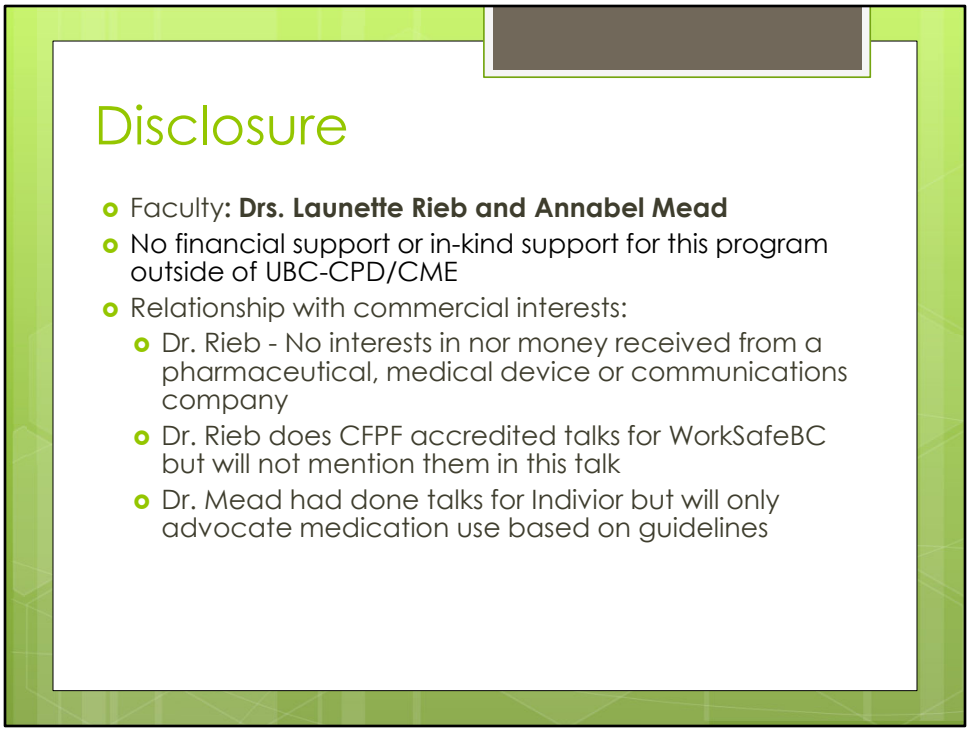


ALCOHOL and OPIOID USE in the time of COVID-19

Dr. Launette Rieb,
MD, MSc, CCFP(AM), FCFP, DABAM, FASAM
Clinical Associate Professor,, Department of Family Practice, UBC

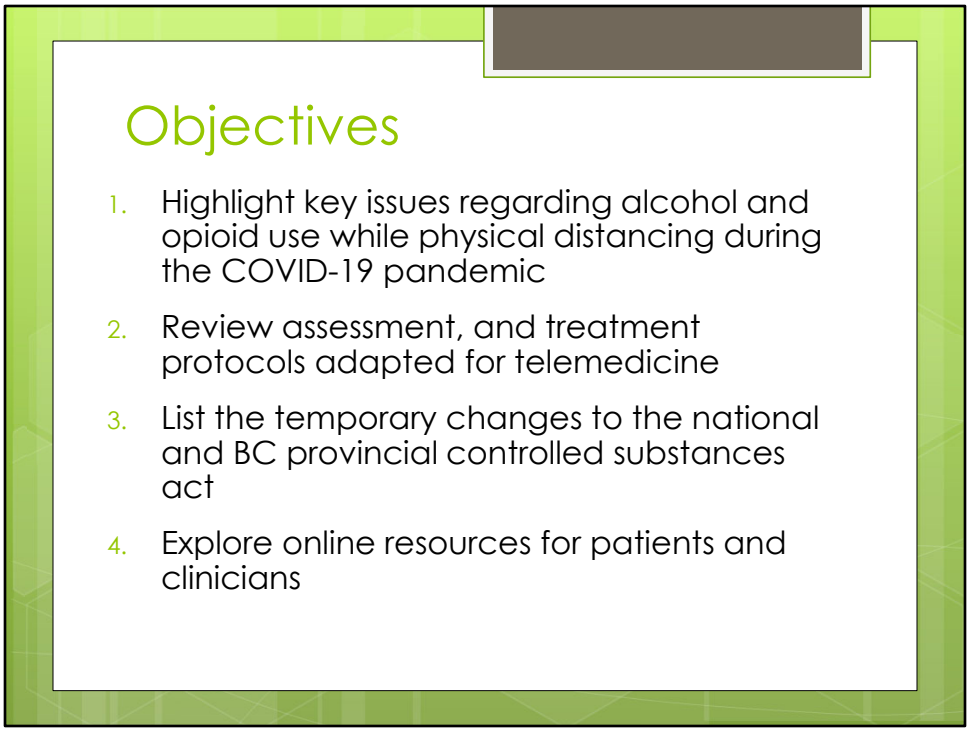
Q&A - Dr. Annabel Mead,
MBBS, FAChAM, DABAM
Clinical Assistant Professor, Dept. Family Practice, UBC

UBC-CPD Webinar April 9, 2020


Disclosure
Faculty: Drs. Launette Rieb and Annabel Mead
No financial support or in-kind support for this program outside of UBC-CPD/CME
Relationship with commercial interests:
Dr. Rieb - No interests in nor money received from a pharmaceutical, medical device or communications company
Dr. Rieb does CFPF accredited talks for WorkSafeBC but will not mention them in this talk
Dr. Mead had done talks for Indivior but will only advocate medication use based on guidelines

Disclaimer

- Please note the protocols shared in this presentation are suggestions only
- They do not take the place of clinical judgment
- I assume no liability for the use of these protocols
- Will not be covering toxidromes or ICU management

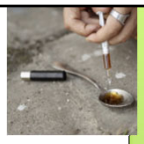


Objectives

1. Highlight key issues regarding alcohol and opioid use while physical distancing during the COVID-19 pandemic
2. Review assessment, and treatment protocols adapted for telemedicine
3. List the temporary changes to the national and BC provincial controlled substances act
4. Explore online resources for patients and clinicians

