Tapering Long-Term Opioid Therapy

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Division of General Internal Medicine
SCHOOL OF MEDICINE
UNIVERSITY OF COLORADO **ANSCHUTZ MEDICAL CAMPUS**

DENVER SEATTLE CENTER OF INNOVATION
FOR VETERAN-CENTERED & VALUE-DRIVEN CARE

Disclosures/Conflicts of Interest

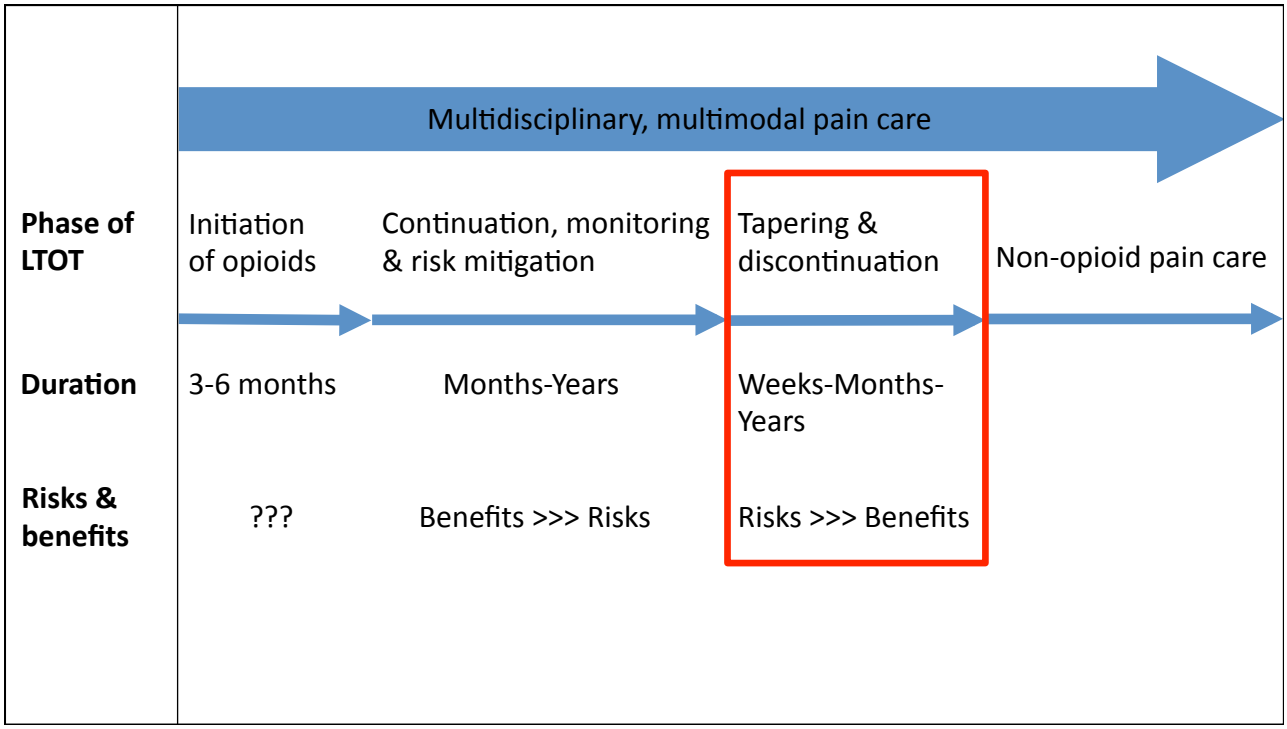
The speakers and planners of this webinar have no relevant financial relationships to disclose.

Session Overview

- The evidence
- The guidelines
- The process of opioid dose reduction

Case

- 52-year-old man with chronic low back pain for the past 11 years following work injury, on daily opioid therapy for 9 years
- Presenting today to a new primary care provider after prior PCP retired
- Currently on long-acting morphine 90mg 3XD & short-acting oxycodone 20mg 4XD PRN
- Ibuprofen, naproxen, topicals not effective on prior trials
- Walks the dog several times weekly, participated in PT 2 years ago



THE EVIDENCE

Question

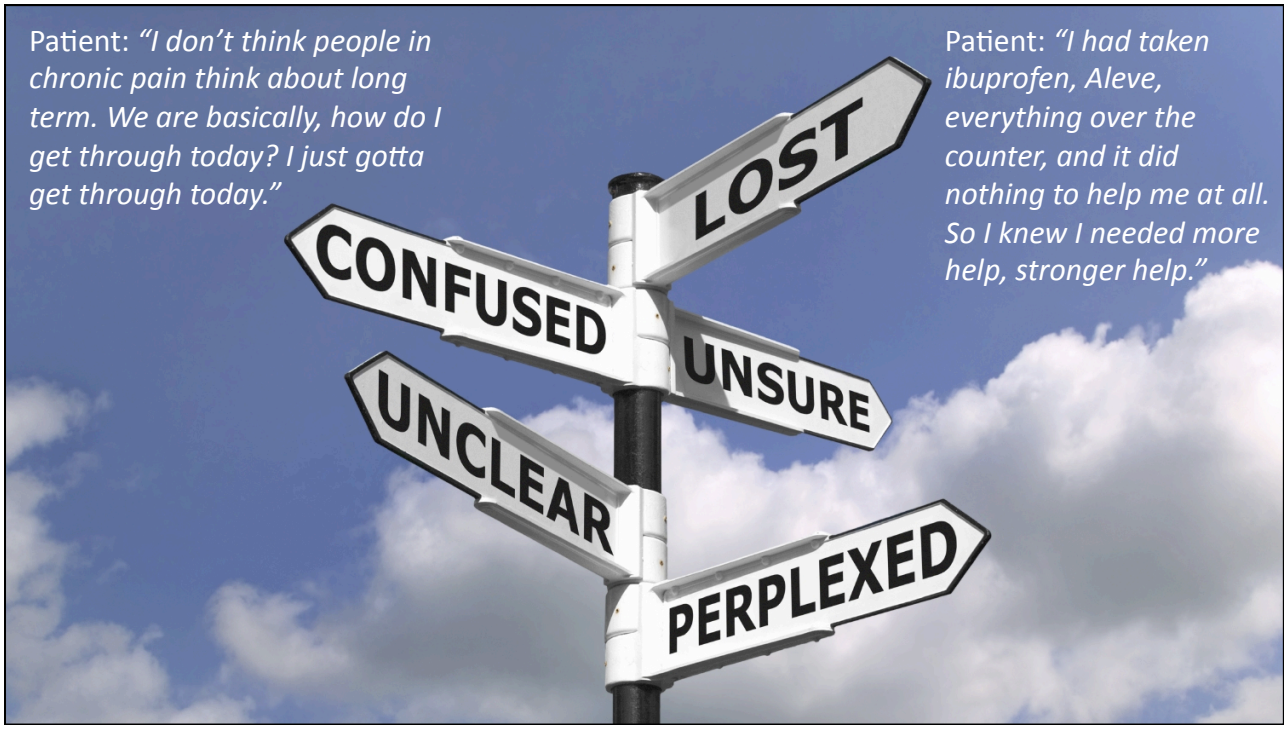
From 1-10, how difficult is your typical conversation when recommending & implementing opioid dose reduction?

