



Management of Acute Opioid Withdrawal in a Patient With an Unknown Prescribing History: A Case Report

Urgent Message: Opioid prescribing in urgent care can present difficulties, particularly in patients with an unclear prescription history where added caution is needed. There are a number of ways to reduce the risks associated with opioid prescribing and to initiate the treatment of opioid withdrawal in the urgent care setting.

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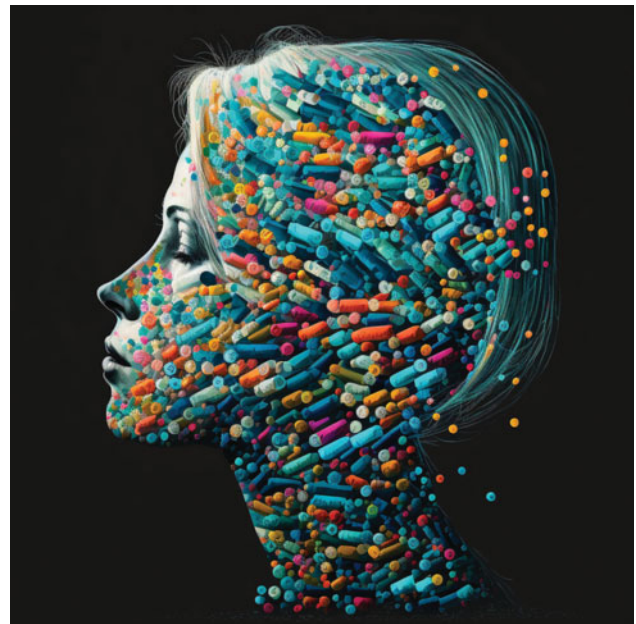
Key Words: Addiction, Opioid Withdrawal, Prescribing, Urgent Care

Abstract

Introduction: We report a complex case of a 37-year-old woman presenting to urgent care with features of acute opioid withdrawal following relocation from Australia and with a lack of reliable documentation confirming her prescribing history.

Presentation: A 37-year-old woman had multiple presentations to urgent care within a few weeks, while requesting chronic opioid refills. She presented a letter from a physician to support her dosage claims. At her final urgent care visit, she complained of abdominal pain and increasing anxiety on missing doses of her regular opioids. Her previous physician letter was found to be fraudulent.

Physical Examination: On examination, the patient was non-toxic but visibly distressed with occasional



vomiting. She was tachycardic with a soft but tender abdomen, with notable piloerection and mydriasis.

Diagnosis: This patient was clinically diagnosed with acute opioid withdrawal.

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Resolution: She was managed with a temporary opioid taper plan and referred to local drug and alcohol services.

Conclusion: This case highlights the challenges faced in urgent care settings when balancing patient safety, withdrawal symptom management, and the risk of prescription misuse.

Introduction

Opioid withdrawal can be acutely distressing and poses significant management challenges, particularly in patients without an established primary care provider or reliable documentation.¹ In urgent care settings, clinicians must often make complex risk-benefit decisions in a short time frame, especially when there is concern for opioid medication dependence or misuse.² This case illustrates these challenges in a patient with suspected iatrogenic dependence on high-dose opioids, an unverifiable medical history, and a transient living situation.

Case Presentation

A 37-year-old female presented to urgent care multiple times in a single month in 2025 requesting opioid prescriptions for chronic pain secondary to a reported motor vehicle accident (MVA) in 2020. She reported that she had recently moved from Australia and was residing with her mother in Northland, New Zealand. The patient stated she had been prescribed modified-release (MR) oxycodone 60 mg twice daily and immediate-release (IR) oxycodone 20 mg twice daily by a general practitioner (GP) in Australia, presenting a letter from her GP as support.

During her initial presentation, she described symptoms of opioid withdrawal following a few days without medication, including worsening abdominal pain and “shocks” through the head. She was alert and hemodynamically stable, with a Glasgow Coma Score of 15. A 1-week prescription of both her MR and IR oxycodone was provided with advice to register with a local GP and engage with chronic pain services. Eleven days later, she re-presented reporting she had temporarily increased her dose of both MR and IR oxycodone after a fall at home. She was issued a strictly controlled repeat prescription for a further 15 days, with dispensing instructions limiting early refills.

The letter she presented at her initial presentation as supporting documentation was suspicious given there were spelling mistakes within the text. The purported GP clinic was contacted to confirm the prescrip-

tion after the first presentation, and a response was received after the second presentation. The clinic staff reported that the letter was fraudulent and that the patient had not been prescribed opioids from their clinic.

Three days later, the patient presented to the clinic in distress, stating that her pharmacy had not received her prescription. A thorough electronic health record review showed that the script had been sent electronically and that the medication had been dispensed. On review, she reported multiple symptoms including severe abdominal pain, nausea, leg cramps, and anxiety. She denied using nonprescribed opioids but admitted to being in withdrawal, stating that her last dose was taken the previous day. She was tachycardic and displayed evidence of hyperalgesia, with a clear chest, regular heart sounds and a tender but soft abdomen. There was notable piloerection and mydriasis.

Diagnosis

The patient was assessed to be in opioid withdrawal.

