

## **COMMUNITY BUPRENORPHINE PRESCRIBING IN OPIATE DEPENDENCE**

### **INTRODUCTION**

High dose sublingual buprenorphine (Subutex) tablets are available in the following strengths – 0.4 mg, 2 mg, and 8 mg. Suboxone tablets, a combination of buprenorphine and naloxone, are available in preparations containing buprenorphine and naloxone in the following ratios; 2mg:0.5mg and 8mg:2mg. Subutex is licensed for the treatment of opiate dependence in individuals over 16 years of age, Suboxone is licensed for the treatment of opiate dependence in individuals over 15 years of age, however, manufacturers advise to use with caution in the age group 15-18, due to the lack of data on adolescents. High dose buprenorphine is effective in the treatment of opiate dependence as it substitutes for other opiates (thereby blocking withdrawal effects), reduces the effect of additional opiates and can be given once daily (or less at higher doses). Buprenorphine may be safer in overdose and is less sedating than methadone. Side effects are usually mild. Headaches are commonly reported as are symptoms of opiate toxicity and withdrawal.

Withdrawal on stopping treatment is similar but often milder than with other opiates, though withdrawal symptoms may last up to several weeks.

We recommend given the high level of support, structure and observation required that opiate detoxification using buprenorphine is undertaken at the Intensive Daily Treatment Service (IDTS). Very stable patients with low degree of dependency and good social support may be detoxified in outpatients. If outpatient detoxification is unsuccessful they should be referred to the IDTS

### **Indications for Buprenorphine**

- Opiate dependence
- Subutex: Over 16 years of age
- Suboxone: Over 15 years of age

### **Precautions**

- Polydrug use especially benzodiazepines and alcohol (increased risk of overdose which can be fatal)
- Chronic pain
- Severe psychiatric illness
- Methadone maintenance at doses of methadone > 40 mg (increased risk of precipitated withdrawal but see later)

### **Contraindications**

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- Pregnancy
- Breast feeding
- Severe hepatic/respiratory insufficiency
- Acute alcoholism or delirium tremens

### Uses

- Detoxification from illicit opiates
- Detoxification from methadone
- Maintenance treatment in opiate dependence (not currently recommended locally because of the lack of supervised consumption at community pharmacies).

### Principles

- To prevent withdrawal symptoms the first dose of buprenorphine should (ideally) be given at least 6 hours after the last dose of heroin and 24 hours after the last dose of methadone.
- If transferring from methadone to buprenorphine reduce the dose of methadone to as low as possible - definitely < 40 mg methadone and preferably less than 30mg daily. At doses of methadone higher than this there is a significant risk of precipitating a mild to moderate withdrawal syndrome as buprenorphine displaces methadone at receptor sites.
- Symptomatic medication e.g. lofexidine, ibuprofen etc (see later) can be used to relieve any withdrawal in the first 1-2 days after switching from other opiates to buprenorphine.
- The first dose should be 4-6 mg. The second dose is variable depending on pre buprenorphine opiate use, degree of dependence and dose response.
- Where possible all consumption during a detoxification should be supervised.

### DETOXIFICATION DOSAGE GUIDELINES

The following is for guidance only. Daily dosage and detoxification length can be altered according to clinical response and daily objective assessment of withdrawal symptoms both clinical assessment and by using the Objective Opiate Withdrawal Scale (OOWS – see next page).

Ideally detoxification should begin on a Monday. Dose reduction should stop over weekends and bank holidays.

Buprenorphine can be prescribed as either Subutex or Suboxone depending on individual preference/dose etc. Take out doses should be with Suboxone if doses are 2mg or above.