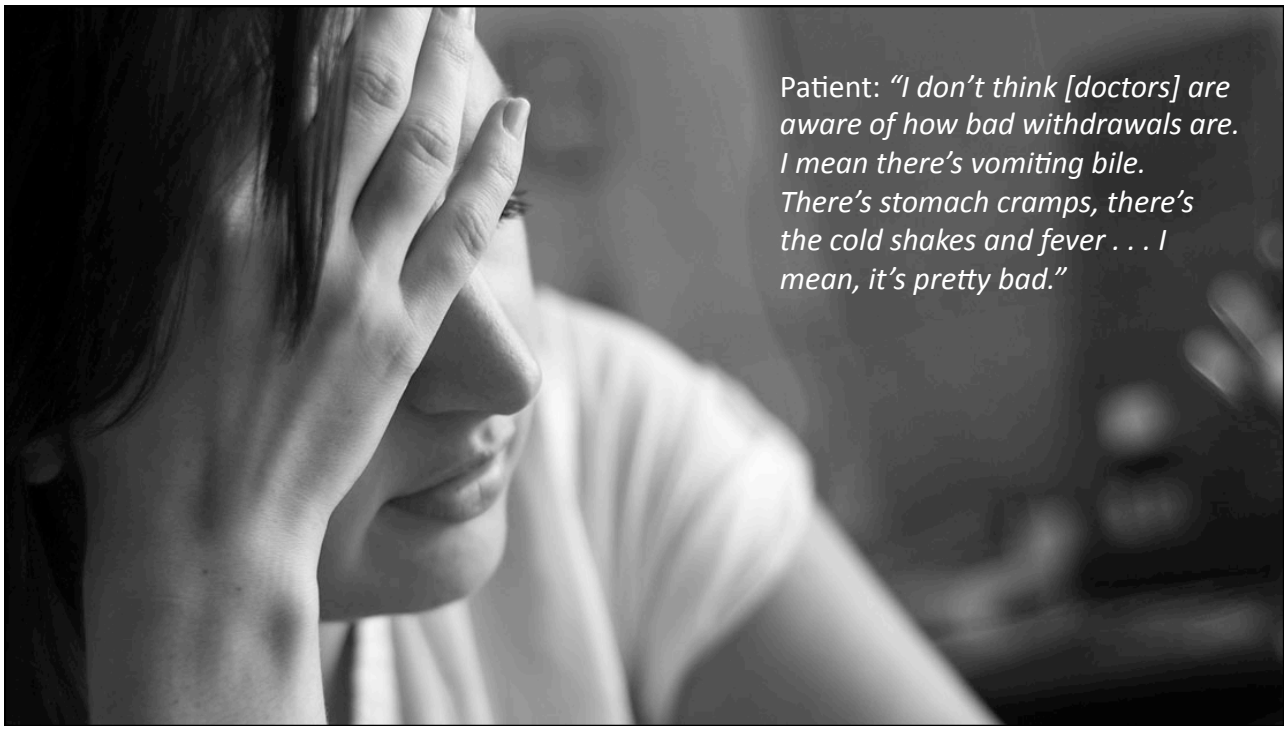
Opioid tapering is challenging

Patients (N=24)

- Barriers
  - Low perceived risk of overdose
  - Pessimism re: non-opioid therapies
  - Prior opioid withdrawal symptoms

Frank et al. Pain Med 2016; Kennedy et al. 2017 Under review


Patient: *"I don't think people in chronic pain think about long term. We are basically, how do I get through today? I just gotta get through today."*
Patient: *"I had taken ibuprofen, Aleve, everything over the counter, and it did nothing to help me at all. So I knew I needed more help, stronger help."*
LOST
CONFUSED
UNSURE
UNCLEAR
PERPLEXED


Patient: *"I don't think [doctors] are aware of how bad withdrawals are. I mean there's vomiting bile. There's stomach cramps, there's the cold shakes and fever . . . I mean, it's pretty bad."*

Opioid tapering is challenging

Patients (N=24)

- Barriers
  - Low perceived risk of overdose
  - Pessimism re: non-opioid therapies
  - Prior opioid withdrawal symptoms

Primary care providers (N=40)

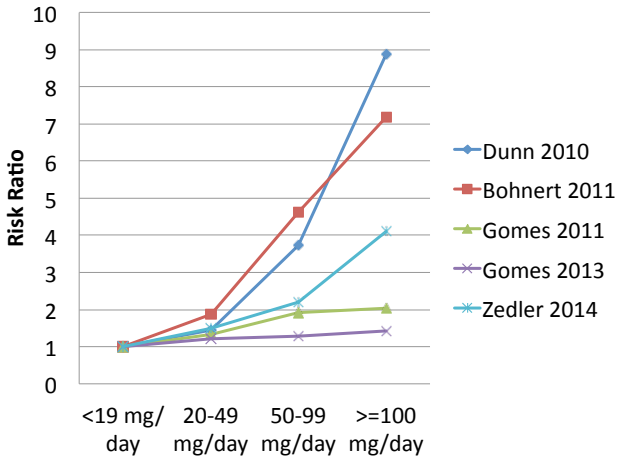
- Barriers
  - Emotional nature of discussion
  - Inadequate training & resources
  - Lack of trust between patient & provider

Frank et al. Pain Med 2016; Kennedy et al. 2017 Under review

PCP: *"A major issue… is time and resources. And, there's no way you can consistently put 20 pounds of potatoes in a five pound bag… I think everyone around the table is very conscientious, very aware of the risks. It's a matter of resources, time, that is not allocated, and that's the nature of medicine today, and it's the nature of primary care."*

Dose-dependent risks of opioid-related harms

- Risk of opioid-related harms associated with high opioid dose
- Dose reduction may decrease risk
- Little evidence on benefits & risks of opioid tapering



Dunn et al. Ann Int Med 2010; Bohnert et al. JAMA 2011; Gomes et al. Arch Int Med 2011; Gomes et al. JAMA Int Med 2013; Zedler et al. Pain Med 2014

Risks & benefits of tapering?

