

The background of the slide is a light gray gradient with several realistic water droplets of various sizes scattered across it. The droplets have highlights and shadows, giving them a three-dimensional appearance. They are located in the top-left, bottom-left, and bottom-right areas of the slide.

PART VI: TAPERING OPIOIDS

ROBERT JENKINSON MD

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TAPERING OPIOIDS

- GETTING STARTED ON OPIOIDS IS EASY BUT GETTING PATIENTS OFF IS HARD
- WE ARE OBLIGED TO TAPER PATIENTS DOWN AND OFF OPIOIDS WHEN MEDICALLY INDICATED
- THIS TALK IS DIRECTED AT TAPERING PATIENTS IN AN OUTPATIENT AMBULATOR CARE SETTING FOCUSING ON CHRONIC PAIN PATIENTS WHO HAVE BEEN ON OPIOIDS FOR MONTHS TO YEARS

INDICATIONS FOR TAPERING LONG-TERM OPIOID TREATMENT

1. Inability to achieve or maintain anticipated *pain relief* or *functional improvement* despite reasonable dose escalation
2. Intolerable adverse effects at the minimum dose that produces effective analgesia, with reasonable attempts at opioid rotation unsuccessful
3. Persistent nonadherence with patient treatment agreement
This can include inappropriate use, failure to comply with monitoring (after excluding this failure is due to personal cost burden), selling prescription drugs, forging prescriptions, stealing or borrowing drugs, aggressive demand for opioids, injecting oral or topical opioids, unsanctioned use of opioids, unsanctioned dose escalation, concurrent use of illicit drugs, obtaining opioids from multiple prescribers and/or multiple pharmacies, recurring emergency department visits for chronic pain management
4. Deterioration in physical, emotional, or social functioning attributed to opioid therapy
5. Resolution or healing of the painful condition


INDICATIONS FOR TAPERING LONG-TERM OPIOID TREATMENT

- **2016 CDC GUIDELINES:**

- REQUESTS DOSAGE REDUCTION
- DOES NOT HAVE CLINICALLY MEANINGFUL IMPROVEMENT IN PAIN AND FUNCTION (E.G., AT LEAST 30% IMPROVEMENT ON THE 3-ITEM PEG SCALE)
- IS ON DOSAGES ≥ 50 MME*/DAY WITHOUT BENEFIT OR OPIOIDS ARE COMBINED WITH BENZODIAZEPINES
- SHOWS SIGNS OF SUBSTANCE USE DISORDER
- EXPERIENCES OVERDOSE OR OTHER SERIOUS ADVERSE EVENT
- SHOWS EARLY WARNING SIGNS FOR OVERDOSE RISK SUCH AS CONFUSION, SEDATION, OR SLURRED SPEECH



CENTRAL ISSUES DURING TAPERING OF LONG TERM OPIOID THERAPY

- **OPIOID WITHDRAWAL**
 - **INCREASED PAIN**
 - **DROPOUT**
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CENTRAL ISSUES DURING TAPERING OF LONG TERM OPIOID THERAPY: **OPIOID WITHDRAWAL**

- **SYMPTOMS:**

- ANXIETY, HYPERTENSION, TACHYCARDIA, RESTLESSNESS, MYDRIASIS, DIAPHORESIS, NAUSEA, ABDOMINAL CRAMPS, DIARRHEA, MYALGIAS OR ARTHRALGIAS, RHINORRHEA, SNEEZING, INSOMNIA, AND YAWNING.
- BEGINS 2 – 3 HALF-LIVES AFTER LAST DOSE. PEAK IN MOST CASES AT 48-72 HOURS AND RESOLVE IN WITHIN 7 TO 14 DAY.
 - DIFFERENT TOOLS ALLOW MEASURING WITHDRAWAL SYMPTOMS, FOR EXAMPLE, THE OBJECTIVE PRACTITIONER ASSESSMENT CLINICAL OPIOID WITHDRAWAL SCALE.

