“BRAVO”

How to Taper Patients Off of Chronic Opioid Therapy: A Biopsychosocial Approach

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Disclosures

I have no conflicts to disclose.
Learning Objectives

● Describe where we are now with opioid prescribing

● Learn how to safely and compassionately taper patients down and off of chronic opioid therapy using the BRAVO protocol
Overview

● Describe where we are now with opioid prescribing

● Learn how to safely and compassionately taper patients down and off of chronic opioid therapy using the BRAVO protocol
The opioid epidemic: Where are we now?
We’re still prescribing too many opioids
Opioid misuse (NSDUH 2016)

11.5 Million People with Past Year Pain Reliever Misuse (97.4% of Opioid Misusers)
641,000 People with Past Year Pain Reliever Misuse and Heroin Use (5.4% of Opioid Misusers)
948,000 People with Past Year Heroin Use (8.0% of Opioid Misusers)
10.9 Million People with Pain Reliever Misuse Only (92.0% of Opioid Misusers)
307,000 People with Heroin Use Only (2.6% of Opioid Misusers)

11.8 Million People Aged 12 or Older with Past Year Opioid Misuse
How Rx opioids obtained (NSDUH 2016)

- Prescription from One Doctor (35.4%)
- Given by, Bought from, or Took from a Friend or Relative (53.0%)
- From Friend or Relative for Free (40.4%)
- Bought from Friend or Relative (8.9%)
- Took from Friend or Relative without Asking (3.7%)
- Stole from Doctor’s Office, Clinic, Hospital, or Pharmacy (0.7%)
- Got through Prescription(s) or Stole from a Health Care Provider (37.5%)
- Bought from Drug Dealer or Other Stranger (6.0%)
- Some Other Way (3.4%)
- Prescriptions from More Than One Doctor (1.4%)
How can we do better?

Enabling

Retaliation
BRAVO!
Laura’s story

• At age 18, developed a mysterious pain in her abdomen that spread to her whole body
  • All medical work-up negative
  • Saw many doctors over time, and was diagnosed with fibromyalgia and rx’d opioids
  • By age 30 was taking >120 MED’s, prescribed by “the most compassionate doctor I ever saw.”
  • Despite meds, pain no better, function worse
Laura moved with her husband and young son to the Bay Area, and was told by her new doctor that he could not continue her opioids at those high doses.

Even before starting a taper, Laura landed in the psychiatric inpatient ward overwhelmed by anxiety at the prospect of an opioid taper.
B = Broaching the subject
Recognize patients are **terrified** to come off opioids
Take more time, and get support
Donald Winnicott’s “holding environment”

“I’ve been thinking a lot about your chronic pain …”
R=Risk benefit calculator
R = Risk benefit calculator

- Side effects
- Pain relief
- Function
Side effects

- Depression
- Pseudo-dementia
- Constipation
- Hormonal imbalance
- Addiction
- Death
- Tolerance
- Dependence
- Withdrawal
- Hyperalgesia
Laura’s story

- On high dose opioids, Laura spent more and more time in bed.
- Her husband remarked she was “detached from family life.” Laura was not aware of being more detached.
- Her pain increased over time.
Involve family in risk assessment

- 2016 Washington Post Kaiser Family Foundation Survey of patients on chronic opioid therapy
  - 33% of patients worried about addiction
  - >50% of family members worried about addiction
Naloxone

Family Practice
123 Main Street | Anytown, USA

Rx
Naloxone HCl 1mg/mL
2 x 2mL as pre-filled
Luer-Lock needleless syringe

2 x Intranasal Mucosal
Atomizing Device (MAD 300)

For suspected opioid overdose.
Spray 1mL in each nostril.
Repeat after 3 minutes if no or
minimal response.

MD __________________________
Signature _____________________
Weighing the Risks and Benefits of Chronic Opioid Therapy

American Family Physician, Lembke, A., 2016◆Volume 93
A = Addiction happens
What is addiction?

● The 3 “C’s”
  ○ Consequences
  ○ Control
  ○ Compulsion
Dependence vs addiction
Tapering (sometimes) a litmus test for who is addicted?
Diagnosing opioid use disorder in the context of a medically managed opioid taper

- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
Diagnosing opioid use disorder in the context of a medically managed opioid taper

- Tolerance

- Note: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.
Normalize the process of getting addicted
State Prescription Monitoring Programs

PDMP/UTox
Check your PDMP!