- Two published systematic reviews included ***5*** small randomized trials of opioid tapering interventions
  - No conclusions drawn
- Our systematic review included ***62*** controlled and uncontrolled studies
  - Multidisciplinary interventions appear effective
    - Few studies in primary care settings
  - 'Very low' quality evidence suggesting benefits on pain and function
    - Few studies assessed involuntary tapering or risk of subsequent substance use or adverse events

Chou et al Annals 2015; Windmill et al. Cochrane Review 2013; Frank et al. 2017 Under review

Risks & benefits of tapering?

MAYO CLINIC SYMPOSIUM ON PAIN MEDICINE

Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice

Chantal Berna, MD, PhD; Ronald J. Kulich, PhD; and James P. Rathmell, MD

- Short-term risks:
  - Opioid withdrawal symptoms, increased pain, and loss to follow-up
- Long-term issues:
  - Relapse, function and medicolegal implications
- "A plan that an individual patient can embrace with a ***significant degree of personal engagement*** might be more important than following a specific protocol"

Berna et al. Mayo Clin Proc 2015

THE GUIDELINES

Special Communication

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Deborah Dowell, MD, MPH; Tamara M. Haegerich, PhD; Roger Chou, MD

- **#2**: Before starting, consider how opioids will be discontinued
- **#5**: Carefully reassess risks & benefits when considering dose increases ≥50mg MEDD & avoid dose increases ≥ 90mg MEDD
- **#7**: If benefits do not outweigh harms, optimize other therapies & work with patients to taper and/or discontinue
- **#12**: Offer or arrange evidence-based treatment for patients with opioid use disorder

Dowell et al. JAMA 2016

VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN

- Recommends against doses >90mg MEDD for chronic pain
- Recommends evaluation for tapering for patients taking >90 mg MEDD
- Recommends evaluation of risks and benefits of continuing LTOT ***along with*** risks and benefits of tapering LTOT

The 2017 Draft Recommendations for Use of Opioids in Chronic Non-Cancer Pain

- Suggests tapering opioid to the lowest possible dose, including discontinuation, for patients using ≥90mg MEDD with persistent, problematic pain or side effects
  - Weak recommendation: Providers should individualize to goals, values & preferences of patients

http://nationalpaincentre.mcmaster.ca/documents/Opioids%20guideline%20English_30Jan2017_correctnumbering.pdf

THE PROCESS OF OPIOID TAPERING

Preparing for End at the Beginning

- Optimize non-pharmacologic & non-opioid pharmacologic therapies for chronic pain
- Establish realistic treatment goals for pain & function
- Discuss risks, especially high-dose therapy
- Consider how opioid therapy will be discontinued if benefits do not outweigh risks
  - Response to aberrant behaviors
  - Treatment of opioid use disorder

Dowell et al. JAMA 2016

***The Washington Post*/Kaiser Family Foundation**
Survey of Long-Term Prescription Painkiller Users and Their Household Members

- At initiation, doctors did ***not*** talk about:
  - Non-opioid treatment options 32%
  - Addiction & dependence 28%
  - Possible side effects 23%
  - Plan for discontinuing **60%**

http://apps.washingtonpost.com/g/page/politics/washington-post-kaiser-family-foundation-long-term-opioid-users-poll/2142/

Discuss, Ask & Educate

Discuss

- Listen to patient's story
- Validate pain
- Involve social support

Ask

- Functional goals
- Side effects
- Prior experience with tapering
- Importance of tapering
  - Confidence
  - Readiness

Educate

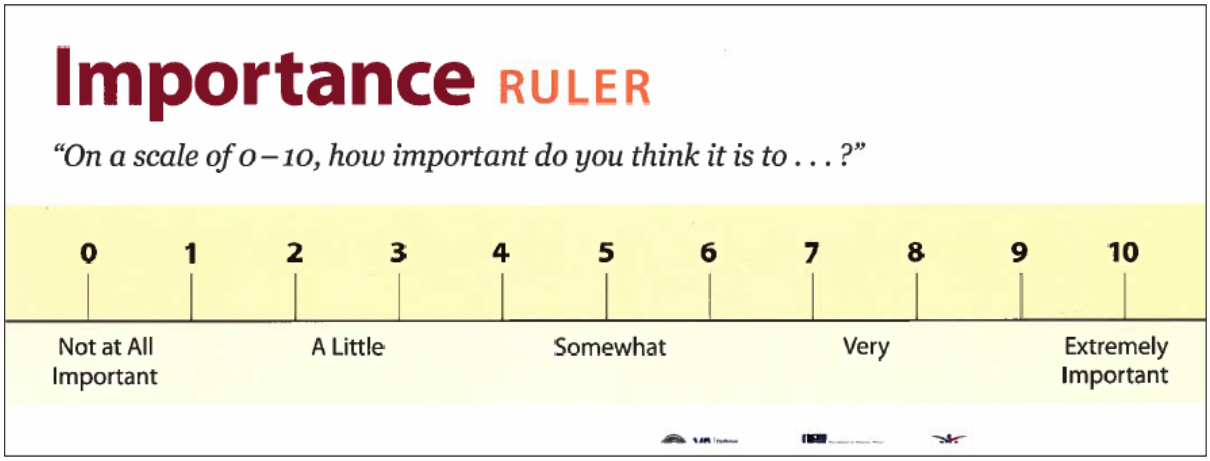
- Biopsychosocial model
- Non-opioid treatments
- Taper planning

VA PBM Academic Detailing Service. Opioid Tapering Decision Tool. www.pbm.va.gov

Ambivalence in long-term opioid therapy

- Among adults on moderate-high dose LTOT (≥ 50mg MEDD),
  - **93%** reported opioids at least moderately helpful
  - **42%** reported side effects as at least moderately bothersome
  - **49%** reported a desire to cut down or stop

