

Help Your Team Manage Medetomidine Overdoses and Withdrawal

Top Takeaways

- Medetomidine is a contaminant that is increasingly found in illicit opioids, which is contributing to overdoses.
- There isn't a medetomidine antidote. But patients should still get a reversal agent (naloxone, etc) to counteract slow breathing caused by opioid overdose.
- Clonidine, guanfacine, tizanidine, or dexmedetomidine can help treat medetomidine withdrawal.

CDC is warning hospitals to **look out for overdoses and withdrawal from medetomidine**...a contaminant increasingly found in illicit opioids.

Medetomidine is very similar to dexmedetomidine...the same sedative we commonly use in the ICU, OR, etc.

You may also hear medetomidine called "rhino tranq," "dex," or "mede." Most cases have been reported in the Northeast US...but lab tests show medetomidine is getting into more street opioids across the country.

Help your pharmacy team treat overdoses from opioids laced with medetomidine...and be ready for medetomidine withdrawal afterward.

Acute management. It's tricky to tease out opioid versus medetomidine overdoses. They can have similar symptoms, such as low heart rate (HR), low blood pressure (BP), sleepiness, etc.

Plus, urine tox screens can detect opioids...but not medetomidine.

Be aware that there isn't a medetomidine antidote. But patients should still get an opioid reversal agent (naloxone, etc) to counteract slow breathing caused by opioid overdose.

The medical team will suspect medetomidine is involved if a patient is still sleepy with low HR and BP despite getting adequate opioid reversal agents.

Then patients will get supportive care (fluids, rest, etc) as overdose symptoms resolve, which typically takes a few hours.

Withdrawal. Medetomidine withdrawal symptoms can start 4-6 hr postexposure...and peak within 12-36 hr. Symptoms include very high BP and HR, severe nausea/vomiting, tremors, anxiety, fluctuating alertness, etc.

Giving meds related to medetomidine can help control symptoms...similar to how certain opioids (methadone, etc) are used to treat opioid use disorder.

For example, you may see complex regimens combining prn oral AND weekly transdermal clonidine PLUS guanfacine or tizanidine Q8H...since these act on the same receptors as medetomidine.

Severe cases may require a dexmedetomidine infusion in the ICU.

Use our treatment algorithm to know what withdrawal meds to expect...and to identify possible errors. For example, watch for mix-ups between immediate- and extended-release guanfacine.

Watch order start and stop times carefully. The medical team will frequently adjust meds based on side effects, patient response, etc. Plus these meds are generally tapered once symptoms are under control.

Expect many patients to also have co-occurring opioid withdrawal.

Use our *Treatment of Opioid Withdrawal* chart to identify additional meds you'll likely see (buprenorphine,

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methadone, etc) to specifically treat opioid withdrawal.

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