Office-Based Management of Opioid Use Disorder (OUD): Maintenance and Detecting/Dealing with Relapse

Developer: Rachel King, MD

Director of Primary Care Integration

DotHouse Health, Boston, MA

Reviewer/Editor: Miriam Komaromy, MD, The ECHO Institute™

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under contract number HHSH250201600015C. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Disclosures

Rachel King has no financial conflicts of interest to disclose

Learning Objectives

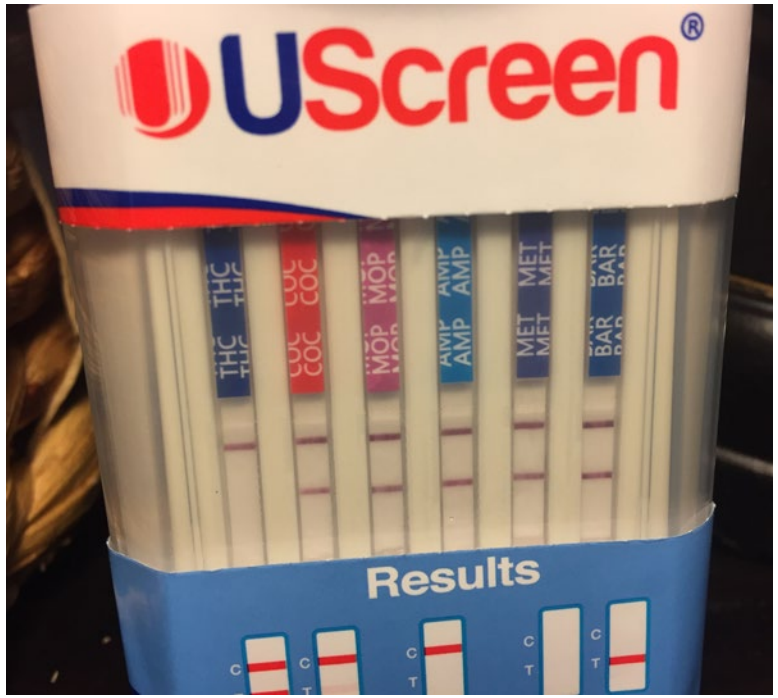
1. Be able to interpret urine drug screen results, while understanding the limitations

2. Review strategies to recognize a relapse and adapt treatment plan

3. Utilize tools to help identify diversion

Urine Drug Screens

- Familiarize yourself with what is available through your lab and toxicologist
- Have a way to confirm unexpected results
- Do not base treatment decisions solely on urine drug screen results
- Ask patients what you will find
- No need to “catch” patient in a lie – be upfront about results