CENTRAL ISSUES DURING TAPERING OF LONG TERM OPIOID THERAPY: **OPIOID WITHDRAWAL**

- PHARMACOLOGIC MANAGEMENT OF OTHER WITHDRAWAL RELATED SIDE EFFECTS
 - ANTIHISTAMINES OR TRAZODONE FOR INSOMNIA/RESTLESSNESS
 - NSAIDS/ACETAMINOPHEN FOR MYALGIAS AND JOINT PAIN
 - LOPERAMIDE/BISMUTH SUBSALICYLATE FOR ABDOMINAL CRAMPING AND DIARRHEA
 - CLONIDINE (PO OR TD) FOR AUTONOMIC SYMPTOMS – TACHYCARDIA, HYPERTENSION, PILOERECTION
 - ONDANSETRON FOR NAUSEA, VOMITING

CENTRAL ISSUES DURING TAPERING OF LONG TERM OPIOID THERAPY: **INCREASED PAIN**

- MANY PATIENTS FEAR THAT THEIR PAIN WILL INCREASE DURING AN OPIOID TAPER
 - PATIENTS TYPICALLY REPORT IMPROVEMENTS IN FUNCTION WITHOUT ASSOCIATED WORSENING IN PAIN OR EVEN DECREASED PAIN LEVELS AFTER OPIOID CESSATION
 - HOWEVER, SENSORY HYPERALGESIA MAY APPEAR IMMEDIATELY AFTER DISCONTINUATION OR REDUCTION OF LONG-TERM OPIOID TREATMENT

CENTRAL ISSUES DURING TAPERING OF LONG TERM OPIOID THERAPY: **DROPOUT**


- **THE RISK THAT PATIENTS WILL REFUSE TO TAPER OPIOIDS OR RESUME LONG-TERM OPIOID TREATMENT WITH A NEW PRESCRIBER**
 - THE MOST SIGNIFICANT PREDICTIVE FACTOR IS DEPRESSIVE SYMPTOMS AT INITIATION OF TAPER
 - HIGH PAIN SCORES, HIGH OPIOID DOSES & LACK OF PROVISIONS FOR TAPER FAILURE ARE OTHER KEY PREDICTORS

CENTRAL ISSUES DURING TAPERING OF LONG TERM OPIOID THERAPY: **DROPOUT**

- IDENTIFY HIGH RISK PATIENTS
- PSYCHOLOGICAL SUPPORT MAY BE NEEDED
 - PRE-TAPER INTRODUCTION OF STRESS-COPING STRATEGIES
- HAVE A PLAN IN PLACE FOR IF AND WHEN THE TAPER PLAN FAILS



MECHANICS OF TAPERING

- **GENERAL PRINCIPALS**
 - **RATE**
 - **MEDICATION CHOICE**
 - **SAFETY CONSIDERATIONS**
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MECHANICS OF TAPERING

GENERAL PRINCIPLES FOR OPIOID TAPERING

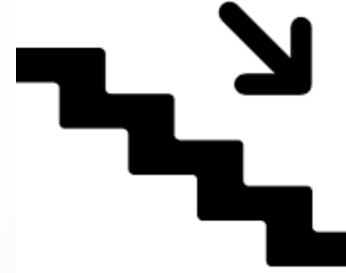
- **#1** OPTIMIZE OTHER PAIN MANAGEMENT (E.G. ADDITION OF CO- ANALGESICS FOR NEUROPATHIC PAIN SUCH AS NORTRIPTYLINE, DULOXETINE, GABAPENTIN OR PREGABALIN)
- **#2** OPTIMIZE MENTAL HEALTH, CONSIDER CONSULTATION WHEN APPROPRIATE
- **#3** ANTICIPATE WITHDRAWAL EFFECTS & HAVE A PLAN TO MANAGE
- **#4** ENCOURAGE FUNCTIONAL GOAL SETTING AND EFFORTS TO ENHANCE NON-DRUG APPROACHES IN MANAGEMENT PLAN
- **#5** SEE PATIENT FREQUENTLY DURING PROCESS AND STRESS BEHAVIORAL SUPPORTS

