

Diagnose Substance Use Disorder (DSM-5)

Impaired CONTROL	<ol style="list-style-type: none"> 1. Larger amounts/longer periods of time 2. Repeated attempts to quit/control use 3. Much time spent using drug 4. Cravings, urges 	<p>5 "C's"</p> <p>Control</p> <p>Cut back</p> <p>Cravings</p> <p>Compulsion</p> <p>Consequences</p> <p>Mild = 2-3</p> <p>Moderate = 4-5</p> <p>Severe = 6+</p>
SOCIAL Impairment	<ol style="list-style-type: none"> 5. Activities given up to use 6. Neglected major roles 7. Interpersonal problems related to use 	
RISKY USE	<ol style="list-style-type: none"> 8. Hazardous use 9. Use despite knowledge of physical/psychological problems 	
Pharmacologic Criteria	<ol style="list-style-type: none"> 10. Withdrawal 11. Tolerance 	

FDA-Approved Medications for AUD

	DISULFIRAM	ACAMPROSATE	NALTREXONE	VIVITROL
Dosage	250-500mg/day	1996mg/day	50mg/day	380mg/month intramuscular
Most common adverse effects	Drowsiness Rare → hepatitis, psychosis, neuropathy, optic neuritis, confusional states	Diarrhea	Somnolence, nausea, vomiting, ↓appetite, abdominal pain	Same as naltrexone plus injection site reaction
Clinical notes	Only makes sense if patient's goal is sustained remission	Need to take multiple times per day → not ideal for unsheltered folks FDA-approved to sustain remission from AUD in those who are in remission at Tx initiation	Can block the effects of opioid Precipitated withdrawal in patients with physical dependence to opioids Efficacy in reducing risk of recurrence and heavy drinking	Same as naltrexone



Source:

Medication for Opioid Use Disorder (MOUD)

MEDICATION	DELIVERY SETTING	INITIATION	SAFETY CONCERNS
Methadone	Certified Opioid Treatment Programs (OTPs)	Start anytime. Daily visits for first days	QTc prolongation, many drug interactions
Buprenorphine	Office-based therapy;	Home. Start in moderate withdrawal.	Minimal. Some concern in acute liver failure
XR Naltrexone	Office-based. Monthly inj.	Opioid abstinence for 7-10d. (Difficult)	Blocks other opioids

THE CURB SIDERS
INTERNAL MEDICINE

Created by @justinberk

Buprenorphine Initiation Strategies

	STANDARD	LOW DOSE NON-OVERLAP	LOW DOSE OVERLAP
Wash-out period	8-72 hours	6 hours	n/a (continue agonist until day 7)
Dosing	<p><u>Standard:</u> 4-8mg, give additional 4-8mg if tolerating</p> <p><u>Macro:</u> 16-32mg</p>	<p><u>Day 1:</u> -0.5mg q2hrs x 4 doses (first 6 hours) -1mg q2hrs x 2 doses (next 4 hours) -2mg q2hrs x 2 doses (next 4 hours) -8mg (2 hours after last 2mg dose)</p> <p><u>Day 2:</u> -8mg BID</p>	<p>Day 1: 0.5mg daily Day 2: 0.5mg BID Day 3: 1mg BID Day 4: 2mg BID Day 5: 4mg BID Day 6: 4mg TID (STOP agonist) Day 7: 8mg BID</p>
Clinical notes	Simplest, careful with standard regarding precipitated withdrawal.	Anecdotal data says works well with fentanyl, reduces time not using. Simpler than overlap.	Best for patients on prescribed agonist. Good for methadone transition to buprenorphine.
Handout/more info			