

Tapering and Discontinuation of Opioids in Chronic Non-Cancer Pain

Rachel R. Waller, MD, FACP

Assistant Professor, Division of General Internal Medicine,
VCUHS

No Disclosures

Learning Objectives

- How do we assess for the appropriateness of opioid dose reduction or discontinuation in our patients with chronic non-cancer pain?
- How do we safely and successfully taper opioids in appropriate patients?
- Which patients on chronic opioids should be referred for evaluation by an addiction specialist?

Case #1

A 60 year-old man with lupus nephritis, end-stage renal disease on dialysis and chronic pain due to back and knee osteoarthritis presents to clinic for follow-up of his chronic pain.

Since starting dialysis 3 months ago, he has developed severe restless legs, which his nephrologist has successfully treated with lorazepam. He did not respond to ropinirole or gabapentin.

He has been on oxycodone 20mg every 6 hours for back and knee pain for over 4 years now.

General Principles of the Opioid Guidelines Related to Opioid Tapering or Discontinuation

- Set limits for the MME (morphine milligram equivalents) over which additional documentation of need is required
- Advise not co-prescribing opioids with other sedative medications, especially benzodiazepines
- Advise continued reassessment of risk/benefit of opioids
- Advise continued reassessment for opioid use disorder
- Advise exit strategy for discontinuation of opioids if not effective

Criteria Identifying Patients in Whom Discontinuation of Long-term Opioid Therapy Should Be Considered (Combining Those Published by the Substance Abuse Mental Health Services Agency and by Fishman)

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

Assessment

- Is my patient at increased risk of opioid overdose due to medication dose, comorbid medical conditions or other medication use?
- Is my patient having concerning side effects from opioid use?
- Is my patient exhibiting aberrant behaviors that put them at risk of opioid overdose or put the community at risk?
- Is my patient demonstrating adequate analgesia and functional improvement on chronic opioids?

