MENTAL HEALTH · PHARM · SUBSTANCE USE

Opioid Withdrawal

Recognition · Management · Medication-Assisted Treatment (MAT)

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📚 **Content Sourcing Note:** This topic was not present in your uploaded reference notes. Content drawn from standard NGN NCLEX 2026 references: Saunders Comprehensive Review, ATI Mental Health, Lippincott Pharmacology, SAMHSA TIP 63, and CDC Clinical Practice Guidelines for Prescribing Opioids (2022).

SECTION ONE

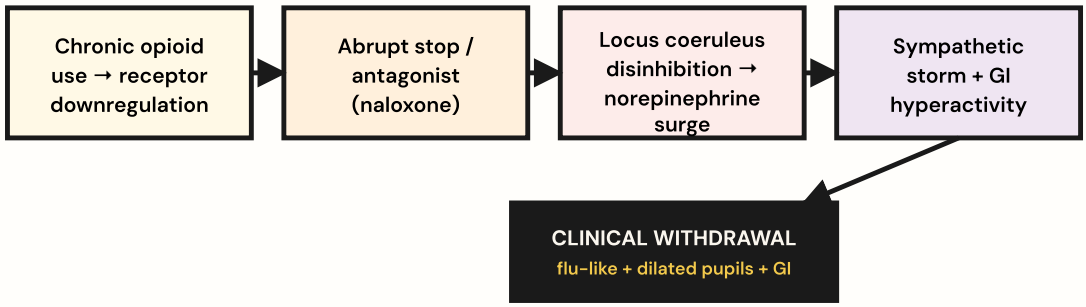
1 Definition & Overview

- **Opioid withdrawal** = constellation of predictable signs & symptoms that emerge when an opioid-dependent person abruptly stops, sharply reduces, or is given an opioid antagonist (e.g., naloxone, naltrexone).
- **Not usually life-threatening in healthy adults** (unlike alcohol or benzodiazepine withdrawal) — but it is severely distressing and drives relapse, which carries a high overdose death risk due to lost tolerance.
- **Life-threatening in:** neonates (Neonatal Abstinence Syndrome / NAS), pregnant clients (preterm labor, fetal distress), and medically fragile clients (cardiac, severe dehydration).
- **Why it matters for NCLEX:** Tests pattern recognition (autonomic surge), prioritization (safety + MAT), and judgment (when to give buprenorphine vs. naloxone).

SECTION TWO

2 Pathophysiology Simplified

Chronic opioid exposure suppresses the brain's **locus coeruleus** (the main norepinephrine center) and downregulates mu-opioid receptors. When opioids are removed, the brakes come off and noradrenergic neurons fire wildly — producing the classic **sympathetic storm**.



Receptor adaptation → withdrawal cascade. The "rebound" is what you assess.

⏱ Onset Timing (Know These)

8–24 hr	36–72 hr	5–7 days	10–14 days
SHORT-ACTING ONSET (HEROIN, OXYCODONE, HYDROCODONE)	PEAK INTENSITY	ACUTE RESOLUTION (SHORT-ACTING)	METHADONE / LONG-ACTING TIMELINE

SECTION THREE

3 Signs & Symptoms

EARLY (8–24 hr)

- **Anxiety**, restlessness, drug craving
- **Yawning** — a classic early cue
- **Lacrimation** (tearing eyes)
- **Rhinorrhea** (runny nose)
- **Diaphoresis** + piloerection ("gooseflesh" → origin of "cold turkey")
- **Mydriasis** (DILATED pupils — opposite of overdose)
- Muscle aches, low-grade chills

PEAK / LATE (24–72 hr)

- **Nausea, vomiting, diarrhea** + abdominal cramping
- **Tachycardia** & **hypertension**
- Low-grade **fever**, hot/cold flashes
- **Tremors**, severe insomnia
- **Hyperalgesia** (heightened pain sensitivity)
- Severe drug craving
- Depression, dysphoria

RED FLAG FINDINGS — ESCALATE IMMEDIATELY

- **Severe dehydration** from intractable vomiting/diarrhea → hypovolemia, electrolyte imbalance (↓K^+, ↓Na^+)
- **Suicidal ideation** — withdrawal-induced dysphoria is a high-risk period
- **Pregnant client** — risk of **preterm labor & fetal distress**; never recommend abrupt cessation in pregnancy (use methadone or buprenorphine)
- **Neonatal Abstinence Syndrome (NAS):** high-pitched cry, hypertonia, tremors, poor feeding, seizures
- **Precipitated withdrawal** after naloxone or early buprenorphine — abrupt severe symptoms within minutes

