

A thick black L-shaped frame surrounds the text. The top-left corner is a horizontal bar extending to the right, then a vertical bar extending downwards. The bottom-right corner is a horizontal bar extending to the left, then a vertical bar extending upwards.

CHRONIC OPIOID THERAPY REVISITED

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Disclosures

- No Disclosures

Objectives

- Create a checklist based on Federation of State Medical Boards (FSMB) ‘Universal Precautions’ to use in your practice prior to starting opioids for chronic pain
- Identify patients in your practice who meet criteria for tapering of opioids and select a tapering strategy that will address withdrawal symptoms
- Recognize patients who meet criteria for addiction and/or would benefit from referral to addiction treatment

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Chronic Pain is a Chronic Disease

- Use a systematic approach
 - *When pain is not controlled, increasing opioids will not necessarily improve pain.*
 - *Using opioids alone is insufficient.*
 - *Monitoring tools include Urine Drug Screen (UDS), Prescription Drug Monitoring Program (PDMP) and pill counts.*
 - *Reassess results frequently and adjust therapy as needed.*
 - *Set realistic expectations with patient.*



Concept of Universal Precautions

- Endorsed by major medical groups including:
 - *The American Pain Society (APS)*
 - *American Academy of Pain Medicine (AAPM)*
 - *American Society of Interventional Pain Physicians (ASIPP)*
 - *Federation of State Medical Boards (FSMB)*
 - *Canadian National Pain Centre*
 - *American College of Physicians (ACP)*
 - *American Academy of Family Practice (AAFP)*
- All patients should have a standardized approach regardless of age, medication or number of pills



Universal Precautions

1. Make a diagnosis with an appropriate differential.
2. Conduct a patient assessment, including risk for substance use disorders.
3. Discuss the proposed treatment plan with the patient and obtain informed consent.
4. Have a written treatment agreement that sets forth the expectations and obligations of both the patient and the treating physician.
5. Initiate an appropriate trial of opioid therapy, with or without adjunctive medications.



Universal Precautions

6. Perform regular assessments of pain and function.
7. Reassess the patient's pain score and level of function.
8. Regularly evaluate the patient in terms of the "5 A's": Analgesia, Activity, Adverse effects, Aberrant behaviors, and Affect.
9. Periodically review the pain diagnosis and any comorbid conditions, including substance use disorders, and adjust the treatment regimen accordingly.
10. Keep careful and complete records of the initial evaluation and each follow-up visit.

Informed Consent and Agreement for Treatment

- The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity.



Informed Consent- Key Points to Address

- Risk of addiction/tolerance/dependence
- Respiratory depression
- Death
- Immunologic dysfunction
- Hypogonadism/hormonal dysfunction
- Depression
- Hyperalgesia
- Sexual dysfunction
- Cognitive decline

Case 1

You are covering your partner and her very sweet 80 y.o. female patient comes in with her 3 y.o. grandson complaining of knee pain. Has had it for “awhile” and is requesting something for pain. Oxycodone has worked well in the past.



What do you do?

A - You check a UDS and the PDMP

B - You give her the Percocet; she is 80 years
old after all!

C - You refer her to PT

D - A&C

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Follow up

- UDS comes back positive for cocaine and the PDMP reveals she has seen 2 other providers earlier this month and received both hydrocodone and oxycodone.