Thielke et al. Clin J Pain 2013



Question

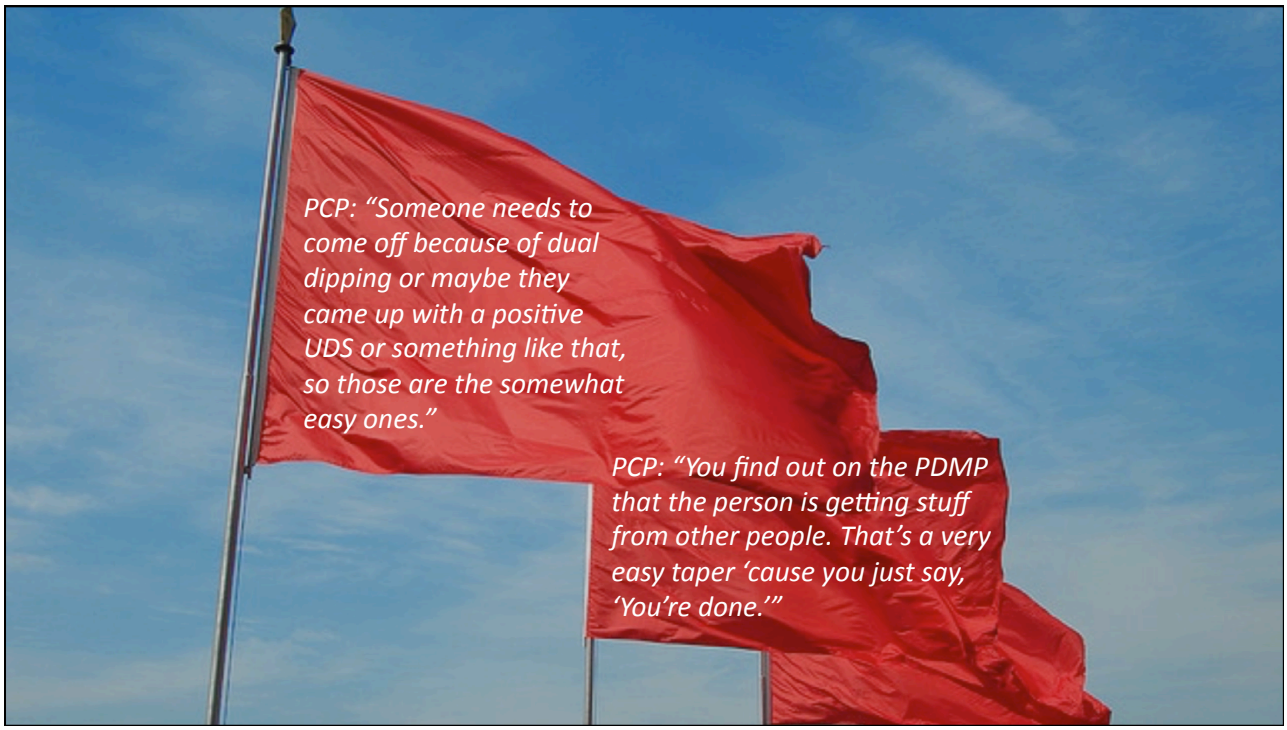
In your experience, what proportion of opioid tapers have been clinician-initiated rather than patient-initiated?

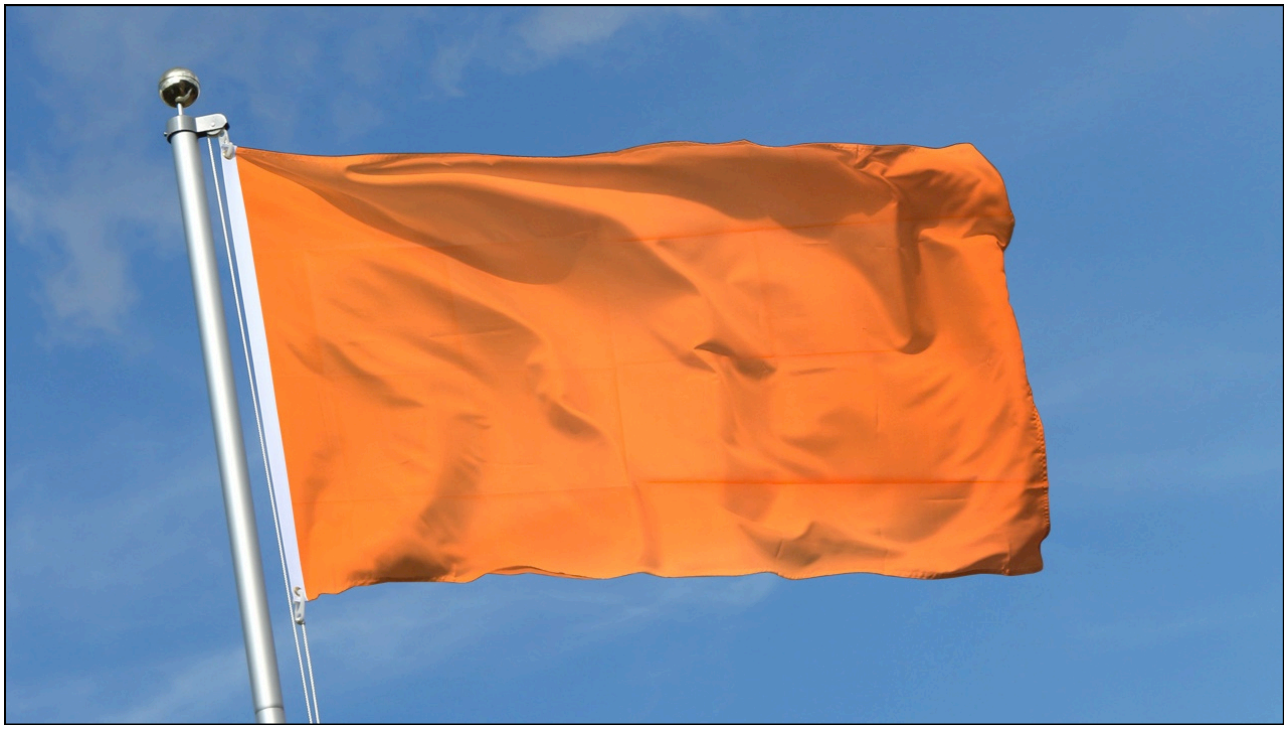
A. 0% (i.e., all patient-initiated)
B. ~25%
C. ~50%
D. ~75%
E. 100% (i.e., all clinician-initiated)

Indications for Opioid Tapering

1. Patient preference
2. Benefits
   - Lack of meaningful functional improvement
   - Improvement in underlying pain condition
   - Pain condition not opioid-responsive
3. Risks/Harms
   - Unmanageable side effects
   - Concurrent high-risk medications (e.g., benzos)
   - Comorbidities
   - Concern for opioid use disorder
   - Non-adherence to risk mitigation strategies
   - Inadequate participation in comprehensive pain care plan

