ST VINCENT'S HOSPITAL (June 2001)

OPIATE WITHDRAWAL RATING SCALE

IDENTIFICATION

WARD:_____

DATE								
TIME	hr	hr	hr	hr	hr	hr	hr	hr
Nausea & vomiting								
Goose flesh								
Sweating								
Restlessness (Tension)								
Tremor								
Lacrimation								
Nasal congestion								
Yawning								
Abdominal changes								
Muscle aches								
Total score								
Average score (=total score divided by 10)								

Ratings for each item: 0=none, 1=mild, 2=moderate, 3=severe.

Average score **1 = mild** **2 = moderate** **3 = severe**

This scale can be used as a guide in monitoring withdrawal from opiates.

Comments:

Prepared by Department of Drug & Alcohol Studies, St Vincent's Hospital from: Gossop M. The development of a short opiate withdrawal scale (SOWS). Addictive Behaviours 1990;15:487-490.

OPIATE WITHDRAWAL SYNDROME

MANAGEMENT GUIDELINES

Non-medicated management

Opiate withdrawal is uncomfortable for the illict drug user. It is not likely to be life threatening or excessively uncomfortable unless the user is heavily dependent. Objective signs of withdrawal discomfort and symptoms are less evident than will often occur during alcohol withdrawal.

The signs of withdrawal usually start to appear 8-12 hours after the last dose and after 12 hours they become progressively more intense. Some of the overt physical signs should be obvious. Withdrawal symptoms usually reach their peak at 48-72 hours.

The opiate withdrawal scale is a useful clinical tool which can assist treatment staff in the management of such patients. **The withdrawal scale should never be used alone without reference to clinical interview and may be misleading in the treatment of complicated withdrawals.** This is particularly so in the poly-drug user. The withdrawal scale alone should not be used to indicate a progression to serious illness.

The physical environment supplied should be unprovocative, lighting should be such that there are no harsh shadows and overall noise levels should be low. Patients should be secure from illicit drug dealers and there should be physical security. Therapies such as spa baths, acupuncture, massage, hot baths and exercise are often found efficacious in helping an individual to withdraw from opiates.

Supporting counseling is often helpful – particularly in allaying misapprehension that the patient may experience while withdrawing. Careful explanation of the withdrawal process and of the physical symptoms that are likely to occur, their possible duration will often be helpful. Regular observations are important. Should deterioration occur, reassessment and a medicated management may be indicated. **Non-medicated withdrawal is not advised in individuals with serious sedative dependence, a past history of withdrawal seizures or the presence of medical/psychiatric conditions that require emergency assistance, including those with suicidal ideation.**

Medicated management

There are a variety of pharmacological agents that can be helpful in assisting symptomatic withdrawal. These include Imodium or Lomotil for distressing diarrhoea, non-steroidal anti-inflammatory drugs (in those in which it is not contra-indicated) for muscle cramps and anti-spasmodics such as Buscopan for those with gastrointestinal colic. In many of these individuals somatic therapies (non-pharmacological) are equally efficacious.

There is no evidence that Codeine or other short-acting narcotic drugs are of any value in the management of opiate withdrawal. Likewise anti-psychotic medications are, on the whole, not recommended.

Evidence of withdrawal

In addition to the 10 symptoms mentioned on the short opiate withdrawal scale, there are a series of physical signs that are often helpful in assessing an individual in opiate

withdrawal. These include sweating, dilated pupils (midriasis), sneezing, diarrhoea, goose flesh (piloerection) – especially on the upper thorax, an elevated pulse rate and/ or blood pressure, and shivering. These should be looked for as objective methods of confirming the presence of opiate withdrawal.

Medications for use in opiate withdrawal

1. Methadone

This is probably the gold standard for individuals undergoing opiate withdrawal. It can be given either as a tapering dose of oral methadone or you set out to stabilise the individual on an inpatient basis so that they can enter a methadone maintenance program.

2. Clonidine

This alpha-2 adrenergic agonist acts to inhibit the release of noradrenalin. It is said to have no abuse or dependency potential. It should only be used in an inpatient setting but can be tapered following discharge. **It is important to be aware that hypotension is a common side effect.** Doses should be withheld if the diastolic pressure falls below 60mm of mercury.

3. Sedative medications

Benzodiazepines may be useful to allay anxiety and agitation that often occurs during opiate withdrawal. Diazepam or Doxepin would appear to be appropriate medications, the latter one particularly as part of night-time sedation.

Withdrawal scales are intended as a guide to therapy, not as diagnostic instruments. Opiate withdrawal may be complicated by acute medical problems (e.g. sepsis). It is wise not to overlook this possibility. Many opiate dependent individuals are also poly-drug users. This can interfere with the validity of the scale. Additional information, including advice on management, can be obtained by contacting the Department of Drug & Alcohol Studies (ext. 2627). After hours, contact the switchboard.

SYMPTOMS AND SIGNS OF OPIATE WITHDRAWAL:

Nausea and vomiting
"Do you feel sick to your stomach? Have you vomited?" – Observation
- 0 = No nausea, no vomiting
- 1 = Mild nausea with no retching or vomiting
- 2 = Intermittent nausea with dry heaves
- 3 = Constant nausea, frequent dry heaves and/ or vomiting

Goose flesh
Observation
- 0 = No goose flesh visible
- 1 = Occasional goose flesh but not elicited by touch, not prominent
- 2 = Prominent goose flesh, in waves and elicited by touch
- 3 = Constant goose flesh over chest and arms

Sweating
Observation
- 0 = No sweat visible
- 1 = Barely perceptible sweating, palms moist
- 2 = Beads of sweat obvious on forehead
- 3 = Drenching sweat over face and chest

Restlessness (Tension)
Observation:
- 0 = Normal activity
- 1 = Somewhat more than normal activity (may move legs up and down, shift position occasionally)
- 2 = Moderately fidgety and restless, shifting position frequently
- 3 = Gross movements most of the time or constantly thrashes about

Tremor
Arms extended and fingers spread apart – Observation
- 0 = No tremor
- 1 = Not visible but can be felt finger tip to finger tip
- 2 = Moderate with patient's arms extended
- 3 = Severe even if arms not extended

Lacrimation
Observation:
- 0 = No lacrimation
- 1 = Eyes watering, tears at corners of eyes
- 2 = Profuse tearing from eyes over face

Nasal congestion
Observation:
- 0 = No nasal congestion or sniffling
- 1 = Frequent sniffling
- 2 = Constant sniffling with watery discharge

Yawning
Observation:
- 0 = No yawning
- 1 = Frequent yawning
- 2 = Constant uncontrolled yawning

Abdominal changes
Ask: "Do you have any pains in your lower abdomen?"
- 0 = No abdominal complaints, normal bowel sounds
- 1 = Reports waves of abdominal crampy pain, active bowel sounds
- 2 = Reports crampy abdominal pain, diarrhoeal movements, active bowel sounds

Muscle aches
Ask: "Do you have any muscle cramps?"
- 0 = No muscle aching reported, e.g. arm and neck muscle soft at rest
- 1 = Mild muscle pains
- 2 = Moderate muscle pains
- 3 = Reports severe muscle pains, muscles of legs, arms and neck in constant state of contraction