Buprenorphine in the ED: Busting the Myths

1. Myth #1: You can't administer Buprenorphine in the ED without an X-Waiver.
   BUSTED: Any ED physician or midlevel provider can use buprenorphine in the ED to treat opiate withdrawal. The patient can return to the ED for 3 days In a row to get buprenorphine.

2. Myth #2: Buprenorphine is a scary drug and will throw my patient into withdrawal.
   BUSTED: Well, kind of busted. Buprenorphine will cause withdrawal symptoms. It should be given only to that subset of patients who are already in withdrawal; the COWS scale can measure this, I use MDcalc. When a patient has a COWS scale of 8 or greater, buprenorphine can be given.

3. Myth #3: Every opiate addicted patient in the county will be inundating my ED for buprenorphine.
   BUSTED: ED's that have initiated buprenorphine have seen a decline on drug seeking behavior.

4. Myth #4: We are trading one addiction for another.
   BUSTED: The goal of medical assisted treatment is to trade addiction for dependency. Abstinence from opiates is the goal. While buprenorphine is an opiate agonist, it works primarily to control withdrawal symptoms so that individuals have more control over their cravings and avoid the risky use of opiates.

If you are interested in a deeper dive into the role of buprenorphine in the ED, please view one of these two webinars:

- Developing an ED Initiated Buprenorphine Program (View)
- Buprenorphine 101 - Demystifying Medication Assisted Treatment in Wisconsin (View)

The following information about ED dosing concepts is thanks to Dr. Donald Stader, an ED doc in Colorado: