How to Taper from Chronic Opioid Therapy

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Clinical Case

- 62 year old African American male
- Patient noted to be admitted for AKI; chest pain (non-cardiac); multiple body pains; …
- Pain Diagnoses:

–Meralgia paresthetica; Trochanteric Bursitis;

–Cervical Stenosis; s/p Lumbar Stenosis surgery

Clinical Case

- Other PMHx:

–DM poor control; HTN; Cholesterol;
–Morbid Obesity, OSA on CPAP; Edema (normal Systolic Heart Function)
–No MH notes for > 10 years; Polypharmacy for
Various diagnoses without full criteria of: “PTSD”, “Bipolar”, “Psychosis”
–Poly-Substance Dependence (hoped to be) in Remission:
Cocaine; Heroin; MJ; Tobacco
One UDS in CPRS = 2/2012 + opiate, + benzo
–Erectile Dysfunction (no Testosterone checked)
–Chronically elevated Creatinine Kinase levels / Chronic Hyponatremia
–(Probable Vitamin D Deficiency - not checked)

Clinical Case

- Medications on admission:

–Morphine Sustained Release 30mg x 7, Q8Hr
–Oxycodocone IR 5mg PRN (enough for Q4hr)
–Temazepam 30mg at bedtime
–Baclofen 20mg/20mg/40mg
–Risperidone 4mg at bedtime; Valproate; Fluoxetine

- Morphine Equivalents Daily (MED)

  630 + 45 = 675 mg MED

Clinical Case

- Admitted 2 ½ days – trimmed Polypharmacy

–Reduced Morphine and Furosemide;

–Stopped Valproate

Discharged on

–Morphine SR 30mg x 3 Q12Hr

–Morphine IR 15mg Q6Hr PRN

–Temazepam; Baclofen; Risperidone …

–Discharge MED = 180-240 mg

- No withdrawal symptoms on 90 mg Q12Hr
- **Plan to**
- **–See Mental Health**

–Continue taper 15mg MED weekly until

OFF opioids, OR

If off Temazepam (and drugs), then to < 45mg MED

Clinical Case

- **BUT June 2013 Medications via PCP**

–Morphine SR 60mg x2 Q 8Hr

–Hydrocodone 10mg 1-2 PRN Q6hr (#180)

–Temazepam 30mg; Risperidone; Baclofen …

Current Contra-Indications and Risks include:

–360 + 60 = 420 mg MED

–Benzodiazepine + Opioid

–OSA…

–No Extended Drug Screen

–Again, NO follow-up with Mental Health

History of Taper Guidance

- Responsible Opioid Prescribing; 2007, Fishman
- –One sentence, under subchapter “Treatment Termination”
- “safe discontinuation may require a tapering schedule”

Earlier Downplay of High Risk Groups Responsible Opioid Prescribing; 2007, Fishman

- "Behaviors More indicative of addiction", as listed below, still recommended for opioids, but with "increase in [physician's] vigilance"

–"Bought pain medications from a street dealer"

–"Stole money to obtain drugs"

–"Performed sex for drugs"

–"Seen two doctors at once without them knowing"

–"Stole drugs from others"

–"Prescription forgery"

- Yet: we now know that RISK >>> Benefit; and

–This advice DIVERTS limited provider resources

Who to Taper?

- Absolute Contra-Indications for COT

–Suicide Watch in last 12 months

–Concurrent Benzodiazepine

–Hx Over Dose

–Uncontrolled PTSD or MDD or … / SIMD

–mTBI (Persistent Post-Concussive Syndrome)

–Alcohol Abuse / Cocaine or Amphetamine

–Homeless

–Hx Diversion

2010 VA-DoD CPG Management of Opioid for Chronic Pain; Atlanta VA Task Force for Opioid Safety; 2013

Who to Taper?