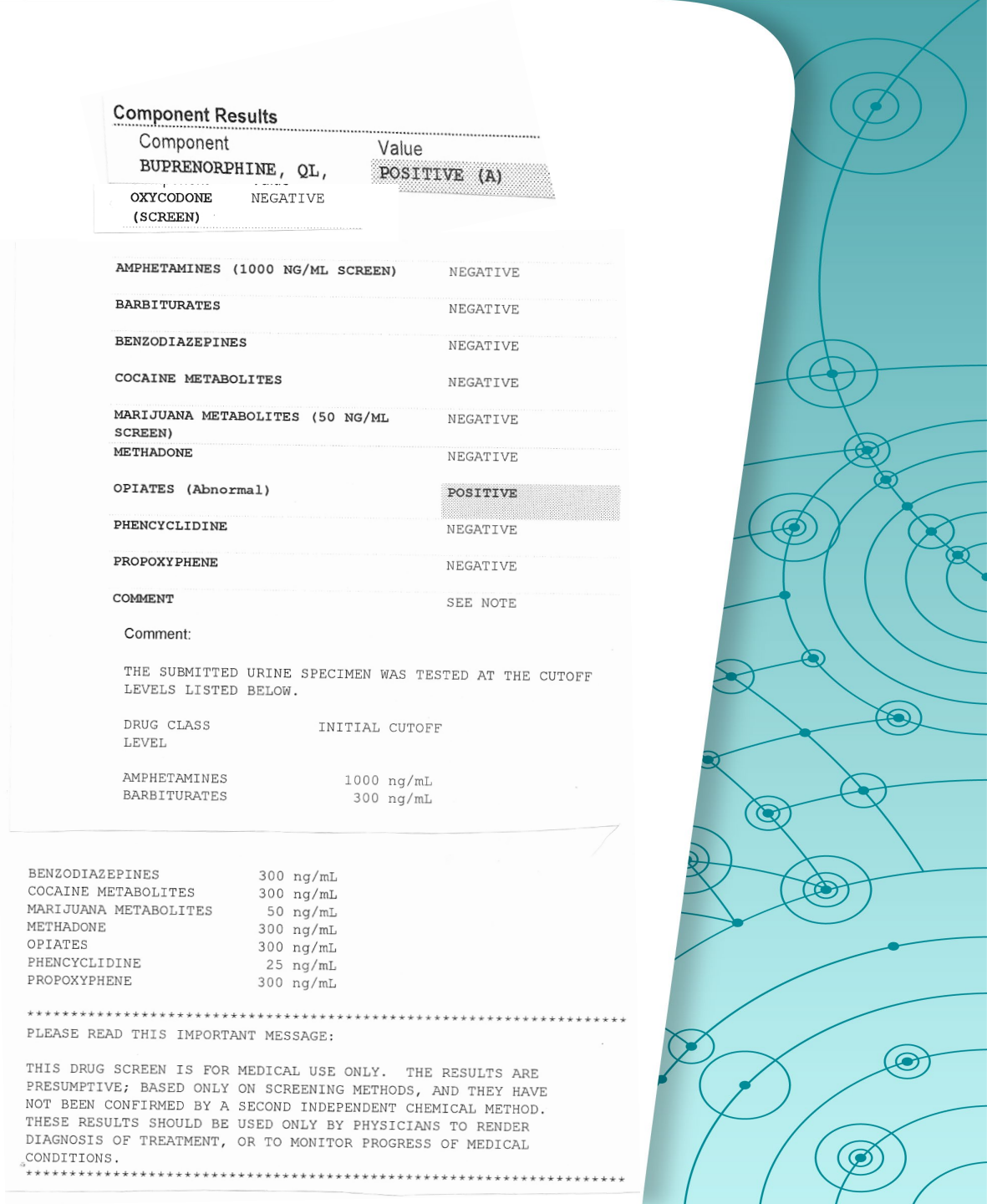
Common Urine Drug Screens

- Opiates – will include heroin, morphine, hydrocodone
  - Will NOT include oxycodone, methadone, fentanyl, buprenorphine (buprenorphine)
- Cocaine – false positives are unusual
- Benzodiazepines
- Marijuana – may stay positive for 28 days in frequent user
- Amphetamines/Barbiturates – false positives more common
- Alcohol urine screen not recommended

Case 1

A patient stable on buprenorphine for months has the following urine drug screen result. He reports doing well on treatment and has no concerns.

Urine drug screen result: Buprenorphine + Opiates + otherwise negative



Component Results

Component	Value
BUPRENORPHINE, QL,	POSITIVE (A)
OXYCODONE (SCREEN)	NEGATIVE
AMPHETAMINES (1000 NG/ML SCREEN)	NEGATIVE
BARBITURATES	NEGATIVE
BENZODIAZEPINES	NEGATIVE
COCAINE METABOLITES	NEGATIVE
MARIJUANA METABOLITES (50 NG/ML SCREEN)	NEGATIVE
METHADONE	NEGATIVE
OPIATES (Abnormal)	POSITIVE
PHENCYCLIDINE	NEGATIVE
PROPOXYPHENE	NEGATIVE
COMMENT	SEE NOTE

Comment:

THE SUBMITTED URINE SPECIMEN WAS TESTED AT THE CUTOFF LEVELS LISTED BELOW.

DRUG CLASS	INITIAL CUTOFF LEVEL
AMPHETAMINES	1000 ng/mL
BARBITURATES	300 ng/mL
BENZODIAZEPINES	300 ng/mL
COCAINE METABOLITES	300 ng/mL
MARIJUANA METABOLITES	50 ng/mL
METHADONE	300 ng/mL
OPIATES	300 ng/mL
PHENCYCLIDINE	25 ng/mL
PROPOXYPHENE	300 ng/mL

****

PLEASE READ THIS IMPORTANT MESSAGE:

THIS DRUG SCREEN IS FOR MEDICAL USE ONLY. THE RESULTS ARE PRESUMPTIVE; BASED ONLY ON SCREENING METHODS, AND THEY HAVE NOT BEEN CONFIRMED BY A SECOND INDEPENDENT CHEMICAL METHOD. THESE RESULTS SHOULD BE USED ONLY BY PHYSICIANS TO RENDER DIAGNOSIS OF TREATMENT, OR TO MONITOR PROGRESS OF MEDICAL CONDITIONS.