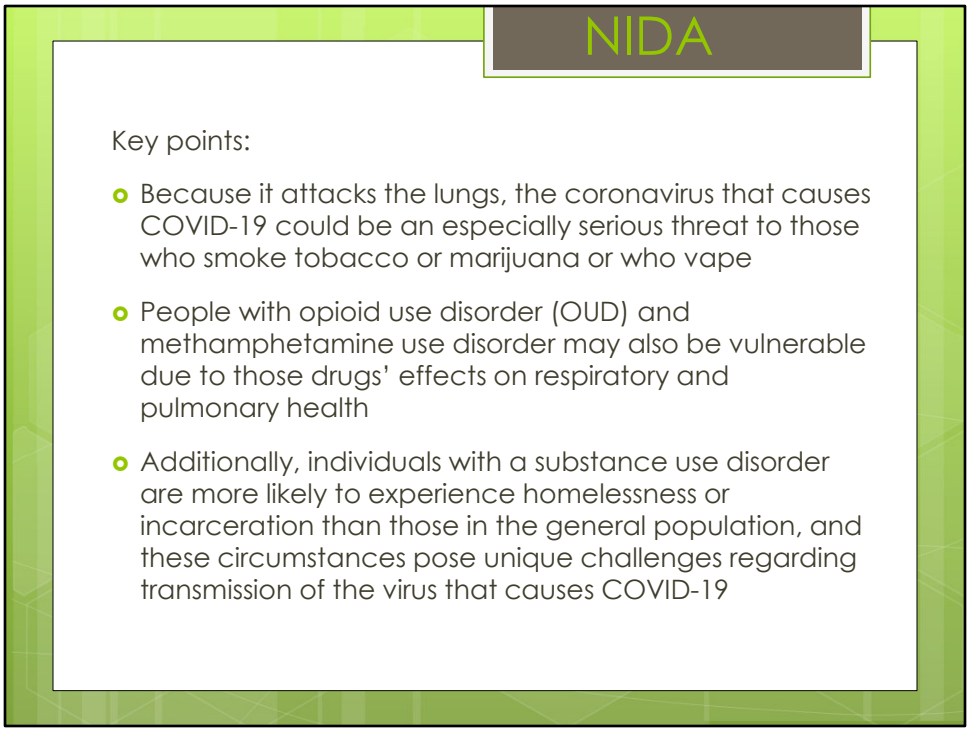
COVID-19



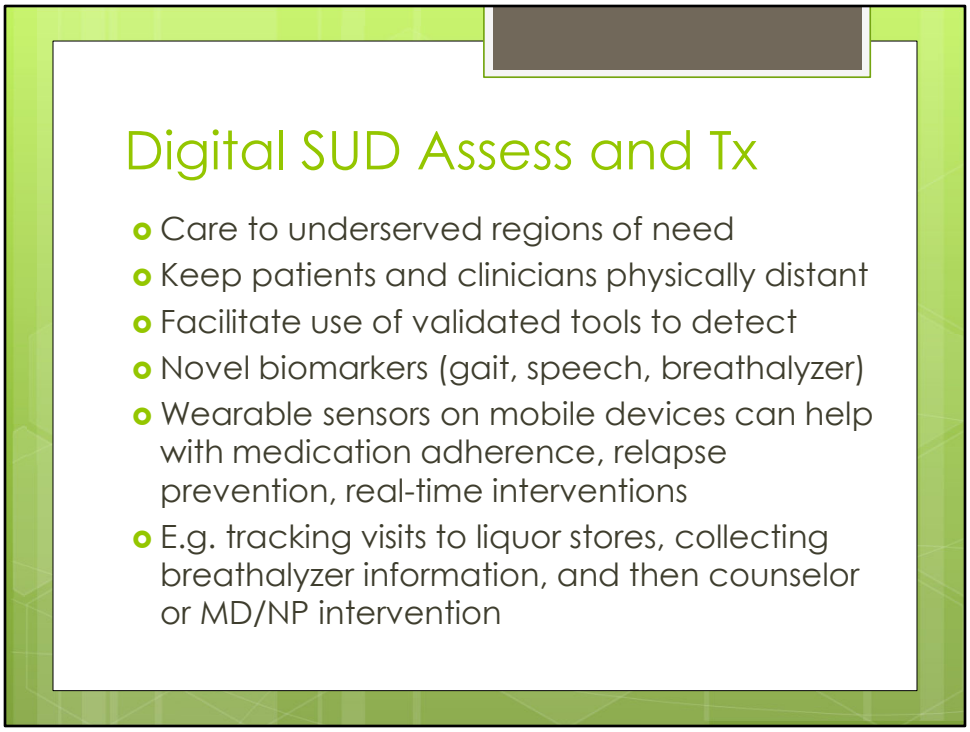


- New issues arise and long standing ones can be exacerbated during the COVID-19 pandemic and isolation protocols
- People may stock pile meds/substances and thus have more availability/access
- Supply chains may be cut off abruptly
- Quality of non-medical supply unreliable/toxic
- People may turn to non-beverage alcohol and non-medical substances to relieve withdrawal or to treat pain
- Psycho-social issues (homelessness, violence, sex trade)
- Sharing paraphernalia – bottles, cigarettes, crack pipes

Risk can also be increased with incarceration



Statement from the National Institute on Drug Abuse (NIDA)



It has been shown that clinicians will use these tools more if they're pre-loaded in the tool they're using to interview the patient

Novel biomarkers can be integrated into smartphones

Ideally face to face over video link; if not, over the phone

Screening tools can be found on BCCSU website (e.g. AUDIT, DAST, CRAFFT, DSM 5)

Alcohol

Many patients don't know what a standard drink is

Half this if age 65 years or older – New from Canadian Geriatric Journal this month
https://cgjonline.ca/index.php/cgj/article/view/425

Contraindications: e.g. pregnancy, breastfeeding, medicated for epilepsy / bipolar / depression, liver failure, anticoagulants, severe substance use disorder

Non-beverage Alcohol

Risk of use increases when…

- Supply chain is stopped of beer, wine, liquor:
  - Stores close, stop stocking or delivering
  - Other household members use the supply or cut off supply to a user
- Cost prohibitive due to gouging from stores or financial stress

For isopropyl alcohol or hand sanitizer even half a bottle can result in ICU admission

Non-beverage Alcohol

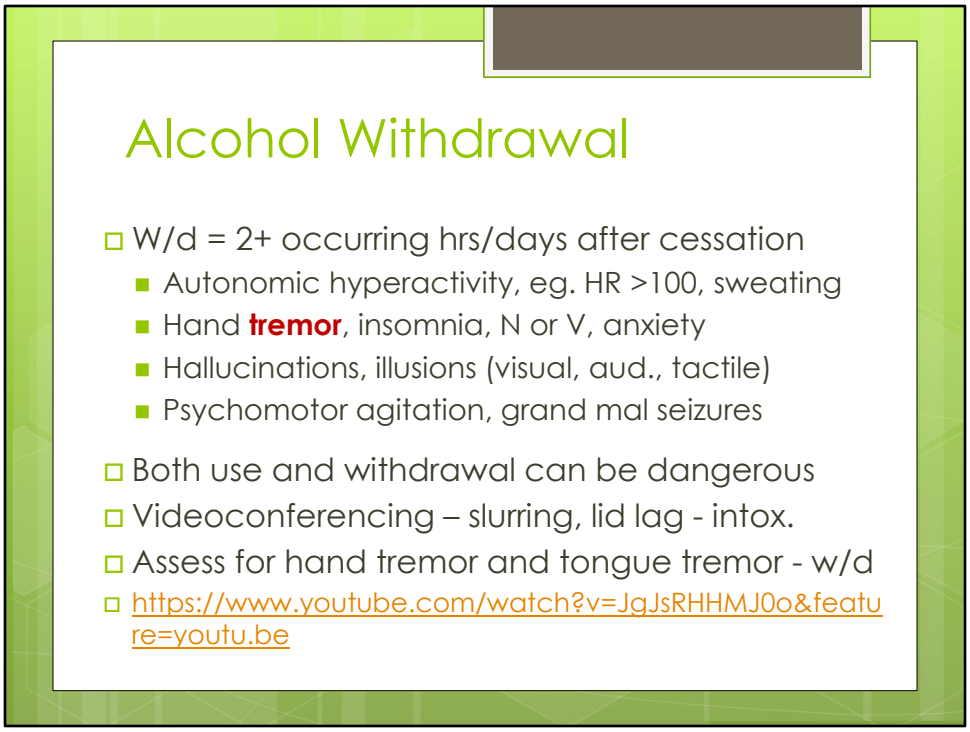
- Hand sanitizer and rubbing alcohol contain isopropyl alcohol
  - 200+ ml toxic to adults, coma/death
  - If mixed with MAOIs particularly lethal

- Antifreeze contains propylene glycol, ethylene glycol and methanol
  - toxic by-products increase over 12 hrs
  - may appear increasingly drunk
  - Multiorgan failure, blindness

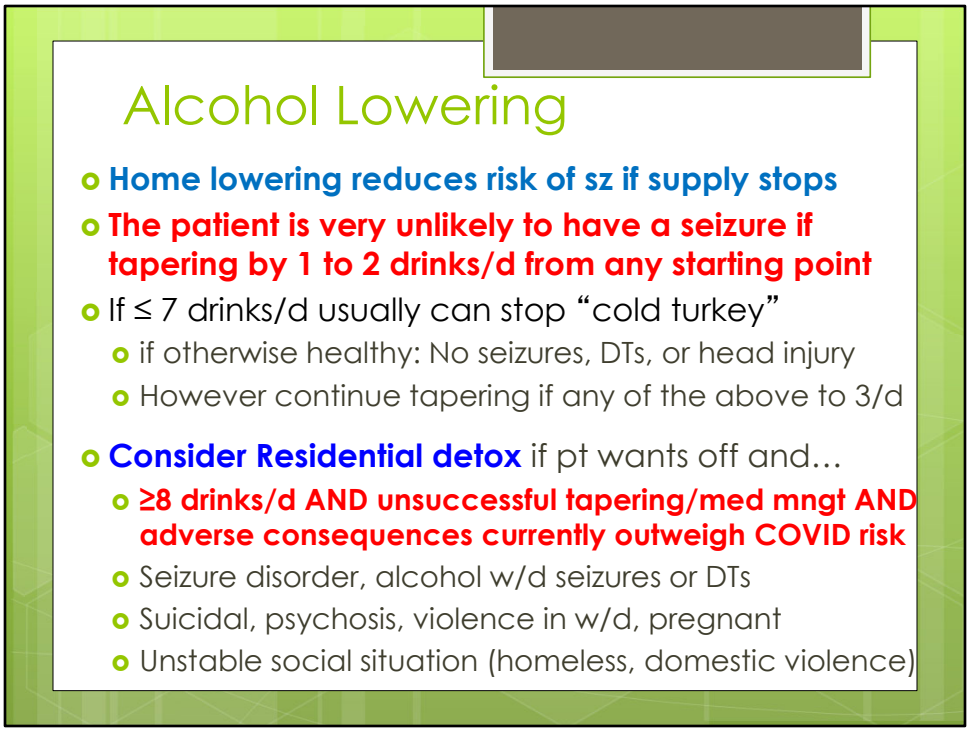
- Rice wine for cooking – high sodium
  - Seizure threshold is lowered
- If available, Managed Alcohol Program (MAP) may help

