Treatment of Opioid Use Disorder in an Internal Medicine Residency Clinic

Aishwarya Vishwanath, MD, M. Catherine Trimbur, MD MPH
[1]Department of Medicine, Division of General Internal Medicine, Warren Alpert Medical School of Brown University;

Background

- Multidisciplinary primary care clinics with robust care coordination are strongest in prescribing medications for OUD (MOUD)[1]
- Low-threshold prescribing MOUD strategies improve outcomes[2-3]
- Barriers: insufficient physician education and social services, transportation, stigmatized nature of this care[4]
- Teaching residents how to prescribe MOUD improves patient outcomes and trainee education[5-6], but studies are limited despite residency clinics serving a large proportion of high-risk patients[7]

Case Details

J.F. is a 52-year-old Spanish-speaking female patient who follows in an Internal Medicine Residency Primary Care Clinic.

Past Medical History:

- Opioid use disorder
  - Heroin
  - Non-prescription methadone and Suboxone
  - Intranasal fentanyl
- Multiple drug overdoses resulting in anoxic brain injury with cognitive impairment and short-term memory loss
- Benzodiazepine use disorder, in remission
- Cocaine use disorder, in remission
- Chronic pain
- Major depressive disorder with multiple suicide attempts
- Severe persistent asthma
- Hypertension

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Case Report

After at least three years of treatment, the patient abruptly self-discontinued methadone therapy in July 2021, citing transportation challenges and strict requirements around daily dosing as barriers to continued engagement. She presented weeks later with symptoms consistent with opiate withdrawal and reported to using intranasal fentanyl to self-treat withdrawal. The patient was amenable to MOUD with buprenorphine-naloxone after counseling on morbidity and mortality benefits.

Via near-daily telemedicine visits by the resident and attending PCPs, the patient was transitioned to a stable dose of buprenorphine-naloxone over the course of one month. Unfortunately, she returned to intranasal fentanyl use within weeks, citing that buprenorphine-naloxone caused her to feel very ill, and was extremely reticent to try again or re-engage in discussions surrounding MOUD. She continued to present to clinic over the next several months, in which we continued to manage her other medical problems, discuss harm-reduction techniques, and conduct motivational interviewing.

Approximately one year later, she independently voiced interest in returning to MOUD, saying “fentanyl is causing me more harm than good”. She is now scheduled for a visit with the Center for Primary Care Recovery Clinic to explore options.

Evidence-Based Components to MOUD Prescribing

Discussion

- Multiple barriers to MOUD prescribing in residency clinic:
  - Scheduling
  - Travel challenges
  - Lack of continuity
  - Insufficient resident education
- Dedicated didactic and experiential educational programs geared towards teaching resident physicians strategies to MOUD prescribing and expanding social work capabilities of clinics have addressed some of these barriers and improved patient care as well as resident education[5-6]
- Most importantly, this case highlights the principle of **non-abandonment**, which allows for therapeutic relationships, trust-building, and ultimately shared decision-making[8], and motivational interviewing and without which it is unlikely this patient would now be seeking care.