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 The minimum recommended interval between stopping the opioid and starting naltrexone depends on the opioid used, duration of use and the amount taken as a last dose. Opioid agonists with long half-lives such as methadone will require a wash-out period of up to 10 days, whereas shorter acting opioids such as heroin, morphine or fentanyl may only require up to 7 days. Experience with buprenorphine indicates that a wash-out period of up to 7 days is sufficient if the final buprenorphine dose is >2mg and duration of use >2 weeks. In some cases naltrexone may be started within 2–3 days of a patient stopping (e.g. if final buprenorphine dose <2mg and duration of use <2 weeks). A test dose of naloxone (0.2–0.8mg) (which has a much shorter half-life than naltrexone) may be given to the patient as an IM dose before starting naltrexone treatment. Any withdrawal symptoms precipitated will be of shorter duration than if precipitated by naltrexone. Patients must be advised of the risk of withdrawal before giving the dose (Box 4.5). It is worth thoroughly questioning the patient as to whether they have taken any opioid-containing preparation unknowingly (e.g. over-the-counter analgesic). Dose of naltrexone An initial dose of 25mg naltrexone should be administered after a suitable opioid-free interval (and naloxone challenge if appropriate). The patient should be monitored for 4 hours after the first dose for symptoms of opioid withdrawal. Symptomatic medication for withdrawal should be available for use, if necessary, on the first day of naltrexone dosing (withdrawal symptoms may last up to 4–8 hours). Once the patient has tolerated this low naltrexone dose, subsequent doses can be increased to 50mg daily as a maintenance dose. Naltrexone is contraindicated in patients with hepatic dysfunction and liver function tests should be monitored during treatment. Pain control in patients on OST Analgesia for methadone-prescribed patients Non-opioid analgesics should be used in preference (e.g. paracetamol, non-steroidal anti-inflammatory drugs [NSAIDs]) initially where appropriate. If opioid analgesia (e.g. codeine, dihydrocodeine, morphine) is indicated due to the type and severity of Box 4.5 Important points regarding prescribing naltrexone ■ ■Ensure the recipient is fully informed of the increased risk of fatal opioid overdose. ■ ■Following detoxification and any period of abstinence, an individual’s tolerance to opioids will decrease markedly. At such a time, using opioids puts the individual at greatly increased risk of overdose. ■ ■Discontinuation of naltrexone may also be associated with

an increase in inadvertent overdose from illicit opioids, emphasising the need for close monitoring and support of the client at this time.

Addictions and substance misuse CHAPTER 4 the pain then this should be titrated accordingly for pain relief in line with usual analgesic protocols. If an opioid analgesic is appropriate, a non--methadone opioid may be co-prescribed, i.e. it is not necessary to 'rationalise' the patient's entire opioid requirements to one drug.97 Analgesia for buprenorphine-prescribed patients Patients taking buprenorphine will have a reduced effect of opioids including those prescribed for analgesia. While there are case reports detailing resolution of acute pain, or easier management of it, following buprenorphine discontinuation, head-to-head comparisons of stopping buprenorphine versus continuing buprenorphine show no superiority of one strategy over the other and there is no expert consensus. The British Peri-operative Pain and Addiction Interdisciplinary Network (PAIN) guidelines state that buprenorphine should be continued during periods of acute pain, for example perioperatively.98 If a patient on buprenorphine requires treatment for acute pain, non- opioid analgesia and regional anaesthetic techniques should be used and an additional opioid added if needed.98 The Australian guidelines include an option to use a more potent opioid (e.g. fentanyl) with the rationale that it may displace buprenorphine.99 The PAIN guidelines state that there is insufficient evidence to choose one full agonist over another. If standard pain approaches do not cause a resolution of the pain, consider reducing the dose of buprenorphine. The Australian guidelines state that second-line adjuvant non-opioid analgesia can also be considered such as ketamine as a potential third step.99 If buprenorphine is stopped during the period when acute pain relief is required, use of low-dose induction to re-establish buprenorphine treatment has been described as acceptable and tolerable.100,101 From an implementation perspective, it is a practical option in the acute hospital as it does not rely on careful monitoring of withdrawal severity and awareness of medications prescribed on the 'prn' side, both of which can be missed on a busy ward. The primary objectives during the period of acute pain are to manage the pain and avoid the consequences of withdrawal (e.g. discharge against medical advice), so it is important to maintain sufficient background medication to achieve both. Liaison with both the in-patient pain team and the local addictions services, as well as collaborative discussion with the patient, is important. In palliative care, the principles of providing analgesia in substance misusers are no different from those for other adult patients needing palliative care, although increased liaison with substance misuse services is essential. Those who are opioid-dependent may receive maintenance therapy from a substance misuse service. For the purposes of palliative care, this should be regarded as a separate prescription from that for analgesia when attending a pain clinic. During admission all medication would usually be received from the in-patient unit, but there should be a clear plan for separate follow- ups for substance misuse and symptom palliation.97 Pregabalin may be used for pain relief but there have been concerns regarding both the abuse potential of the drug81 and the potential for co-prescription of pregabalin and opioids to increase the potential for fatal overdose.102

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