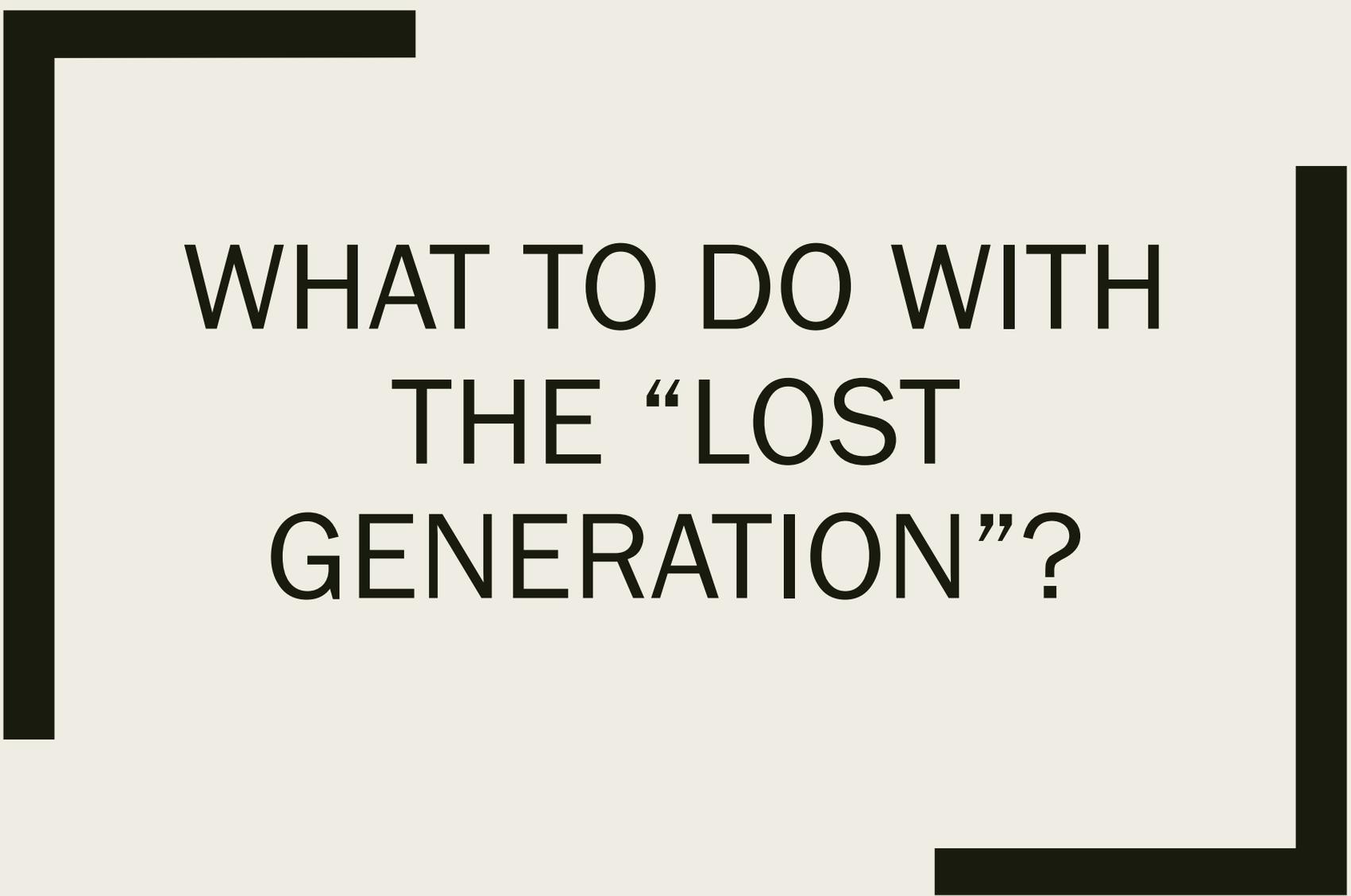


“Checklist” per FSMB

- Copies of signed agreement
- Medical history, exam and results of tests
- Risk assessment (substance abuse history, co-morbid conditions, SOAPP-14, etc.)
- Description of treatment provided
- Results of patient progress (or lack thereof)
 - Example: 5As, COTAT, Functional Pain Scale*
- Specialists' evaluations
- Information to support the initiation, continuation, revision or termination of therapy.
- Response to aberrant behaviors

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WHAT TO DO WITH
THE “LOST
GENERATION”?



American Pain Society/American Academy of Pain Medicine Guideline-2009

- ‘Although there is insufficient evidence to guide specific recommendations on optimal strategies, a taper or wean can often be achieved in the outpatient setting in patients without severe medical or psychiatric co-morbidities.’

