3 Patient Assessment

Overview

This chapter presents guidance on screening for the presence of opioid use disorders and for the further assessment of patients in whom screening indicates the potential presence of a problem. Guidelines are provided for determining when buprenorphine is an appropriate treatment option for patients who have an opioid addiction. Additional information about many of the topics discussed in this chapter can be found in appendix E.

Screening and Assessment of Opioid Use Disorders

Screening

The consensus panel that developed the Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction recommends that physicians periodically and regularly screen all patients for substance use and substance-related problems, not just those patients who fit the stereotypical picture of addiction. Although addiction to drugs and alcohol is common, currently fewer than one-third of physicians in the United States carefully screen for addiction (National Center on Addiction and Substance Abuse 2000).

Conducting ongoing, regular substance abuse screening as part of medical care facilitates the early identification, intervention, and treatment of addiction. Periodic assessments for abuse, addiction, or other adverse effects are particularly helpful when the primary care physician or specialist is prescribing opioids for the treatment of pain. Office-based physicians may conduct further assessment and provide primary opioid addiction treatment for those patients who are determined to be appropriate candidates for office-based treatment. Alternatively, when indicated, patients may be referred for treatment in another setting.

Goals of Screening

The goals of addiction screening and assessment are to

- Identify individuals who are at risk for developing drug- or alcohol-related problems
- Identify individuals who may have developed drug- or alcohol-related problems or addiction
- Identify individuals who require further medical or addiction assessment
- Diagnose addiction or other substance-related disorders
- Develop recommendations and plan for appropriate addiction treatment
- Assess the biopsychosocial needs of patients with addictions

Initial Screening

Initial screening should consist of a combination of objective screening instruments, laboratory evaluations, and interview(s). If the physician suspects an addiction problem after reviewing the initial results, further assessment is indicated. In-depth interviews and standardized assessments are the most effective means of gathering further information.

Several validated addiction screening instruments are available. In addition, many physicians develop their own set of screening questions for medical illnesses. Screening questionnaires may be given to all patients in a physician’s practice,
not just to those patients considered to be “at risk” for drug or alcohol problems.

Examples of addiction screening instruments include

- **Drugs:**
  - COWS (Clinical Opiate Withdrawal Scale) (Wesson et al. 1999)
  - SOWS (Subjective Opiate Withdrawal Scale) (Bradley et al. 1987; Gossop 1990; Handelsman et al. 1987)
  - DAST-10 (Drug Abuse Screening Test) (Skinner 1982)
  - CINA (Clinical Institute Narcotic Assessment Scale for Withdrawal Symptoms) (Peachey and Lei 1988)
  - CAGE-AID (CAGE Adapted to Include Drugs) (Brown and Rounds 1995)
  - Narcotic Withdrawal Scale (Fultz and Senay 1975)

- **Alcohol:**
  - CAGE (Maisto and Saiz 2003)
  - AUDIT (Alcohol Use Disorders Identification Test) (Babor et al. 2001)
  - MAST (Michigan Alcohol Screening Test) (Selzer 1971)
  - SMAST (Short Michigan Alcohol Screening Test) (Selzer et al. 1975)

For more information about such tools, see appendix B. The reader also can review the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Substance Abuse Treatment (CSAT) TIP 24, *A Guide to Substance Abuse Services for Primary Care Clinicians* (CSAT 1997). See http://www.kap.samhsa.gov/products/manuals/index.htm.

### Assessment

If screening indicates the presence of an opioid use disorder, further assessment is indicated to thoroughly delineate the patient’s problem, to identify comorbid or complicating medical or emotional conditions, and to determine the appropriate treatment setting and level of treatment intensity for the patient. To determine the appropriateness of office-based or other opioid agonist treatment, a comprehensive patient assessment is essential. The assessment may be accomplished in stages over a 3- to 4-week period, during initiation of treatment and gradual acquisition of increasingly detailed information. Several office visits may be required to obtain all the information necessary to make a comprehensive set of diagnoses and to develop an appropriate treatment plan, although these efforts also can be completed in a single, extended visit if so desired. Treatment should not be delayed, however, pending complete patient assessment.

### Goals of Assessment

The goals of the medical assessment of a patient who is addicted to opioids are to

- Establish the diagnosis or diagnoses
- Determine appropriateness for treatment
- Make initial treatment recommendations
- Formulate an initial treatment plan
- Plan for engagement in psychosocial treatment
- Ensure that there are no contraindications to the recommended treatments
- Assess other medical problems or conditions that need to be addressed during early treatment
- Assess other psychiatric or psychosocial problems that need to be addressed during early treatment

### Components of Assessment
The components of the assessment of a patient who is addicted to opioids should include:

- Complete history
- Physical examination
- Mental status examination
- Relevant laboratory testing
- Formal psychiatric assessment (if indicated)

In forming a framework for assessment, physicians may include questions and evaluations pertinent to the most recent edition of the American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC) and the categories of the Addiction Severity Index (ASI) (McLellan et al. 1992; Mee-Lee 2001). The ASAM PPC may be ordered from ASAM at [http://www.asam.org](http://www.asam.org). The full text of the ASI can be downloaded from the Treatment Research Institute Web site at [http://www.tresearch.org](http://www.tresearch.org).

**Complete History Taking—Interviewing Patients Who Are Addicted**

*Attitude of the Physician.* The approach and attitude the physician shows to patients who have an addiction are of paramount importance. Patients are often hesitant or reluctant to disclose their drug use or problems. Patients who are addicted report discomfort, shame, fear, distrust, hopelessness, and the desire to continue using drugs as reasons they do not discuss addiction openly with their physicians (National Center on Addiction and Substance Abuse 2000). Patients in treatment for pain may fear the loss of their opioid pain medications should they disclose to a physician their concerns about their possible addiction. Physicians need to approach patients who have an addiction in an honest, respectful, matter-of-fact way, just as they would approach patients with any other medical illness or problem. A physician’s responsibility is to deal appropriately with his or her own attitudes and emotional reactions to a patient. For evaluation to be effective, personal biases and opinions about drug use, individuals who have addictions, sexual behavior, lifestyle differences, and other emotionally laden issues must be set aside or dealt with openly and therapeutically.

Certain characteristics of treatment providers facilitate effective evaluation and treatment of addiction, and these characteristics should be cultivated by physicians who plan to treat patients who have addictions (CSAT 1999b; Miller et al. 1993; Najavits and Weiss 1994). These attributes are listed in figure 3-1.