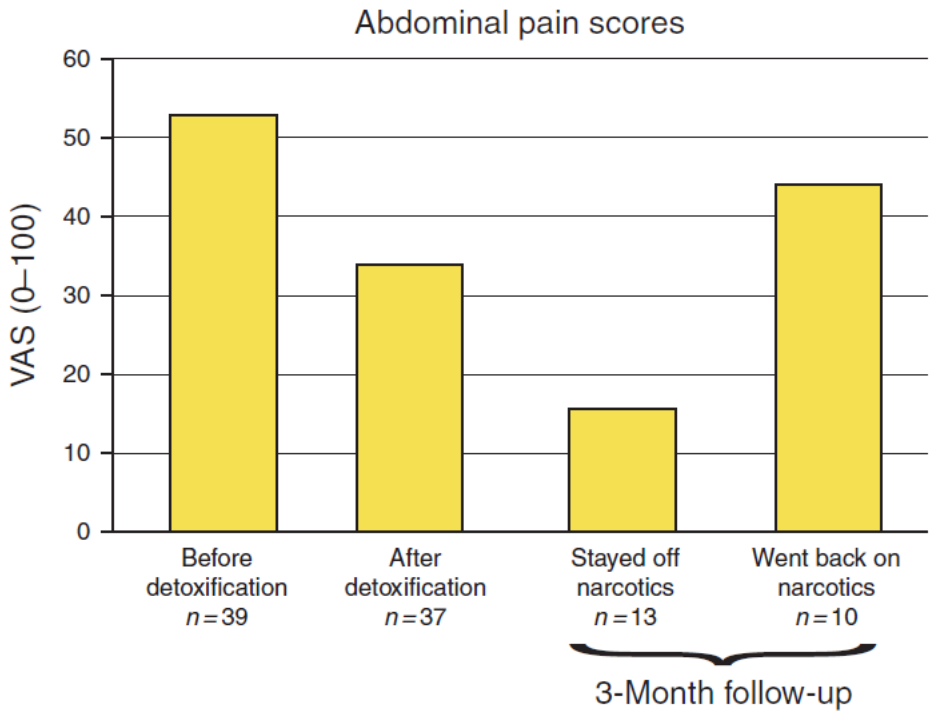
- Absolute Contra-Indications for COT

–Central Sensitization States
–Bursitis as sole Pain diagnosis
–Non-adherence to appropriate therapy
–Pregnancy
–Sleep Apnea
–Prolonged QTc if on Methadone

2010 VA-DoD CPG Management of Opioids for Chronic Pain;
Canadian Guideline – Safe and Effective – Opioid for CNMP, 2010;
Atlanta VA Task Force for Opioid Safety; 2013

Central Sensitization: Narcotic Bowel ie Chronic Opioids fail to improve Abd Pain

Drossman, Am J Gastro, 2012, Diagnosis, Characterization and Outcomes – Narcotic Bowel



Who to Taper?

- Greater than Safe Ceiling Dosages
- –>100 mg MED if NO Contra-Indications
- –>30-45 mg MED if Relative Contra-Indications
- Those Active duty members and veterans who desire it
- –Ask them

2010 VA-DoD CPG Management Opioid Therapy for Chronic Pain

- LOTS of good advice, including updated:

–Factsheet May 2013

- “Tapering and Discontinuing Opioids”

Before Tapering

- Educate patient's health care team

–Best practices for Chronic Pain Management

- Encourage Inter-Professional Learning

–Discuss

- Feelings
- Why change
- How each member can support better care
- Give heads up for particular patient needs

Principles for Tapering Interactions

- Discuss: Patient's functional Goals

–Cannot contain words like "Pain"

–Goal for each in next 3-6 months:

- Physical _____
- Social / Recreational _____
- Vocational / Productive _____
- Document in updated Medication Agreement

Principles for Tapering Interactions

- Highlight SAFETY
- Avoid “Power Dynamics”
  - Use “I” statements
- “I am so worried about you and your safety”
- Practice consistency / fairness
  - Update and implement Policy

Motivational Interviewing, To Move Patient

- From refusing these or other therapies

—“It didn’t do anything”

- To trying a medication because

—It helps “a little bit”

Before and/or With Taper

- Screen documentation for

–Red Flags

–Diagnoses and prior indication for COT

–Contra-Indications for COT

Before and/or With Taper

- Screen for and offer to treat:

–Undertreated

- ANXIETY / PTSD / Depression
- Substance Use Disorders

Before and/or With Taper

- Assess and augment non-medical support

–Chaplaincy/Ministry

–Group - American Chronic Pain Association

- Educate

–Patient and significant others

- Encourage

–Chronic Pain CBT and Stress Management Groups

–Gradual Progressive Exercise

- Walking …

Before and/or With Taper

- Consider community resources like proven Complementary Medicine
- ”Out of pocket” expenses in most cases

–Alexander technique (?or Feldenkrais)

–Yoga or other Movement Therapies

–Mindfulness or other Acceptance Therapies

–Massage, Spinal Manipulation or Acupuncture

OMT!