Alcohol is preferred over non-beverage alcohol

Managed Alcohol Program (MAP) may help – available in some communities

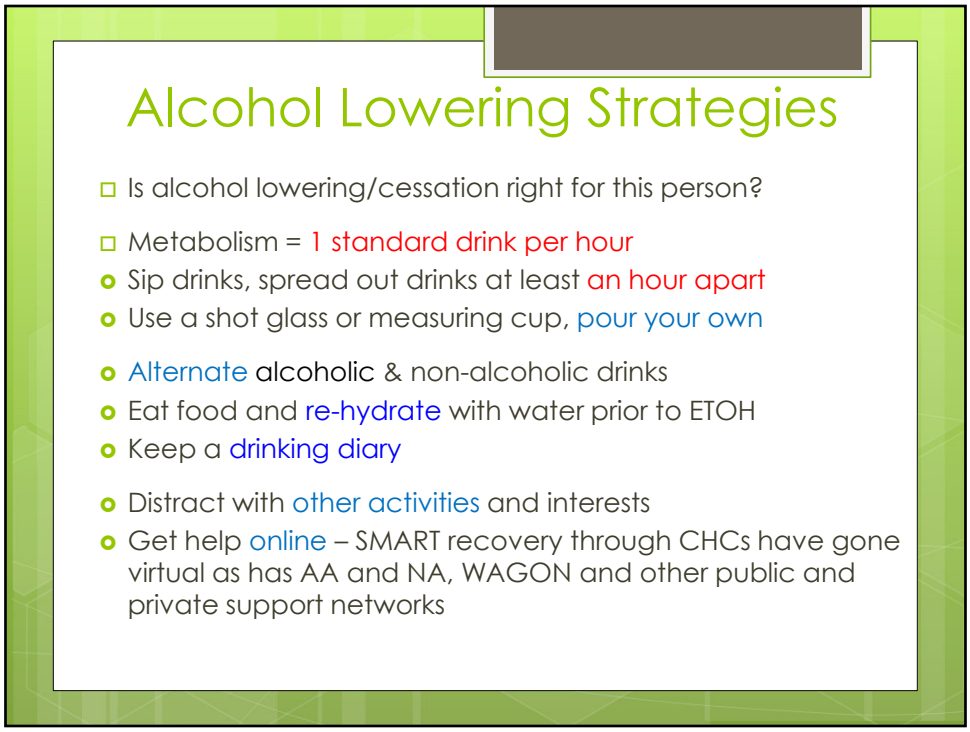


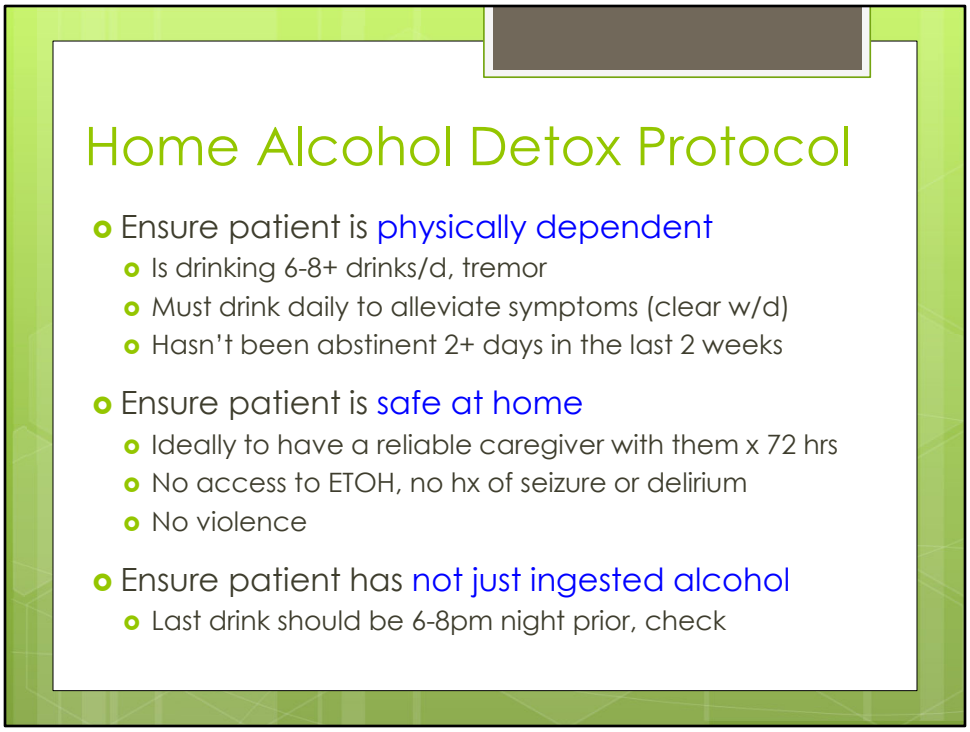
The best predictor of impending seizure is hand tremor; tongue tremor is also predictive



It is rare for someone to have a seizure if they're drinking 7 drinks or less. If they have a head injury seizures, delirium tremens target less than 4-5 drinks per day. This way, the patient can stop 'cold turkey' with minimal risk of seizure.

Reduction of drinking can reduce risk e.g. cutting down from 10 drinks a day to 5 (World Health Organization)


Alcohol Lowering Strategies
Is alcohol lowering/cessation right for this person?
Metabolism = 1 standard drink per hour
Sip drinks, spread out drinks at least an hour apart
Use a shot glass or measuring cup, pour your own
Alternate alcoholic & non-alcoholic drinks
Eat food and re-hydrate with water prior to ETOH
Keep a drinking diary
Distract with other activities and interests
Get help online – SMART recovery through CHCs have gone virtual as has AA and NA, WAGON and other public and private support networks

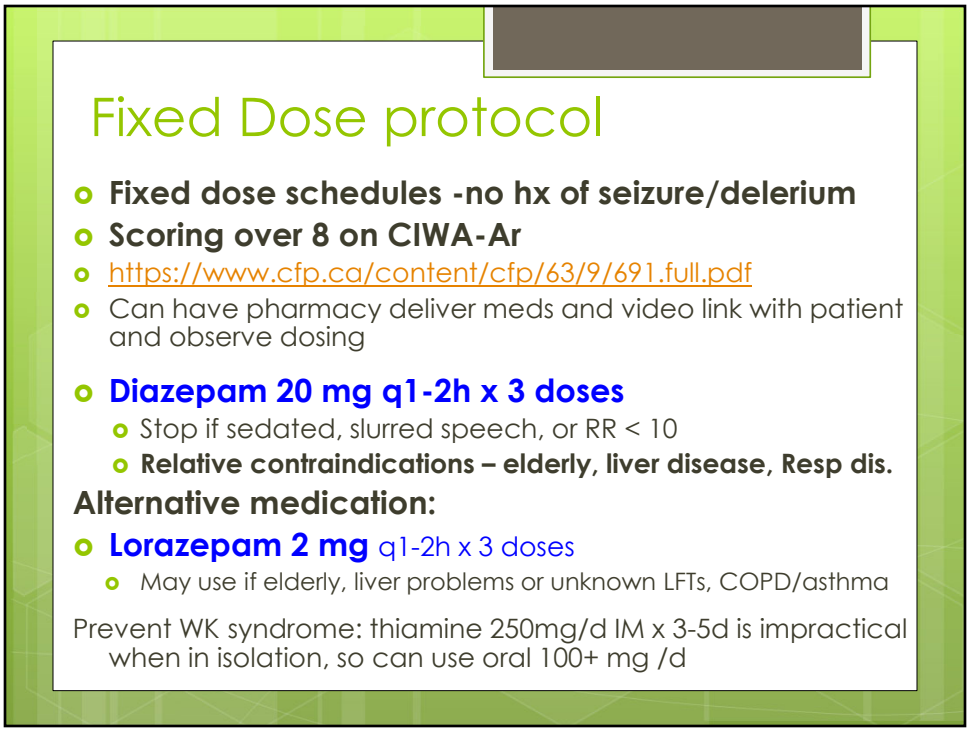


Safest option: taper by 1-2 drinks / day.

If unable to taper: consider Home Alcohol Detox Protocol

Patients who are abstinent > 2 days / week likely don't need a detox protocol

Ensure the reliable caregiver controlling the alcohol supply is not at risk of violence

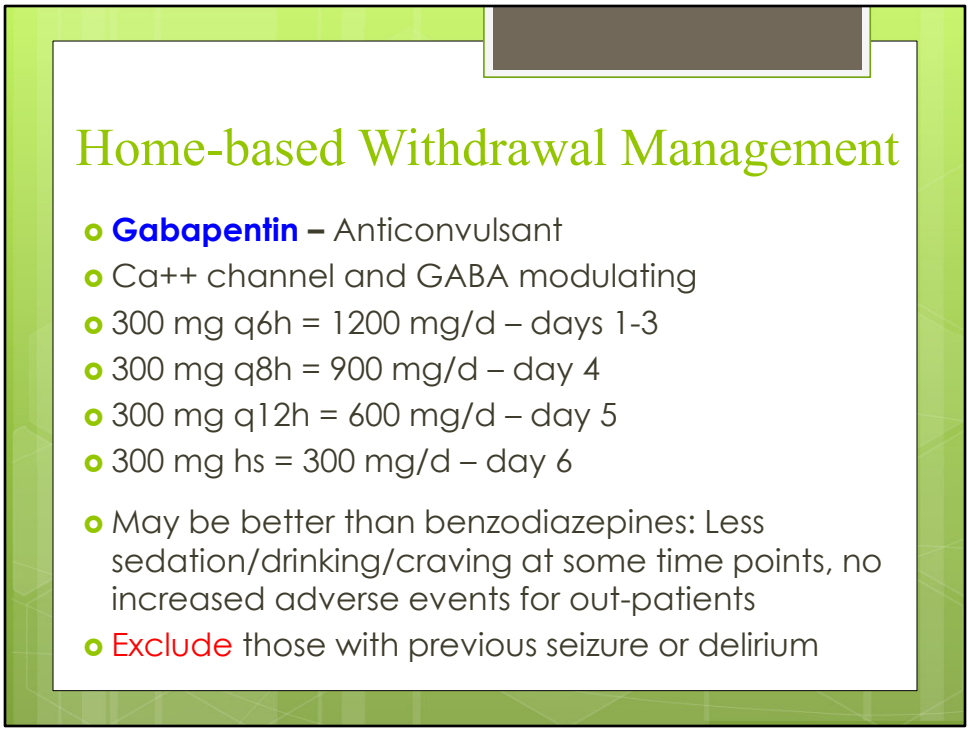


Sedation, slurred speech, and RR can be assessed over the phone

Home-based Withdrawal Mngt

Another fixed dose schedule option:

- **Diazepam 10 mg q6h x 4 doses**
  - **then 5 mg q6h x 8 doses**
  - Relative contraindications – elderly, liver disease, respiratory disease
  - Start with pt in w/d in am (CIWA >8) - tremor
  - **MD can witness first dose, reassess 2 hrs later, and adjust if needed**
- Or…Lorazepam 2mg x 4 doses then 1mg x 8 doses
- Use thiamine 250mg im x3-5d optimally, or oral 100+mg/d
- Ideally reliable caregiver must administer meds
- Caregiver must stop if sedated or pt relapses



This protocol is for detoxification. Other gabapentinoid protocols are also available.