American Society of Interventional Pain Physicians Guideline-2012

- ‘If there is any indication of abuse, misuse, lack of analgesia, lack of activity, adverse effects, or aberrant behavior, the physician must taper the drug therapy and discontinue.’
- ‘Tapering may be carried out slowly with a decrease by 10% of the original dose per week. This is generally well tolerated with minimal adverse physiological effects. However, some patients can be tapered or weaned more rapidly without any major problems over a 6 to 8 week period.’

Case 2



57 yo female with h/o-

- *Right knee DJD*
- *Diffuse pains of uncertain etiology (prior negative rheumatologic work-up)*
- *Depression*
- *Hyperlipidemia*
- *Asthma*
- *Tobacco Dependence*



Case 2 continued

- Presented to clinic in 9/2010, 4 years into COT which had been prescribed by another provider requesting refills
- Oxycontin 60mg BID AND
Hydrocodone/APAP 7.5/500 #180 per month

What would you do?



Case 2 continued

- Immediately decreased hydrocodone prescription to #90/month
- Over subsequent years have tried to incorporate:
 - *Non-opioid pain medications*
 - *Physical therapy*
 - *Mental health treatment*
 - *Ongoing care of her other health problems*
- No aberrant behaviors

1. What number best describes your pain, on average, in the past week?

No pain
1 0
2 0
3 0
4 0
5 0
6 0
7 0
8 0
9 0
10 ●
→
 Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

Does not interfere
1 0
2 0
3 0
4 0
5 0
6 0
7 0
8 0
9 0
10 ●
→
 Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

Does not interfere
1 0
2 0
3 0
4 0
5 0
6 0
7 0
8 0
9 0
10 ●
→
 Completely interferes

Over the past 2 weeks, have you been bothered by these problems?

	Not at all	Several days	More days than not	Nearly every day
Feeling nervous, anxious, or on edge	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Not being able to stop or control crying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Feeling down, depressed, or hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Little interest or pleasure in doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
The thought of harming myself has occurred to me..	● No ○ Yes			

In the past 1 week, how often have you had these symptoms?

	Never	Rarely	Sometimes	Very often
Nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Vomiting	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Constipation (hard to have a BM)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Itching	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sweating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>
Tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>

Case 2 continued

- Elected to discuss opioid tapering based on:
 - *non-adherence to non-opioid treatments*
 - *lack of improvement on opioid therapy*
 - *reports of depression*
 - *reported side effects*
- Patient extremely angry and sought care from two other providers.
- Other providers supported taper plan and patient resumed care with me.



5 Major Steps to Intervention

- **Ask**-Identify and document opioid use status for every patient at every visit
- **Advise**-In a clear, strong, personalized manner, urge every opioid user to taper
- **Assess**-Is the opioid user willing to taper their opioids?
- **Assist**-For patients willing to make a taper attempt, use counseling and pharmacotherapy to help him or her taper
- **Arrange**-Schedule follow-up



Reasons to Taper/Discontinue Chronic Opioid Therapy

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 non-adherence with patient treatment agreement
4. Deterioration in physical, emotional, or social functioning attributed to opioid therapy
5. Resolution or healing of the painful condition
6. Patient taking dose more than 90-200 morphine equivalents per day

So Why Taper?

The better question is. . .

Why Not Taper?

Taper Agreement

TABLE 5. Key Points to Include in an Opioid Taper agreement

Opioid taper formulated due to ... (formal rationale)

The taper starts _____ and is planned to end _____

Weekly/monthly reduction plan: 1)...., 2)...., 3)...., etc.