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### OPIATE WITHDRAWAL SIGNS AND SYMPTOMS

Objective Signs (observable and not easily feigned)	Subjective Symptoms (not directly observable and easily feigned)
• Increased blood pressure	• Nausea
• Increased pulse rate	• Muscle (bone) aches
• Increased temperature	• Abdominal (stomach) cramps
• Piloerection (goose flesh)	• Irritability
• Increased pupil size	• Anorexia
• Rhinorrhea	• Weakness/tiredness
• Lacrimation	• Restlessness
• Tremor	• Headache
• Insomnia (Not Self-Report)	• Dizziness/light headedness
• Diarrhoea	• Sneezing
• Vomiting (sometimes may be self – induced)	• Hot or cold flashes
	• Drug craving

### THE OBJECTIVE OPIOID WITHDRAWAL SCALE (OOWS)

- Observe the patient for 5 minutes
- Indicate a score for each of the withdrawal signs listed below
- Add the scores for each item to obtain a total

**Patient name**

**Date**

	SIGN	MEASURES	SCORE
1	Yawning	0 = no yawns    1 = $\geq 1$ yawn	
2	Rhinorrhea	0 = < 3 sniffs    1 = $\geq 3$ sniffs	
3	Piloerection	0 = absent    1 = present	
4	Perspiration	0 = absent    1 = present	
5	Lacrimation	0 = absent    1 = present	
6	Tremor (hands)	0 = absent    1 = present	
7	Mydriasis (dilated pupils)	0 = absent    1 = $\geq 3$ mm	
8	Hot & cold flushes	0 = absent    1 = shivering/huddling for warmth	
9	Restlessness	0 = absent    1 = frequent shifts of position	
10	Vomiting	0 = absent    1 = present	
11	Muscle twitches	0 = absent    1 = present	
12	Abdominal cramps	0 = absent    1 = holding stomach	
13	Anxiety	0 = absent    1 = mild-severe	
<b>TOTAL SCORE</b>			

(Handelsman et al 1987)

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<b>Titration Phase</b> (indicative)			
<b>Total Daily Dose of Buprenorphine</b>			
<b>Week</b>	<b>Day</b>	<b>Crossover from methadone 30 mg or heroin £30 daily</b>	<b>Crossover from methadone 20 mg or heroin £20 daily</b>
1	1(Monday)	4-6 mg morning (+2 mg at 4 pm if required)	4 mg (+2 mg at 4 pm if required)
	2	6-10 mg	6-8 mg
	3	6-12 mg	6-8 mg
	4	6-12 mg	6-8 mg
	5	6-12 mg	6-8 mg
<b>Continue Friday dose over the weekend</b>			

<b>Withdrawal Phase</b> (indicative)	
<b>Withdrawal from 8 mg Buprenorphine</b>	<b>Withdrawal from 6 mg Buprenorphine</b>
Reduce dose by 2 mg every 2-4 days until dose is 2 mg daily	
then	
Reduce dose by 0.4 mg every 2-4 days until 0	

The patient should be assessed regularly throughout. The rate of titration and/or withdrawal can be either speeded up or slowed down depending on clinical response