**Figure 3-1 Attributes of an Effective Addiction Treatment Provider**

- Ability to establish a helping alliance
- Good interpersonal skills
- Nonpossessive warmth
- Friendliness
- Genuineness
- Respect
- Affirmation
- Empathy
- Supportive style
- Patient-centered approach
- Reflective listening
Targeted, open-ended questions, such as those presented in figure 3-2, about the use of drugs and alcohol will elicit more information than simple, closed-ended, “yes” or “no” or single-answer questions. Refer to TIP 34, Brief Interventions and Brief Therapies for Substance Abuse (CSAT 1999a) at http://www.kap.samhsa.gov/products/manuals/index.htm for specific examples of interview questions.

Figure 3-2 Targeted, Open-Ended Questions About Drug and Alcohol Use

- “How has heroin use affected your life?”
- “How has hydrocodone affected your life?”
- “In the past, what factors have helped you stop using?”
- “What specific concerns do you have today?”

Most patients are willing and able to provide reliable, factual information regarding their drug use; however, many cannot articulate their reasons or motivation for using drugs. An effective interview should focus on drug use, patterns and consequences of use, past attempts to deal with problems, medical and psychiatric history (the “what, who, when, where, how”)—not on the reasons (the “why”) for addiction problems. Questions should be asked in a direct and straightforward manner, using simple language and avoiding street terms. Assumptive or quantifiable questions, such as those in figure 3-3, yield more accurate responses in the initial phases of the interview.

Figure 3-3 Quantifiable Interview Questions

- “At what age did you first use alcohol or other drugs?”
- “How many days of the week do you drink alcohol?”
- “How often do you use heroin?”
- “When was the last time you were high?”
- “How many times did you use last month?”

Components of the Complete History. A thorough and comprehensive medical, social, and drug use history should be taken on all patients being evaluated for substance use disorders. The components of a complete history are shown in figure 3-4.

Figure 3-4 Components of a Complete Substance Abuse Assessment History

- Substance use history (e.g., age of first use; substances used; change in effects over time; history of tolerance, overdose, withdrawal; attempts to quit; current problems with compulsivity or cravings)
- Addiction treatment history (e.g., previous treatments for addiction, types of treatments tried, outcomes of treatment attempts)
- Psychiatric history (e.g., patient’s diagnoses, psychiatric treatments recommended/attempted, outcomes of treatments)
- Family history (e.g., substance use disorders in family, family medical and psychiatric history)
- Medical history (e.g., detailed review of systems, past medical/surgical history, sexual history [for women, determine likelihood of pregnancy], current and past medications, pain history)
- Social history (e.g., quality of recovery environment, family/living environment, substance use by members of support network)
- Readiness to change (e.g., patient’s understanding of his or her substance use problem, Stage of Change the patient is in [see appendix G], patient’s interest in treatment now, whether treatment is coerced or voluntary)
Physical Examination

The physical examination should focus on physical findings related to addiction. Several physical findings may lead the physician to suspect addiction in patients who deny drug use or have equivocal screening results. Figure 3-5 lists physical examination findings that suggest addiction or its complications. The physical complications of opioid addiction should be identified and addressed as part of the overall treatment plan.

**Figure 3-5 Examination Findings Suggestive of Addiction or Its Complications**

- **General:**
  - Odor of alcohol on breath
  - Odor of marijuana on clothing
  - Odor of nicotine or smoke on breath or clothing
  - Poor nutritional status
  - Poor personal hygiene

- **Behavior:**
  - Intoxicated behavior during exam
  - Slurred speech
  - Staggering gait
  - Scratching

- **Skin:**
  - Signs of physical injury
  - Bruises
  - Lacerations
  - Scratches
  - Burns
  - Needle marks
  - Skin abscesses
  - Cellulitis
  - Jaundice
  - Palmar erythema
  - Hair loss
  - Diaphoresis
  - Rash
  - Puffy hands

- **Head, Eyes, Ears, Nose, Throat (HEENT):**
  - Conjunctival irritation or injection
Inflamed nasal mucosa
Perforated nasal septum
Blanched nasal septum
Sinus tenderness
Gum disease, gingivitis
Gingival ulceration
Rhinitis
Sinusitis
Pale mucosae
Burns in oral cavity

- Gastrointestinal:
  - Hepatomegaly
  - Liver tenderness
  - Positive stool hemoccult

- Immune:
  - Lymphadenopathy

- Cardiovascular:
  - Hypertension
  - Tachycardia
  - Cardiac arrhythmia
  - Heart murmurs, clicks
  - Edema
  - Swelling

- Pulmonary:
  - Wheezing, rales, rhonchi
  - Cough
  - Respiratory depression

- Female reproductive/endocrine:
  - Pelvic tenderness
  - Vaginal discharge

- Male reproductive/endocrine:
  - Testicular atrophy
  - Penile discharge
Gynecomastia

- Neurologic:
  - Sensory impairment
  - Memory impairment
  - Motor impairment
  - Ophthalmoplegia
  - Myopathy
  - Neuropathy
  - Tremor
  - Cognitive deficits
  - Ataxia
  - Pupillary dilation or constriction

Assessing Intoxication and Overdose. It is vitally important to assess for signs of opioid intoxication, overdose, or withdrawal during the physical examination. Opioid overdose should be treated as a medical emergency. Figure 3-6 lists the signs of opioid intoxication and overdose.

### Signs of Opioid Intoxication and Overdose

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Physical Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opioid Intoxication</td>
<td>Conscious Sedated, drowsy Slurred speech “Nodding” or intermittently dozing Memory impairment Mood normal to euphoric Pupillary constriction</td>
</tr>
<tr>
<td>Opioid Overdose</td>
<td>Unconscious Pinpoint pupils Slow, shallow respirations; respirations below 10 per minute Pulse rate below 40 per minute Overdose triad: apnea, coma, pinpoint pupils (with terminal anoxia: fixed and dilated pupils)</td>
</tr>
</tbody>
</table>

Assessing Opioid Withdrawal. Opioid withdrawal can be objectively assessed by using one of the following several instruments:

- COWS (Clinical Opiate Withdrawal Scale) (Wesson et al. 1999)
- SOWS (Short Opiate Withdrawal Scale) (Bradley et al. 1987; Gossop 1990; Handelsman et al. 1987)
- CINA (Clinical Institute Narcotic Assessment Scale for Withdrawal Symptoms) (Peachey and Lei 1988)
- Narcotic Withdrawal Scale (Fultz and Senay 1975)

Full text and/or links to these instruments are included in appendix B. Figure 3-7 shows methods of staging and grading opioid withdrawal.