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Tell patients about treatment for opioid addiction before the taper.
Buprenorphine rotation in our outpatient clinic

- 12-48 hours no opioids, then …
- See patient in clinic and assess for opioid withdrawal
- Send patient home with prescription for home induction, typically 2 mg TID prn daily for the first week (for patients on 150 MED or less)
- Follow up by phone during the week prn
- RTC day seven for seven day refill, urine tox screen, PDMP check
## Buprenorphine Rotation (courtesy of Paul Coelho)

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The Bernese Method

Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method

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Antje Kemter²
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Background: Buprenorphine is a partial μ-opioid receptor agonist used for maintenance treatment of opioid dependence. Because of the partial agonism and high receptor affinity, it may precipitate withdrawal symptoms during induction in persons on full μ-opioid receptor agonists. Therefore, current guidelines and drug labels recommend leaving a sufficient time period since the last full agonist use, waiting for clear and objective withdrawal symptoms, and reducing pre-existing full agonist therapies before administering buprenorphine. However, even with these precautions, for many patients the induction of buprenorphine is a difficult experience, due to withdrawal symptoms. Furthermore, tapering of the full agonist bears the risk of relapse to illicit opioid use.

Cases: We present two cases of successful initiation of buprenorphine treatment with the Bernese method, ie, gradual induction overlapping with full agonist use. The first patient began buprenorphine with overlapping street heroin use after repeatedly experiencing relapse, withdrawal, and trauma reactivation symptoms during conventional induction. The second patient was maintained on high doses of diacetylmorphine (ie, pharmaceutical heroin) and methadone during induction. Both patients tolerated the induction procedure well and reported only mild withdrawal symptoms.

Discussion: Overlapping induction of buprenorphine maintenance treatment with full μ-opioid receptor agonist use is feasible and may be associated with better tolerability and acceptability.
Laura’ story

• Laura never met criteria for opioid use disorder/addiction

• Laura did meet DSM-IV criteria for opioid dependence
V = Velocity (and validate)
Mechanics

- Go slowly
- Start wherever the patient is willing to start
- Let the patient drive (within reason)
- Keep dosing schedule (BID, TID, etc)
- Take breaks
What to expect when you’re tapering

- Body fluids
- Psych symptoms (irritability, anxiety, insomnia, dysphoria)
- More PAIN!!!
- The pain of withdrawal “is not the pain you’ll have to live with when this is over.”
- Cancer treatment metaphor
Medications to tx withdrawal

- Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP & watch for hypotension)
  - Diarrhea: Hyocosamine 0.125mg every 4-6 hours PRN
  - Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs
    - Anxiety: Hydroxyzine 25mg po TID
  - Insomnia: Trazodone 50-300mg po QHS
- Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check QTc)
  - NO BENZOS!
Laura’ story

• In the psych unit, Laura’s opioids were decreased from 120 MEDs to methadone 15 mg daily

• As an outpatient, it took from Aug. 2014 to March 2016 to get down to methadone 2mg …18 months!!

• Laura went into the hospital for a week to get off the last 2 mg.
O = Other treatments for pain
Opposite action

• Acting opposite to the emotional urge in the service of pursing values or goals.

• Encourage patients to do the opposite of dialing into pain, and instead, engage in activities, within reason, in spite of pain being present.
Radical Acceptance

- Radical acceptance is accepting reality as it is, not as we wish it would be.

- For chronic pain patients, this often means that their pain may likely never go away, but life can still be worth living even if it includes pain.
Reframing pain

- Pain as a source of creativity, compassion, gratitude, spirituality, meaning
BRANO!
Laura’s story

- Two years later, Laura still off of opioids.
- Still with daily pain, but less.
- Much more active and engaged in her life
The decision to taper opioids

A. Should occur in every patient taking more than 120 MME’s daily

B. Should take into account adverse effects, pain relief, and functionality

C. Should only be initiated by the patient

D. Should occur in every patient who is opioid dependent
Increased pain during opioid withdrawal in chronic pain patients

A. Is a sign of the underlying pain disorder getting worse

B. Is an indication that the taper needs to be stopped and the dose raised again

C. Is likely to cause the patient only minimal discomfort

D. Requires reassurance that withdrawal-mediated pain is not a symptom of the underlying pain condition