Unlike benzodiazepines, gabapentin can be continued as a maintenance

Follow-up of Home Detox

- Ideally see the patient every day through video link
- Initial load should be enough to prevent seizure in most cases (long half life)
- May need a benzo taper – for example:
  - lorazepam 2mg tid x3d, 2mg bid x1d, 2mg hs, off
- After benzo taper, then use trazodone, nortriptyline, or gabapentin to control sleep (off-label suggestion)
- Relapse? Review strengths and triggers. Try again.

Especially prolonged sleep latency

However, in the first 5 months learlier and more REM (REM pressure thus dreams) is predictive of continued recovery!

Acaprosate also has good evidence to treat AUD. We chose not to discuss it in the talk since currently there is a worldwide shortage and thus it is typically unavailable.

Gabapentin for AUD

- **Gabapentin 600 mg q8h** – depending on response start with 300 q8h
- Ca++ channel and GABA modulating
- Significantly improves abstinence and heavy drinking rates, dysphoria, insomnia, and craving over 12 weeks
- Potential side effects – potential sedation, memory impairment, word-finding difficulty, dangerous to drink with this med since it may increase risk of OD, sleep apnea

Original Investigation

ONLINE FIRST

March 9, 2020

Efficacy of Gabapentin for the Treatment of Alcohol Use Disorder in Patients With Alcohol Withdrawal Symptoms

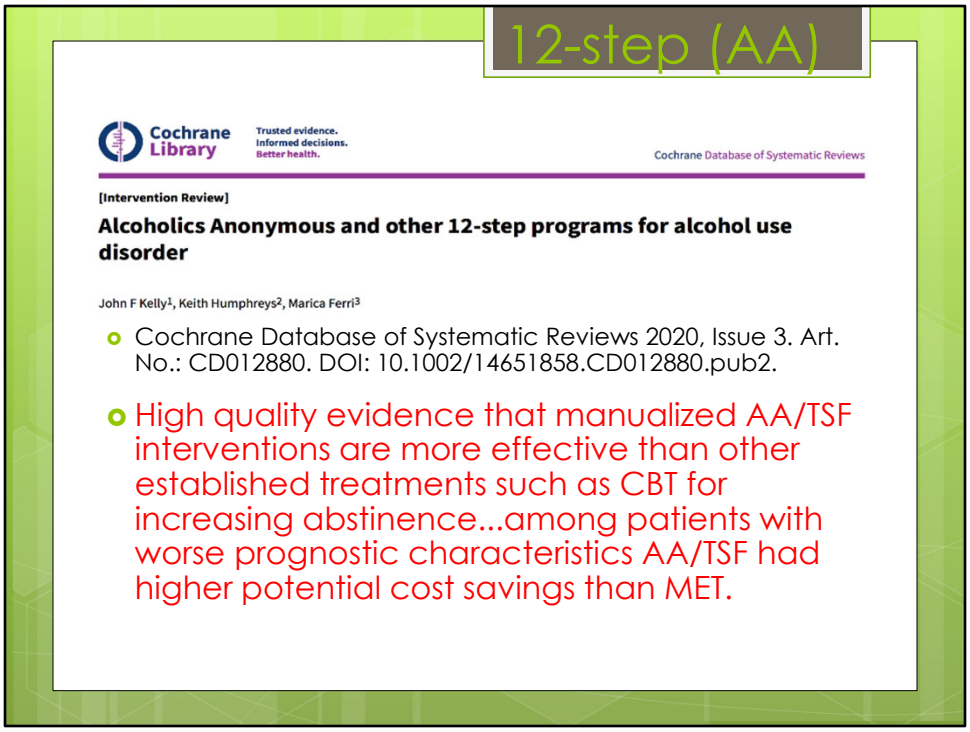
A Randomized Clinical Trial

Raymond F. Anton, MD[1]; Patricia Latham, PhD[1]; Konstantin Voronin, MD, PhD[1]; et al

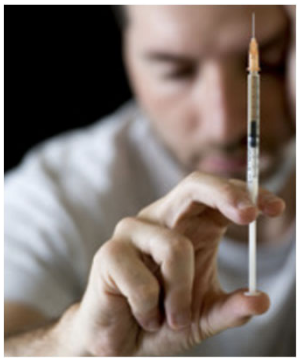
» Author Affiliations

JAMA Intern Med. Published online March 9, 2020. doi:10.1001/jamainternmed.2020.0249

Findings In this randomized clinical trial, gabapentin compared with placebo significantly increased the number of people with total abstinence and reduced drinking. This effect was most significantly observed in those with greater pretreatment alcohol withdrawal symptoms—41% of participants with high alcohol withdrawal symptoms had total abstinence on gabapentin compared with 1% of participants in the placebo arm.


12-step (AA)
Cochrane Library
Trusted evidence.
Informed decisions.
Better health.
Cochrane Database of Systematic Reviews
[Intervention Review]
Alcoholics Anonymous and other 12-step programs for alcohol use disorder
John F Kelly[1], Keith Humphreys[2], Marica Ferri[3]
Cochrane Database of Systematic Reviews 2020, Issue 3. Art. No.: CD012880. DOI: 10.1002/14651858.CD012880.pub2.
High quality evidence that manualized AA/TSF interventions are more effective than other established treatments such as CBT for increasing abstinence...among patients with worse prognostic characteristics AA/TSF had higher potential cost savings than MET.

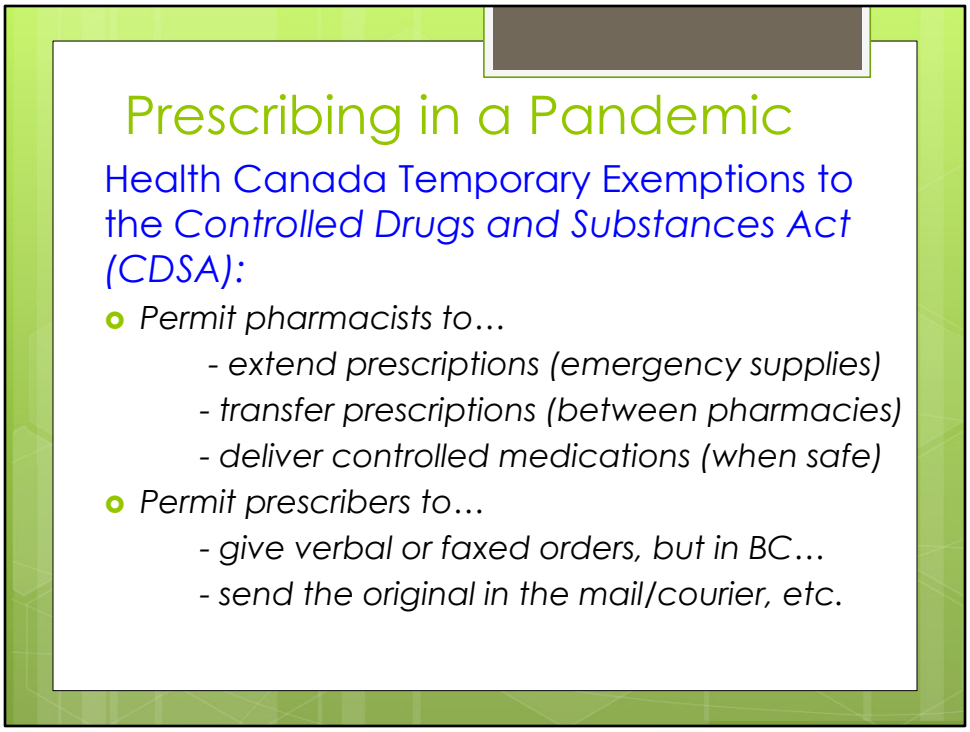
Opioids



The number 1 opioid that is recommended is buprenorphine as 2 months supply can be given since OD rates are low, so even if diverted the risk of harm is lower than other opioids. Second best is methadone, third option is morphine.