### Staging and Grading Systems of Opioid Withdrawal

<table>
<thead>
<tr>
<th>Stage</th>
<th>Grade</th>
<th>Physical Signs/Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Withdrawal (8–24 hours after last use)</td>
<td>Grade 1</td>
<td>Lacrimation and/or rhinorrhea Diaphoresis Yawning Restlessness Insomnia</td>
</tr>
<tr>
<td></td>
<td>Grade</td>
<td>Dilated pupils Piloerection Muscle twitching Myalgia Arthralgia</td>
</tr>
<tr>
<td>Fully Developed Withdrawal (1–3 days after last use)</td>
<td>Grade 2</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td></td>
<td>Grade 3</td>
<td>Tachycardia Hypertension Tachypnea Fever Anorexia or nausea Extreme restlessness</td>
</tr>
<tr>
<td></td>
<td>Grade 4</td>
<td>Diarrhea and/or vomiting Dehydration Hyperglycemia Hypotension Curled-up position</td>
</tr>
</tbody>
</table>

**Assessing Other Drug Intoxication or Withdrawal Syndromes.** Instruments for assessing withdrawal from alcohol and benzodiazepines include

- CIWA-Ar (Clinical Institute Withdrawal Assessment for Alcohol, Revised) (Sullivan et al. 1989)
- CIWA-B (Clinical Institute Withdrawal Assessment for Benzodiazepines) (Busto et al. 1989)

**Mental Status Examination**

In addition to observing a patient’s behavior during history taking and the physical examination, a formal mental status examination (MSE) should be performed, including the components shown in figure 3-8.

**Figure 3-8 Mental Status Examination Checklist**

- General appearance
- Behavior and interaction with interviewer
- Speech and voice
- Motor activity
- Mood and affect
- Perceptions
  - Hallucinations
- Thought process
- Thought content
  - Suicidal ideation
  - Homicidal ideation
  - Delusions
- Insight
- Judgment
- Motivation and readiness to change
  - Patient’s stated goals and expectations
- Cognitive function
  - Orientation
  - Memory
  - Attention
  - Concentration
  - Fund of information
  - Literacy skills
  - Abstraction
  - Intelligence
- Personality characteristics
- Defense mechanisms

Information from the interview and MSE may reveal significant current or past psychiatric problems. Depending on the physician’s expertise and comfort in managing psychiatric disorders, referral to an addiction psychiatrist or psychologist for a full mental health evaluation and/or formal psychiatric diagnosis may be indicated before starting treatment for addiction.

**Laboratory Evaluations**

Laboratory testing is an important part of the assessment and evaluation of patients who have an addiction. Laboratory tests cannot make a diagnosis of addiction, but a variety of laboratory evaluations are useful in the comprehensive assessment of patients who have an addiction.

The recommended baseline laboratory evaluation of patients who are addicted to opioids is shown in figure 3-9.

**Figure 3-9 Recommended Baseline Laboratory Evaluation of Patients Who Are Addicted to Opioids**

- Serum electrolytes
- BUN and creatinine
- CBC with differential and platelet count
- Liver function tests (GGT, AST, ALT, PT or INR, albumin)
- Lipid profile
- Urinalysis
- Pregnancy test (for women of childbearing age)
- Toxicology tests for drugs of abuse
- Hepatitis B and C screens

The following additional laboratory evaluations should be considered and offered as indicated:

- Blood alcohol level (using a breath testing instrument or a blood sample)
- Infectious disease evaluation:
  - HIV antibody testing
  - Hepatitis B virus (HBV) and hepatitis C virus (HCV) screens
  - Serology test for syphilis—Venereal Disease Research Laboratories (VDRL)
  - Purified protein derivative (PPD) test for tuberculosis, preferably with control skin tests

In addition, other laboratory evaluations may be indicated by the patient’s history or physical examination. Appropriate counseling should be provided, and consent obtained, before testing for certain infectious diseases (e.g., HIV, hepatitis C). Abnormalities or medical problems detected by laboratory evaluation should be addressed as they would be for patients who are not addicted.

Several findings may alert physicians to potential complications to treatment with buprenorphine. Alcohol use may complicate buprenorphine treatment; indirect indicators of excess alcohol use include elevated mean corpuscular volume (MCV) and gamma glutamyl transpeptidase (GGT). Liver enzyme abnormalities also may suggest liver disease from toxicity, infection, or other factors. Additional biomedical markers such as Carbohydrate-Deficient Transferrin (CDT) may provide further objective information on screening and confirmation of acute or recent alcohol consumption, relapse to use, heavy or harmful use, and alcohol-related organ dysfunction. Guidance on liver disease in patients who are
addicted to opioids will be available from SAMHSA’s Division of Pharmacologic Therapies (DPT) Web site at http://www.dpt.samhsa.gov.

As described elsewhere, pregnancy, HIV treatment, and active hepatitis or liver disease also may complicate treatment with buprenorphine. Pregnant women may not be optimal candidates for buprenorphine treatment. HIV-positive status does not preclude buprenorphine treatment, but as-yet-unrecognized antiretroviral medication interactions with buprenorphine may potentially interfere with treatment. Positive results on hepatitis B surface antigen testing indicate active HBV infection, possibly associated with active hepatitis. Further testing (e.g., serial enzymes) may be indicated to determine whether HBV infection complicates buprenorphine treatment. Hepatitis B information for health professionals can be accessed on the Centers for Disease Control and Prevention (CDC) Web site at http://www.cdc.gov/ncidod/diseases/hepatitis/b/index.htm.


Positive serology tests for syphilis may indicate active or past infection with Treponema pallidum. All patients with such positive test results should be treated onsite or referred to a local health department for further evaluation and treatment. It should be noted, however, that biologic false positive results on serology tests for syphilis are common in individuals who abuse drugs intravenously. Only those with confirmatory fluorescent treponemal antibody absorption (FTA-ABS) tests are likely to have actual treponemal infection. The most current treatment recommendations for syphilis and other sexually transmitted diseases (STDs) are posted on the CDC Web site at http://www.cdc.gov/std/.

A positive PPD skin test may indicate past or current infection with tuberculosis. Any patient with a positive PPD test should be referred to a local health department for further evaluation and treatment. Additional information on tuberculosis and its treatment is found on the CDC Web site at http://www.cdc.gov/nchstp/tb/links.htm. Physicians should be familiar with all reporting requirements for infectious diseases in their State.

