Case 1:

36 year-old man comes to see you in urgent care for redness and swelling of his arm. He reports active injection heroin use and notes the swelling and redness began two days ago around an injection site. The area is tender and fluctuant. He tells you he was prescribed oxycodone after a sports injury and he began using more and more. Once his doctor stopped prescribing to him he began buying it, first using it via intranasal use, then transitioning to intranasal heroin and ultimately injection heroin use. He uses three times per day. He has never had an overdose. He was diagnosed with HCV two years ago. He tries to hide his use from his parents and his girlfriend. He has been to detox and residential treatment a dozen times but always relapses shortly after. He smokes 1 PPD but otherwise uses no other substances.

Is office-based buprenorphine treatment appropriate for him?

Case 2:

52 year-old gentleman with history of injection heroin use since age 20 presents to your clinic asking for help. His substance use history is notable for early initiation of alcohol use, followed by marijuana, cocaine, and then heroin use at age 20 with rapid initiation of injection use. His longest period of sobriety was for four years when he was on methadone maintenance and did very well at a dose of 110 mg daily. He had take homes, was working full time, and not using any other substances. He decided to taper off methadone and unfortunately relapsed to heroin use. Since then he has been using pretty consistently for the past five years. He has tried buprenorphine numerous times through different treatment programs but each time ran into issues with having his medication lost or stolen and continued ongoing heroin use. He notes that he found it hard to commit to taking his medication on his own every day and then the temptation to use would overwhelm him. He is currently homeless. In addition to heroin he uses injection cocaine intermittently- he estimates a few times per week.

Is office-based buprenorphine treatment appropriate for him?

Case 3:

28 year-old woman with history of Crohn's disease with a long history of abdominal pain for which she is prescribed hydromorphone. She presents frequently to clinic requesting early refills. On the PMP there is evidence of multiple overlapping prescriptions and different prescribers. She reports buying some additional oxycodone on the street when she isn't able to get prescriptions for hydromorphone. She says she needs the pain medication for her abdominal pain but it also helps her manage stress and feel "normal." She frequently takes more than prescribed because she likes the way it makes her feel. She was recently fired for stealing money from her job to buy pills. Her mom is concerned because she is always sleepy at home. She denies injection use. She has never had an overdose. She has tried to stop using pain medication on her own but finds she thinks about it constantly and feels physically sick.

Is office-based buprenorphine treatment appropriate for her?

Case 4:

A 45 year-old woman with a history of opioid use disorder in remission on buprenorphine/naloxone 8mg/2mg daily comes to see you for pre-op planning. She is scheduled to have dental surgery and is wondering what to do about her buprenorphine and pain management.

What are her options?

Case 5:

A 34 year-old woman who has been stable on buprenorphine/naloxone 8mg/2mg BID for several years finds out she is pregnant. She is excited about the pregnancy and comes to see you immediately after a home pregnancy test is positive to discuss what to do.

What do you do with her buprenorphine/naloxone?

Case 6:

A 22 year-old woman comes to see you for ongoing management of her opioid use disorder. She has a two year history of prescription opioid use. She was using several times per week, via intranasal use. She was never using daily. She had cravings, tolerance, but minimal withdrawal symptoms. She started an IOP and was able to stop using on her own. She still finds herself thinking about using occasionally but feels very committed to sobriety. She is starting back at college in the fall and is worried that being around old friends might be a trigger.

Is office-based buprenorphine treatment appropriate for her?

Case 7:

40 year old male comes to your clinic for evaluation. For two years, he was treated for OUD with 16 mg buprenorphine daily; this worked well for him until he moved to another town and did not resume care with a new provider. Three months ago after suffering an overdose, he completed a supervised withdrawal/detox, and then transitioned to a sober living home. He has abstained from any substance use since his overdose, but now he's reporting intense cravings every day. He states that buprenorphine worked well for him in the past, and he would like to re-start this medication.

Is office-based buprenorphine treatment appropriate for him?

Case 8:

28 year old female presents for evaluation for treatment of OUD. She currently uses IV heroin and illicit PO clonazepam daily. She is homeless, as her parents do not allow her to stay at her house when she is actively using substances. She is not currently employed, and endorses occasionally exchanging sex for drugs or housing. She expresses a desire to "get my life in order," however does not know where to start.

Is office-based buprenorphine treatment appropriate for her?

DSM5

Opioid Use Disorder

2-3: mild

4-5: moderate

6+: severe

Tolerance

Withdrawal

Using larger amounts than intended

Persistent desire and inability to cut down

Can't stop despite knowledge of harm

Spending a lot of time using/obtaining/recovering from substance use

Cravings

Using the substance in Dangerous situations

Important social and other activities are given up for drug use

Failed role obligations

Social conflict