

Concurrent Stimulant and Opioid Use

Significance

- **Rising crisis:** 40% of fatal overdoses in Washington State in 2024 involved both methamphetamine and opioids, primarily fentanyl.¹
- **Increased mortality risk:** Co-use of stimulants and opioids increases the risk of fatal overdose. This may be due to the cumulative cardiovascular stress from long-term stimulant use. Acutely, cardiovascular stress (stimulants) and respiratory stress (opioids) increase risk of arrhythmia, hypoxia, and myocardial infarction.²
- **Clinical complexity:** People who use stimulants and opioids are more likely to have 3+ comorbid conditions. Co-use can complicate withdrawal/intoxication assessment.²
- **Barriers to care:** Patients may fear judgment; providers may lack confidence managing co-occurring use or mistakenly believe MOUD is contraindicated.

Clinical assessment

Patients may present with overlapping symptoms of opioid and stimulant use, including intoxication, complicated withdrawal syndromes, and psychiatric complications.

Toxidrome recognition

FINDING	OPIOID INTOXICATION	OPIOID WITHDRAWAL	STIMULANT INTOXICATION	STIMULANT WITHDRAWAL
Mental status	Sedated, obtunded	Anxious, restless, irritable	Agitated, hyperalert, paranoid	Hypersomnia, fatigue, depression, anhedonia
Pupils	Miosis (pinpoint)	Mydriasis (dilated)	Mydriasis (dilated)	Normal or mildly dilated
Vital signs	↓HR, ↓RR, ↓BP	↑HR, ↑BP, mild temp elevation	↑HR, ↑BP, hyperthermia	Normal or ↓HR, ↓BP
Other signs	Hyporeflexia, constipation	Lacrimation, rhinorrhea, yawning, piloerection, GI distress, myalgias	Diaphoresis, bruxism, tremor, psychosis	Increased appetite, psychomotor slowing, vivid dreams

KEY TERMS:

StUD – Stimulant Use Disorder

MOUD – Medications for Opioid Use Disorder

COWS – Clinical Opiate Withdrawal Scale

RESOURCES:

[ADAI Stimulants and Health Guide](#), patient education handout and accompanying guide

[CIAO SFDPH Opioids and Stimulants: A Guide for Healthcare Providers](#), clinical reference for providers

Assessment challenges

- **Masking effect:** Stimulants can mask opioid intoxication signs (respiratory depression, sedation). Stimulant intoxication may be unmasked following naloxone or buprenorphine administration. Maintain high suspicion in patients with known co-use even when vitals appear normal.
- **Falsely elevated COWS:** Stimulant use can inflate COWS scores by causing tachycardia, hypertension, diaphoresis, anxiety, and restlessness. Focus on opioid-specific items (yawning, lacrimation, rhinorrhea, piloerection, GI upset) to differentiate true opioid withdrawal from stimulant effects.
- **Common mimics:**
 - Hypersomnia/fatigue → may be stimulant withdrawal, not opioid intoxication. Check: normal pupils, normal RR, patient report.
 - Tachycardia/agitation/diaphoresis → may be opioid withdrawal, not stimulant intoxication. Check: lacrimation, rhinorrhea, yawning, piloerection, GI symptoms.
 - Post-naloxone agitation → may be unmasked stimulant intoxication, not opioid withdrawal alone. Check: hyperthermia, psychosis, severe hypertension.
 - "Normal" vitals despite known co-use → may be falsely reassuring; stimulants can mask opioid toxicity. Check: mid-range pupils, fluctuating mental status; high overdose risk remains.
- **Treat patient-reported symptoms:** Use clinical judgment and patient history to contextualize COWS. Treat withdrawal symptoms as long as it is safe to do so, even if COWS is confounded.

Management

Medications for OUD: Buprenorphine and methadone reduce opioid-related harms and should be offered/continued regardless of stimulant use.

MOUD retention and outcomes: Concurrent methamphetamine use is associated with lower MOUD retention; however, sustained buprenorphine treatment is associated with reduced methamphetamine use over time.³

Medications for StUD: No FDA-approved medications exist for StUD, but off-label pharmacotherapy (e.g., extended-release naltrexone + bupropion, mirtazapine) should be considered.^{4, 5} See [Emergency Department Care of Stimulant Use Disorder](#). Ensure co-occurring OUD is assessed and treated.

Contingency management (CM): CM is the most effective evidence-based treatment for StUD and is the current standard of care.⁵ Availability is limited; refer when possible. Patients on medications for StUD or MOUD should continue it while engaged in CM.

Comorbidities

People who use stimulants and opioids are more likely to have 3 or more comorbid conditions, compared to those who use stimulants or opioids alone.² Below are suggestions for comorbidity screening and interventions for common conditions.^{6, 7}

COMORBIDITY / CONDITION	SCREENING AND INTERVENTIONS
Cardiovascular	• Monitor BP • Consider statin/aspirin for high-risk patients aged 30-60 • Treat cardiomyopathy
Infectious disease	• Screen for HIV, Hep B/C, STIs • Offer PEP/PrEP/Doxy-PEP as indicated
Skin / wounds	• Assess for injection-related infections • Provide wound care supplies
Oral health (↓ saliva, ↑ caries, infection risk)	• Antibiotics for dental infections as needed • Provide prevention education and dental referral
Reproductive health	• Offer pregnancy testing/contraception • Link to SUD-experienced OBGYN if pregnant
Mental health	• Screen for suicidal ideation • Coordinate mental health treatment • Consider antipsychotics for persistent psychotic symptoms
Intimate partner violence and sexual assault	• Screen for intimate partner violence (e.g., HARK, HITS, WAST, OVAT)⁸ • Provide education, harm reduction strategies, and referral to services

Key takeaways

1. **Watch for masking.** Stimulants can hide opioid over-sedation (risk for overdose).
2. **Stimulants can inflate COWS scores.** Interpret COWS with opioid-specific symptoms and patient history/report.
3. **Treat reported opioid withdrawal symptoms** if safe to do so, even if COWS is confounded.
4. **Don't withhold MOUD.** Initiate/continue even when stimulant use is present.
5. **Offer medications for StUD.** See [Emergency Department Care of Stimulant Use Disorder](#).
6. **Screen for comorbidities.** People who co-use have higher rates of cardiovascular, infectious, and mental health conditions.
7. **Use compassionate, nonjudgmental care.** Stigma is a barrier to care.

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