VA/DoD 2017 Clinical Practice Guideline





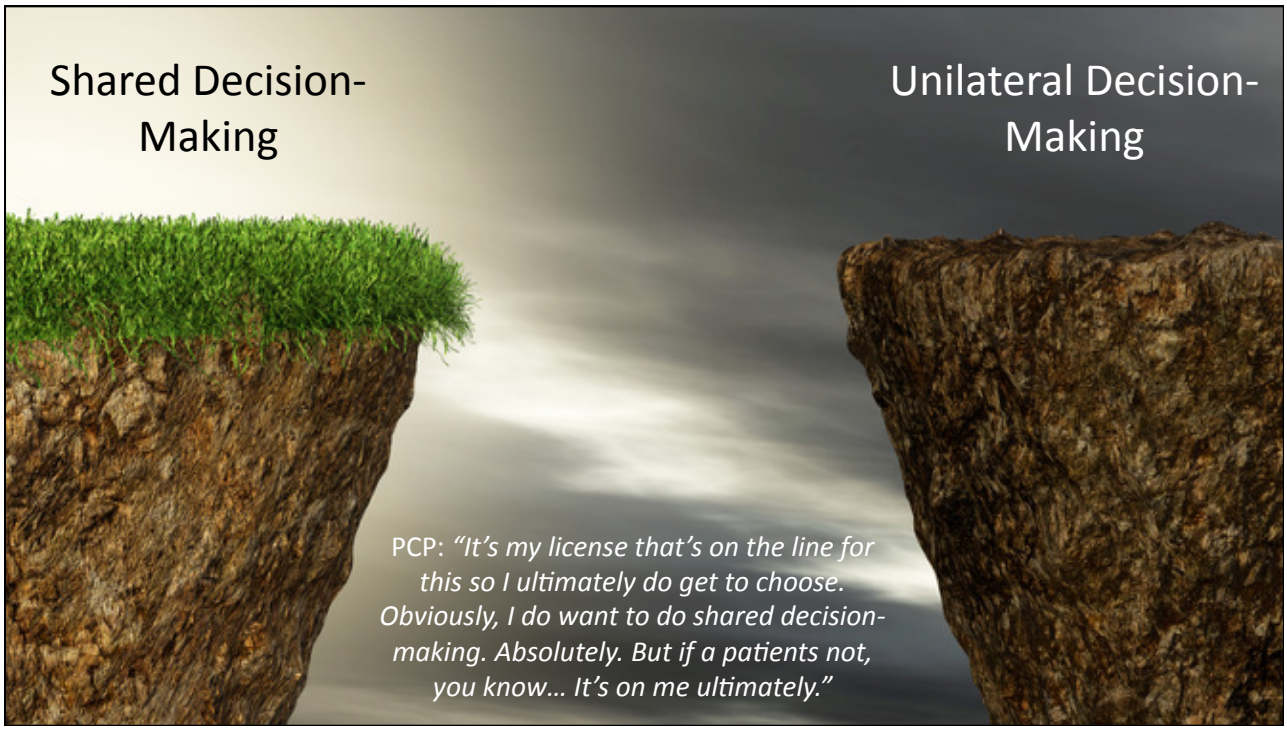
Case

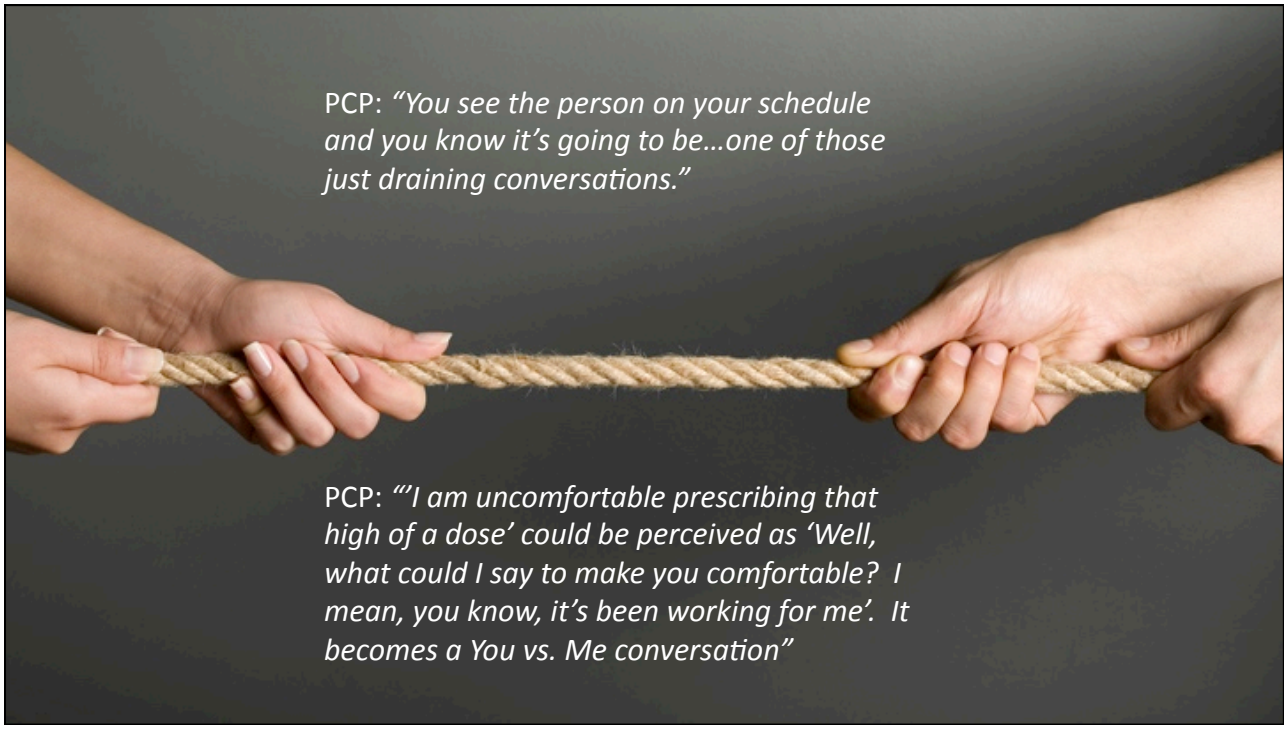
- At your second visit, your patient reports that his level of function has declined substantially in the past year. His long-acting medication is helpful but lasts 3-4 hours. He notes frequent but manageable constipation.
- His wife joins him today. She expresses concern about his frequent daytime napping & tells you that he had a minor car accident last week.
- He did not complete a urine drug screen but agrees to do so today.
- He missed a Physical Therapy appointment last week.

