Disclosures

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  • Nothing to disclose

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Overview

• The intersection of active illicit opioid use, acute pain and severe mental illness can be particularly challenging especially for generalist clinicians on the inpatient medical service.

• This case discussion reviews the challenges and approaches to:
  • Managing acute pain in patients with an active opioid use disorder
  • Managing patients with co-morbid depression with chronic suicidality and substance use disorders

Case Overview

• 45 year old male with chronic HCV, bipolar disorder, major depressive disorder with suicidal ideation, PTSD, severe opioid use disorder on buprenorphine/naloxone (bup/nlx) and cocaine use disorder

• Recently relapsed to heroin, cocaine

• Developed purulent cellulitis and tendon necrosis after injecting heroin into his foot

• Admitted to hospital for IV antibiotics, wound debridement and pain control
Medical, Family and Social History

• Chronic hepatitis C
• HIV negative

• Substance use history
  • Heroin 1g/day IV, started in his 20s. Last use 2 days PTA
  • Cocaine 1g/day, IN and smoked, last use 2days PTA
  • Daily tobacco
  • Denies ETOH, benzodiazepine or crystal methamphetamine

• Reports at least 1 opioid overdose
• Triggers: Pain, breakup with girlfriend, cocaine use

Medical, Family and Social History

• Prior substance use treatment
  • History of detox, residential treatment
  • Methadone – never, “not interested”
  • Naltrexone - never
  • Bup/nlx: recently on clinic x 6 months at 8-2mg BID, successful while in residential treatment

• Family history: siblings with polysubstance use
• Social: homeless, stays with family, friends, shelters. Children with DCF

Psychiatric History

• Bipolar disorder, MDD with chronic suicidal ideation, PTSD, SUD
• Multiple ED visits for suicidality, prior self harm, inpatient psychiatric care
• EMR alerts due to history of
  • Manipulative behavior
  • Concern for medication seeking
  • Concern for secondary gain, e.g. housing

Medications

• Active medications:
  • Olanzapine (Zyprexa) 10mg qAM/30mg qPM
  • Mirtazapine (Remeron) 30mg qhs
  • Divalproex (Depakote) 500mg bid
  • Prazosin 2mg qhs
  • Bup/nlx 8-2mg BID (last dose 2 PTA)

• Outpatient psychiatrist unreachable
Discussion Questions

• What are the options for managing his opioid use disorder, opioid withdrawal and acute pain in the hospital?

• Should this patient remain on bup/nlx treatment during and after his hospitalization?

Hospitalization #1: Hospital Course

• Continued on outpatient psychiatric medications
• Violent outburst after a large knife in his possession is confiscated
• He endorsed suicidal ideation with plan for overdose

• Psychiatry consulted:
  • Safety concerns due to his report of suicidal ideation, history of depression, violent outburst
  • Concern for seeking secondary gain

Discussion Questions

• What is your assessment of this patient’s psychiatric issues?
• What additional information would you want?

• What are your management recommendations?
Hospital Course (17 days) and Discharge

- **Cellulitis and tendon necrosis**: IV antibiotics, debridement in OR x 2
- **Opioid use disorder**: Restarted bup/nx 8-2 BID
- **Pain control**: Started on PRN oxycodone, requiring 15mg q8h
- **Depression and suicidality**: Olanzapine decreased to 20mg qhs and linked to outpatient treatment once mood stabilized
- **Discharged** on Hospital Day 17 to girlfriend's house
  - Given a limited number of oxycodone for acute pain management (#12)
  - 30 days of PO antibiotics
  - VNA for wound dressing changes
  - Close follow up with podiatry
  - No linkage back to bup/nx provider

2 Weeks Post-Discharge

- Did not follow up with podiatry, seen in ED
- Unable to refill bup/nx, used IN heroin for pain after running out of oxycodone within days
- Actively using cocaine
- SI with plan to step in front of car or overdose on fentanyl
- Worsening infection despite adherence to oral antibiotics
- Sent to the ED by VNA for 4 days of fever and worsening pain

Hospitalization #2: Hospital Course 28 Days

- **Readmitted** for worsening infection requiring debridement x 2
  - Completed 14 days of IV antibiotics
  - Plan for 4-6 weeks of wound vac as tissue not ready for graft

- **Psychiatric evaluation for SI**:
  - Denied suicidal plan when seen by psychiatry
  - Symptoms felt consistent with substance use worsening chronic suicidal ideation
  - Recommend continue current medications
Discussion

• What is your reaction to his ongoing suicidal statements?