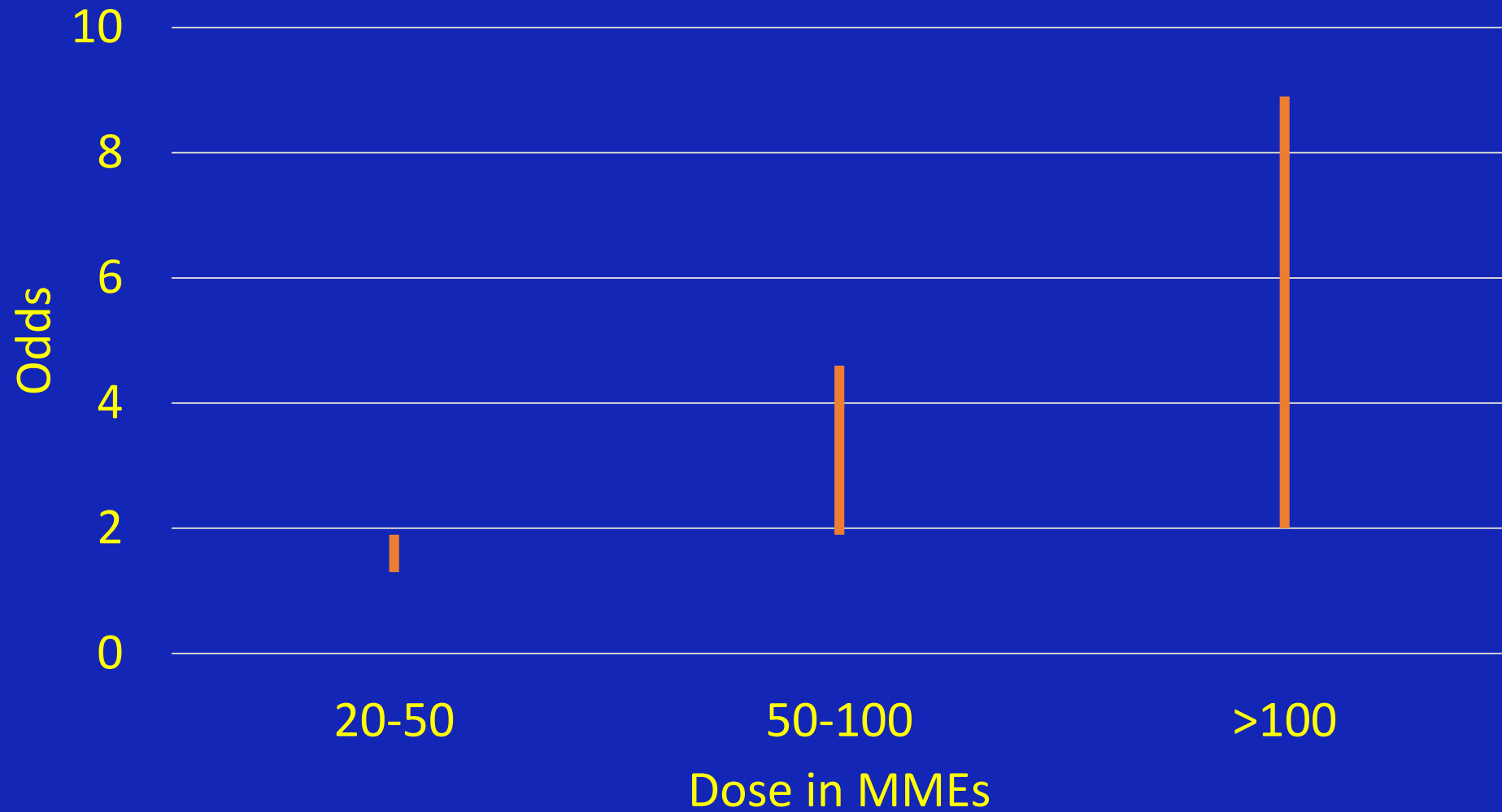
Assessment

- Is my patient at increased risk of opioid overdose due to medication dose, comorbid medical conditions or other medication use?

Opioid Dose

- Measured in morphine milligram equivalents. The Prescription Monitoring Program (PMP) documents the MME for providers.
<https://virginia.pmpaware.net>
- Virginia requires that justification for doses >50 MME be documented in the medical chart. Pain management consultation is suggested for doses >120 MME.
<http://agencymeddirectors.wa.gov/Calculator/DoseCalculator.htm>

Odds of Overdose Death per Dose in MMEs



Medical Conditions that Increase Overdose Risk

- Chronic renal insufficiency
- Chronic liver disease
- Sleep apnea
- Depression
- Substance use disorder

Medications that Increase Overdose Risk

- Benzodiazepines*
 - Sedative hypnotics
 - Gabapentin
 - Carisoprodol
 - Barbituates
-
- * Benzodiazepines are implicated in 30% of opioid deaths

Assessment

- Is my patient having concerning side effects from opioid use?

Case #1

The patient says he has had some increased fatigue lately, which he thinks may be due to dialysis. He has had increased difficulty with constipation, despite the regular use of senna. He also reports a 6-month history of erectile dysfunction.

Side Effects of Chronic Opioid Use

- Sedation
- Poor concentration and memory
- Mood changes
- Constipation
- Dry mouth
- Abdominal pain
- Nausea
- Hypogonadism (leading to erectile dysfunction and bone loss in males)

Assessment

- Is my patient exhibiting aberrant behaviors that put them at risk of opioid overdose or put the community at risk?

Case #1

The patient brought his medication bottles today, as he does every visit. The pill count of his oxycodone is appropriate, and his PMP demonstrates an appropriate fill history. He has complied with random urine drug screens and they have consistently been appropriate.

He takes care of his 4 year-old granddaughter during the day. He keeps his medications in a locked box at the top of his closet.

Assessing for Substance Use Disorder

- Drug Use Screen: How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?
- Screener and Opioid Assessment for Patients with Pain (SOAPP[®] Version 1.0 –SF)

<https://www.nhms.org/sites/default/files/Pdfs/SOAPP-5.pdf>

- Current Opioid Misuse Measure (COMM)[®]

<http://mytopcare.org/wp-content/uploads/2013/05/COMM.pdf>

Assessment

- Is my patient exhibiting adequate analgesia and functional improvement on his chronic opioids?

Assessing for Functional Improvement

3 Item (PEG) Assessment Scale

- What number best describes your pain on average in the past week?
- What number best describes how, during the past week, pain has interfered with your enjoyment of life?
- What number best describes how, during the past week, pain has interfered with your general activity?

Assessing for Functional Improvement

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

0 1 2 3 4 5 6 7 8 9 10

No pain

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?

0 1 2 3 4 5 6 7 8 9 10

Does not
interfere

Completely
interferes

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

0 1 2 3 4 5 6 7 8 9 10

Does not
interfere

Completely
interferes

- J Gen Int Med. 2009 Jun; 24(6): 733–738

Case #1

Your patient was assessed with the PEG tool after initiation of therapy, and demonstrated a 30% improvement in function. Lately he has been less active due to fatigue after hemodialysis, but he has had no change in his pain.

