CASE # 3: FENTANYL TO BUPRENORPHINE (INPATIENT)

This case study explores the management of a patient with Opioid Use Disorder (OUD) during childbirth who is not currently taking MOUD (Medication for Opioid Use Disorder).

PATIENT

25 yo G3P1011 at 26 weeks gestation, admitted to hospital for abdominal discomfort, N/V, with history of OUD.

ASSESSMENT AND TREATMENT

On admission, RN utilizes the validated AUDIT C+2 screening tool. Patient reports using fentanyl 20-25 pills or fentanyl powder per day, last use was 10 hours ago. She is currently reporting nausea, chills, HR 115. She expresses significant fear of withdrawal. In addition, she wants to start on MOUD treatment, with a strong preference for buprenorphine (no OTP in her area).

Q & A

Q: What is the most likely cause of her symptoms?
Q: What are next steps?
Q: Who in your hospital would you call for help/consult?
Q: How do you start buprenorphine from fentanyl use?

Q: What are your concerns with transitioning her from fentanyl to buprenorphine?

A: Fentanyl is a full agonist opioid, while buprenorphine is a partial agonist opioid. With fentanyl still in her system (due to chronic use), starting buprenorphine abruptly may put her into significant precipitated withdrawal.

Q: How do you address the "opioid deficit" of withdrawal to buy yourself time to start buprenorphine?

A: Replace her full agonist (illicit fentanyl) with a full agonist opioid agent. Options include methadone, hydromorphone, oxycodone.

Q: How do you start the buprenorphine?

A: Using a low-dose (or micro) titration method, start day 1 with a small dose of buprenorphine, then increase over 5-7 days to target dose. Continue full agonist opioid.

Q: What if the patient still experiences withdrawal?

A: Use adjuvant nonopioid medications. They will not mask moderate-to-severe opioid withdrawal, but will help support the patient with specific symptoms (N/V, muscle cramps, pain, sleep, diarrhea). However, they are NOT a substitute for full agonist opioid initiation or deficit management.

Q: What about polypharmacy concerns?

A: Some providers will end up giving multiple different adjuvants, all with their own and synergistic side effects, in an attempt to avoid/minimize giving full agonist opioids. Don't fall for this trick! Opioid withdrawal is treated with opioids, adjuvants are just that: add-ons to the main therapy, not a stand-alone treatment.

RESOURCES

SCAN FOR MOMS+ INPATIENT BUPRENORPHINE ORDER PATHWAY

SCAN FOR MOMS+ PATIENT FACING NOWS GUIDE

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

MOMs

(Maternal Overdose Matters)

BUPRENORPHINE INITIATION PLAN

Address the "opioid deficit" of withdrawal to buy yourself time to start buprenorphine via a 3-part medication plan.

Part 1: Full Agonist Opioid
Compared to outpatient setting in which patient will continue use of full agonist (fentanyl) themselves in order to successfully follow low-dose buprenorphine titration, when patient is in the hospital and no longer using fentanyl, it must be replaced in order to successfully utilize a low-dose buprenorphine protocol. Options include:

- Methadone
- Hydromorphone
- Oxycodone
- MS Contin

Part 2: Low-Dose Buprenorphine Titration and continue the full agonist

- Day 1: 0.5 mg buprenorphine SL q 6 hr
- Day 2: 1 mg buprenorphine SL q 6 hr
- Day 3: 2 mg buprenorphine SL q 6 hr
- Day 4: 4 mg buprenorphine SL q 6 hr
- Day 5: 8 mg buprenorphine SL TID to QID (*stop full agonist opioid*)

Can go quicker in the hospital, since can always give additional full agonist opioids, adjuvant meds, etc to treat through any mild precipitated withdrawal

Part 3: Adjuvant Meds

- Clonidine, hydroxyzine, ondansetron, dicyclomine, trazodone, acetaminophen, gabapentin and promethazine as needed to provide relief with withdrawal and more comfort.
- Will not mask moderate to severe opioid withdrawal
- Will help support patients with specific symptoms (nausea, muscle cramps, pain, sleep, etc)
- Not a substitute for full agonist opioid initiation or deficit management
- Pitfall: polypharmacy

Day 5: Patient stabilized on 8 mg SL TID, ready to go home!
Ideally, you have been able to use time in hospital to explore and connect with additional treatment plans and recovery resources:

- Residential, IOP, sober living, community groups
- Peer Support Specialist/Peer Recovery Doula
- Nicotine cessation plan (if applicable)
- Clear plan for follow up for prenatal care, with appt scheduled
- Clear plan for follow up for buprenorphine prescription (with prenatal care provider? Other?)

Ensure patient is very clear on who to call to access resource, is scheduled with an appt, and has been provided with take-home naloxone and overdose prevention education.

MOMs +

(Maternal Overdose Matters)