MECHANICS OF TAPERING

ADDITIONAL POINTS

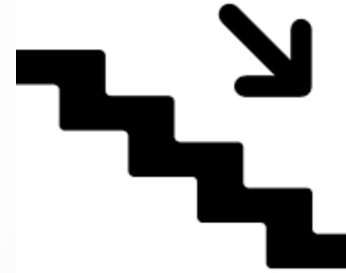
- IS DOSE REDUCTION IS REASONABLE OR IS COMPLETE DISCONTINUATION IS MORE SUITABLE?
- TAPERING PLAN MAY BE HELD/REASSESSED AT ANY POINT IF PAIN/FUNCTION DETERIORATES OR WITHDRAWAL SYMPTOMS PERSIST.
 - HOWEVER, THE “HOLD OFF ON FURTHER TAPER & PLAN TO RESTART TAPER” CONVERSATION SHOULD HAVE A DESIGNATED ENDPOINT AND BE ONE CONVERSATION, NOT TWO!

MECHANICS: RATE



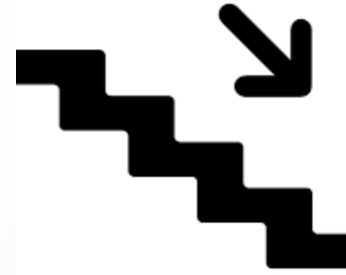
- **NO PUBLISHED COMPARISON OF SPEED OF TAPERS IN PATIENTS WITH LONG TERM OPIOID TREATMENT**
 - A FAST OR ULTRAFast TAPER CAN BE CONSIDERED WHEN INPATIENT TAPER IS NEEDED BECAUSE OF SIGNIFICANT COEXISTING PSYCHIATRIC OR MEDICAL ILLNESS, SUCH AS SUD OR UNSTABLE CARDIAC DISEASE
- **ACCORDING TO OUR CENTER'S EXPERIENCE:**
 - CALCULATE TOTAL MORPHINE MILLIEQUIVALENT DAILY DOSE
 - A DECREASE OF 10% OF THE ORIGINAL DOSE EVERY 2-4 WEEKS UNTIL 30-50% OF THE ORIGINAL DOSE IS REACHED
 - FOLLOWED BY A WEEKLY OR BIWEEKLY DECREASE BY 10% OF THE REMAINING DOSE
 - THIS PROTOCOL RARELY PRECIPITATES WITHDRAWAL SYMPTOMS AND FACILITATES ADHERENCE
- **RATE SHOULD BE INVERSELY CORRELATED WITH DURATION OF TREATMENT**

MECHANICS: MEDICATION CHOICE



- **EMPIRICAL PROTOCOLS SINCE THE 1990S FAVOR TAPERS USING THE PATIENT'S LONG-TERM OPIOID TREATMENT MEDICATION**
- A SHORT-ACTING FORMULATION CAN BE INTRODUCED AFTER TAPERING TO THE LOWEST INCREMENT OF A LONG-ACTING MEDICATION
- METHADONE TAPERING WILL TAKE LONGER DUE TO EXTENDED HALF LIFE

MECHANICS: SAFETY CONSIDERATIONS



- **IMMEDIATE DISCONTINUATION, NOT TAPER, IF THERE IS DIVERSION OR NON-MEDICAL USE**
- **RAPID TAPER IF THE PATIENT HAS HAD A SEVERE ADVERSE OUTCOME SUCH AS OVERDOSE**
- **STRONGLY CAUTION PATIENTS THAT:**
 - A) THEY HAVE LOST THEIR TOLERANCE TO OPIOIDS AFTER AS LITTLE AS A WEEK OR TWO OF ABSTINENCE
 - B) THEY ARE AT RISK FOR OVERDOSE IF THEY RELAPSE/RESUME THEIR ORIGINAL DOSE
- **WATCH FOR SIGNS OF UNMASKED MENTAL HEALTH DISORDERS DURING TAPER, ESPECIALLY IN PATIENTS ON PROLONGED OR HIGH DOSE OPIOIDS**