In the event of breakthrough withdrawal symptoms consider the following

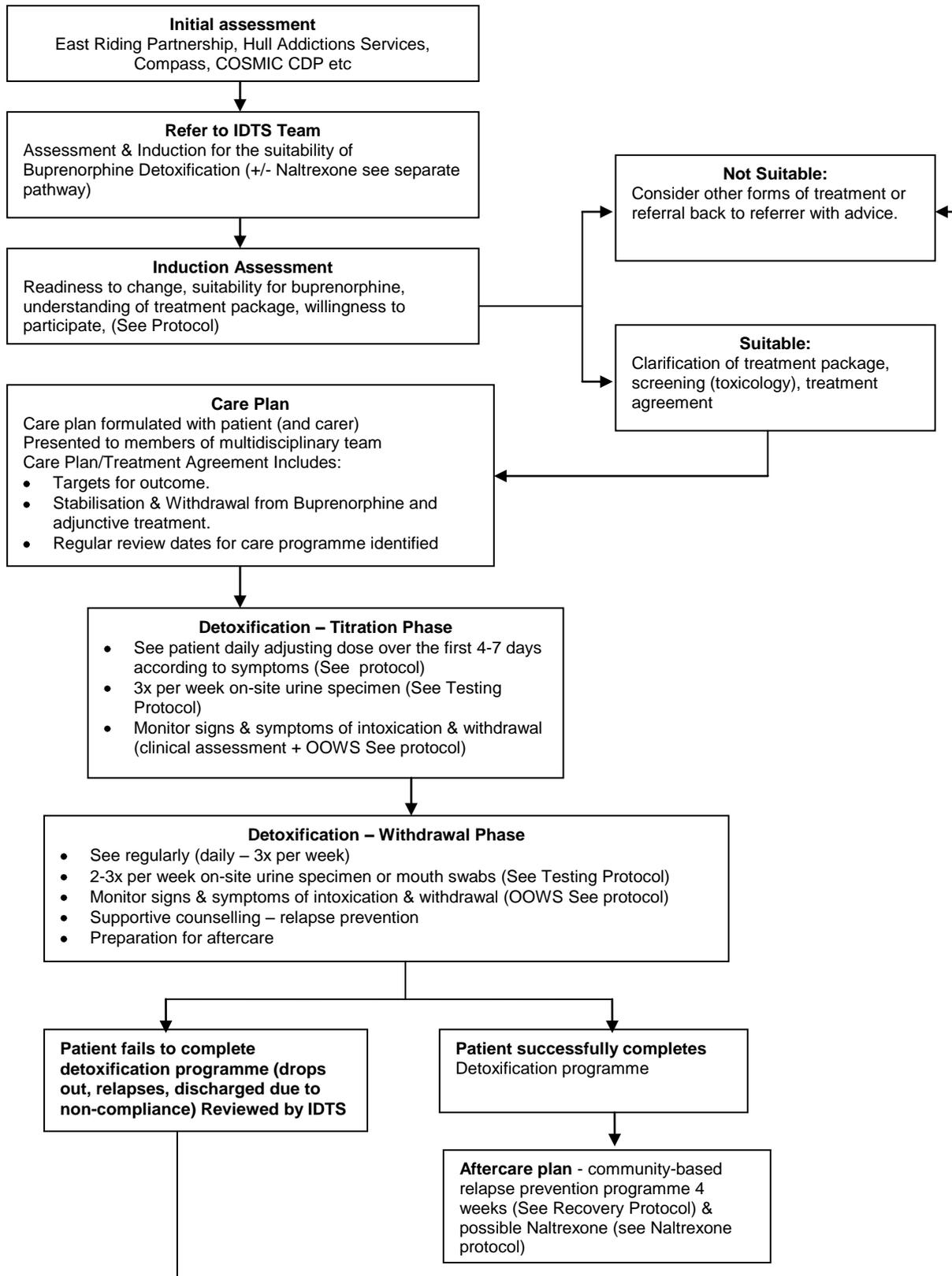
- Slow down the rate of dose reduction  
and/or
- Prescribe a small dose of lofexidine (e.g. 0.2mg tds) for 2-5 days  
and/or
- Prescribe symptomatic treatment as follows

Abdominal cramps	-	Hyoscine butylbromide 20 mg tds prn
Diarrhoea	-	Loperamide 2 mg prn up to qds
Muscle/joint pains	-	Ibuprofen 200-400 mg tds/qds prn
Insomnia	-	Trazodone 50-100 mg at night

Naltrexone can be initiated 4 days after the last dose of buprenorphine provided no other opiates have been taken in the previous seven days (see Naltrexone Protocol).

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## Care Pathway: IDTS Community Buprenorphine Detoxification



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### References/Further Reading

Lintzeris N et al. National Clinical Guidelines and Procedures for the use of Buprenorphine in the Treatment of Heroin Dependence. Australia March 2001