Consider Oral Agents for Central Sensitization:

- Norepinephrine effects:

–TCA – low dose – if no contra-indication; OR

- Continue TCA-like agent,

–If already on Cyclobenzaprine long term

–Not FDA approved; OR

–SNRI - Venlafaxine

- Gabapentinoid effects

–Gabapentin – slowly titrated to high dose

Daniel Clauw, Fundamentals Pain Management, PRIMER, APS 2013

Topical Adjuvants

- Capsaicin Cream

–Hand OA1

- Diclofenac gel 1% rather than oral NSAID
- Especially if >75 years[1]

–Hand or Knee OA[1]

- Menthol / methyl salicylate cream
- Lidocaine 2.5% / Prilocaine 2.5% cream or gel

1Hochberg et al, Arthritis Care Research, 2012, Treatment OAHand Hip Knee – American College RheumatologyRecommendations;

Short Term Oral Analgesics

- IF compensated liver dysfunction, AND no alcohol abuse
- –Acetaminophen[1] up to 1000mg Q12Hr (Q8Hr if no Liver D/O)
  Avoid other Over the Counter (OTC) sources

•IF <65 years AND preserved renal AND cardiac function

–AND IF no history of PUD/gastritis

- Oral NSAIDS - 2% annual UGI Bleeding Risk

–Naproxen sodium OTC – No increase in CV Risk – Lancet 2013; OR

–Ibuprofen[2] OTC – 1% annual CV Risk

–IF history of PUD/gastritis

•Salsalate, OR

Low dose meloxicam ie 7.5mg daily, OR

Other NSAID with full dose PPI (such as 10mg omeprazole daily)

[1]Group Health, 2007, Treating Withdrawal;

[1]Canadian Guideline - Safe and Effective - Opioid in CNCP, 2010; Appendix B12: Tapering;

[2]Baron & McDonald, J Opioid Management, 2006 (200mg Ibuprofen <= Q4Hr)

Breakthrough Pain

- Educate about “Bad Days”

–Waxing and waning symptoms are normal

–[Don’t panic]

- Help patient with teaching

–Develop plan for increased pain or stress

–Reflect on triggers

- To avoid next time

–“Overdoing” i.e. lack of Pacing

–Missed sleep

- To address with new skills

–Stressful relationship …

Re- Educate about Goals of Taper

- Feel better / reduce pain intensity
- Improve mood and ability to do more
- Increase safety

Educate on Withdrawal Symptoms

- Uncomfortable

–but usually not dangerous

- Transient Onset: Duration:

–Immediate acting 8-24 Hr 4-10 Days

–Sustained Release 12-48 Hr 10-20 Days

VISN 20 Opioid Guideline - Oct 2007; OpioidTransition and Taper; Canadian Guideline - Safe and Effective - Opioid in CNCP, 2010; Appendix B12: Tapering

Educate on Withdrawal Symptoms

- Nausea / Diarrhea / Stomach Cramps
- Runny Nose
- Muscle aches
- Anxiety
- Sweating / Fast Heart Beat
- Chills / Goose Bumps
- Trouble Sleeping

VISN 20 Opioid Guideline - Oct 2007; Opioid Transition and Taper; Canadian Guideline - Safe and Effective - Opioid in CNCP, 2010; Appendix B12: Tapering

Self-Care to Lessen Withdrawal

- Remember symptoms will pass
- Drink lots of fluids
- Relaxation

–Deep Breathing

–Quite room, soothing music

- Distraction

–Stretch, move and exercise

–Movie

- Hot Bath / Ice packs to painful areas

Agents to Lessen Withdrawal

- Clonidine to counter Sympathetic drive
- First line agent[1] recommendation from Group Health

–Not FDA approved

- Consider test dose of 0.1 mg orally

–Risk of hypotension, but usually hypertensive with W/D; then

–Oral1,2 0.1 mg Q8Hr during taper

- With possible up-titration for a week or more

–Titration would require rechecking BP/HR

[1]Group Health, 2007, Treating Withdrawal; 2VISN 20 Opioid Guideline, Oct 2007, Taper; (2010 VA-DoD CPG) Factsheet "Tapering and Discontinuing Opioids", May 2013

Agents to Lessen Withdrawal

- Avoid

–Benzodiazepine

•Except for those on Benzo, which necessitated Opioid Taper

–Zolpidem

•Anxiolytic / Sedative

–Hydroxyzine Pamoate or Diphenhydramine

•25mg Q6Hr PRN and additional 25mg at bedtime

•** For age < 65 years; AND/OR

–See also sedating GI medications following, OR

–? Baclofen[1] 10 mg Q8Hr increasing transiently to 20mg

Group Health, 2007, Treating Withdrawal; Canadian Guideline - Safe and Effective - Opioid in CNCP, 2010; Appendix B12: Tapering; [1]Robeck, Chronic Pain AudioConferences, 2013