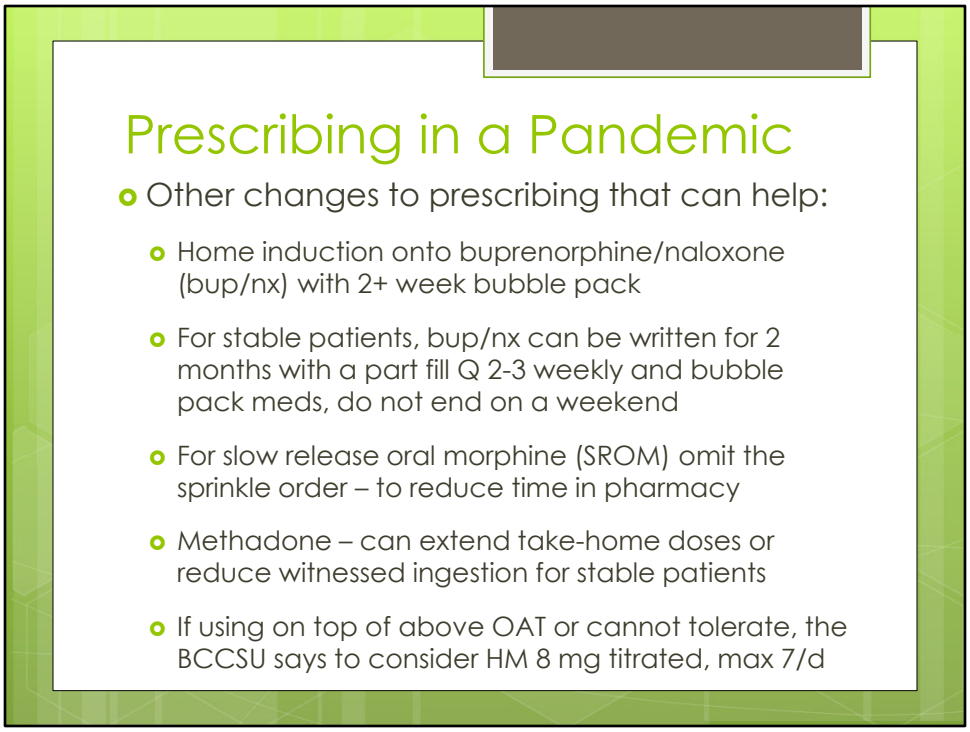
New guidelines for OUD tx among older adults:
https://cgjonline.ca/index.php/cgj/article/view/420

Injectable treatment requires 3-4 times a day visits which is too much during COVID distancing restrictions, so convert to oral treatment.



Pharmacists can extend (not change) prescriptions

Pharmacists in BC have requested a hard copy of the original prescription if it is telephoned or faxed

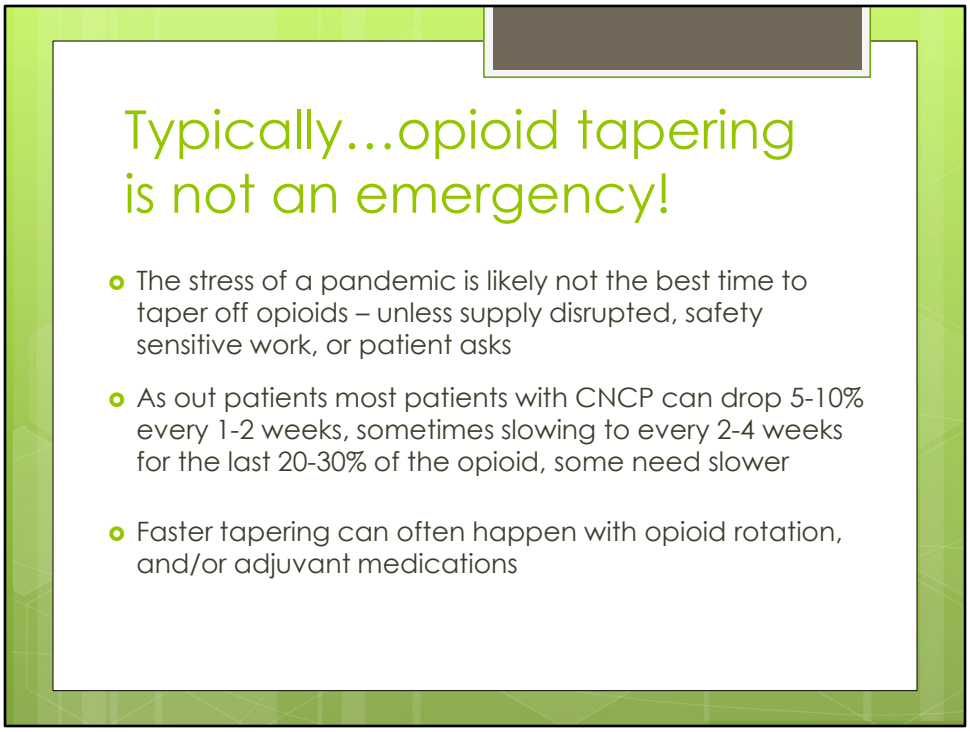


Protocol and training available on the BCCSU website

During the pandemic only, the BCCSU and stakeholders have agreed that for select patients at exceptional risk take home hydromorphone 8mg can be given. Link to a webinar on this topic is available on the BCCSU website.

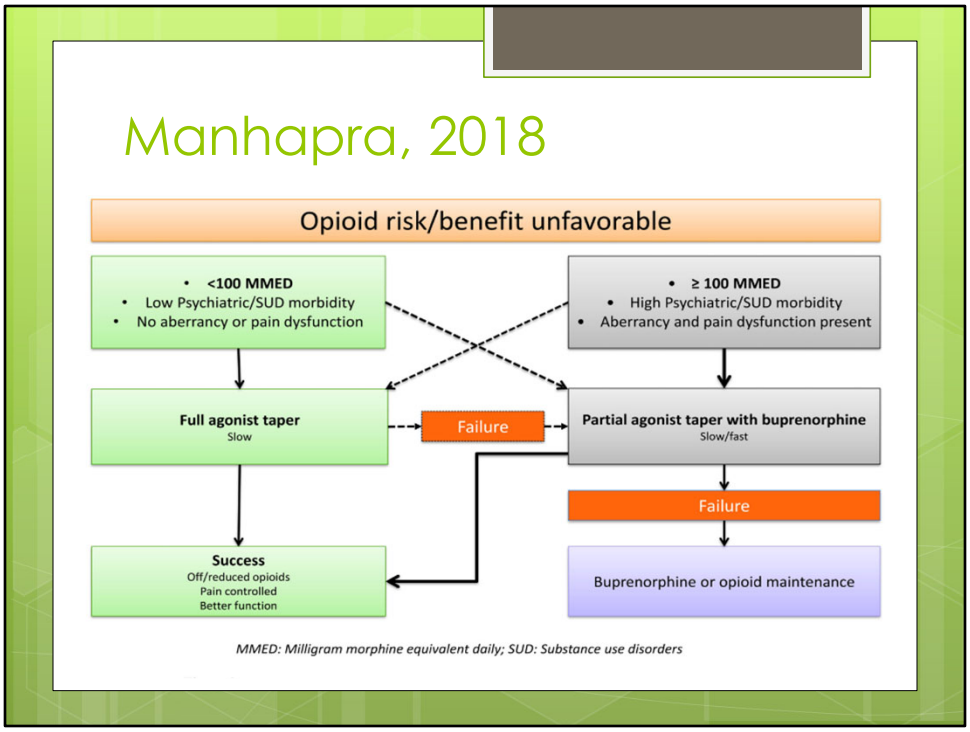
Prescribing Resources

- College of Pharmacist's COVID-19 Response https://www.bcpharmacists.org/news/bc's-covid-19-response—-temporary-authorizations-controlled-drugs-and-substances
- BC Centre on Substance Use COVID-19 information including Guidance: Risk mitigation in the context of dual public health emergencies; and a webinar on Substance use and safer supply
- https://www.bccsu.ca/covid-19/

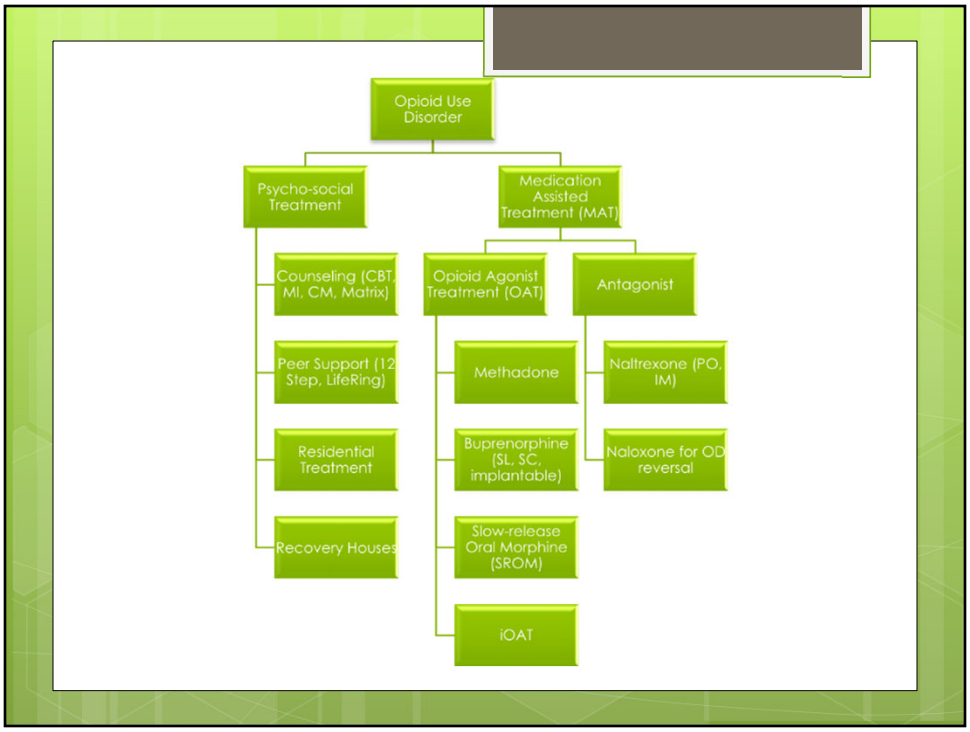

Typically…opioid tapering is not an emergency!
The stress of a pandemic is likely not the best time to taper off opioids – unless supply disrupted, safety sensitive work, or patient asks
As out patients most patients with CNCP can drop 5-10% every 1-2 weeks, sometimes slowing to every 2-4 weeks for the last 20-30% of the opioid, some need slower
Faster tapering can often happen with opioid rotation, and/or adjuvant medications