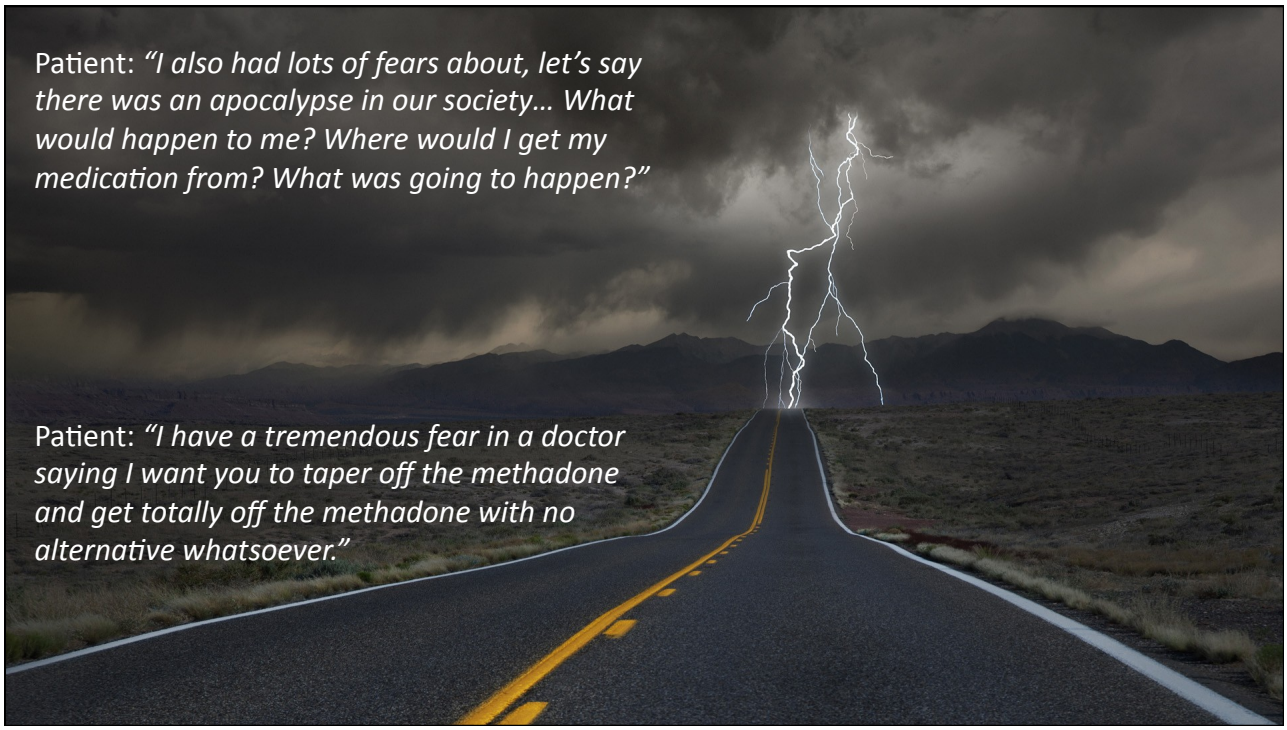
Question

You recommend which of the following?

A. Increase MSSR to 4XD
B. Continue current medications
C. Begin slow taper with next fill
D. Rapid discontinuation d/t adverse event

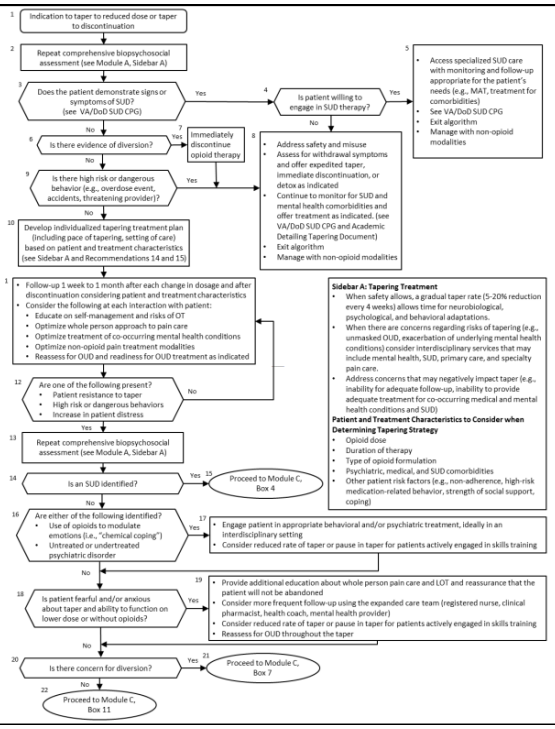



PCP: *"You see the person on your schedule and you know it's going to be…one of those just draining conversations."*
PCP: *"'I am uncomfortable prescribing that high of a dose' could be perceived as 'Well, what could I say to make you comfortable? I mean, you know, it's been working for me'. It becomes a You vs. Me conversation"*

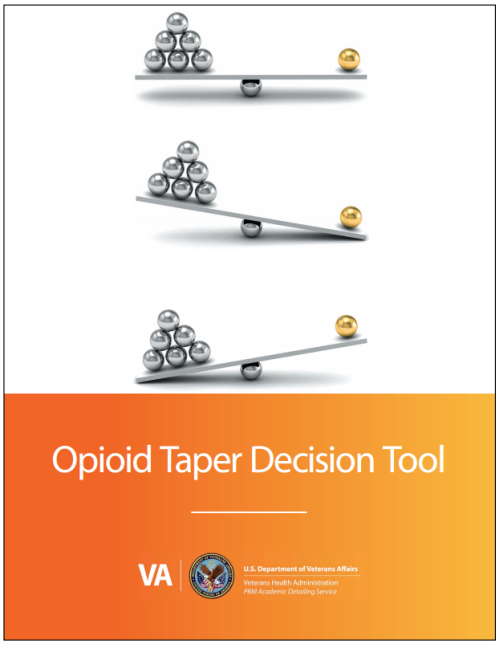

Patient: *"I also had lots of fears about, let's say there was an apocalypse in our society… What would happen to me? Where would I get my medication from? What was going to happen?"*
Patient: *"I have a tremendous fear in a doctor saying I want you to taper off the methadone and get totally off the methadone with no alternative whatsoever."*

