Capsule Commentary on D'Onofrio et al., Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention

Irene Berita Murimi, PhD, MA

Center for Drug Safety and Effectiveness, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA.

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More than two million Americans have an opioid abuse disorder.[1] For each person who dies from an opiate overdose, many more require emergency care or hospitalization to survive. Central to the goal of reversing this epidemic is the challenging task of improving linkage to treatment for opioid-dependent patients. Despite strong clinical evidence, the use of buprenorphine-naloxone as maintenance therapy for opioid dependence remains low.

In this issue, D'Onofrio et al.[2] explored whether emergency department (ED)-initiated buprenorphine-naloxone with continued primary care is better for promoting treatment engagement, deterring illicit drug use and reducing HIV risk behaviors over the long term (at 2, 6 and 12 months) than treatment referral only or a brief intervention with referral to treatment. Results of the study indicate that adult patients in the ED-initiated study arm were more likely to still be in treatment and to report less illicit opioid use at 2 months than those in the comparator arms.

Benefits of ED-initiated buprenorphine-naloxone treatment at the 2-month mark should be interpreted cautiously. First, the veracity of self-reported drug use may have been influenced by the fact that patients in the ED-initiated treatment arm were still receiving 10 weeks of continued care through the study. Second, there was no statistical difference in the urine toxicology test results across the three groups.

The absence of differences in any of the outcomes at the 6- and 12-month assessment points raises even broader questions regarding the discontinuation of buprenorphine-naloxone therapy and its associated consequences. Previous studies have shown that patients who use buprenorphine for 12 months are less likely to be hospitalized or to visit the ED than those who discontinue treatment within 5 months.[3] Treatment barriers including scarcity of buprenorphine prescribers and coverage gaps have been well documented, particularly within marginalized groups.[4,5]

The results at the 2-month mark indicate that patients offered continued treatment were more likely to use it. This finding suggests the need for concerted efforts by clinicians, payers and policymakers alike to address not only the barriers to buprenorphine therapy initiation, but also the challenges that limit its continued use.

Corresponding Author: *Irene Berita Murimi, PhD, MA; Center for Drug Safety and Effectiveness, Department of EpidemiologyJohns Hopkins Bloomberg School of Public Health, Baltimore, MD, USA (e-mail: imurimi1@jhmi.edu).*

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Conflict of Interest: *The author declares that she does not have a conflict of interest.*

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