Opioid Lowering Options for those with CNCP who choose or need to lower:

1. Convert to long acting opioid – taper
2. Taper with short acting opioid
3. Withdrawal symptom management
4. Opioid substitution/rotation - taper

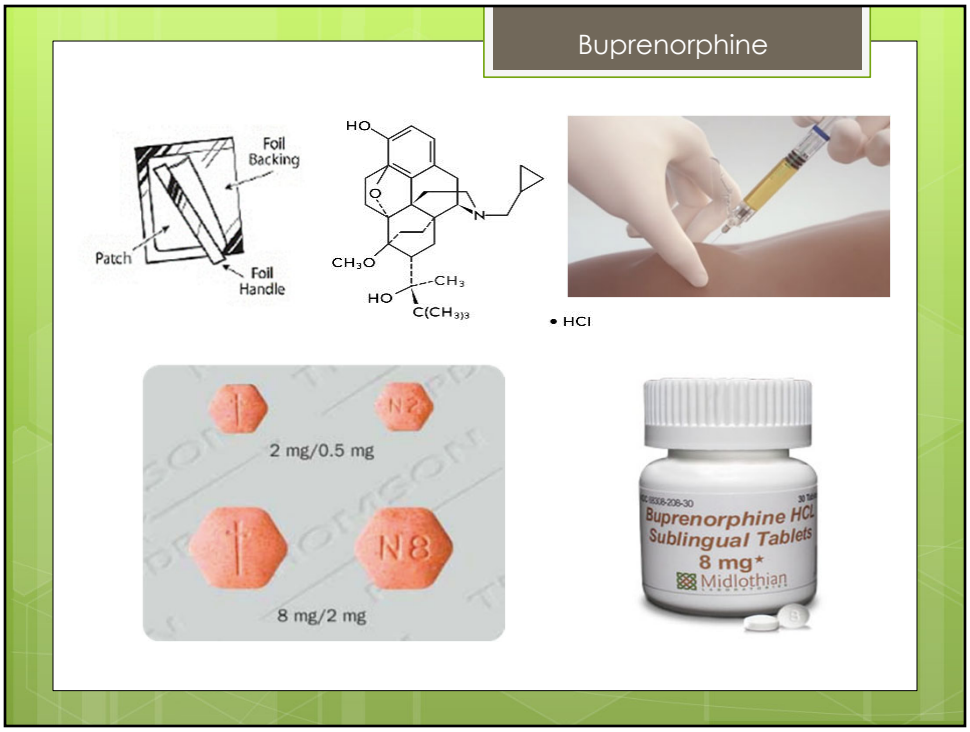


Decision tree for buprenorphine for chronic non-cancer pain (not Health Canada approved but it does have less chance of overdose and better analgesic effect than morphine)



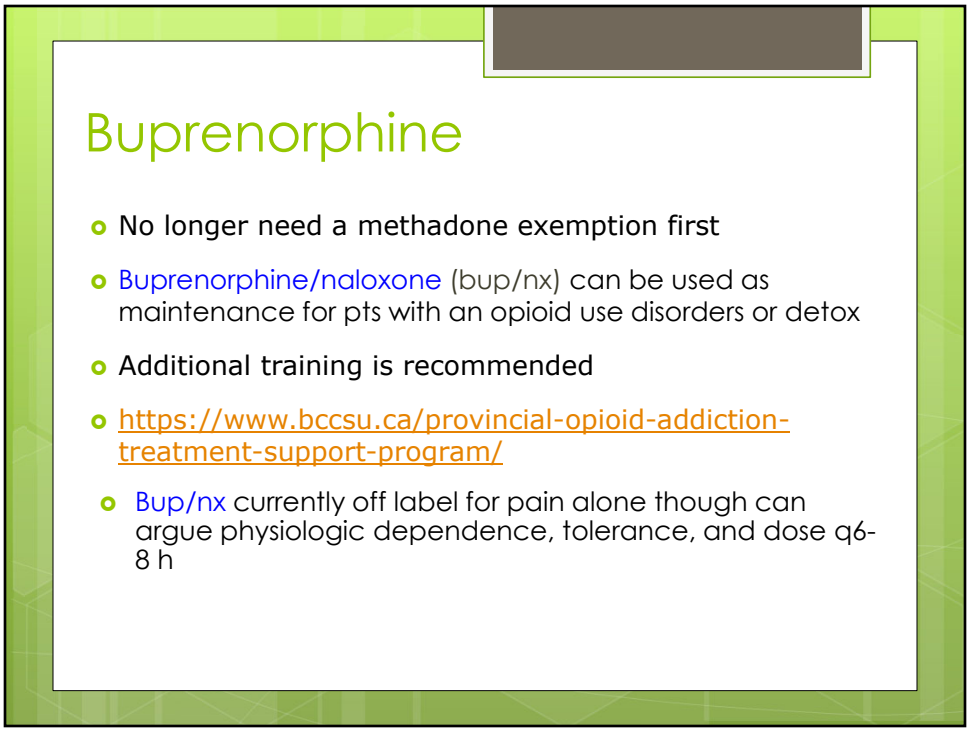
PO naltrexone: Overdose risk may be increased if intermittently taken
IM naltrexone: not covered in this webinar since it is not available currently in Canada. It is non-inferior to bup/nx in efficacy.

For those with OUD who are highly physiologically dependent and using high dose opioids – the following protocols are shared…



Forms:

- Patch – not covered on formulary but helpful bridging tool
- Sublingual
- Injection will hopefully be covered soon on formulary – a great option in a pandemic!

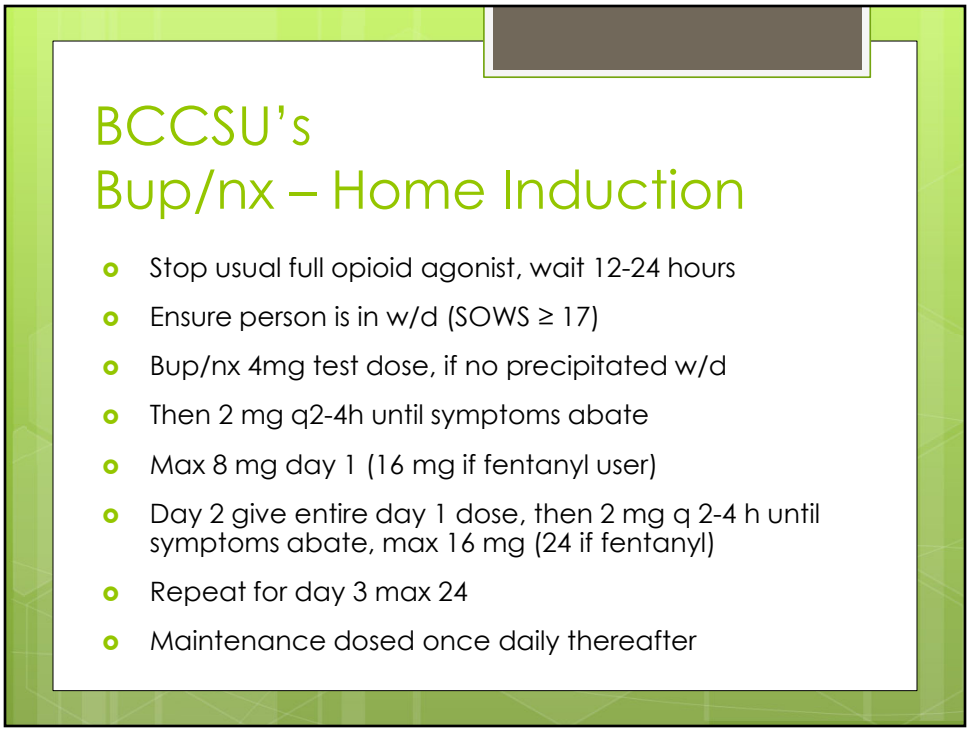

Buprenorphine
No longer need a methadone exemption first
Buprenorphine/naloxone (bup/nx) can be used as maintenance for pts with an opioid use disorders or detox
Additional training is recommended
https://www.bccsu.ca/provincial-opioid-addiction-treatment-support-program/
Bup/nx currently off label for pain alone though can argue physiologic dependence, tolerance, and dose q6-8 h