**Evaluations of Drug Use**

Tests for illicit drugs are not sufficient to diagnose addiction and cannot substitute for a clinical interview and medical evaluation of the patient (Casavant 2002). Hammett-Stabler et al. (2002) point out that the term drug screen is a misnomer, because not all drugs are, and cannot be, tested for routinely. Physicians must decide which drug tests are necessary in each clinical setting, including office-based buprenorphine treatment. Physicians and laboratory personnel must understand the limitations of the assays used, the pharmacokinetic characteristics of the drugs assayed, the parent compound–metabolite relationships, and how to interpret laboratory results (Hammett-Stabler et al. 2002). Testing for drugs can be performed on a number of bodily fluids and tissues, including urine, blood, saliva, sweat, and hair. Urine screening is the method most commonly employed. A comprehensive discussion of urine drug testing in the primary care setting can be found in *Urine Drug Testing in Primary Care: Dispelling the Myths & Designing Strategies* (Gourlay et al. 2002). When selecting drug tests, physicians should consider the cost to patients, as testing for all possible drugs of abuse can be costly.

In buprenorphine treatment, appropriate tests for illicit drug use should be administered as part of patient assessment. Physicians should explain the role of drug testing at the beginning of treatment for addiction. The literature supports the therapeutic utility of random drug testing in clinical settings (Preston et al. 2002). Laboratory test results can be used in the physician–patient interaction to further treatment objectives, to address patient denial, and to reinforce abstinence from other drugs. Initial and ongoing drug screening should be used to detect or confirm the recent use of drugs (e.g., alcohol, benzodiazepines, barbiturates) that could complicate management of a patient on buprenorphine.
When a patient requests treatment with buprenorphine, a toxicology screen can help to establish that the patient is indeed using either a prescribed substance such as heroin or a prescribed substance such as oxycodone. A negative test does not necessarily mean that the patient is not using an opioid. It may mean that the patient has not used an opioid within a period of time sufficient to produce measurable metabolic products or that the patient was not using the drug for which he or she was tested. Thus, as with any patient, the physician is alerted to a spectrum of possibilities and works with the patient using the information collected from the toxicology screen.

Several manufacturers produce combination urine collection and test kits that facilitate in-office urine testing. In-office testing facilitates prompt evaluation of clinical parameters and allows the physician to present the results to the patient and to make immediate therapeutic use of the information. However, physicians who do not work in a setting with an onsite, federally regulated laboratory must ensure that they are using in-office testing kits waived from regulatory oversight under the Clinical Laboratory Improvement Amendments (CLIA) law of 1988. See the CLIA pages on the Food and Drug Administration (FDA) Web site at http://www.fda.gov/cdrh/clia/cliaawaived.html for more information about the law and CLIA-waived point-of-care testing kits. For the current listing of CLIA-waived urine drug tests, refer to the FDA Web site at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCIA/testswaived.cfm or search the FDA CLIA database at http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCLIA/search.cfm.

Toxicology testing for drugs of abuse that takes place at scheduled visits cannot be truly random; nevertheless, it is clinically worthwhile. Urine samples should be collected in a room where they cannot be diluted or otherwise adulterated and where patients are not permitted to bring briefcases, purses, bags, or containers of any sort. If these conditions are not feasible, temperature-sensitive strips, specific gravity, and creatinine can be used to minimize the possibility of false or adulterated urine specimens. If the physician’s office cannot provide this service, patients can be referred to a facility that is equipped to perform monitored specimen collection. Another option that is sometimes feasible is to collect a sample of oral fluid (saliva) to be sent to a laboratory for testing.

Timely shipment of samples for testing and rapid turnaround time for the results are also important issues that should be resolved before undertaking office-based treatment of opioid addiction. If a patient needs drug test results for employment or for legal monitoring, strict chain-of-custody procedures must be followed, and samples should be evaluated by a SAMHSA-certified laboratory. If a patient subsequently wants to use the drug test result for other purposes, both the physician and the patient should understand the limits of the office testing and other requirements for the test. Other than for U.S. Department of Health and Human Services and U.S. Department of Transportation, private-sector testing requirements may be less rigorous. Further information about the detection of drugs in urine and other biological samples is found in appendix E.

**Diagnosis of Opioid-Related Disorders**

After a thorough assessment of a patient has been conducted, a formal diagnosis can be made. Criteria for substance dependence, such as those set forth in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision (DSM-IV-TR) (American Psychiatric Association 2000) (see Appendix C) or the *International Classification of Diseases—Ninth Edition—Clinical Modification: ICD-9-CM*, should be used to document a diagnosis of opioid dependence. (This diagnosis is not merely physical dependence on opioids but corresponds to opioid addiction, classically defined as compulsive use despite harm.)

DSM-IV-TR defines several opioid-related disorders. (See figure 3-10.) A DSM-IV-TR diagnosis of either opioid dependence or abuse is based on a cluster of behaviors and physiological effects occurring within a specific timeframe. The diagnosis of opioid dependence always takes precedence over that of opioid abuse (i.e., a diagnosis of abuse is made only if DSM-IV-TR criteria for dependence have never been met). As a general rule, to be considered for buprenorphine maintenance, patients should meet the DSM-IV-TR criteria for a diagnosis of opioid dependence. (See full diagnostic criteria in appendix C.) In rare instances, a patient may be physiologically dependent on opioids and meet DSM-IV-TR criteria for abuse, but not for dependence. In such a case, a short course of buprenorphine may be considered for detoxification. Maintenance treatment with buprenorphine is not recommended for patients who do not meet DSM-IV-TR criteria for opioid dependence.
Figure 3-10 DSM-IV-TR Opioid Use Disorders (ICD-9 Code)

- Opioid Abuse (305.50)
- Opioid Dependence (304.00)
- Opioid Intoxication (292.89)
- Opioid Withdrawal (292.0)
- Opioid Intoxication Delirium (292.81)
- Opioid-Induced Psychotic Disorder, With Delusions (292.11)
- Opioid-Induced Psychotic Disorder, With Hallucinations (292.12)
- Opioid-Induced Mood Disorder (292.84)
- Opioid-Induced Sexual Dysfunction (292.89)
- Opioid-Induced Sleep Disorder (292.89)
- Opioid-Related Disorder NOS (292.9)


Common Comorbid Medical Conditions

Individuals addicted to opioids may have the same chronic diseases seen in the general population and should be evaluated as appropriate for diseases that require treatment (e.g., diabetes, hypertension). In addition, a number of medical conditions are commonly associated with opioid and other drug addictions. During the course of a medical history and physical examination, the possible existence of these conditions should be evaluated. Refer to figure 3-11 for a detailed list of selected medical disorders related to drug and alcohol use.