⚖ Overdose vs. Withdrawal — Tested Almost Every Cycle

OVERDOSE (Toxidrome)

- **Pinpoint** pupils (miosis)
- **Hypoventilation** (RR < 12) — kills
- Hypotension, **bradycardia**
- Sedation → coma
- Cool, clammy skin
- **Treat with NALOXONE**

WITHDRAWAL (Sympathetic Surge)

- **Dilated** pupils (mydriasis)
- **Tachypnea**, yawning
- Hypertension, **tachycardia**
- Agitation, anxiety, insomnia
- Diaphoretic, piloerection
- **Treat with MAT + comfort meds**

SECTION FOUR

4 Priority Nursing Interventions (ABCs + Safety)

- **A — Airway:** Position upright; monitor for aspiration risk during emesis. Have suction available.
- **B — Breathing:** *Assess respiratory rate & SpO_2 — but expect TACHYPNEA* in pure withdrawal (the opposite of overdose). A drop in RR after dosing means you over-medicated.
- **C — Circulation:** Monitor HR, BP, rhythm. Establish IV access. Replace volume with **0.9% Normal Saline** for dehydration. Replace electrolytes (K^+, Mg^{2+}) per labs.
- **Assess severity:** Use the **COWS** (Clinical Opiate Withdrawal Scale) — 11 items, score guides dosing. *Buprenorphine induction requires COWS ≥ 8–12.*
- **Safety first:** Suicide-risk screening. Quiet, dimly lit, low-stimulation environment. Fall precautions (weakness, dizziness).
- **Comfort cluster:** Warm blankets for chills, cool cloths for diaphoresis, antiemetics, antidiarrheals, NSAIDs for aches, hydroxyzine for anxiety/insomnia.
- **Administer MAT** per protocol (methadone, buprenorphine, or clonidine — see Pharm).
- **Document & reassess** COWS q2–4h during acute phase.
- **Pregnant client:** Continuous fetal monitoring; **never withhold MAT** — withdrawal harms fetus more than the medication.
- **Discharge prep:** Take-home naloxone (Narcan) kit + training; connect to outpatient MAT and counseling before discharge.

SECTION FIVE

5 Pharmacology — MAT & Comfort Meds

DRUG / CLASS	MECHANISM	KEY SIDE EFFECTS / CAUTIONS	NURSING CONSIDERATIONS
Methadone *Full mu-opioid agonist*	Long-acting agonist replaces illicit opioid; suppresses craving & withdrawal	QT prolongation, respiratory depression, sedation, constipation	Federally regulated; dispensed daily from licensed clinic. Baseline + periodic ECG. Safe in pregnancy.
Buprenorphine / Buprenorphine-Naloxone (Suboxone) *Partial mu agonist*	Ceiling effect on respiratory depression; blocks other opioids' high	⚠ **PRECIPITATED WITHDRAWAL** if given too early; headache, constipation	**Patient must be in moderate withdrawal (COWS ≥ 8–12)** before first dose. Sublingual — do NOT swallow. Naloxone in combo prevents IV misuse.
Clonidine *Central α_2-agonist*	Suppresses NE outflow → reduces sweating, anxiety, HTN, tachycardia, cramping	**Hypotension, bradycardia, sedation, dry mouth**; rebound HTN if stopped abruptly	Hold for SBP < 90 or HR < 60. Check BP/HR before each dose. Taper when discontinuing. Does NOT treat craving.
Lofexidine (Lucemyra) *Selective α_2-agonist*	Like clonidine, but FDA-approved specifically for opioid withdrawal	Hypotension, bradycardia, QT prolongation, syncope, insomnia	Up to 14 days of treatment. Monitor BP & HR; assess orthostatic vitals.
Naltrexone *Long-acting mu antagonist*	Blocks opioid receptors → prevents relapse high	Will **precipitate severe withdrawal** if opioids still on board; hepatotoxicity	Client must be **opioid-free 7–10 days** (or 10–14 for long-acting) before starting. Used AFTER detox, not during.
Naloxone (Narcan) *Pure opioid antagonist*	Reverses overdose by displacing opioids from receptors	**Precipitates abrupt severe withdrawal** in dependent users	**Use for OVERDOSE, not withdrawal.** Effect = 30–90 min; redose if respirations drop again. Send all clients home with a kit.
Adjuncts	Symptom-targeted	—	Ondansetron (N/V), loperamide (diarrhea), NSAIDs (aches), hydroxyzine (anxiety/sleep), trazodone (insomnia)

SECTION SIX

6 NCLEX Test Traps ⚠

❌ WRONG THINKING

"Opioid withdrawal is life-threatening just like alcohol withdrawal — I'll prioritize seizure precautions."