COWS

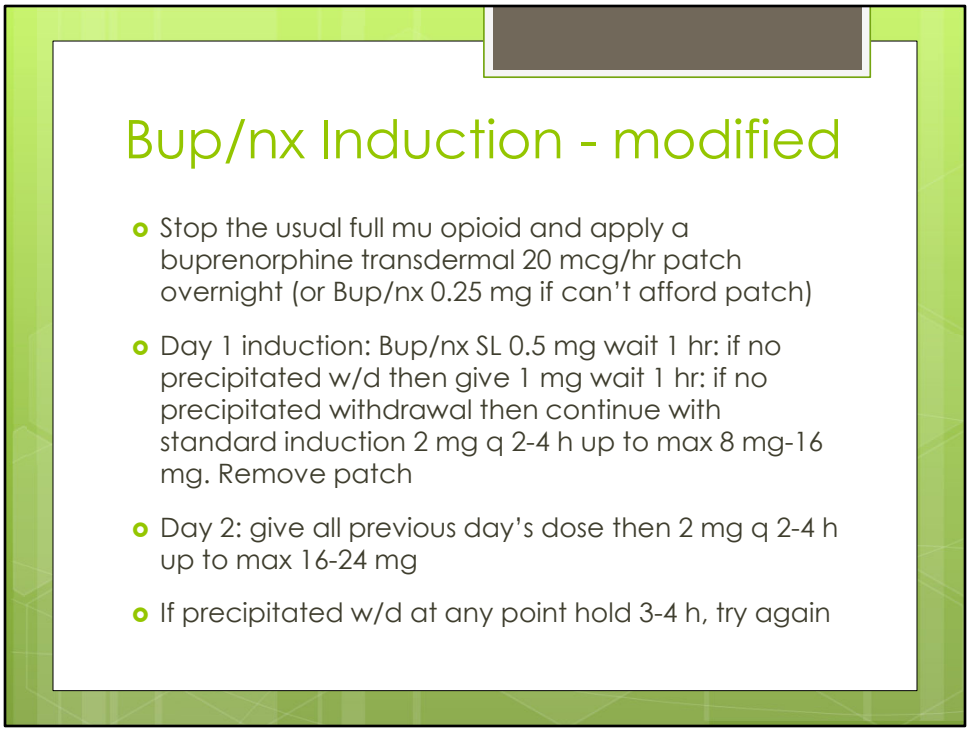
- **COWS** (Clinical Opiate Withdrawal Scale)
- Health practitioner administered
- Cows score above 13 can initiate meds – either a clonidine protocol or buprenorphine
- https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf

SOWS

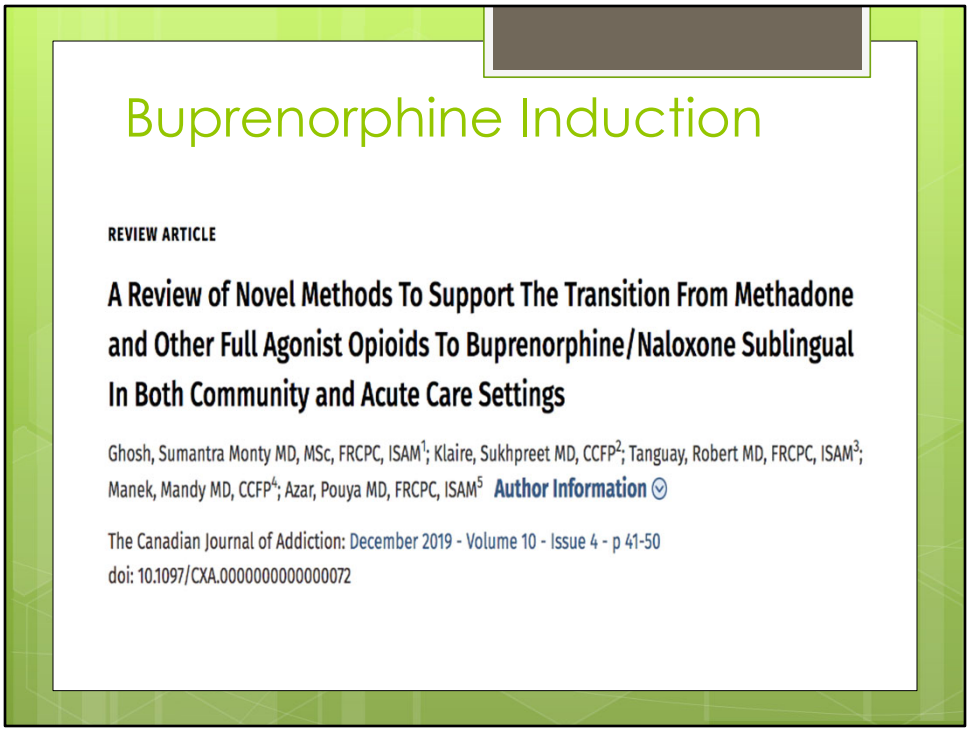
- **SOWS** (Subjective Opiate Withdrawal Scale)
- Patient administered 16 questions, 4 pts each
- Withdrawal score: mild = 1 – 10;
  Moderate = 11 – 20; and Severe = 21 – 30
- Sows score above 11 can initiate meds – either a clonidine protocol or buprenorphine
- https://www.asam.org/docs/default-source/education-docs/sows_8-28-2017.pdf?sfvrsn=f30540c2_2



The doses here are for people with high-dose opioid use disorders (not for chronic pain alone).



In clinical experience, precipitated withdrawal is rare with this modified protocol



This review contains multiple helpful protocols

New

Buprenorphine Injection

- Buprenorphine extended-release injection
- Titrate or taper bup/nx to 8 mg/d
- Loading doses: 300 mg SC x 2 months
- Maintenance dose: 100 mg SC q monthly
- Advantages: Only monthly contact with health care providers, auto-tapers over months so little to no withdrawal if supply chain disrupted. Cost may be prohibitive
- Must register www.sublocadecertification.ca


METHADONE

OAT: Methadone

- **Methadone** can be used for pts with an opioid use disorders and/or pain, and for detox
  - Dose **once daily** to eliminate withdrawal and block other opioids – may be sufficient for pain
- **Methadone used for pain typical daily dosing range is 6-40 mg split q6-8h, for OUD 60-160 OD**
- If on methadone at admission to detox centre or hospital - Lower the dose by at least 25% and give the rest in 5 mg prn doses, witnessed ingestion, hold if sedated

OAT for pts failing bup, meth

Slow release oral morphine (SROM)

- Once daily witnessed ingestion
- Typically no take home doses, exceptions may be made for stable patients in the pandemic but this will reverse once crisis over

Injectable opioid agonist treatment (iOAT)

e.g. Hydromorphone or Heroin assisted therapy (HAT)
AKA diacetyl morphine (DAM) therapy:

- 3x/d witnessed injectable heroin, often supplemented with 30-40 mg methadone HS
- Higher risk in pandemic – switch to SROM, methadone

Opioid w/d – Symptom Mngt

- Clonidine 0.1mg qidx4d, tidx1d, bidx1d, hsx1d prn
  - Test dose 0.1mg, BP pre & 1-2h post in the office can be done – OK if BP >90/60, OR if cannot leave home make sure no dizziness post dose
- Gabapentin 300 – 600 mg tid, for anxiety, insomnia, pain
- Trazodone 50 mg 1-2 tabs hs for insomnia *
- Loperamide 2 mg after loose stool, 8/d max
- Dimenhydrinate 25mg 1-2 tid N+V
- Ibuprofen 400 mg q 6-8h for pain
- Acetaminophen 500mg q6h for pain
- * Substitutions for anxiety and insomnia:
  - Quetiapine 25 mg ½ -1 bid - tid and 1-2 hs

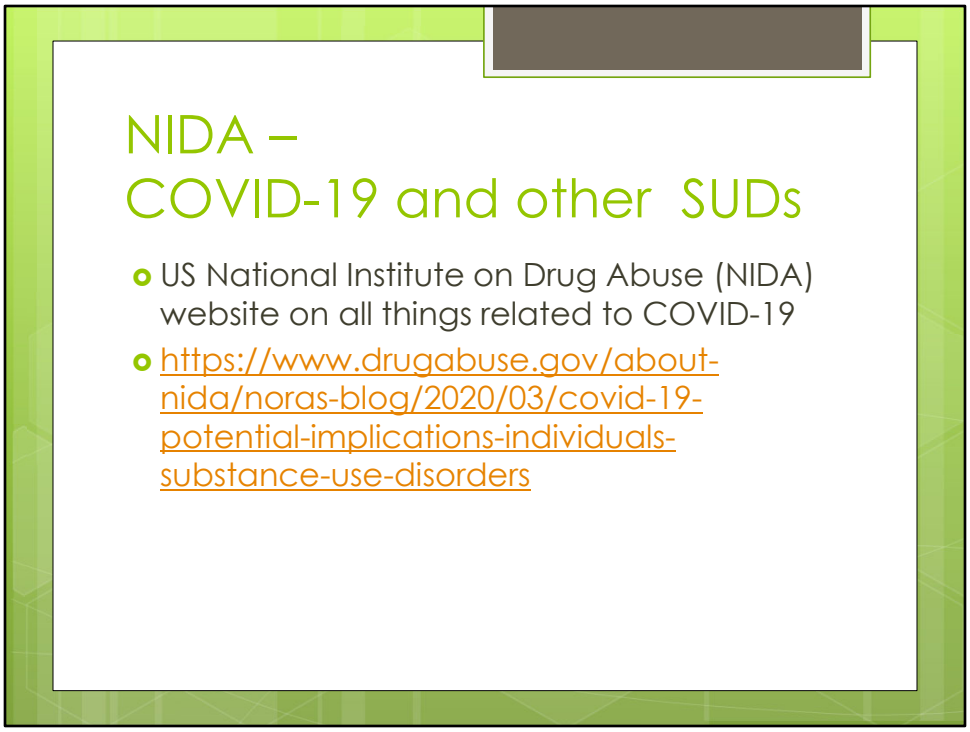
Naloxone Take Home Kits

- Nasal or injectable naloxone kits given to people prescribed opioids for pain or addiction
- Train Pt and others living with them
- Can save lives in OD situations
- Sometimes Pt uses it on a friend
- Find out what is available/allowable in your area