Selected Medical Disorders Related to Alcohol and Other Drug Use

| Cardiovascular | Alcohol: Cardiomyopathy, atrial fibrillation (holiday heart), hypertension, dysrhythmia, masks angina symptoms, coronary artery spasm, myocardial ischemia, high-output states, coronary artery disease, sudden death. Cocaine: Hypertension, myocardial infarction, angina, chest pain, supraventricular tachycardia, ventricular dysrhythmias, cardiomyopathy, cardiovascular collapse from body-packing rupture, moyamoya vasculopathy, left ventricular hypertrophy, myocarditis, sudden death, aortic dissection. Tobacco: Atherosclerosis, stroke, myocardial infarction, peripheral vascular disease, cor pulmonale, erectile dysfunction, worse control of hypertension, angina, dysrhythmia. Injection drug use: Endocarditis, septic thrombophlebitis. |
dysfunction, osteopenia, osteoporosis, fractures, estrogen alterations, insulin resistance. Any addiction: Amenorrhea.

Hepatic

**Alcohol**: Steatosis (fatty liver), acute and chronic hepatitis (infectious [that is, B or C] or toxic [that is, acetaminophen]), alcoholic hepatitis, cirrhosis, portal hypertension and varices, spontaneous bacterial peritonitis. **Cocaine**: Ischemic necrosis, hepatitis. **Opiates**: Granulomatosis. **Injection drug use or high-risk sexual behavior**: Infectious hepatitis B and C (acute and chronic) and delta.

Hematologic

**Alcohol**: Macrocytic anemia, pancytopenia because of marrow toxicity and/or splenic sequestration, leukopenia, thrombocytopenia, megaloblastic anemia because of liver disease, iron deficiency, folate deficiency, spur cell anemia, burr cell anemia. **Tobacco**: Hypercoagulability. **Injection drug use or high-risk sexual behavior**: Hematologic consequences of liver disease, hepatitis C-related cryoglobulinemia and purpura.

Infectious

**Alcohol**: Hepatitis C, pneumonia, tuberculosis (including meningitis), HIV, sexually transmitted diseases, spontaneous bacterial peritonitis, brain abscess, meningitis. **Opiates**: Aspiration pneumonia. **Tobacco**: Bronchitis, pneumonia, upper respiratory tract infections. **Injection drug use or high-risk sexual behavior**: Transmission of hepatitis B, C, and delta; HIV; sexually transmitted diseases.

Neurologic

**Alcohol**: Peripheral and autonomic neuropathy, seizure, hepatic encephalopathy, Korsakoff dementia, Wernicke syndrome, cerebellar dysfunction, Marchiafava-Bignami syndrome, central pontine myelinolysis, myopathy, amilplasia, stroke, withdrawal, delirium, hallucinations, toxic leukoencephalopathy, subdural hematoma, intracranial hemorrhage. **Cocaine**: Stroke, seizure, status epilepticus, headache, delirium, depression, hypersomnia, cognitive deficits. **Opiates**: Seizure (overdose and hypoxia), compression neuropathy. **Tobacco**: Stroke, small vessel ischemia and cognitive deficits. Any addiction: Compression neuropathy.

Nutritional

**Alcohol**: Vitamin and mineral deficiencies (B₁, B₆, riboflavin, niacin, vitamin D, magnesium, calcium, folate, phosphate, zinc). Any addiction: Protein malnutrition.

Other Gastrointestinal

**Alcohol**: Gastritis, esophagitis, pancreatitis, diarrhea, malabsorption (because of pancreatic exocrine insufficiency, or folate or lactase deficiency), parotid enlargement, malignancy, colitis, Barrett esophagus, gastroesophageal reflux, Mallory-Weiss syndrome, gastrointestinal bleeding. **Cocaine**: Ischemic bowel and colitis. **Opiates**: Constipation, ileus, intestinal pseudo-obstruction. **Tobacco**: Peptic ulcers, gastroesophageal reflux, malignancy (pancreas, stomach). Any addiction: Overdose from body-packing.

Prenatal and Perinatal

**Alcohol**: Fetal alcohol effects and syndrome. **Cocaine**: Placental abruption, teratogenesis, neonatal irritability. **Opiates**: Neonatal abstinence syndrome, including seizures. **Tobacco**: Teratogenesis, low birth weight, spontaneous abortion, abruptio placenta, placenta previa, perinatal mortality, sudden infant death syndrome, neurodevelopmental impairment.

Perioperative

**Alcohol**: Withdrawal, perioperative complications (delirium, infection, bleeding, pneumonia, delayed wound healing, dysrhythmia), hepatic decompensation, hepatorenal syndrome, death. **Cocaine**: Hypersomnia and depression in withdrawal, mimicking of postoperative neurologic complications, complications from underlying drug-induced cardiopulmonary disease. **Opiates**: Withdrawal, inadequate analgesia. **Tobacco**: Pulmonary infection, difficulty weaning, respiratory failure, reactive airways exacerbations.

Pulmonary

**Alcohol**: Aspiration, sleep apnea, respiratory depression, apnea, chemical or infectious pneumonia. **Cocaine**: Nasal septum perforation, gingival ulceration, perennial rhinitis, sinusitis, hemoptysis, upper airway obstruction, fibrosis, hypersensitivity pneumonitis, epilgittitis, pulmonary hemorrhage, pulmonary hypertension, pulmonary edema, emphysema, interstitial fibrosis, hypersensitivity

Renal

**Alcohol:** Hepatorenal syndrome, rhabdomyolysis and acute renal failure, volume depletion and prerenal failure, acidosis, hypokalemia, hypophosphatemia. **Cocaine:** Rhabdomyolysis and acute renal failure, vasculitis, necrotizing angitis, accelerated hypertension, nephrosclerosis, ischemia. **Opiates:** Rhabdomyolysis, acute renal failure, factitious hematuria. **Tobacco:** Renal failure, hypertension. Injection drug use or high-risk sexual behavior: Focal glomerular sclerosis (HIV, heroin), glomerulonephritis from hepatitis or endocarditis, chronic renal failure, amyloidosis, nephrotic syndrome (hepatitis C).

