BRITISH COLUMBIA CENTRE ON SUBSTANCE USE

Managing Concurrent Opioid-Medetomidine Withdrawal

Quick Reference

The BC Centre on Substance Use has published **Concurrent Medetomidine-opioid Poisoning and Withdrawal Bulletin** which offers guidance on recognizing, assessing, and managing medetomidine-involved poisoning and withdrawal. This is a quick-reference guide focused on managing co-occurring opioid-medetomidine withdrawal; it does not provide stand-alone guidance.

Recognizing Medetomidine Withdrawal

- Medetomidine dependence may develop within days to weeks of repeated exposure
- **Withdrawal can emerge rapidly** following cessation of use, often within 4–6 hours
- Hallmark features: tachycardia, profound hypertension, and vomiting that is often severe, non-responsive
- Other common symptoms: tremors, diaphoresis, and hyperthermia

Managing Withdrawal

Concurrent opioid withdrawal

- Should be treated with short-acting opioids and/or initiation or continuation of opioid agonist treatment (OAT), titrated to resolve opioid withdrawal symptoms
- In the case of outpatient management, short-acting opioids are subject to witnessed dosing as per the BC Ministry of Health's **Access to Prescribed Alternatives in British Columbia: Policy Direction**

Medetomidine Withdrawal

First-line treatment: Clonidine (oral)

- **Initial doses:** 0.2–0.6 mg, guided by vital signs and symptom severity, higher doses may be necessary
- **Loading doses:** q2–4h (up to 3 doses) until symptoms improve, followed by similar or decreased doses q4–6h, as part of a scheduled taper

Dopamine antagonists are preferred for **medetomidine-associated withdrawal symptom control**, particularly severe nausea and vomiting.

• **Metoclopramide** (oral/SC/IM/IV)	5–10 mg q4–6h PRN
• **Haloperidol** (oral/SC/IM/IV)	1 mg q6h PRN; max daily dose 20 mg
• **Olanzapine** (oral/ODT/IM)	2.5–5 mg q8h PRN; max daily dose 10 mg
• **Prochlorperazine** (oral/rectal)	5–10 mg q4h PRN; max daily dose 40 mg

Monitor for QTc prolongation, particularly when using antiemetics or in patients with electrolyte abnormalities or other risk factors.

Escalating care

- IV dexmedetomidine should only considered for severe or refractory cases, and when patients cannot tolerate oral clonidine.
- Patients with sustained hemodynamic instability, severe agitation, decreased level of consciousness, withdrawal complications, or refractory symptoms may require transfer to a higher level of care for IV dexmedetomidine and close monitoring.

Early addiction medicine and/or toxicology consultation is recommended for suspected cases.

Clinicians are encouraged to consult the **24/7 Addiction Medicine Clinician Support Line** (778-945-7619) or the **RACE App** to discuss any concerns with managing withdrawal symptoms.