Agents to Lessen Withdrawal

- Nausea

–** Promethazine 25mg Q6Hr PRN Oral or Rectal

- Diarrhea

–Loperamide (2mg capsule) Oral 4mg initially

- Then 2mg with each loose stool
- Not to exceed 16mg in 24 Hr
- Dyspepsia

–Calcium carbonate (Tums) 1-2 Tab Q8Hr PRN

Group Health, 2007, Treating Withdrawal;
VISN 20 Opioid Guideline, Oct 2007, Taper

Provide supportive counseling in Taper

- Phone Calls

–weekly

- Visits

–as directed by patient risks and needs

- Note: following slides discuss Tapering speed, capacity of Health Care team to support Taper affects choice of speed of tapering regimens

–Assuming that it is safe to slowly taper

How Much to Decrease Opioid?

- First confirm on stable dosage

–Check records AND UDS specific for that opioid

–IF missed dosages,

- Then already self Tapering or Tapered

How Much to Decrease Each Time?

- Withdrawal symptoms often occur more

–With last of taper

–Than with same amount initially

How Much to Decrease ?

- "The rapid detoxification literature indicates that a patient needs 20% of the previous day's dose to prevent withdrawal symptoms"

  (2010 VA-DoD CPG) Factsheet "Tapering and Discontinuing Opioids", May 2013

How Much to Decrease Each Time?

- Options (as calculated from original dosage):
  - Steady 10-25% decrease
  - Initial 20-50% decrease
- Once or so;
- Then 10-20% decrease

Opioid Taper Schedule & Dispensing

- Scheduled dosing, not PRN
- Prescribe at frequent dispensing intervals
  - At 1, 2 or 4 weeks depending on
- Control abilities of patient and their significant others
  - While not possible within Primary Care, some patients will need daily dispensing
  - Do not refill if patient runs out
- Clearly explain to patient at the outset
  - Re-inforce during check-in calls…

Canadian Guideline - Safe and Effective - Opioid in CNCP, 2010; Appendix B12: Tapering

How Fast to Taper?

- "Faster" groups

–Active drug addiction

- If Opioid addiction – consult for Buprenorphine

–Other High Risk / Absolute Contra-Indications

- Except Pregnancy requires slower taper

- "Slower" groups

–Long term safety

–Lack of efficacy

VISN 20 Opioid Guideline - Oct 2007; Opioid Transition and Taper;
Canadian Guideline - Safe and Effective - Opioid in CNCP, 2010; Appendix B12: Tapering

How Fast to Decrease? Other Examples

- Stop now with no further refills

–Cocaine + or very strong suspicion for diversion

- Fast Taper – Daily decreases (at least initially)

–Medically dangerous

- Slow Taper – Weekly decreases

– >200 mg MED

- Slowest Taper – 2-4 Week decreases

– Failed to improve function

Where to Taper?

- Inpatient If
  - Medically or Psychologically unstable
- E.g. “I will kill myself if I don’t get my [xx]”
  - Admitted for another reason; allows start
- Outpatient
  - Usually

Opioid Taper Agent

- Morphine Sustained Release

–PREFERRED

- IF Conversion from other opioid then

–Reduced by 25-50% = 1st decrease, for safety

- Incomplete Cross-Tolerance

–Then steady 20-50% decrease until 45mg/day

- Note SR dosage forms of 15mg or 30mg

–Round off to one of these for convenience of patient

(2010 VA-DoD CPG) Factsheet “Tapering and Discontinuing Opioids”, May 2013 Canadian Guideline - Safe and Effective - Opioid in CNCP, 2010; Appendix B12: Tapering

Morphine Sustained Release Taper

- "Decrease dose by 20-50% per day until you reach 45 mg/day; then
- Decrease by 15mg/day every 2-5 days"

(2010 VA-DoD CPG) Factsheet "Tapering and Discontinuing Opioids", May 2013

E.g.: Taper off Oxycontin 80mg Q8Hr AFTER Confirmation of This Dosage

- Calculate MED 80x3x1.5 = 360 mg Morphine Daily
- Reduce for Incomplete Cross Tolerance
  - –180 to 270 mg MED; e.g. 225
- Adjust to Morphine SR forms and frequency
  - –({30mg x 2} + 15mg) Q8Hr for one week; then
  - –(30mg x 2) Q8Hr for one week; then
  - –(30mg + 15mg) Q8Hr for one week; then
  - –30mg Q8Hr for one week; then
  - –15mg Q8Hr for one week; then
  - –15mg Q12Hr for one week; then…
- Notes: - Speed of reduction will vary by indication…;
  - –This many pills may be better to be released by Pharmacy
    - One week at a time

