

Heroin withdrawal

Individuals using heroin regularly (e.g. daily) over an extended period of time are likely to experience withdrawal when ceasing or reducing their heroin use. Good planning can assist withdrawal from heroin and many people will benefit from assistance from their general practitioner.

The major risk associated with heroin withdrawal, is subsequent overdose due to loss of tolerance.

Most patients should be considered for ongoing methadone or Suboxone treatment. Suboxone can be prescribed by non-accredited GPs, for managing heroin withdrawal, or for ongoing longer term treatment. Methadone needs to be prescribed by an accredited prescriber.

However there are situations where the patient decides on a short heroin withdrawal.

1. Assessment

History

- Drug use: quantity (amount, cost, number of injections per day), frequency, duration, route of admin, when last used, features of dependence
- Use of other drugs, (e.g. benzodiazepines, alcohol, etc)
- Withdrawal history; what has worked / not worked in the past
- Home environment and social supports
- Medical and psychiatric history
- Pregnancy
- If concerned re drug seeking behaviour, check with [Prescription Shopping Program](#) (Medicare Australia) (Monday to Friday 9-5 on 1800 631 181).

Examination

- Vital signs (BP, pulse, respiratory rate)
- Evidence of intoxication (pinpoint pupils, sedation, slurred speech, lowered BP, slowed pulse) or withdrawal from heroin (see below) or other drug use
- Evidence of complications of injecting drug use, including injection sites, liver, lymphadenopathy, cardiac, mental state.

Investigation

- Urinary drug screen can be helpful in confirming the history
- Consider LFT's, HIV, Hep B&C testing at some stage with appropriate pre and post test counselling (generally when withdrawal completed).

2. Planning withdrawal

In most cases, heroin withdrawal can be safely completed in the community if there are sufficient supports, however there are some exceptions:

Relative contraindications

- Previous recent drug overdoses.
- Pregnancy - consider referral for methadone or buprenorphine treatment. Withdrawal during pregnancy can lead to miscarriage or premature delivery.
- Unsupportive home environment (e.g. other drug users in the home or no-one to safely supervise).
- Polydrug dependence (in this case you may need to discuss with a specialist agency e.g. Drug and Alcohol Clinical advisory Service [DACAS]).

Withdrawal features

- Insomnia
- Headaches
- Runny nose, watery eyes, yawning
- Poor appetite, nausea, vomiting
- Sweating, goose bumps, hot and cold flushes
- Diarrhoea, abdominal cramps
- Anxiety, agitation, restlessness
- Tachycardia, elevated blood pressure
- Cravings, strong desire to use
- Muscle and joint pain.

Although heroin withdrawal is unpleasant, it is not life threatening unless there is serious underlying disease. Withdrawal symptoms generally start within 6-24 hours of last use and last about 5-7 days with a peak at 48-72 hours.

The main physical symptoms subside but sleep disturbance and mood changes can persist for weeks, and the desire to use again for much longer. Hallucinations and seizures are not typical features of heroin withdrawal and should alert you to other causes or disorders.

3. Management

Supportive care

- Offer written information e.g. 'Getting through heroin withdrawal' booklet which can be ordered from Turning Point, Victoria via this link www.turningpoint.org.au
- Supportive counselling from a GP or other health worker
- Telephone support and counselling is available from the Alcohol and Drug Information Service (ADIS) 8:30am – 10:00pm 7 days /week – Phone: 1300 131 340.

Nutrition and fluids

Recommend that the patient:

- Drinks plenty of fluids (e.g. 2-3 litres of water or fruit juice daily)
- Avoids caffeine and alcohol
- Eats light and healthy meals (small meals several times a day are better than one big meal).

Medication

❖ NON-SUBOXONE SYMPTOMATIC TREATMENT

The following medications can provide symptomatic relief. If concerned about compliance, organise daily pick up from pharmacy, or have medication supervised by a responsible adult:

- Anti-emetic preparation (e.g. metoclopramide 10 – 20 mg qid for up to 3 - 4 days)
- Anti-diarrhoeal preparation (e.g. loperamide 2mg i - ii tab tds for up to 3 - 4 days)
- Anti-inflammatory (e.g. ibuprofen 400 mg qid for up to a week)
- Benzodiazepines can be useful but are not usually required or recommended beyond 5 days
- If diazepam is prescribed use a reducing regime (e.g. diazepam up to 5mg qid for 3/7; then bd for 2/7 then nocte for 1/7).

❖ SUBOXONE (BUPRENORPHINE-NALOXONE)

Suboxone is a superior treatment for opioid withdrawal.

The prescriber will need to obtain an authority for this through the Drugs of Dependence Unit (DDU). See [link](#) for the authority form. Download, complete, and fax or email to DDU with your contact number.

Doses are as follows:

Day	Medication dose
Day 1	4 mg at onset of withdrawal and additional 2 to 4 mg 4 to 6 hours later prn if severe withdrawal
Day 2	4mg mane, additional 2 to 4 evening dose prn
Day 3	4mg mane, additional 2mg evening dose prn
Day 4	2mg mane, additional 2mg evening dose prn
Day 5	2mg mane then cease

Monitor the patient regularly and adjust the medication and treatment plan according to the client's response and level of drug use.

Withhold the medication if the patient is intoxicated.

Drugs **NOT** recommended for outpatient heroin withdrawal: Antipsychotics; flunitrazepam; high dose clonidine (>900micrograms per day due to risk of hypotension and sedation).

Monitoring

Daily review is recommended by the GP or a suitable health worker (e.g. home based withdrawal worker).

Emergency Plan

A plan needs to be made for dealing with complications which may arise, and include phone numbers for counselling support (e.g. ADIS 1300 131 340), the GP or locum cover, and ambulance.

Ongoing Plan

- It is essential to WARN patients regarding overdose - decreased tolerance after even a short period of abstinence can lead to death if the same quantities of heroin are used as before. Mixing medications with alcohol or other drugs can also lead to overdose.
- Training in relaxation techniques can be helpful in giving an alternative to reaching for drugs when anxious.
- Withdrawal services can be a life-saving intervention for some patients. However, on its own, withdrawal treatment is not associated with long term benefits. Ongoing participation in treatment is required to achieve long term changes.
- If relapse occurs, longer term treatment with methadone or Suboxone is available.
- Consult with ADIS on 1300 131 340 regarding post withdrawal treatment options.

4. Harm minimisation approach

- Discuss safe using, blood borne virus testing and vaccination
- Discuss other treatment options if initial plan is unsuccessful (e.g. referral to methadone treatment, inpatient detox – ADIS can assist with appropriate referrals).
- Discuss peer-administered naloxone. This can be prescribed as an S4 for patients. (1mg/ml pre-filled 2ml syringe x 1, 400 microgm amps x 5. Information on naloxone can be obtained at [this link](#)).

Disclaimer

This information is a general guide for the management of heroin withdrawal. Consultation with a specialist drug and alcohol service such as the Drug and Alcohol Clinical Advisory Service (DACAS) is recommended for patients using multiple drugs or with serious medical or psychiatric conditions. Telephone DACAS on (08) 7087 1742. The drug doses given are a guide only and should be adjusted to suit individuals.

For more information

Drug and Alcohol Clinical Advisory Service (DACAS)
Specialist support and advice for health professionals
Telephone: (08) 7087 1742
8:30am - 10pm 7 days/week including public holidays
HealthDACASenquiries@sa.gov.au



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