

Importance of Opioid Agonist Therapy to Reduce Injection-Related Infections

TO THE EDITOR—We read with interest the recent study by Harvey and colleagues describing the effectiveness of the “Six Moments of Infection Prevention in Injection Drug Use” educational toolkit for clinicians to prevent infection in people who inject drugs (PWID) [1]. The toolkit focuses on the importance of new, sterile needles and other injection equipment, as well as cleaning the skin prior to each injection. Training using this toolkit was delivered to 75 providers—56% of whom were medical practitioners or trainees, with administration of pre- and posttraining surveys to assess knowledge, attitudes, and comfort with the harm reduction interventions described. They note that following this training, 86.6% of respondents reported intention to incorporate this model into their own practices. The use of a global approach to infection prevention, modeled on the World Health Organization’s “Five Moments for Hand Hygiene” campaign [2], provides an important framework for infectious disease clinicians to understand widely used harm reduction strategies and identify ways to reduce the risk of injection-related infections.

Along with the 6 moments of infection prevention that Harvey and colleagues describe, we would like to suggest that readers also consider initiation of opioid agonist therapy (OAT) as an additional important tool to prevent infections among PWID. OAT—which includes methadone and buprenorphine (either on its own or co-formulated with naloxone) is an evidence-based intervention intended to reduce illicit opioid use, cravings, and death among people with opioid use disorder. Receipt of OAT has been shown to reduce the risk of human immunodeficiency virus (HIV) and hepatitis C virus acquisition [3, 4]

and promote HIV viral suppression [5]. Additionally, in-hospital initiation of OAT has been found to reduce the risk of recurrent injection-related skin and soft tissue infections [6] as well as 1-year all-cause rehospitalization following admission for infective endocarditis among people with opioid use disorder [7]. In light of the ongoing overdose crisis in North America, it is also notable that initiation of OAT among people with opioid use disorder hospitalized for endocarditis has been found to reduce risk of subsequent opioid-related overdose [7].

There has been an increased call for the integration of infectious diseases (ID) and addiction medicine services [8], and ID care providers have a unique opportunity to assess for and treat opioid use disorder in patients experiencing injection-related infections. However, in a recent survey of ID providers in the United States, only 18 of 526 respondents who reported treating PWID as part of their clinical practice reported being able to prescribe buprenorphine [9]. As such, we believe that enhanced training and resources to support the expansion of OAT prescribing among ID care providers represents a promising strategy to reduce morbidity and mortality among PWID. Indeed, a recent modeling study estimated that expanded prescribing of OAT in hospital settings alone would reduce hospitalizations by 3.2% among people who inject opioids in the United States [10]. As source control is one of the most important aspects of ID practice, we encourage readers to consider the importance of OAT, in addition to the toolkit provided by Harvey and colleagues, in further reducing injection-related infections and other serious harms among PWID.

Notes

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version and have agreed to be personally accountable for any questions related to accuracy or integrity of any part of the work.

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