Module 4: Patients with Current OUD

Welcome to Compass SHARP in Practice, a quick high-yield learning session made for busy healthcare professionals like you. In each episode, our Compass coaches will explore a real-world case, define a clinical goal, and walk through practical strategies to improve care. Whether you're tuning in via video, audio, or reading the summary, we hope to sharpen your skills and build knowledge that helps you better care for your patients.

A Patient Case

Elliot is a 50-year-old man with untreated opioid use disorder who presents to the emergency department with right lower quadrant abdominal pain. He reports using approximately 10 to 20 fentanyl tablets daily, which he smokes. He appears restless and anxious and describes severe pain. Imaging confirms acute appendicitis.

The surgical team is consulted, and after a successful appendectomy, they decide to avoid opioids entirely due to concern about "worsening his addiction". Postoperatively, nurses struggle to manage his pain, and Elliot becomes increasingly frustrated and agitated. The next morning, upset about his treatment, he leaves the hospital against medical advice.

Scenarios like this highlight common misunderstandings about addiction and opioid dependency. Avoiding opioids in patients with opioid use disorder often leads to poor patient outcomes, challenging encounters for healthcare teams, and negative experiences for everyone involved. Evidence shows that patients with opioid use disorder frequently receive suboptimal pain control and face stigma and blame in both hospital and post-operative settings.

Moreover, if a patient's opioid tolerance is not maintained, healthcare teams may unintentionally increase the risk of AMA discharges, overdose and mortality. Caring for these patients requires nuance, but there are evidence-based and compassionate approaches that can safely manage pain while supporting recovery.

Goal

Our goal in this module is to implement evidence-based strategies that reduce harm, improve safety, and build trust for patients with active opioid use disorder.

First, aggressively treat pain and opioid withdrawal in patients with OUD. Patients with opioid use disorder often have significant opioid tolerance, and unmanaged withdrawal can lead to serious complications during their hospital stay. The use of full agonist opioids, such as morphine, hydromorphone, and fentanyl, is appropriate and should not be withheld simply because a patient has OUD. Patients may require higher doses of full agonist therapy and should be transitioned to a long-acting opioid, such as MS-Contin, with short-acting opioids available for breakthrough pain. Whenever possible, a pain or addiction medicine consultation should be obtained to optimize care.

Second, utilize multimodal therapy and regional analgesia for pain management. Patients with OUD often have opioid tolerance, and their baseline opioid needs must be met. However, post-surgical pain can often be effectively managed using multimodal analgesia. Scheduled non-opioid medications, such as acetaminophen and NSAIDs, along with regional analgesia, should form the foundation of pain control. Opioids should still be available for breakthrough pain and should not be withheld.

Third, treat the hospital admission as an opportunity to explore addiction treatment. Ask patients if they are interested in addiction treatment or exploring recovery. If the patient is open, the care team can consult local resources, including opioid treatment programs or MAT providers. Patients can even be initiated on medications for opioid use disorder, such as buprenorphine or methadone, during hospitalization. Ensure that discharge includes a warm handoff to addiction care rather than just a list of providers.

Fourth, provide harm reduction counseling. Addiction is a medical condition, and our goal is to keep patients safe. Provide naloxone and referrals to harm reduction resources in the community, such as syringe exchange programs or public health services, especially if the patient is ambivalent about treatment. Even a brief discussion about overdose prevention can build trust and support patient safety.

Back to the Case

Let's revisit Elliot's case to see what happens when we apply these strategies.

This time, his care team recognizes his opioid withdrawal and manages it aggressively, initially with IV hydromorphone and later with oral morphine sulfate and IV hydromorphone for breakthrough pain. The patient required roughly 240 morphine milligram equivalents to meet his baseline opioid needs.

The anesthesiologist, aware of the complexity of this case, performed a TAP block and used a multimodal approach during surgery. Postoperatively, the patient received scheduled Toradol, acetaminophen, and PRN ketamine in addition to his baseline opioids. His withdrawal symptoms were well controlled, and he was referred to an opioid treatment program with follow-up scheduled for the next day.

Nursing staff reviewed harm reduction principles and naloxone was prescribed at discharge. The patient left the hospital stable, informed, connected to recovery resources, and satisfied with his care.

Takeaways

- Implement screening for opioid use history on every surgical admission.
- Treat opioid withdrawal aggressively and do not deny opioids to patients with opioid tolerance who require emergent or non-elective surgery.
- When patients are identified as having opioid use disorder, use the hospitalization to encourage and refer them to addiction treatment or even initiate treatment during their stay.
- Include harm reduction and naloxone education in discharge teaching, and track readmission and AMA discharge rates among this vulnerable patient population as quality measures for engagement.

Thank You

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Thank you for all you do caring for your patients.