Sleep

**Alcohol:** Apnea, periodic limb movements of sleep, insomnia, disrupted sleep, daytime fatigue. **Cocaine:** Hypersomnia in withdrawal. **Opiates:** Insomnia. **Tobacco:** Insomnia, increased sleep latency.

Trauma

**Alcohol:** Motor vehicle crash, fatal and nonfatal injury, physical and sexual abuse. **Cocaine:** Death during "Russian Roulette." **Opiates:** Motor vehicle crash, other violent injury. **Tobacco:** Burns, smoke inhalation. Any addiction: Sexual and physical abuse.

Musculoskeletal

**Alcohol:** Rhabdomyolysis, compartment syndromes, gout, saturnine gout, fracture, osteopenia, osteonecrosis. **Cocaine:** Rhabdomyolysis. **Opiates:** Osteopenia. Any addiction: Compartment syndromes, fractures.


Infectious diseases are more common among individuals who are addicted to opioids, individuals who are addicted to other drugs, and individuals who inject drugs. For example, in some areas, more than 50 percent of injection drug users may be HIV positive. There are wide variations in the epidemiology of HIV infection, however, and in other areas the prevalence of HIV infection among injection drug users may be less than 10 percent. Because of the potential impact of HIV on the lives of affected patients and the availability of effective treatments, it is important to screen for HIV infection among patients who present for buprenorphine treatment.

Tuberculosis is also a major problem among substance abusers. In 2001, 2.3 percent of tuberculosis cases in the United States occurred in injection drug users, 7.2 percent in noninjection drug users, and 15.2 percent in individuals with excessive alcohol use in the past 12 months (CDC 2002; http://www.cdc.gov/nchstp/tb/surv/surv2001/default.htm. See tables 28, 29, and 30). Individuals who abuse drugs and alcohol are also at increased risk of engaging in high-risk sexual behavior (e.g., exposure to multiple partners, inconsistent use of safe sexual practices) and of contracting syphilis, gonorrhea, and other STDs.

Among individuals who are opioid addicted, other common medical conditions are related to the use of other drugs and to the life disruptions that often accompany addiction. These conditions include nutritional deficiencies and anemia caused by poor eating habits; chronic obstructive pulmonary disease secondary to cigarette smoking; impaired hepatic function or moderately elevated liver enzymes from various forms of chronic hepatitis (particularly hepatitis B and C) and alcohol consumption; and cirrhosis, neuropathies, or cardiomyopathy secondary to alcohol dependence.

**Summary**

After completing a comprehensive assessment of a candidate for treatment, the physician should be prepared to
Establish the diagnosis or diagnoses

Determine appropriate treatment options for the patient

Make initial treatment recommendations

Formulate an initial treatment plan

Plan for engagement in psychosocial treatment

Ensure that there are no absolute contraindications to the recommended treatments

Assess other medical problems or conditions that need to be addressed during early treatment

Assess other psychiatric or psychosocial problems that need to be addressed during early treatment

The next section describes methods for determining the appropriateness of buprenorphine treatment for patients who have an opioid addiction.

**Determining Appropriateness for Buprenorphine Treatment**

Several issues should be considered in evaluating whether a patient is an appropriate candidate for buprenorphine treatment of opioid addiction in the office or other setting.

First, a candidate for buprenorphine treatment for opioid addiction should have an objectively ascertained diagnosis of opioid addiction (compulsive use of opioids despite harm), otherwise known as opioid dependence as defined in the latest edition of the DSM-IV-TR of the APA (2000). Refer to appendix C for DSM-IV-TR diagnostic criteria for opioid dependence and opioid abuse. In rare instances, a patient may be physiologically dependent on opioids and meet DSM-IV-TR criteria for abuse, but not for dependence. In such a case, a short course of buprenorphine may be considered for detoxification. Maintenance treatment with buprenorphine is not recommended for patients who do not meet DSM-IV-TR criteria for opioid dependence.

Second, a candidate for buprenorphine treatment should, at a minimum

- Be interested in treatment for opioid addiction
- Have no absolute contraindication (i.e., known hypersensitivity) to buprenorphine (or to naloxone if treating with the buprenorphine/naloxone combination)
- Be expected to be reasonably compliant with such treatment
- Understand the risks and benefits of buprenorphine treatment
- Be willing to follow safety precautions for buprenorphine treatment
- Agree to buprenorphine treatment after a review of treatment options

Patients who request treatment with buprenorphine to achieve abstinence from all illicit opioid use should be able to receive this treatment, if it is clinically indicated.

**Evaluation Questions**

To thoroughly evaluate a patient for appropriateness for opioid addiction treatment with buprenorphine, the physician should ask the following questions:

1. **Does the patient have a diagnosis of opioid dependence?** Candidates for buprenorphine treatment should have a diagnosis of opioid dependence. Buprenorphine treatment is not indicated for other disorders.
2. **Are there current signs of intoxication or withdrawal? Is there a risk for severe withdrawal?** The physician should assess the patient for current signs of intoxication or withdrawal from opioids or other drugs as well as for the risk of severe withdrawal. The risk of severe opioid withdrawal is not a contraindication to buprenorphine treatment. The risk of withdrawal from sedative-hypnotics, however, may initially preclude the use of buprenorphine in an office setting.

3. **Is the patient interested in buprenorphine treatment?** If a patient with opioid addiction has not heard of or presented specifically for buprenorphine treatment, buprenorphine treatment should be discussed as a treatment option.

4. **Does the patient understand the risks and benefits of buprenorphine treatment?** (Refer to chapter 2 and appendix H.) It should be assumed that many patients are unaware that buprenorphine is an opioid, thus they should be so informed. The risks and benefits of buprenorphine treatment should be presented to potential patients, and their understanding of these factors evaluated. Physicians must review the safety, efficacy, side effects, potential treatment duration, and other factors with each patient.

5. **Can the patient be expected to adhere to the treatment plan?** This is a judgment call, based on the patient’s past adherence to treatment for addiction or other medical conditions, comorbid psychiatric conditions, psychosocial stability, comorbid substance use disorders, and other factors.

6. **Is the patient willing and able to follow safety procedures?** If a patient is unwilling or unable to follow safety procedures, or is dismissive of them, then that patient is not a good candidate for office-based treatment with buprenorphine.

