Calgary Zone Department of Emergency Medicine
EM Grand Rounds Research Day Q&A Report – Oct 29, 2020

Q#	Questions and Comments	Asker Name
Q1	I believe in safe consumption sites. It saves lives for sure. Just wondering your thoughts on best LOCATION for these sites. Most people wouldn't want the safe consumption site near where they live, their kids go to school, etc. Thoughts?	**dave**
A1	*Yes, not in my back yard. Evidence also shows us that SCS have overall positive impacts on communities. We need them where substnace use is happening*	
Q2	If the correlation is high between adult substance use disorder and high ACE scores (which I believe personally is very true), are there initiatives to look at the vulnerable childhood populations to prevent the downstream epidemic that we are talking about today?	**carrie hiscock**
A2	*I am not aware of specific upstream initiatives to address the epidemic, but I agree that that would be a meaningful and effective apporach.* *Hi Carrie - my Mom helped to implement the Foothills Children's Wellness Network https://www.foothillsnetwork.ca/ (there are similar ones in other rural communities) - they've implemented ACEs screening at their low risk OB clinics and other community agencies*	
Q3	Can you speak to the reasons why individuals often deny having used opioids immediately upon waking up after being given naloxone?	**Marleen Dorrestijn**
A3	*This I beleive is related to fear of being judged and shame.*	
Q4	If we work SHC/RGH/FMC/ACH - can we consult ARCH for questions? Or are there addictions MDs available(?daytime hours)?	**Kelsey MacLeod**
A4	*there is a provicial physician advie consult line, I can send you the info if you email.* *And yes, ARCH MDs are usually happy to provide phone help. 7 days 08-21,*	
Q5	when you are talking about harm reduction for admitted patients that are not interested in starting OAT, how do you order opioids for them?	**Jenny Strong**
A5	*We try to get an idea of their opioid tolerance, asking how much they use (and by what method). This mainly gives an idea of what doses we may need to get to to control withdrawal/cravings. We will not take the amount they disclose they use and convert it to hydromorphone/morphine as it is difficult to know exactly what is in the substances they use so we generally start PRN morphine (ex. 10-30mg PO q1-2h PRN) or hydromorphone (2-5mg q1-2h PRN for example) and titrate up as needed based on withdrawals. If severe we will order PRN IV as well.* *When we have a better idea of the patients tolerance based on PRN usage we may order scheduled doses on top of PRN to avoid the patient having to ask for doses, often patients will not ask for PRNs for fear of being judged as a drug seeker*	
Q6	What is the best strategy to work around government levels who do not believe in harm reduction strategies and are very effective in spreading disinformation/stigma around addicitons, and funding/legal barriers to these programs	**tomrich**
A6	*I wish I knew the answer to that. Persistence, providing education and ongoing advocacy*	
Q7	Do we need the methadone license to order it in the ER? I must admit I've ordered it several times for patients who are on it with no license and I've never had a problem (usu they know their dose, and I can confirm on netcare)	**Charles Kai-Hang Wong**
A7	*You do not need a license to continue methadone in hospital at the dose the patient has been receiving in community, you would need a license if adjusting the dose or initiating methadone in hospital*	

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Q8	Mark can you elaborate on the patient population you would order Naltrexone for in the ED or send home with Rx? Thanks!	**Kelsey Ragan**
A8	*Before starting naltrexone we want to make sure the patient* *a) is not currently taking opioids* *b) have adequate liver function, primarily ALT<3x ULN and* *c) do they have coverage in place (AISH, alberta works)*	
Q9	One of the things I have learned over the years is that the strategy of "taxi voucher to Renfew in the morning" is extremely unreliable. I have started calling Renfew ahead of time (just google "Renfew detox" and the number is there) to confirm that the patient is eligible to be treated there (many patients have flags on their records there preventing them from being admitted during usual intake) and that they will likely have a bed available. In an ideal world, we would use RAAPID or another formal transfer system to reliably get patients to Renfew or similar detox centres.	**James Andruchow**
A9	*excellent point*	
Q10	why are we then accepting of the current system for Renfrew intake? RENFREW (apologies for the missspelling)	**James Andruchow**
A10	*Likely because there is an extreme lack of other viable options at the time?*	
Q11	what's your take on the "micro-dosing " of suboxone to initiate for those who aren't yet in moderate withdrawal with COWS>13? i.e their COWS will be… 9 or 10, but they're geting symptomatic and heading towards moderate w/d	**Marissa Tsoi**
A11	*live answered*	
Q12	Any chance for arch rig ram to come to Lethbridge	**Bilal Mir**
A12	*live answered*	
Q13	Great talk. We need you guys at all sites!! Is this going to happen?	**DaveDyck**
A13	*live answered*	
Q14	Do you choose between naltrexone and acpamprosate based on symptomatoloy ex cravings or anxiety or sleep? Is it ok to give two medcations? Ex gabapentin & naltrexone?	**Colleen Carey**
A14	*live answered*	
	Phenomenal and inspiring presentation - Thanks Brad, MArk and Tacie	**Eddy Lang**
Q15	There wasn't much benefit I think in terms of Rx acamprosate and naltrexone together	Ryan Chuang
A15	*Correct, no evidence that I am aware for Acamp and Naltrex together.*	
	Always a good reminder! Thanks Nadim!	**Matt Frey**