

CASE #1: FENTANYL TO METHADONE (INPATIENT)

This case study explores the initiation of methadone for a perinatal patient with OUD (Opioid Use Disorder) who has never previously engaged in treatment.



PATIENT

Patient is 25 yo G3P1011 at approx 26 weeks gestation, presents to OBED with concern for contractions.

ASSESSMENT

On admission, RN utilizes the validated 5Ps screening tool. Patient reports using 20-25 “blues”/day, last one 8-10 hours ago. Patient trying to “detox at home” but started having contractions, so came in.

Q & A

Q: What are “blues”?

Q: What are next steps?

Q: Who in your hospital would you call for help/consult?

Q: Where is your local OTP/methadone clinic?

Q: What are benefits of methadone initiation during labor?

A: Methadone effectively manages withdrawal symptoms, promoting maternal comfort and potentially improving labor outcomes.

Q: Why is methadone preferred over buprenorphine?

A: Patients with illicit fentanyl use may find starting treatment with methadone easier than buprenorphine. Methadone is beneficial in that it can be started right away, without a waiting period to prevent precipitating withdrawal.

Q: Can we give methadone in the hospital birthing unit?

A: Yes. Methadone can be provided throughout the entire birthing admission, as treatment of OUD is incidental to the reason for admission.

Q: Can methadone be provided on discharge?

A: Yes, up to a 72 hour supply of methadone can be sent home with the patient at discharge, to allow time for engagement with an OTP clinic for continued treatment.

Q: Can we administer other pharmacologic agents to manage her withdrawal, in addition to starting the methadone?

A: Yes, methadone is typically started at a conservative daily dose of 30-50 mg, then increased by 10 mg per day. Some patients with illicit fentanyl use will feel better faster with additional agents to treat withdrawal symptoms, including the addition of other opioids. Options include oral hydromorphone or oxycodone, +/- morphine extended release.

You may also offer nonopioid options such as clonidine, hydroxyzine, ondansetron, dicyclomine, trazodone, acetaminophen, gabapentin and promethazine as needed to provide relief with withdrawal and more comfort.

RESOURCES



SCAN FOR
MOMS+
METHADONE
ORDER
PATHWAY

SCAN FOR MOMS+
LEGAL AND
REGULATORY
CONSIDERATIONS
OF HOSPITAL OUD
TREATMENT



SCAN FOR
MOMS+ FULL
TOOLKIT OF
EDUCATIONAL
RESOURCES AND
ORDER
PATHWAYS

MOMS +

(Maternal Overdose Matters)

METHADONE INITIATION PLAN

Day 1:

Give Methadone 30 mg orally once now.

- Reassess in 4 hours. If no sedation and/or continued withdrawal, give another 10 mg.
- Reassess in 4 hours. If no sedation and/or continued withdrawal, give another 10 mg.
- May give up to a total of 50 mg on day 1, per updated regulation.
- May give supplemental opioid medication (oral oxycodone, hydromorphone).
- May give nonopioid adjuvants.

Day 2:

Give Methadone 40-50 mg orally once.

- Reassess in 4 hours. If no sedation and/or continued withdrawal, give another 10 mg.
- Additional opioids/adjuvants PRN.
- Discuss plans for medication, additional labs, resources not completed on intake.
- Order take-home naloxone and provide training.

Day 3:

Give Methadone 50-60 mg orally once now.

- Reassess in 4 hours. If no sedation and/or continued withdrawal, give another 10 mg.
- Prepare for discharge. Connect patient to your local OTP for same-day or next-day intake.
- If there is to be a gap between discharge and OTP intake, consider dispensing a 72-hour supply of methadone to ensure continuity of treatment.

<https://tinyurl.com/comomsmethadoneinpatient>

ADJUNCT TREATMENTS (+/-)

- Clonidine 0.1 mg orally q4h PRN restlessness, hot/cold flashes or anxiety
- Hydroxyzine 25-50 mg orally q6h PRN anxiety or insomnia
- Ondansetron 4 mg orally q6h PRN nausea
- Dicyclomine 10 mg orally TID PRN abdominal cramping
- Trazodone 50-100 mg orally qHS PRN insomnia
- Acetaminophen 500-1000 mg orally q6h PRN headache or pain
- Gabapentin 300 mg orally TID PRN restless legs, anxiety, agitation
- Promethazine 12.5-25 mg orally q6h PRN nausea (if preferred to ondansetron, or not having success with ondansetron)