7. **Does the patient agree to treatment after review of the options?** Buprenorphine treatment is not coercive; the patient must agree to treatment before it is initiated. Treatment options (including no treatment, dose-reduction, abstinence-based treatment, and the variety of medication treatments) and their associated risks and benefits should be reviewed so that patients can make informed decisions about buprenorphine treatment.

8. **Can the needed resources for the patient be provided (either onsite or offsite)?** Each patient’s needs should be assessed. If the resources that are available onsite or offsite are insufficient for a particular patient, he or she should be referred to an appropriate treatment setting or provider.

9. **Is the patient psychiatrically stable?** Is the patient actively suicidal or homicidal? Has he or she recently attempted suicide or homicide? Do current emotional, behavioral, or cognitive conditions complicate treatment? Patients who have significant untreated psychiatric comorbidity are less-than-ideal candidates for office-based buprenorphine treatment. A full psychiatric assessment is indicated for all patients who have significant psychiatric comorbidity. Psychiatric comorbidity requires appropriate management or referral as part of treatment. It should be noted that the buprenorphine clinical trials reported to date have not included patients maintained on antipsychotic or mood-stabilizing agents (e.g., lithium), and thus there is limited or no information on the potential interactions with these medications.

10. **Is the patient pregnant?** If a patient is pregnant or is likely to become pregnant during the course of treatment, buprenorphine may not be the best choice. (See “Pregnant Women and Neonates” in chapter 5.) Currently, methadone maintenance, when it is available, is the treatment of choice for patients who are pregnant and are opioid addicted.

11. **Is the patient currently dependent on or abusing alcohol?** Patients with alcohol abuse or dependence, whether continuous or periodic in pattern, may be at risk of overdose from the combination of alcohol with buprenorphine. Patients with high-risk or harmful drinking patterns are, therefore, less likely to be appropriate candidates for office-based buprenorphine treatment.

12. **Is the patient currently dependent on or abusing benzodiazepines, barbiturates, or other sedative-hypnotics?** Patients who have sedative-hypnotic abuse or dependence, whether continuous or periodic in pattern, may be at some risk of overdose and death from the combination of sedative-hypnotics with buprenorphine.
13. **What is the patient’s risk for continued opioid use or continued problems? Does the patient have a history of multiple previous treatments or relapses, or is the patient at high risk for relapse to opioid use? Is the patient using other drugs?** Several factors may increase a patient’s risk for continued use of opioids or continued problems. A patient who is using other (nonopioid) drugs or who has a history of multiple previous treatments or relapses may not be an appropriate candidate for office-based buprenorphine treatment. Physicians should assess the patient’s understanding of problems and relapse triggers, as well as his or her skills in managing cravings and controlling impulses to use drugs. Multiple previous attempts at detoxification which were followed by relapse to opioid use, however, are not a contradiction to maintenance with buprenorphine. Rather, such a history is a strong indication for maintenance treatment with pharmacotherapy.

14. **Has the patient had prior adverse reactions to buprenorphine?** Cases of acute and chronic hypersensitivity to Subutex® have been reported both in clinical trials and in the postmarketing experience. The most common signs and symptoms include rashes, hives, and pruritus. Cases of bronchospasm, angioneurotic edema, and anaphylactic shock have been reported. A history of hypersensitivity to buprenorphine is a contraindication to Subutex® and Suboxone® use. A history of hypersensitivity to naloxone is a contraindication to Suboxone® use. (Reckitt Benckiser Healthcare (UK), Ltd. and Reckitt Benckiser Pharmaceuticals, Inc. 2002).

15. **Is the patient taking other medications that may interact with buprenorphine?** Certain medications (e.g., naltrexone) may be absolutely contraindicated with buprenorphine treatment (see chapter 2) and must be discontinued or changed before starting buprenorphine. If this is not a reasonable clinical alternative, the patient may not be a candidate for buprenorphine treatment. Use of other medications, such as those metabolized by the cytochrome P450 3A4 system (e.g., azoles, macrolide antibiotics, calcium channel blockers, selective serotonin reuptake inhibitors [SSRIs]) may need to be closely monitored when used concurrently with buprenorphine. (See figure 2-3.)

16. **Does the patient have medical problems that are contraindications to buprenorphine treatment? Could physical illnesses complicate treatment?** A complete history and physical assessment must address any medical problems or physical illnesses, and physicians must evaluate the impact of these conditions on buprenorphine treatment.

17. **What kind of recovery environment does the patient have? Are the patient’s psychosocial circumstances sufficiently stable and supportive?** Any threats to the patient’s safety or treatment engagement should be addressed at the beginning of assessment. Supportive relationships and resources will increase the likelihood of successful treatment.

18. **What is the patient’s level of motivation? What stage of change characterizes the patient?** Motivation is a dynamic quality that can be enhanced by treatment providers. Physicians may wish to determine each patient’s readiness to change using tools such as the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) (see appendix G) and to make interventions directed to the patient’s current stage of change. Highly motivated individuals are more appropriate candidates for office-based buprenorphine treatment.

Figure 3-12 provides a checklist for ascertaining the appropriateness for buprenorphine treatment.

**Figure 3-12 Buprenorphine Treatment Checklist**

1. Does the patient have a diagnosis of opioid dependence?
2. Are there current signs of intoxication or withdrawal? Is there a risk for severe withdrawal?
3. Is the patient interested in buprenorphine treatment?
4. Does the patient understand the risks and benefits of buprenorphine treatment?
5. Can the patient be expected to adhere to the treatment plan?
6. Is the patient willing and able to follow safety procedures?
7. Does the patient agree to treatment after a review of the options?

8. Can the needed resources for the patient be provided (either on- or offsite)?

9. Is the patient psychically stable? Is the patient actively suicidal or homicidal; has he or she recently attempted suicide or homicide? Does the patient exhibit emotional, behavioral, or cognitive conditions that complicate treatment?

10. Is the patient pregnant?

11. Is the patient currently dependent on or abusing alcohol?

12. Is the patient currently dependent on benzodiazepines, barbiturates, or other sedative-hypnotics?

13. What is the patient’s risk for continued use or continued problems? Does the patient have a history of multiple previous treatments or relapses, or is the patient at high risk for relapse to opioid use? Is the patient using other drugs?

14. Has the patient had prior adverse reactions to buprenorphine?

15. Is the patient taking other medications that may interact with buprenorphine?

16. Does the patient have medical problems that are contraindications to buprenorphine treatment? Are there physical illnesses that complicate treatment?