Case #1

You discuss with the patient your concerns about the safety of his current regimen.

The patient definitely wants to continue the lorazepam, because he could not sleep at all with his restless legs.

He is open to tapering the oxycodone for safety reasons, and because he agrees he may be experiencing side effects.

He is on the transplant list and achieving that is an important goal.

Principles of Successful Opioid Tapering

- Engage the patient in the tapering process
- Avoid or minimize withdrawal symptoms
- Utilize adjunctive therapies to support the patient through the tapering process
- Tailor treatment to the patient's life circumstances

Principles of Successful Opioid Tapering: Engaging the Patient

Address the patient's fear of pain:

- Overall, studies of long term opioid treatment tapers demonstrate improvement in function without associated worsening in pain
- Patients may experience transient hyperalgesia, but this is self-limited

Principles of Successful Opioid Tapering: Engaging the Patient

- Consider offering a maintenance treatment option
 - In a randomized study of 42 patients, 95% of patients in a group who were offered a maintenance option stayed in the study for 3 weeks, while 76% of the control group quit treatment

Principles of Successful Opioid Tapering: Choosing a Taper Regimen

- No strong evidence for rapid tapers compared with slower ones
- A decrease of 10% of the original dose weekly until down to 30% of the original dose, followed by a weekly decrease by 10% of the remaining dose rarely precipitates withdrawal
- The speed of the taper can be slower on cooperative patients who have been on chronic opioids for >2 years

Principles of Successful Opioid Tapering

Basic principle: For longer-acting drugs and a more stable patient, use slower taper. For shorter-acting drugs, less stable patient, use faster taper.

1. Use an MED calculator to help plan your tapering strategy. Methadone MED calculations increase exponentially as the dose increases, so methadone tapering is generally a slower process.
2. Long-acting opioid: Decrease total daily dose by 5-10% of initial dose per week. Short-acting opioids: Decrease total daily dose by 5-15% per week.
3. See patient frequently during process and stress behavioral supports. Consider UDS, pill counts, and POMP to help determine adherence.
4. After 1/4 to 1/2 of the dose has been reached, with a cooperative patient, you can slow the process down.
5. Consider adjuvant medications: antidepressants, gabapentin, NSAIDs, clonidine, anti-nausea, anti-diarrhea agents.

Principles of Successful Opioid Tapering: Choosing a Taper Regimen

- Finding a plan that a patient can engage in may be more important than following a specific protocol
- Slowing the taper pace during periods of stress or when patient is experiencing withdrawal may improve adherence
- Patients should be re-evaluated frequently during the tapering process

Principles of Successful Opioid Tapering: Choosing a Taper Regimen

- Start by tapering the long-acting medication, then use short-acting medication to gradually lower the total MME
- Reduce the medication to the smallest dosage, then increase the time between doses
- Fentanyl can be tapered using 12 mcg patches. The potency of this opioid can make this challenging

Principles of Successful Opioid Tapering: Controlling Withdrawal Symptoms

- Tapering at the rate previously described can help prevent withdrawal
- An opioid withdrawal scale can be used to assess severity of symptoms
- Alpha2-adrenergic agonists such as clonidine, guanfacine or tizanidine can reduce the sympathetic activity associated with withdrawal

Principles of Successful Opioid Tapering: Providing Adjunctive Support

- Cognitive-behavioral therapy (CBT) is well-documented to improve function in chronic pain. It may also help with the anxiety experienced during tapering.
- Consider consulting physical therapy or an interventional pain specialist for focused pain control during the tapering process.
- Interdisciplinary pain management programs may be beneficial, if available.

Principles of Successful Opioid Tapering: Risk Factors for Poor Success

- Uncontrolled depression
- High pain scores at both the beginning and end of the taper
- Substance use disorder

Case #1

You and the patient plan together on an opioid taper that reduces the dose by 10% per week, and the patient comes to see you every two weeks in follow-up. You document the taper schedule in the chart, and the patient is advised to review his note on the patient portal if he needs to refer back to his regimen.

Part-way into the taper, he gets his renal transplant. He receives appropriate pain control in the post-operative period, then is able to wean completely off of opioids following subacute rehabilitation.