BRAVO METHOD



- DEVELOPED BY DR. ANNA LEMBKE AS A SET OF CARDINAL PRINCIPLES FOR TAPERING PATIENTS OFF OF CHRONIC OPIOID THERAPY. GUIDELINES AND VIDEOS WIDELY AVAILABLE ONLINE.
- **B**ROACHING THE SUBJECT
- **R**ISK-BENEFIT CALCULATOR
- **A**DDICTION HAPPENS
- **V**ELOCITY MATTERS & SO DOES VALIDATION
- **O**THER STRATEGIES FOR COPING WITH PAIN

BRAVO METHOD



- **BROACHING THE SUBJECT**

- LEAVE ENOUGH TIME!
- EVEN SUGGESTING A TAPER CAN CAUSE SIGNIFICANT ANXIETY
 - IDENTIFY THESE FEELINGS, NORMALIZE AND EXPRESS EMPATHY
- MAKE CLEAR THAT OPIOID TAPER WAS CAREFULLY CONSIDERED, NOT IMPULSIVE AND NOT PUNITIVE

BRAVO METHOD



- **RISK-BENEFIT CALCULATOR**
- WEIGHT PAIN RELIEF AGAINST FUNCTION
- TRACK COMMON RISKS VS BENEFIT OF PAIN RELIEF: TOLERANCE, DEPENDENCE, WITHDRAWAL, HYPERALGESIA, DEPRESSION, ADDICTION, ALTERED MENTAL STATUS, FATIGUE
 - INVOLVE FAMILY MEMBERS FOR MORE OBJECTIVE VIEWS ON A PATIENT'S OPIOID USE AND FUNCTION
- INCLUDE THESE FACTORS WHEN DISCUSSING REASONS FOR TAPERING OFF OPIOIDS

BRAVO METHOD



- **ADDICTION HAPPENS**
- **DISCUSS ADDICTION AND OPIOID USE DISORDER BEFORE THE TAPER BEGINS**
 - BE TRANSPARENT ABOUT HOW THE HEALTH CARE FIELD HAS CONTRIBUTED TO THE OPIOID EPIDEMIC
 - DISCUSS TREATMENT OPTIONS FOR OPIOID USE DISORDER UPFRONT.
- **MISUSE OF OPIOIDS IN LONG TERM OPIOID THERAPY IS COMMON AND CAN PREDICT SUBSEQUENT ADDICTION**
 - PHYSICAL DEPENDENCE, WITHDRAWAL AND TOLERANCE BY THEMSELVES DO NOT DEFINE ADDICTION
 - ADDICTION REFERS TO THE BEHAVIORS ASSOCIATED WITH OPIOID USE. THINK OF THE 4 C'S: CONTROL, COMPULSION, CRAVING, CONTINUED USE (DESPITE CONSEQUENCES)
 - NORMALIZE THE CONCEPT OF ADDICTION TO MEDICATIONS PRESCRIBED FOR PAIN AND REASSURE PATIENTS THAT THERE ARE EFFECTIVE TREATMENTS

BRAVO METHOD



- **VELOCITY AND VALIDATION**
- **THE BIGGEST MISTAKE PROVIDERS MAKE IN TAPERING PATIENTS OFF CHRONIC OPIOID THERAPY IS TAPERING TOO FAST.**
 - STANDARD RECOMMENDATIONS ARE OFTEN OVERLY AGGRESSIVE
 - SEE MECHANICS AS PREVIOUSLY DISCUSSED
- **VALIDATE THEIR OPINIONS AND FEARS**
 - IT IS OK TO INVOLVE THE PATIENT IN SOME ASPECTS OF THE DECISION TO TAPER
 - LET THEM KNOW ABOUT OPIOID WITHDRAWAL & FORMULATE A PLAN

BRAVO METHOD



- **OTHER STRATEGIES**

- MANY WE HAVE PREVIOUSLY DISCUSSED AS PART OF OUR ECHO CONFERENCE
- DO NOT PRESCRIBE BENZODIAZEPINES AS AN ALTERNATIVE
- NON-MEDICATION SKILLS:
 - TEACH PATIENTS MINDFULNESS BASED PRACTICES
 - STRETCHING, ROM EXERCISE, MYOFASCIAL RELEASE

THANK YOU!

- QUESTIONS OR COMMENTS?