Hospitalization #2: Hospital Course 28 Days

• Pain and substance use disorder:
  • Restarted on bup/nlx 8-2mg BID
  • Due to repeated instrumentation and significant pain with wound vac ordered oxycodone sliding scale at 5-15mg q 4h PRN
    • Received oxycodone 15 mg ~q4-6h (60-90 mg per day) x 28 days
  • Due to persistent pain from wound vac ordered oxycodone sliding scale at 5-15mg q 4h PRN

• Discharge planning:
  • Patient requires 4-6 weeks of wound vac treatment due to slow healing
  • Physical Therapy initially recommended subacute rehab

Hospitalization #2: Discharge Planning Challenges

• Unable to be placed in subacute rehab due to behavioral issues and treatment with bup/nlx
• His outpatient bup/nlx prescriber would not continue prescribing if patient remained on additional opioid analgesics (i.e., oxycodone)
• Unable to taper oxycodone due to persistent pain from wound vac
• Addiction consult service called 21 days into the hospitalization when primary team unable to make safe discharge plan
Discussion

• Without access to a monitored setting, what are some options for outpatient acute pain management in this patient with active opioid use disorder?

High Risk Discharge Plan, Hospital Day #28

• Discharged to his brother’s house with VNA, home PT and transportation arranged for podiatry, psychiatry and primary care follow-up

• Due to concerns about outpatient safety with prescription opioid pills, transitioned to fentanyl patches for pain control
  • Bup/nlx discontinued
  • Prescribed fentanyl patches with taper schedule
    • Plan: d/d/sewing 50 mcg → 37.5 mcg → 25 mcg → 12 mcg
    • Due to insurance issues: only able to pick up 25 mcg and 12 mcg patches
    • Limited number of oxycodone PRN dressing change (#20)

• Referred to outpatient addiction clinic to resume bup/nlx after fentanyl taper

Hospitalization #3: Psychiatric Evaluation (3 days)

• Re-presented to the ED 6 days later in setting of increased drainage from wound and suicide attempt with psychiatric medications
  • Continued fentanyl taper per last hospitalization

• Psychiatry: chronically elevated suicide risk
  • Initially required 1:1 monitoring, outreach to primary psychiatrist
  • No change in medications
  • Cleared 1:1 suicide risk, returned to baseline
  • Offered crisis stabilization placement but he declined

• No evidence of wound infection
  • Discharged with follow up wound care
Hospitalization #4: SI, OUD and Pain (4 Days)

- Readmitted 5 days later for SI and pain control
  - Delay in getting lower fentanyl dose due to insurance issues
  - Did not follow up with PCP
  - Actively using heroin for pain

- Psychiatry: Desire to kill himself via strangulation and IVDU
  - Passive SI w/ concern for secondary gain
  - Once medically cleared needs psychiatric admission

- Wound vac discontinued with no sign of infection

Fentanyl plan discontinued due to insurance complexities
- Restarted bup/nlx given ongoing heroin use
  - 16mg bup divided TID for pain control
  - Continued to require high dose oxycodone PRN

- Discharged to crisis stabilization unit and then respite care to complete oxycodone taper
- Scheduled for follow up in new opioid urgent care clinic for bup/nlx refill

What is an Opioid Urgent Care Clinic?
In Retrospect...

4 hospitalizations in 4 months w/ total of 52 inpatient days

• What could have been done differently to avoid the multiple readmissions?

• Are these discharge challenges (patient declined by multiple rehabs) similar across the country?

Follow up

• Administratively discharged from respite care after 1 week for behavior
• Not engaging with primary care despite repeated encouragement
• Repeated no show with plastic surgery (attended 1/5 scheduled visits)

• Walking in to wound clinic for dressing changes PRN
• Intermittent follow up in FASTER PATHS clinic for short bup/nx prescriptions
  • Use: cocaine, opiates, norfentanyl, and intermittent buprenorphine
  • Continues to complain of pain, awaiting wound graft
  • No further opioid prescriptions (other than bup/nx)
  • Plan for up-titratiob of bup/nx q8 hour for pain if able to attend follow up appointments

• Working on getting back into respite care
  • Remains depressed, suicidal thoughts, considering residential program
  • Remains out of hospital for 6 weeks

Learning Objectives

• Summarize treatment options for managing acute opioid withdrawal and acute pain on the inpatient service

• Explain how to manage chronic suicidality in a patient with opioid use disorder and pain

• Identify factors involved in safe discharge planning for patients with comorbid opioid use disorders, suicidality and pain
Take Home Messages

• Active substance use and mental illness are the underlying cause his of severe infection and are contributing to the ongoing complications

• Outpatient management of acute pain in patients with active OUD is extremely challenging
  - Early involvement in addiction/pain specialist is recommended

• Patients with passive suicidality have chronic elevated risk of self harm and require continued vigilance and coordination with psychiatry

Key References


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