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The College of Physicians & Surgeons of Manitoba

Buprenorphine/naloxone Recommended Practice Manual

Introduction: Recommendations for Opioid Use Disorder

EVIDENCE SUMMARY

The treatment of choice for people with opioid use disorder (OUD) is opioid agonist therapy (OAT), ideally, though not necessarily, in combination with psychosocial interventions such as counseling, contingency management, and/or peer support. The main options for OAT include buprenorphine/naloxone (Suboxone) and methadone, with Sustained Release Oral Morphine (SROM) as a third line option. Novel long-acting formulations of buprenorphine are also available.

First-line Treatment

Due to its comparable effectiveness and an enhanced safety and side-effect profile, buprenorphine/naloxone is the preferred first-line treatment for OUD. For the majority of people with OUD, it should be used preferentially. Further reasons to strongly consider buprenorphine/naloxone as the optimal pharmacologic treatment include significant alcohol, benzodiazepine, or other sedative/hypnotic use, or significant respiratory disease.

Consideration for methadone as an alternative agent may be appropriate in the presence of:

- Significant cirrhosis (where activity of the naloxone component is enhanced due to reduced first pass effect, causing problematic withdrawal symptoms),
- Previous failed treatment with buprenorphine/naloxone, or
- Very high opioid tolerance unlikely to stabilize on a partial opioid agonist.

Personal preference should also be considered, though it is important to ensure that people understand the risks and benefits of the various OAT medications and make an informed choice.

In rare situations, a third-line option such as SROM or injectable OAT (iOAT) may be appropriate, *in consultation with an addiction medicine specialist*.

Opioid Antagonists

Alternative pharmacologic options that have been studied include opioid antagonists. While there is emerging evidence to support sustained release injectable naltrexone as an alternative to OAT in some populations, it is not currently available in Canada.

Oral naltrexone is available but is not supported by the evidence. However, in people who decline OAT in favour of abstinence-based treatment, oral naltrexone may be considered as an adjunct to reduce risk of overdose in the event of resumption of opioid use.

Detox NOT Recommended

Withdrawal management, or detox, without transition to OAT and long-term treatment is **specifically NOT recommended as it has been associated with increased morbidity, such as HIV transmission, and mortality secondary to overdose.**

If people decline OAT despite the risks, a slow outpatient taper of opioids is a safer approach than admission to a hospital or residential detox setting. Other considerations to improve safety include the use of oral naltrexone for overdose protection, take-home-naloxone for overdose treatment, and enrolment in intensive psychosocial interventions including long-term residential treatment or recovery housing.

Harm-Reduction is Paramount

Finally, there is **ample evidence to support harm-reduction interventions for all people who use opioids**, including those engaged in OAT or other treatment.

Specific interventions with strong evidence include:

- Harm reduction supply distribution (e.g., needle/syringe programs)
- Supervised consumption/overdose prevention sites, and
- Take-home-naloxone training.

These interventions should be made widely available with low barriers to help reduce opioid related harms.

In Summary

For the treatment of opioid use disorder, the evidence suggests:

- OAT with buprenorphine is the preferred first-line treatment.

- OAT with methadone is an alternative first-line treatment.
- OAT with SROM or injectable options are *specialist-led approaches* for severe or complex disease.
- Oral naltrexone is not recommended as primary treatment. It may be used to reduce the risk of overdose if OAT is refused.
- Withdrawal management (i.e., detox), without immediate transition to OAT and long-term treatment, is *NOT recommended.*
- Harm reduction interventions, including supply distribution, supervised consumption, and take-home-naloxone training should be widely available, promoted, and considered standard of care for all people at risk of opioid related harms.