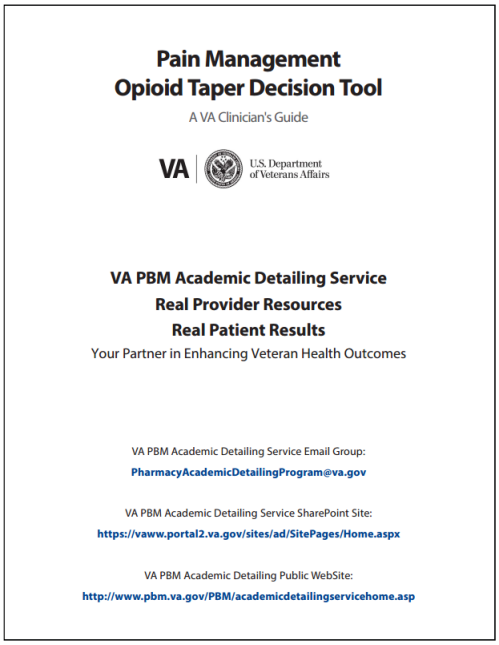
VA/DoD CLINICAL PRACTICE GUIDELINE FOR OPIOID THERAPY FOR CHRONIC PAIN

Module C: Tapering or Discontinuation of Opioid Therapy



VA/DoD 2017 Clinical Practice Guideline





VA PBM Academic Detailing Service. Opioid Tapering Decision Tool. www.pbm.va.gov

Decision-Making During Opioid Tapering

- Goals
- Timing of initiation
- Speed
- Medication order
- Pain management
- Opioid withdrawal management
- Comorbidity management
- Education

Decision-Making During Opioid Tapering

- **Goals**
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Side effects?
Functional goals?
Opioid withdrawal?
Dose?
Discontinuation?

Decision-Making During Opioid Tapering

- Goals
- **Timing of initiation**
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Today?

Next refill?

Patient-driven?

Decision-Making During Opioid Tapering

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CDC 2016:

- 10% per week
- 10% per month if long-term

VA/DoD 2017:

- 5-20% per 28 days

Follow up with the Veteran during the taper:

Follow Up	Slowest Taper (over years)	Slower Taper (over months)	Faster Taper (over weeks)	Rapid Taper (over days)
When	1 to 4 weeks after starting taper then monthly before each reduction	1 to 4 weeks after starting taper then monthly before each reduction	Weekly before each dose reduction	Daily before each dose reduction or if available offer inpatient admission
Who	PACT Team*			
How	Clinic and/or telephone**	Clinic and/or telephone**	Clinic and/or telephone**	Hospital, clinic or telephone**
What	Patient function,*** pain intensity, sleep, physical activity, personal goals, and stress level			

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Prescription Opioid Taper Support for Outpatients With Chronic Pain: A Randomized Controlled Trial

Mark D. Sullivan, Judith A. Turner, Cory DiLodovico, Angela D'Appollonio, Kari Stephens, and Ya-Fen Chan

- Randomized controlled trial of 22-week opioid taper support intervention
  - Weekly visits with PA
  - Motivational Interviewing
  - Self-management training

% reduction @ 22 weeks	Intervention (N=18)	Usual Care (N=17)
0%	4 (22%)	8 (47%)
1-49%	6 (33%)	5 (29%)
50-99%	7 (39%)	2 (12%)
100%	1 (6%)	1 (6%)

Sullivan et al. J Pain 2017.

Research

Clinical Implications of Tapering Chronic Opioids in a Veteran Population

- Cohort study of Veterans undergoing voluntary opioid dose reduction (N=50)
- Average dose decreased by 46% over 12 months
  - Discontinuation in only 6 patients
  - Dose reduction "paused" for at least 3 months in 25 patients
  - Dose "readjusted higher" in 6 patients

Harden et al. Pain Medicine 2015.

Decision-Making During Opioid Tapering

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Example Tapers for Opioids[5-9]

Slowest Taper (over years)	**Slower Taper (over months or years)**	**Faster Taper (over weeks)****	**Rapid Taper (over days)****
Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed *Consider for patients taking high doses of long-acting opioids for many years*	Reduce by 5 to 20% every 4 weeks with pauses in taper as needed **MOST COMMON TAPER**	Reduce by 10 to 20% every week	Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day
Ex: morphine SR 90 mg Q8h = 270 MEDD **Month 1:** 90 mg SR qam, 75 mg noon, 90 mg qpm [5% reduction]* **Month 2:** 75 mg SR qam, 75 mg noon, 90 mg qpm **Month 3:** 75 mg SR (60 mg+15 mg) Q8h **Month 4:** 75 mg SR qam, 60 mg noon, 75 mg qpm **Month 5:** 60 mg SR qam, 60 mg noon, 75 mg qpm **Month 6:** 60 mg SR Q8h **Month 7:** 60 mg SR qam, 45 mg noon, 60 mg qpm **Month 8:** 45 mg SR qam, 45 mg noon, 60 mg qpm **Month 9:** 45 mg SR Q8h**	Ex: morphine SR 90 mg Q8h = 270 MEDD **Month 1:** 75 mg (60 mg+15 mg)SR Q8h [16% reduction] **Month 2:** 60 mg SR Q8h **Month 3:** 45 mg SR Q8h **Month 4:** 30 mg SR Q8h **Month 5:** 15 mg SR Q8h **Month 6:** 15 mg SR Q12h **Month 7:** 15mg SR QHS, then stop***	Ex: morphine SR 90 mg Q8h = 270 MEDD **Week 1:** 75 mg SR Q8h [16% reduction] **Week 2:** 60 mg SR (15 mg x 4) Q8h **Week 3:** 45 mg SR (15 mg x 3) Q8h **Week 4:** 30 mg SR (15 mg x 2) Q8h **Week 5:** 15 mg SR Q8h **Week 6:** 15 mg SR Q12h **Week 7:** 15 mg SR QHS x 7 days, then stop***	Ex: morphine SR 90 mg Q8h = 270 MEDD **Day 1:** 60 mg SR (15 mg x 4) Q8h [33% reduction] **Day 2:** 45 mg SR (15 mg x 3) Q8h **Day 3:** 30 mg SR (15 mg x 2) Q8h **Day 4:** 15 mg SR Q8h **Days 5-7:** 15 mg SR Q12h **Days 8-11:** 15 mg SR QHS, then stop***

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Long-acting

vs.