****

Possible Scenarios

1. Patient relapsed with an opioid such as heroin

2. Patient was prescribed opioids for a medical reason, such as cough syrup with codeine

3. Patient has false positive from poppy seed ingestion or technical error

Addressing Relapse

- Relapses are expected and will vary in severity
- Do not “fire” a patient for positive urine
- Intensify treatment plan through more frequent visits, urine drug screens, and psychosocial supports
- Have a guide for when you will refer for higher level of care (i.e., methadone or inpatient)

How to approach patient-Urine Drug Screen Mismatch

- Consider confirmatory testing with quantitative levels
- Do not focus on patient characteristics “you relapsed” but focus on result “the urine was positive for cocaine”
- If patient reluctant to intensify treatment, present this as standard care and not a personal decision

Back to Case… Next Steps

- Tell patient “urine showed opioids”
- Confirm with patient any prescriptions, poppy seed ingestion, recent medical procedures

Patient denies relapse -->

- Ask lab to confirm results
- Check PDMP
- Inquire about recent triggers
- Intensify treatment by increasing visit frequency, behavioral health (BH) support

Case 2

A patient has been struggling since engaging in treatment. She has had intermittent relapses with heroin and benzos. She continues to smoke MJ daily. She is at risk of losing custody of her child. She struggles with anxiety and insomnia. Today she presents as sedated and guarded, and denies any recent drug use.

Urine drug screen result:

Buprenorphine + otherwise negative

Possible Scenarios

1. Patient is taking buprenorphine and sedation is due to non-drug effect

2. Patient is taking buprenorphine and sedation is due to use of drug not tested for on urine drug screen (such as alcohol or fentanyl)

3. Patient tampered with urine, since it would be unusual for a daily cannabis user to have a urine negative for cannabis

Polysubstance Use

- Research shows mixed results about effect of other drug use on retention in buprenorphine treatment
- Alcohol and benzos are the riskiest because of overdose risk
- Determine if habitual use or if meets criteria for substance use disorder (SUD)
- Maximize psychosocial supports
- Decide how your program will approach ongoing use of other substances

Back to Case… Next Steps

- Let patient know that you're concerned about how they're doing, and aim to build rapport
- Intensify treatment with frequent clinic visits, mental health support, and possible SSRI to treat anxiety
- If concern for tampering, ask for repeat urine or consider other testing (such as oral swab, urine temperature/creatinine)

Case 3

A patient is stabilizing on buprenorphine, has been adherent with recommended treatment, and you have no concerns.

Urine drug screen result:

Negative for all substances (including buprenorphine)

Possible Scenarios

1. Patient is diverting buprenorphine
2. Patient has run out early of buprenorphine
3. Patient is fast metabolizer or has dilute urine
4. Patient has tampered with urine to hide relapse

Detecting Diversion

- Urine drug screens must include buprenorphine testing
- Consider occasional specific metabolite testing (norbuprenorphine)
- Do random visits with pill counts for stable patients
- Routine PDMP checks

Addressing Diversion

- Use of non-prescribed buprenorphine is often to self-treat withdrawal *
- Risk of diversion may increase as patients stabilize and choose to self-taper the medication
- Educate patients up front about importance of not diverting
- Must stop prescribing if strong evidence of diversion

* Allen B J Subst Abuse Treat. 2016 Nov

Back to Case… Next Steps

- Ask lab to run quantitative testing
- Consider checking urine creatinine/specific gravity
- Call patient back for random pill count
- Disclose result with patient “the urine did not show any buprenorphine”
- Confirm they are taking buprenorphine as prescribed
- If patient no-shows to random call back, high suspicion for diversion

Resources

HRSA Opioids Crisis Webpage

Help with Urine Drug Screen Interpretation from MyTopCare.org

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under contract number HHSH250201600015C. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.