Should be provided to everyone

Prescribing Resources

- College of Pharmacist's COVID-19 Response https://www.bcpharmacists.org/news/bc's-covid-19-response—-temporary-authorizations-controlled-drugs-and-substances
- BC Centre on Substance Use COVID-19 information including Guidance: Risk mitigation in the context of dual public health emergencies; and a webinar on Substance use and safer supply
- https://www.bccsu.ca/covid-19/


NIDA –
COVID-19 and other SUDs
US National Institute on Drug Abuse (NIDA) website on all things related to COVID-19
https://www.drugabuse.gov/about-nida/noras-blog/2020/03/covid-19-potential-implications-individuals-substance-use-disorders

Resources for Clinicians

- **Rapid access addiction clinics (RAACs)** may be able to provide telehealth support, both consultation for prescribers and patient assessment
  - **Victoria**: 250-381-3222
  - **Vancouver**: 604-806-8867
  - **Surrey**: 604-587-3755

- **Rapid Access to Consultative Expertise (RACE)** for Addictions is available M-F 8am-5pm for additional consultation and support: http://www.raceconnect.ca/
  Local calls: 604-696-2131
  Toll free: 1-877-696-2131

OAT Resources

- **OAT Clinics Accepting New Patients:** This list may be consulted for referral, for physicians and nurse practitioners who do not have extensive experience providing addiction medicine whose patients are at risk of withdrawal. https://www.bccsu.ca/wp-content/uploads/2020/01/OAT-Clinics-Accepting-New-Patients.pdf
- **VCH:** Physician questions should be directed to the **Overdose Outreach Team (OOT).** The OOT phone line and specialist phone consultation is available 7 days per week, 8:00am to 8:00pm at 604-360-2874.

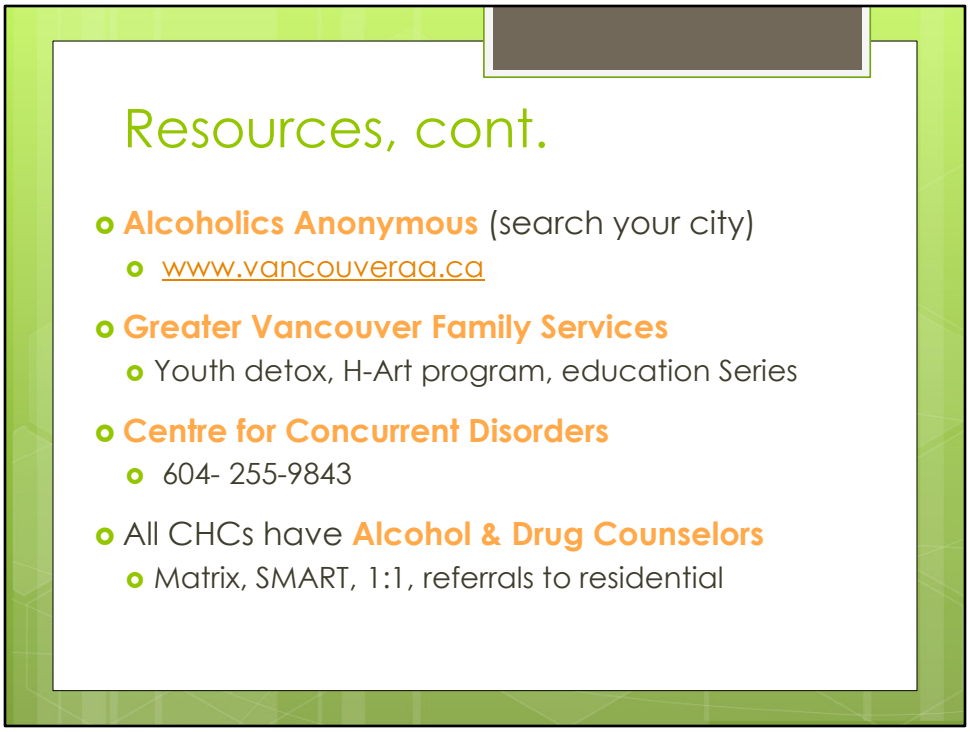
Additional Resources

- **Alcohol and Drug information and Referral Line**
  - 24 hour service
  - Lower mainland 604-660-9382
  - BC Province wide 1-800-663-1441
- **Inform Line** 604-875-6381 or just **211**
  - 24 hour service
  - Fraser Health and Vancouver Coastal Health Regions

Resources, cont.

- **The Red Book Online**
  - www2.vpl.vancouver.bc.ca/DBs/Redbook/htmlpages/home.html
  - Type in key words and pick "entire record"
  - Community, government, social services in LML

- **Access Central** 1-866-658-1221
  - Detox and addiction housing services for VCH
  - Calls returned same or next day, wait 1-7d
  - Vancouver detox, Cordova detox, Daytox



Alcoholics Anonymous has gone virtual during COVID


Online resources
BCCSU Resources for patients, clinicians, families
https://www.bccsu.ca/resources/
Bounce Back BC – free online skill building for stress, and mild-mod anxiety/depression
https://bouncebackbc.ca/
Yoga with Adriene – free yoga + meditation
https://www.youtube.com/user/yogawithadriene
Beach Body - $99/year – hundreds of workouts
https://www.beachbodyondemand.com/plans
Lots of Apps – Headspace, free CBTi (for insomnia), etc.

Treatment Centres - examples

Publically funded provincial facilities:

- Heartwood Centre: Highest detox, women
- Pacifica: men and women
- Maple Ridge Treatment Centre: M & W
- Peardonville House: takes women & children
- Burnaby Centre: Severe concurrent disorder
- Harbor Light – men – Salvation Army

Numerous private facilities in BC

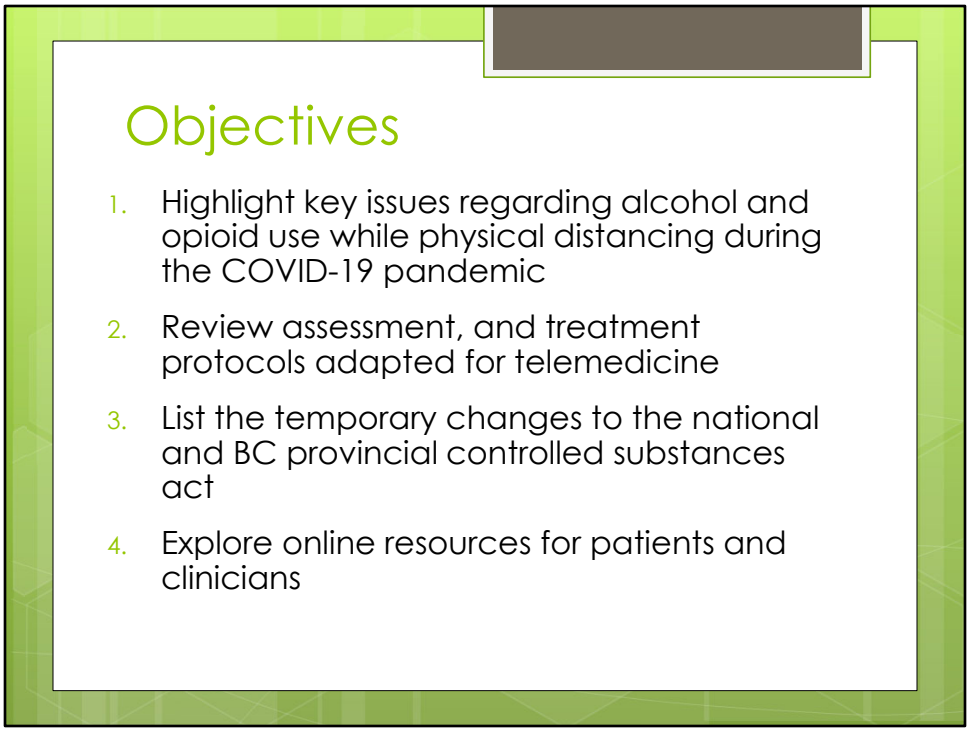
Together We Can, and Central City Lodge are 2 other examples of Recovery houses.

Out of Province Resources

- **Homewood** in Guelph, Ontario
  - Concurrent eating disorder and SUD
  - Health Care professionals
- **Bellwood** in Toronto, Ontario
  - Sexual addiction +/- SUD
  - Gambling addiction
- For either you must write a letter to MSP in Victoria for special consideration

Additional References

- Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.
- This site provides the CIWA form: https://umem.org/files/uploads/1104212257_**CIWA-Ar**.pdf
- This site calculates the CIWA – Ar online for you www.mdcalc.com/**ciwa**-**ar**-for-alcohol-withdrawal/
- Maldonado JR, et al. The "Prediction of Alcohol Withdrawal Severity Scale" (PAWSS): Systematic literature review and pilot study of a new scale for the prediction of complicated alcohol withdrawal syndrome. Alcohol 48 (2014) 375e390


Objectives
1. Highlight key issues regarding alcohol and opioid use while physical distancing during the COVID-19 pandemic
2. Review assessment, and treatment protocols adapted for telemedicine
3. List the temporary changes to the national and BC provincial controlled substances act
4. Explore online resources for patients and clinicians

Thank you!