Principles of Successful Opioid Tapering: Risk Reduction

- If a patient is unable to successfully discontinue opioids, risk reduction can still be achieved by reducing the dose as much as possible
- Attempts should be made to minimize the risk of a patient seeking opioids through illicit means (“street drugs”)

Principles of Successful Opioid Tapering: Risk Reduction

- Patients who are known to be diverting opioids cannot receive an opioid taper
- Patients who clearly have access to a variety of controlled substances may not be safe to taper
- Withdrawal is not usually fatal

Case #2

A 40 year old man with a past medical history of tobacco use disorder and knee pain presents for follow-up of his chronic pain. He has been on morphine for the past 3 years, started after a work-related knee injury. He has just had a second drug screen come back positive for cocaine. He denies all knowledge of how this could have occurred. His drug screen was appropriate for morphine and his PMP has been appropriate. He declines any evaluation by an addiction specialist, and states that he will not be back to see you if you are not going to continue opioid treatment.

How Would You Manage this Patient?

- Assess risk
- Offer support and resources
- Provide a fairly rapid taper
- Review risks of non-compliance with patient
- Offer treatment for withdrawal symptoms
- Document

Case #3

A 65 y.o. man with a history of ankylosing spondylitis returns to clinic for follow-up of his chronic pain, for which he takes oxycodone. He has a history of heroin abuse, but had been abstinent for several years after successful methadone therapy. He started using heroin initially after he had to stop indomethacin due to an ulcer.

Recently he experienced worsening pain after he developed a severe allergic reaction to his Remicaid. He was started on oxycodone with weekly follow-up.

Case #3

His urine drug screen is positive for methadone, heroin, fentanyl and clonazepam. He admits he ran out of percocet a week ago.

He lives in a senior high rise and his neighbors are happy to share their medications with him when they see that he is suffering.

At the initiation of opioid therapy, you had counseled the patient that he could reach out to you if he was struggling with his pain, but he elected self-management.

How would you manage this patient?

- Assess risk
 - Access to high risk meds
 - Poor coping skills
 - High risk of relapse give substance use disorder and severe chronic pain
- This patient needs a substance use disorder program

Case #3

You discuss with the patient your grave concern that he will accidentally overdose, including pulling up recent articles for him regarding fentanyl overdose.

You discuss treatment with suboxone or methadone for his substance use disorder. The patient had both good pain control and a good abstinence record on his previous methadone program, and would like to pursue this again.

The patient calls RBHA for intake while he is in the room with you.

Case #3

You give the patient clonidine to help with his withdrawal symptoms while awaiting intake, and arrange to see him weekly.

3 weeks later, he is successfully enrolled in counseling and has started methadone maintenance.

In Summary

- Assess your patients' need for continued opioid therapy and their readiness to engage in discontinuation or taper at every visit in which you address pain management.
- Standardized tools can help assess patients' functional improvement and risk for substance use disorder.
- Stable, cooperative patients can safely participate in a slow opioid taper. Patient engagement in the tapering plan may be more important than the actual regimen chosen.
- Use risk reduction principles in choosing whether to provide an opioid taper to patients.
- Refer patients with substance use disorder to addiction services.

References and Resources

Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain, Federation of State Medical Boards, 2004

Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain, Federation of State Medical Boards, 2013

CDC Guidelines for Prescribing Opioids for Chronic Pain- United States, 2016

Dowell D, Haegerich TM, Chou R

MMWR Recomm Rep 2016: 65 (No RR-1) :1-49

Regulations Governing Opioid Prescribing for Pain and Prescribing or Buprenorphine for Addiction Treatment 2017

Virginia Board of Medicine, Department of Health Professions

<http://townhall.virginia.gov/I/ViewXML.cfm?textid=11462>

Virginia Board of Medicine Board Briefs #83, May 2017

<https://www.dhp.virginia.gov/medicine/newsletters/BoardBrief83.pdf>

References and Resources

Tapering Long-term Opioid Therapy in Chronic Noncancer Pain

Berna C, Kulich R, Rathmell J

Mayo Clinic Proc. June 2015;90(6):828-842

Risk Stratification of Opioid Misuse Among Patients with Cancer Pain Using the SOAPP-SF

Koyyalagunta D, Bruera E, Aigner C, Nusrat H, Driver L, Novy D.

Pain Med. 2013 May;14(5):667-75

Development and Validation of the Current Opioid Misuse Measure.

Butler SF, Budman SH, Fernandez KC, et al.

Pain. 2007;130(1-2):144-156. doi:10.1016/j.pain.2007.01.014.

Oregon Pain Guidance

www.oregonpainguidance.org

References and Resources

Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference
Krebs EE, Lorenz KA, Bair MJ, Damush TM, Wu J, Sutherland JM, Asch SM, Kroenke K.
J Gen Intern Med. 2009 Jun;24(6):733-8.

Oregon Pain Guidance

www.oregonpainguidance.org