Option: IF on Synthetic Opioids

- Fentanyl Patch

–Decrease by 25-50 microgram patch increments

•Every 3 days initially

•Slowing taper thereafter

–At 25 microgram, transition to Morphine SR

•25 microgram/Hr is approximately 50-100mg MED

•Decrease dose 25-50% for incomplete cross tolerance

•On 3rd Day of last 25 microgram patch, remove patch

–Begin Morphine SR 15mg Q8Hr for up to 7 days,

»Then resume taper off remaining Morphine

Suggested Methadone Taper

"Decrease dose by 20-50% per day
until you reach 30 mg/day; then
Decrease by 5mg/day every 3-5 days
to 10mg/day; then
Decrease by 2.5mg/day every 3-5 days"

(2010 VA-DoD CPG) Factsheet "Tapering and Discontinuing Opioids", May 2013

Option: If Initially only on Short Acting AND IF MED < 60 mg

- Consider taper with original agent

–20-50% initial decrease, then

–10-20% decrease until off

7 Day Taper: Percocet 5/325mgQ6Hr (OR Lortab 5/325mg Q6hrs):

- I.e. 30 mg MED (or 20) Morphine Equivalents Daily;

- Give # 12 tablets of Same

–1 tab Q8hrs x 2 days 22.5 (15)

–1 tab Q12hrs x 2 days 15 (10)

–1 tab Qday x 2 days 7.5 (5)

7 Day Taper: Lortab 10 /325mg Q8hrs OR From: Morphine SR 15mg Q12hrs:

- I.e. 30 mg MED

- Give # 20 tablets Hydrocodone/Lortab 5/325
  - 1 tab Q6Hr x 2 day 20mg MED
  - 1 tab Q8Hr x 2 days 15
  - 1 tab Q12Hr x 2 days 10
  - 1 tab QDay x 2 days 5

Final Taper from Morphine SR

- When 30mg Morphine Sustained Release daily

–Few Days or weeks on 15 mg SR Q12Hr, then

- Few Days on 15 mg SR at bedtime, then stop opioids

–Or consider one time end of taper with hydrocodone 5mg/acetaminophen (<= 20 tablets)

- 1 Q6Hr for 1-few days;
- 1 Q8Hr for 1-few days;
- 1 Q12Hr for 1-few days; then stop opioids

–DOCUMENT! All these details for others to see

Best if Taper Initiated by Provider Immediately IF

- Concurrent Benzodiazepine with Opioid
- Follow-up UDS “+” Cocaine
- “Double Dipping”

–State Prescription Drug Monitoring Program…

- By phone, letter and ASAP appointment

Best if Taper Initiated by Provider Gradually IF

- Lack of improvement in Function
- Enabling avoidance of Mental Health care
- Introduce need for taper now
  - Initiate taper during follow-up
- Visit or Call (with Letter)
- Do NOT wait for routine Follow-up

How to Help Presented Case?

Even after good inpatient start to taper

- Continued on Benzodiazepine + Opioid
- Escalated already High Dose Opioid
- Avoided Mental Health follow-up

How to Help Presented Case?

- Multi-D approach
  - PCM, Pain Specialists, Nurse Case Manager, Clinical Pharmacist, Behavioral Health, Psychologists for Group Meetings, Physical and Occupational Therapists
  - Education and Reinforcement
  - Increased Access for Efficacy
  - Documentation, Urine drug screens, Medication Agreements

Outpatient References

- Gold et. al., LANCET, 1978, Clonidine blocks acute opiate withdrawal symptoms
- Kleber et. al., ARCH GEN PSYCH, 1985, Clonidine in outpatient detoxification from methadone
- Dobscha et. al., JAMA, 2009, Collaborative Care for Chronic Pain in Primary Care

Inpatient References

- Buckley, Sizemore and Charlton; PAIN, 1986, Review of Use of a Drug Withdrawal Protocol
- Barron and McDonald; J Opioid Management, 2006, Significant Pain Reduction in Chronic Pain Patients after Detoxification from High Dose Opioids
- Murphy, Clark and Banou, Clinical J Pain, 2013, Opioid Cessation and Outcomes after Interdisciplinary Chronic Pain Treatment

Any Questions?