✅ RIGHT THINKING

Opioid withdrawal is **NOT typically life-threatening in adults**. Alcohol & benzo withdrawal cause seizures/death; opioid withdrawal causes misery + relapse risk. Exceptions: neonates, pregnancy, fragile clients.

❌ WRONG THINKING

"Client is in opioid withdrawal — give naloxone."

✅ RIGHT THINKING

Naloxone is for OVERDOSE (pinpoint pupils, RR < 12). Giving it during withdrawal triggers **precipitated withdrawal** — severe, abrupt symptoms.

❌ WRONG THINKING

"Start buprenorphine right away to make the client feel better."

✅ RIGHT THINKING

Wait until **moderate withdrawal (COWS ≥ 8–12)**. Too-early buprenorphine kicks opioids off receptors and precipitates withdrawal.

❌ WRONG THINKING

"Client has pinpoint pupils — must be withdrawal."

✅ RIGHT THINKING

Pinpoint = overdose. DILATED = withdrawal. Memorize this — it appears on almost every cycle.

❌ WRONG THINKING

"Pregnant client is in withdrawal — taper her off opioids quickly."

✅ RIGHT THINKING

Never abrupt withdrawal in pregnancy — risk of preterm labor & fetal demise. Continue MAT (methadone or buprenorphine) throughout pregnancy.

❌ WRONG THINKING

"Clonidine is enough — it'll cover everything."

✅ RIGHT THINKING

Clonidine treats **autonomic symptoms only** (sweating, HTN, anxiety). It does **NOT reduce**

craving. Pair with MAT or adjuncts.

❌ WRONG THINKING

"Client completed detox 3 days ago — safe to start naltrexone."

✅ RIGHT THINKING

Naltrexone requires **7–10 opioid-free days** (10–14 for methadone). Giving early precipitates severe withdrawal.

7

SECTION SEVEN

Patient & Family Education

- **Withdrawal is severe but not deadly** (in healthy adults) — feels like the worst flu of your life. You will get through it.
- **Never stop opioids abruptly** if you've been on chronic prescription therapy — taper with your provider.
- **MAT is gold standard** — methadone or buprenorphine cuts mortality by ~50%. It's not "replacing one drug with another"; it's treating a brain disease.
- **Relapse = overdose risk.** After even a few days of abstinence, your tolerance drops. The dose you used before may now be fatal. Always have **naloxone (Narcan) on hand**.
- **Carry naloxone** — teach family to recognize overdose (pinpoint pupils, slow breathing, blue lips) and administer intranasal naloxone, call 911, do rescue breathing.
- **Cravings can persist for months** beyond acute withdrawal — this is normal, not failure. Stay connected to support.
- **Hydrate & eat** — small frequent meals, electrolyte drinks, clear fluids.
- **Pregnancy:** stay on MAT — your baby is safer with stable medication than with withdrawal.
- **Support:** Narcotics Anonymous, SMART Recovery, outpatient counseling, peer recovery specialists.
- **Avoid alcohol & benzodiazepines** — combination with opioids dramatically raises overdose risk.

SECTION EIGHT

8 Memory Boosters & Mnemonics

🐄 COWS — Clinical Opiate Withdrawal Scale

The standardized 11-item assessment tool. Score directs buprenorphine induction:

- **5–12** = Mild
- **13–24** = Moderate ← *buprenorphine induction threshold*
- **25–36** = Moderately Severe
- **> 36** = Severe

💪 "WITHDRAWAL" — Symptom Cluster

W	**W**atery eyes (lacrimation) + runny nose
I	**I**ncreased BP, HR, RR (sympathetic surge)
T	**T**remors
H	**H**ot/cold flashes, sweating, gooseflesh
D	**D**iarrhea + abdominal cramping
R	**R**estlessness + anxiety
A	**A**ches in muscles + bones
W	**W**ide pupils (mydriasis) — opposite of overdose
A	**A**wake (insomnia) + yawning paradox
L	**L**oss of appetite, N/V

The "OPPOSITES" Rule

Withdrawal is the **mirror image of overdose**. If overdose causes it, withdrawal does the opposite.