17. What kind of recovery environment does the patient have? Are the patient’s psychosocial circumstances sufficiently stable and supportive?

18. What is the patient’s level of motivation? What stage of change characterizes this patient?

Patients less likely to be appropriate candidates for office-based treatment are individuals whose circumstances or conditions include or have previously included those listed in figure 3-13.

Figure 3-13 Conditions and Circumstances That May Preclude a Patient as a Candidate for Office-Based Buprenorphine Treatment

- Comorbid dependence on high doses of benzodiazepines or other central nervous system depressants (including alcohol)
- Significant untreated psychiatric comorbidity
- Active or chronic suicidal or homicidal ideation or attempts
- Multiple previous treatments for drug abuse with frequent relapses (except that multiple previous detoxification episodes with relapse are a strong indication for long-term maintenance treatment)
- Poor response to previous well-conducted attempts at buprenorphine treatment
- Significant medical complications
- Conditions that are outside the area of the treating physician’s expertise

Cautions and Contraindications for Buprenorphine Treatment

Several medical conditions and medications, as well as concurrent abuse of other drugs and alcohol, necessitate caution or are relative contraindications to buprenorphine treatment.

Seizures
Buprenorphine should be used cautiously in patients who are being treated for seizure disorders. When buprenorphine is used concurrently with antiseizure medications (e.g., phenytoin, carbamazepine, valproic acid, and others), metabolism of buprenorphine and/or the antiseizure medications may be altered. (See figure 2-3.) In addition, the relative risk of interaction between buprenorphine and sedative-hypnotics (e.g., phenobarbital, clonazepam) should be kept in mind. Monitoring for therapeutic plasma levels of seizure medications should be considered.

**HIV Treatment**

Buprenorphine should be used cautiously in combination with HIV antiretroviral medications that may inhibit, induce, or be metabolized by the cytochrome P450 3A4 enzyme system. (See figure 2-3.) Protease inhibitors inhibit cytochrome P450 3A4. Metabolism of buprenorphine and/or the antiretroviral medications may be altered when they are combined. In some cases, therapeutic blood levels may need to be monitored. Note that this is a caution, not a contraindication; successful treatment of addiction with buprenorphine in HIV-infected patients has been well demonstrated (Berson et al. 2001; Carrieri et al. 2000; McCance-Katz et al. 2001; Moatti et al. 2000).

**Hepatitis and Impaired Hepatic Function**

Pharmacotherapy with buprenorphine is not contraindicated on the basis of mildly elevated liver enzymes; however, elevated liver enzymes should be appropriately evaluated and monitored frequently. Viral hepatitis (especially infection with HBV or HCV) is common among individuals who abuse opioids and should be evaluated and treated appropriately.

**Pregnancy**

Buprenorphine is classified by FDA as a Category C agent. Very few studies exist on the use of buprenorphine in pregnant women. If a patient is pregnant or is likely to become pregnant during the course of treatment with buprenorphine, the physician must consider whether buprenorphine is the appropriate treatment and must weigh the risks and benefits of buprenorphine treatment against all the risks associated with continued heroin or other opioid use. In the United States, methadone is the standard of care for pregnant women who are addicted to opioids. (See “Pregnant Women and Neonates” in chapter 5.)

**Use of Other Drugs**

Buprenorphine is a treatment for opioid addiction, not for addiction to other classes of drugs. Although the use of other drugs tends to be a predictor of poor adherence, other drug use is not an absolute contraindication to buprenorphine treatment. (See below for exceptions.)

Patients should be encouraged to abstain from the use of all nonprescribed drugs while receiving buprenorphine treatment. However, abuse of or dependence on other drugs (e.g., alcohol, cocaine, stimulants, sedative-hypnotics, hallucinogens, inhalants) is common among individuals who are addicted to opioids, and such abuse or dependence may interfere with overall treatment adherence.

Patients who use or abuse more than one substance present unique problems and may need referral to resources outside the office setting for more intensive treatment. Patients should be encouraged to be truthful about their use of all drugs. A recent drug use history and a toxicology screen for drugs of abuse are guides to help assess use, abuse, and dependence on opioids and other drugs. Treatment of patients with more than one addiction problem will depend largely on the physician’s level of comfort in treating addiction, the availability of psychosocial support and counseling, and the availability of other forms of addiction treatment. (See “Polysubstance Abuse” in chapter 5.)

**Sedative-Hypnotics**

The use of sedative-hypnotics (benzodiazepines, barbiturates, and others) is a relative contraindication to treatment with buprenorphine because the combination (especially in overdose) has been reported to be associated with deaths (Reynaud et al. 1998a,b). The combination of buprenorphine and sedative-hypnotics may increase depression of the
central nervous system. If treatment with buprenorphine and sedative-hypnotics is necessary, the doses of both medications may need to be lowered. Physicians must assess for use, intoxication, and withdrawal from sedative-hypnotics. Unfortunately, the use of certain benzodiazepines and other sedatives may not be detected on routine drug screens. Physicians must determine their laboratory’s specific parameters for detection of sedative-hypnotic use.

**Alcohol**

Because alcohol is a sedative-hypnotic drug, patients should be advised to abstain from alcohol while taking buprenorphine. Rarely are individuals with active, current alcohol dependence appropriate candidates for office-based buprenorphine treatment. (It may be possible to treat such patients through initial, intensive services that effectively detoxify the patient from alcohol while concurrently starting buprenorphine [e.g., in an inpatient or residential setting].)

Patients may present with withdrawal symptoms from other drugs at the same time they are experiencing opioid withdrawal symptoms. Buprenorphine will not control seizures caused by withdrawal from alcohol or other sedative-hypnotic substances. Benzodiazepines and barbiturates, the most commonly used pharmacological treatments for seizures caused by alcohol or other sedative-hypnotic withdrawal, should be used only with caution in combination with buprenorphine because of the increased risk of central nervous system and respiratory depression from the combination.

**Summary**

Patients who may be good candidates for opioid addiction treatment with buprenorphine are those who have an objective diagnosis of opioid addiction, who have the appropriate understanding of and motivation for buprenorphine treatment, and who do not have medical or psychiatric contraindications to this form of treatment. This chapter has provided information on the questions, cautions, and contraindications that should be considered when determining whether a patient is an appropriate candidate for opioid addiction treatment with buprenorphine. Chapter 4 describes the next steps in providing treatment with buprenorphine for opioid addiction.

**Footnotes**


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