Short-acting

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Sample written instructions

	Morning	Afternoon	Evening
Days 1 to 10	4 tablets = 60 mg	3 tablets = 45 mg	4 tablets = 60 mg
Days 11 to 20	3 tablets = 45 mg	3 tablets = 45 mg	4 tablets = 60 mg
Days 21 to 30	3 tablets = 45 mg	3 tablets = 45 mg	3 tablets = 45 mg

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- NSAIDs
- APAP
- Topicals
- TCAs
- Injections
- CBT
- MBSR
- Massage
- Acupuncture
- Exercise
- Aquatherapy
- Physical Therapy
- Occupational Therapy
- Spinal manipulation
- Yoga
- Tai chi
- Heat
- Ice
- TENS
- Autogenic training
- Relaxation
- Biofeedback

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Early Symptoms (hours to days)	Late Symptoms (days to weeks)	Prolonged Symptoms (weeks to months)
• Anxiety/restlessness • Rapid short respirations • Runny nose, tearing eyes, sweating • Insomnia • Dilated reactive pupils	• Runny nose, tearing eyes • Rapid breathing, yawning • Tremor, diffuse muscle spasms/aches • Piloerection • Nausea, vomiting, and diarrhea • Abdominal pain • Fever, chills • Increased white blood cells if sudden withdrawal	• Irritability, fatigue • Bradycardia • Decreased body temperature • Craving • Insomnia

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Indication	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	**First line** • Clonidine 0.1 to 0.2 mg oral every 6 to 8 hours; hold dose if blood pressure <90/60 mmHg (0.1 to 0.2 mg 2 to 4 times daily is commonly used in the outpatient setting) – Recommend test dose (0.1 mg oral) with blood pressure check 1 hour post dose; obtain daily blood pressure checks; increasing dose requires additional blood pressure checks – Re-evaluate in 3 to 7 days; taper to stop; average duration 15 days **Alternatives** • Baclofen 5 mg 3 times daily may increase to 40 mg total daily dose – Re-evaluate in 3 to 7 days; average duration 15 days – May continue after acute withdrawal to help decrease cravings – Should be tapered when it is discontinued • Gabapentin start at 100 to 300 mg and titrate to 1800 to 2100 mg divided in 2 to 3 daily doses* – Can help reduce withdrawal symptoms and help with pain, anxiety, and sleep • Tizanidine 4 mg three times daily, can increase to 8 mg three times daily
Anxiety, dysphoria, lacrimation, rhinorrhea	• Hydroxyzine 25 to 50 mg three times a day as needed • Diphenhydramine 25 mg every 6 hours as needed**
Myalgias	• NSAIDs (e.g., naproxen 375 to 500 mg twice daily or ibuprofen 400 to 600 mg four times daily)*** • Acetaminophen 650 mg every 6 hours as needed • Topical medications like menthol/methylsalicylate cream, lidocaine cream/ointment
Sleep disturbance	• Trazodone 25 to 300 mg orally at bedtime
Nausea	• Prochlorperazine 5 to 10 mg every 4 hours as needed • Promethazine 25 mg orally or rectally every 6 hours as needed • Ondansetron 4 mg every 6 hours as needed
Abdominal cramping	• Dicyclomine 20 mg every 6 to 8 hours as needed
Diarrhea	• Loperamide 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily • Bismuth subsalicylate 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg/day

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Mental Health
Substance Use
Sleep
Weight
Other medical conditions

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Overdose risk
– Loss of tolerance & ***naloxone***
– Illicit opioid use

Follow-up plan
– Visit frequency
– Point of contact

Case

- Over the past 6 months, your patient has decreased from 390mg MEDD to 120mg MEDD.
- He is tearful today and reports that his pain level has increased in the last month. He missed his last appointment with you.
- He ran out of medication 1 week ago, experience withdrawal symptoms and bought opioid medications from a neighbor.
- He acknowledges a loss of control and negative consequences impacting his marriage.

Question

You recommend which of the following dosing strategies?

A. Pause opioid taper at current dose
B. Continue slow taper
C. Rapid discontinuation
D. Switch to buprenorphine

DSM-V Opioid Use Disorder Diagnosis

1. Larger amounts or over a longer period than intended
2. Unsuccessful efforts to cut down or control use
3. Time spent obtaining, using or recovering
4. Craving
5. Failure to fulfill major role obligations
6. Social or interpersonal problems
7. Activities given up or reduced
8. Use when it is physically hazardous
9. Physical or psychological problem
10. Tolerance*
11. Withdrawal*

Mild = 2-3
Moderate = 4-5
Severe ≥ 6

Degenhardt et al. Lancet Psychiatry 2015;2(4):314-322

Obtaining a waiver

- Buprenorphine training
  - Eight hours, available in online format
  - Peer-to-peer mentoring
- CDC: "In communities without sufficient treatment capacity", physicians should "***strongly consider***" obtaining a waiver from SAMHSA that allows them to prescribe buprenorphine

Dowell et al. JAMA 2016

Take home points

- A discussion of opioid tapering should begin and continue during long-term opioid therapy
- Opioid tapering should seek to optimize:
  - Benefits & risks of opioid medications *and* opioid tapering
  - Function and quality of life
  - Patient engagement
- The complexity of opioid tapering offers challenge but also opportunities for shared decision-making

Materials

- VA/DoD 2017 Clinical Practice Guidelines on the Management of Opioid Therapy for Chronic Pain
  - https://www.healthquality.va.gov/guidelines/pain/cot/index.asp
- VA Opioid Taper Decision Tool
  - https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf
- VA Opioid Safety Quick Reference Guide (2014)
  - https://www.va.gov/PAINMANAGEMENT/docs/PainProviderADQuickReferenceGuide508.pdf
- CDC Opioid Guideline Resources
  - https://www.cdc.gov/drugoverdose/prescribing/resources.html
- CDC Pocket Guide for Tapering Opioids for Chronic Pain
  - https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf
- February CSAM Webinar on 'Psychological/ Behavioral Strategies for Pain Control: Tools for PCPs to Use in a 20 Minute Visit'
  - https://tapcprogram.files.wordpress.com/2017/03/csam-pain-webinar-resource-list-final.pdf

Questions?

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NEXT WEBINAR: Friday, 05/19/2017
Naloxone Prescribing in Primary Care: Why, Who, and How

Friday, 06/23/2017
Friday, 07/28/2017
Friday, 08/18/2017*
Friday, 09/22/2017

BWH BRIGHAM AND WOMEN'S HOSPITAL

HARVARD MEDICAL SCHOOL
TEACHING AFFILIATE

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Save the date!
CSAM Addiction Medicine Review Course
and Board Exam Preparation
August 24 - August 27, 2017
Hilton San Francisco Union Square