- Overdose: **pinpoint** pupils → Withdrawal: **dilated**
- Overdose: **hypoventilation** → Withdrawal: **tachypnea + yawning**
- Overdose: **bradycardia + hypotension** → Withdrawal: **tachycardia + hypertension**

- Overdose: **sedation/coma** → Withdrawal: **agitation + insomnia**
- Overdose: **constipation** → Withdrawal: **diarrhea + cramping**

🦃 "Cold Turkey" Origin

Piloerection (gooseflesh on the skin) looks like a plucked cold turkey — that's where the phrase comes from. When you see it on an exam stem, think *opioid withdrawal*.

SECTION NINE

9 NCJMM Clinical Judgment Scenario

Scenario: *A 32-year-old client is admitted to the medical-surgical unit 14 hours after his last dose of oxycodone (history of chronic use for 3 years). He reports muscle aches and "feeling jittery." VS: T 99.6°F, HR 108, RR 22, BP 152/94, SpO_2 98% on room air. Pupils 6 mm and reactive. Skin diaphoretic with piloerection. Reports anxiety (8/10), nausea, and abdominal cramping. He says: "I can't take this — I need something now."*

1 Recognize Cues

Relevant cues: Time since last dose (14 hr — matches short-acting withdrawal window), HR 108 (↑), BP 152/94 (↑), RR 22 (↑), low-grade fever, diaphoresis, piloerection, **dilated pupils (6 mm)**, GI symptoms, anxiety, severe craving. *Irrelevant:* SpO_2 98% is normal — not the priority cue here.

2 Analyze Cues

The cluster of **sympathetic surge (↑HR, ↑BP, ↑RR, diaphoresis, mydriasis) + GI hyperactivity + craving** fits **moderate opioid withdrawal**. The timing aligns with oxycodone (8–24 hr onset). This is *not* overdose (no pinpoint pupils, no respiratory depression). It is *not* alcohol withdrawal (no seizure risk pattern, no tremor + confusion typical of DT trajectory).

3 Prioritize Hypotheses

Top hypothesis: Moderate opioid withdrawal (estimated COWS ~13–18 → moderate range, near buprenorphine induction threshold).
Concurrent concerns: Dehydration risk from GI losses; safety risk from agitation; high relapse risk if untreated.
Rule out: Sepsis (no infection source, only low-grade fever), thyroid storm (no goiter/exophthalmos), stimulant intoxication (history points to opioid use).

4 Generate Solutions

- Complete formal **COWS assessment** to quantify severity
- Establish IV access; obtain CMP, CBC, urine drug screen
- Notify provider; anticipate **buprenorphine induction** once COWS ≥ 8–12, or clonidine + adjuncts if buprenorphine not yet indicated
- Administer comfort meds: ondansetron for nausea, loperamide for diarrhea, NSAID for aches, hydroxyzine for anxiety
- IV NS to replace volume; encourage PO fluids as tolerated
- Quiet, low-stimulation room; reassurance; suicide risk screen

- Initiate referral to outpatient MAT & counseling; arrange take-home naloxone

5 Take Action

Nurse performs COWS (score 14 → moderate). Establishes IV, draws labs, initiates 1 L 0.9% NS at 125 mL/hr. Administers ondansetron 4 mg IV and ibuprofen 600 mg PO. Notifies provider; buprenorphine 4 mg SL is ordered and given (COWS ≥ 12 met). Client placed in quiet single room with reassurance. VS rechecked q15min × 4, then q1h. Suicide-risk screening completed (negative). Family education begun on naloxone kit.

6 Evaluate Outcomes

Expected outcomes within 1–2 hr of buprenorphine: COWS drops by ≥ 50%; HR < 100; BP trending down; diaphoresis resolving; anxiety self-rated < 4/10; client tolerating PO fluids.
If COWS worsens after buprenorphine: Suspect **precipitated withdrawal** — notify provider; supportive care, additional buprenorphine per protocol; do NOT give naloxone.
Discharge readiness: Stable VS, COWS < 5, connected to outpatient MAT, naloxone kit dispensed, support person identified, follow-up appointment scheduled within 72 hr.