Patient Perspective

The patient denied opioid addiction but acknowledged a physical dependence and expressed suicidal ideation if not provided with medications. She was open to engaging with addiction services.

Disposition and Medical Decision Making

Due to the timing over a holiday weekend and inability to access further care, a compromise plan was reached: a reduced dose of MR oxycodone 50 mg twice daily was prescribed for 4 days. No IR oxycodone was provided. The patient was referred to local drug and alcohol services, and alerts were placed with the pharmacy restricting opioid prescribing to our urgent care only until she was registered with a GP or seen by addiction specialists who could take over her opioid prescribing in order to prevent duplicate prescriptions.

Discussion

This case highlights critical challenges in urgent care opioid management, including verifying medical history, discerning misuse from iatrogenic dependence, ethical prescribing during acute withdrawal, and implementing a multidisciplinary approach.

The use of a fraudulent medical letter signals caution in relying solely on provided documentation. Clinicians should verify opioid prescribing through additional channels, such as:

- Directly calling the purported prescriber or clinic

to confirm prescription legitimacy

- Reviewing dispensing history from local pharmacies through the use of prescription drug monitoring programs (PDMPs), which allow clinicians to access databases to detect “doctor shopping” or overlapping prescriptions
- Detailed clinical history taking with a focus on asking targeted questions about medication names, dosages, and prescribing timelines, which can often reveal inconsistencies that raise concern for misuse.^{3,4,5}

It is also important to note that long-term opioid use can lead to physical dependence without misuse, complicating interpretation in patients with incomplete histories.⁶ In this case, the patient exhibited signs of dependence—tolerance and withdrawal—but her inconsistent narrative, lack of documentation, and rapid use of week-long opioid prescriptions raised concerns for misuse.

Distinguishing between appropriate use, iatrogenic dependence (addiction caused by usage at the prescribed dose and frequency),¹ and misuse (usage contrary to the prescribed dose and frequency)⁴ is crucial and often relies on a combination of history, physical exam, and, when available, objective data from PDMPs and pharmacies.⁷ Given this difficulty in differentiating iatrogenic dependence from misuse—and the blurred line that exists between them—an empathetic humanitarian approach should be used when treating these patients.⁸

A thorough clinical history and examination should be performed with careful consideration given to the appropriateness of managing an individual in the urgent care setting. Very high withdrawal symptom severity, abnormalities in vital signs, and multisubstance withdrawal may dictate secondary care assessment and admission. Whether managed in the community or in secondary care facilities, some patients may benefit from the use of buprenorphine (or other similar medications) in the management of their opioid dependence,⁹ although of note, this was unavailable in our case due to the rural service location.

Buprenorphine should be administered in patients with evidence of clinical opioid withdrawal supported by a Clinical Opioid Withdrawal Scale score of greater than 7, a stratifying score taking into account the patient’s physical and psychological symptoms.^{10,11} Ideally, buprenorphine administration should be delayed until at least 6–12 hours after short-acting opioids and 24–72 hours after long-acting opioids to avoid precipitated withdrawal, although clinical

judgement should be exercised given that patients do not always accurately report their opioid use and metabolism varies between individuals.¹²

Typically, dose initiation involves commencing 2–4 mg sublingual buprenorphine, a 1–2 hour observation period, and then dose titration of an additional 2–8 mg based on symptoms. Typical total daily dose ranges from 8–16 mg, with an upper limit of 24 mg/day.¹³ Once withdrawal symptoms and cravings are controlled, typical maintenance dosing is 8–16 mg/day, though higher doses (up to 24–32 mg/day) may improve outcomes in patients with high opioid tolerance. Regular follow-up, urine drug screens, and adherence monitoring through PDMPs are recommended to maintain remission.¹⁴

When immediate substitution therapy is unavailable, such as in our case, a short-term opioid taper may be used with close monitoring, although this approach carries the risk of withdrawal and relapse. Regardless, consultation with pharmacy staff and addiction specialists, clear communication among providers, and coordination of follow-up care are imperative to mitigate risks and improve outcomes.^{13,14}

Conclusion

This case illustrates the complex decision-making required in urgent care opioid management. Key lessons include: the necessity of verifying medical documentation via provider contact, pharmacy review, and PDMPs; the importance and difficulty of differentiating iatrogenic dependence versus misuse, particularly in patients with inconsistent histories; the effective and ethical use of buprenorphine; and the utility of a multidisciplinary approach involving the patient’s primary care provider and addiction services that prioritize patient safety during withdrawal and continuity into long-term treatment. By applying these strategies, urgent care clinicians can better manage high-risk, acute opioid dependent patients and mitigate the potential harms of uncontrolled prescribing.

Ethics Statement

The patient was unable to be contacted because the contact details provided appear to have been incorrect. Therefore, demographics and some details of the case were changed to protect patient anonymity and confidentiality.

Takeaway Points

- Always verify documentation before prescribing controlled substances, especially in recently relocated patients.

- Opioid withdrawal can present urgently and must be managed compassionately and safely, even without clear diagnostic certainty.
- Multidisciplinary and inter-agency communication is essential in managing patients with complex opioid needs in urgent care.
- Buprenorphine substitution therapy can provide symptomatic relief for opioid withdrawal and can be acutely initiated safely in the urgent care setting. ■

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