Outline risks (withdrawal symptoms, fluctuations in pain, anxiety) and management thereof

Patient agrees to:

- Keep all regularly scheduled appointments with the treatment staff
- Comply with other consultations as requested by the physician
- Contact the treatment physician immediately to discuss continuation or changes in the plan if an issue occurs
- Engage in relevant pain management strategies concurrent with the taper (eg, multidisciplinary functional restoration program, [detail])
- Regular urine toxicology and prescription monitoring program checks
- No changes to plan without conferring with the prescribing physician
- No controlled substances from other physicians without prenotification of treating physician
- No new medication without agreement of prescribing physician
- Notify the physician of any factors, such as development of increasing depression symptoms, that may be a barrier to success
- Where appropriate, involve actively the significant other to provide support

Provisions for taper failure (could include some of the following elements, depending on the reason for taper and likely cause of failure):

- New taper attempt with revised schedule
- Referral to structured inpatient taper
- Referral for consultation with addiction medicine or cognitive therapy specialists
- No more opioid prescriptions, no more prescriptions of a certain medication, or no more prescriptions above a certain dose beyond date...
- Long-term maintenance opioid therapy (with current or other prescriber), can include specific substance or maximum dose
- Long-term as needed opioid rescue doses (eg, limited 10 doses supply per month)

List state-specific locations where remaining opioids can be appropriately disposed of



Voluntary Taper

- Inability to achieve or maintain anticipated pain relief or functional improvement despite reasonable dose escalation
- Intolerable adverse effects at the minimum dose that produces effective analgesia with reasonable attempts at opioid rotation unsuccessful
- Deterioration in physical, emotional, or social functioning attributed to opioid therapy
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Involuntary Taper

- Persistent nonadherence with patient treatment agreement



Speed of Opioid Taper

- Recommend quick taper for involuntary tapers
- Scant literature to define how quickly to taper in voluntary tapers
 - *No trial that compares rapid or ultrarapid vs slower protocols in patients with chronic non-cancer pain (CNCP)*
- Daily dose to prevent acute withdrawal is approximately 25% of the previous day's dose (from addiction literature)

1. Berna et al. Tapering Long-Term Opioid Therapy in Chronic Non-Cancer Pain: Evidence and Recommendations for Every Day Practice. Mayo Clinic Proceedings. 2015.

2. Chou et al. The Effectiveness and Risks of Long-term Opioid Therapy for Chronic Pain. Annals of Internal Medicine 2015.



Speed of Opioid Taper

- Intelligibility considerations
- **‘Ultimately, finding a plan that an individual patient can embrace with a significant degree of personal engagement might be more important than following a specific protocol’**



Withdrawal Symptoms

- Symptoms start 2-3 half-lives after the last dose of opioids
 - *Half-lives of common opioids*
 - Oxycotin-5 hrs
 - Mscontin-2-5 hrs
 - Hydrocodone-3.5 hrs
 - Oxycodone-3.5 hrs
 - Hydromorphone-2.6 hrs
- Withdrawal worsened by co-morbid anxiety
- In general, opioid withdrawal is not life threatening



Withdrawal Symptoms & Signs

Symptoms

- Anxiety/Restlessness
- Dysphoria
- Anorexia/Nausea/Diarrhea
- Abdominal cramps
- Dizziness
- Hot flashes
- Shivering
- Myalgias/Arthralgia
- Rhinorrhea/Sneezing
- Insomnia/Yawning

Signs

- Hypertension
- Tachycardia
- Mydriasis
- Diaphoresis
- Tremor
- Piloerection



Interventions for Reduction of Prescribed Opioid Use

- 2 RCTs that included a total of 86 participants
- Interventions
 - *Electroacupuncture*
 - *Cognitive Behavioral Therapy/Therapeutic Interactive Response*
- No conclusions could be drawn regarding effectiveness of these interventions for opioid withdrawal in non-cancer pain

Treating Withdrawal Symptoms- Pharmacotherapy

Category of Drug	Symptoms Targeting	Drug
Drugs to reduce adrenergic outflow	Hypertension, tremors, sweats, anxiety, restlessness	Clonidine 0.1-0.2mg every 6 hours Guanfacine 0.03-1.75mg at night Tizanidine 2mg at night Lofexidine 0.1mg every 8-12hrs
Drugs to control diarrhea	Diarrhea	Lomotil 2 tablets 4x a day
Drugs to minimize nausea, flu-like symptoms	Nausea, vomiting, muscle aches	Promethazine 25mg every 6 hr Metoclopramide 10mg every 6hr Acetaminophen 500mg every 4hr Ibuprofen 600mg every 6hr
Anxiolytics	Anxiety	Hydroxyzine 25-50mg every 6hr Benzodiazepines?????



Address Behavioral Health Issues

- Depression is a key predictor of opioid tapering drop-out
- No data yet to support use of psychological support in this setting
- Offer support for:
 - *Anxiety related to taper*
 - *Underlying depression*
 - *Deficient pain and stress coping strategies*



Is There Increased Pain with Tapering of Opioids?

According to studies of Chronic Opioid Therapy (COT) tapers, overall, patients report **improvements in function** without associated worsening in pain

Or even decreased pain
levels

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Substance Abuse Disorder Defined

- Definition changes with DSM-5
- 11 criteria
- **Severity:**
 - *Mild: 2-3 symptoms*
 - *Moderate: 4-5 symptoms*
 - *Severe: 6 or more symptoms.*

Opioid Use Disorder

TABLE 1

Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	<ul style="list-style-type: none">• Opioids used in larger amounts or for longer than intended• Unsuccessful efforts or desire to cut back or control opioid use• Excessive amount of time spent obtaining, using, or recovering from opioids• Craving to use opioids
Social impairment	<ul style="list-style-type: none">• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use• Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems• Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	<ul style="list-style-type: none">• Opioid use in physically hazardous situations• Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use
Pharmacological properties	<ul style="list-style-type: none">• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount• Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal



Consider Referral to Addiction Treatment when:

- Concerning circumstances such as unexplained need for dose escalation, frequent ED visits for more meds etc.
- Further education of patients may lead to recognition of addiction
- Co-existing cannabis use disorder is suspected
- Seeking advice for medication tapering



Refer to Addiction Treatment when:

- Positive drug screens for non-prescribed opioids
- Aberrancy in setting of prescribed opioids: frequent overuse, early refills, doctor shopping, illicit substance use, alcohol overuse or alcohol use disorder.
- Frank evidence of an opioid use disorder, i.e. per DSM 5 criteria
 - *Compulsion, cravings, obsession, continued use despite known negative consequences*

Case 3

35 yo male comes into the office complaining of ongoing pain. The medications you are giving him are not working anymore. You review the previous records and see that his last confirmatory UDS showed only oxycodone. He is currently only receiving hydrocodone from you.



Case 3 continued

Based on these findings you:

A: Increase his pain medication

B: Obtain more history

C: Review 11 criteria for opioid use disorder

D: Refer to Addiction Treatment

E: B, C, D

Case 3 continued

Based on these findings you:

A: Increase his pain medication

B: Obtain more history

C: Review 11 criteria for opioid use disorder

D: Refer to Addiction Treatment

E: B, C, D



Case 3-continued

- You complete the 11 questions and he scores a 6. Specifically, he admits to craving and missing work repeatedly among others. PHQ9 is 20.
- You now:
 - A: Start an antidepressant*
 - B: Repeat UDS*
 - C: Refer to behavioral health*
 - D: All of the above*



Summary

- Use a “checklist” and follow universal precautions with all patients on chronic opioid therapy
- Consider opioid taper when:
 - *No functional improvement*
 - *Adverse side effects*
 - *Non-adherence to treatment agreement*
 - *Decrease in physical, emotional or social functioning*
 - *Resolution of condition*
 - *High morphine equivalents*
- Consider Addiction Treatment when:
 - *Aberrant behavior*
 - *Unexpected UDS findings*
 - *Clear evidence of addiction*

CO State Medical Board Policy

- <https://drive.google.com/file/d/0B-K5DhxXxJZbd01vVXdTTkIZLVU/view?pli=1>