Patient-Centered Tapering Of High-Dose Long Term Opioid Users

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Disclosures

Dr. Coelho has nothing to disclose. He will not be discussing any Off-label uses of medications or devices.
Learning Objectives

1. Describe the two most common risks of continued high dose opioid prescribing.
2. Understand the harm-reduction role of deprescribing practices.
3. Realize that taping high dose opioid regimens often results in less pain.
Although opioids are beneficial when taken for less than three months, studies of long-term use show that the drugs, while they may relieve pain, do little to improve function. Those who take the drugs for the longest periods of time, and in the heaviest doses, tend to be patients with psychiatric and substance-abuse disorders—a phenomenon that Mark Sullivan, a professor of psychiatry at the University of Washington, has called “adverse selection.” Sullivan told me that in poor, rural regions doctors are using opioids to treat a “complex mixture of physical and emotional distress.” He said, “It’s much more convenient for both patient and physician to speak in the language of physical pain, which is less stigmatized than psychological pain.” Some of these patients could be said to be suffering from what his colleague calls “terribly-sad-life syndrome.” “These patients are at a dead end, life has stymied them, they are hurting,” he said. “They want to be numb.” He believes that doctors are inappropriately adopting a “palliative-care mentality” to “relieve the suffering of people who have had very tough lives.”
Prescription Opioid Use among Adults with Mental Health Disorders in the United States.

Davis MA1, Lin LA2, Liu H2, Sites BD2.

Abstract

BACKGROUND: The extent to which adults with mental health disorders in the United States receive opioids has not been adequately reported.

METHODS: We performed a cross-sectional study of a nationally representative sample of the noninstitutionalized U.S. adult population from the Medical Expenditure Panel Survey. We examined the relationship between mental health (mood and anxiety) disorders and prescription opioid use (defined as receiving at least 2 prescriptions in a calendar year).

RESULTS: We estimate that among the 38.6 million Americans with mental health disorders, 18.7% (7.2 million of 38.6 million) use prescription opioids. Adults with mental health conditions receive 51.4% (60 million of 115 million prescriptions) of the total opioid prescriptions distributed in the United States each year. Compared with adults without mental health disorders, adults with mental health disorders were significantly more likely to use opioids (18.7% vs 5.0%; \( P < .001 \)). In adjusted analyses, having a mental health disorder was associated with prescription opioid use overall (odds ratio, 2.08; 95% confidence interval, 1.83-2.35).

CONCLUSIONS: The 16% of Americans who have mental health disorders receive over half of all opioids prescribed in the United States. Improving pain management among this population is critical to reduce national dependency on opioids.

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KEYWORDS: Analgesics; Anxiety Disorders; Cross-sectional Studies; Mental Health; Opioid; Opioid-Related Disorders; Pain Management; Prescriptions; Surveys and Questionnaires

PMID: 28720623 DOI: 10.3122/jabfm.2017.04.170112
SSD Opioid Prescribing 2007-2011

US SSD Opioid Prescribing 2007-2017

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6066997/
Overdose Deaths Women Aged 30 - 64

FIGURE 1. Drug overdose deaths* (unadjusted) per 100,000 women aged 30–64 years, by involved drug or drug class — National Vital Statistics System (NVSS), 1999–2017.5

https://www.cdc.gov/mmwr/volumes/68/wr/mm6801a1.htm
2017 CDC

**BRAVO: The Cardinal Principles of Tapering Patients Off of Chronic Opioid Therapy**

BRAVO is an acronym that outlines Dr. Anna Lembke’s cardinal principles for tapering patients off of chronic opioid therapy. BRAVO stands for Broaching the Subject, Risk-Benefit Calculator, Addiction Happens, Velocity Matters—and so does Validation and Other Strategies for Coping with Pain.

**Broaching the Subject**
- Schedule enough time with your patient to have a discussion on this difficult topic
- Anticipate the patient’s strong emotional reaction
- Identify the feelings, normalize those feelings and express empathy with the concerns they may have

**Risk-Benefit Calculator**
- When assessing benefits, weigh a patient’s pain relief against their functionality
- Involves family members for more objective views on a patient’s opioid use
- Track common risks such as tolerance & opioid-induced hyperalgesia
- Include all of these factors with discussing reasons for tapering off opioids

**Addiction Happens**
- Addiction is defined by The Three C’s: Compulsive use, Continued use despite consequences, and use that is out of control
- Dependence happens when a body relies on a drug to function normally
- Dependence and Addiction are not equivalent

**Velocity Matters—and So Does Validation**
- Go Slowly, take the necessary time to ease your patients down on their doses
- Let the patient be involved when deciding how much to decrease it at what time
- It is O.K. to take breaks in lowering the dosage
- Never go backwards; your patient’s tolerance will increase & progress will be lost

**Other Strategies for Coping with Pain**
- Teach patients three Dialectical Behavior Therapy (DBT) practices:
  - STOP: Stop, Take a breath, Observe internal & external experiences, 
  - Proceed mindfully
- Opposite Action Skills: acting opposite to a negative emotional urge in the service of pursuing values or goals
- Radical Acceptance: accepting reality as it is and not as we wish it would be

These materials are part of the Stanford Medicine Center for Continuing Medical Education (CME) Online Activity: How to Taper Patients Off of Chronic Opioid Therapy.
Opioid Tapering Flowchart

Systematically Assess Risks & Benefits (see document)

Risks > Benefits
- Initiate BRAVO protocol
  - Able to taper down until Benefits > Risks
    - On a quarterly basis, re-assess and document the risks & benefits
      - Dx = Opioid Use Disorder
        - Transition to MAT with buprenorphine (X-Waiver required) or other OUD Tx
  - Not able to taper down until Benefits > Risks
    - Dx = Complex Persistent Opioid Dependence (see document for definition)
      - Transition to buprenorphine off-label for pain (X-Waiver not required but recommended)
        - Slow down taper
          - On a quarterly basis, re-assess and document the risks & benefits

Benefits > Risks
- Document Risk Benefit Assessment (RBA)
  - Monitor RBA Quarterly
- On a quarterly basis, re-assess and document the risks & benefits
Broach The Subject Early & Often

• We have a fixed referral base at SH. PCPs broach the subject with their patients – in writing – prior to the referral.

• Our MA’s broach the subject again when new patient visits are booked.

• Patients are given the opportunity to cancel prior to the visit.

• Stable high-dose LTOT patients don’t taper on their first refill in an effort to establish trust.

• Our team tells patients that – on average – pain does not increase post-taper.
Changes In Pain When Tapering


Does Opioid Tapering in Chronic Pain Patients Result in Improved Pain or Same Pain vs Increased Pain at Taper Completion? A Structured Evidence-Based Systematic Review.

Fishbain DA, Pulikal A.

Abstract

OBJECTIVE: To support or refute the hypothesis that opioid tapering in chronic pain patients (CPPs) improves pain or maintains the same pain level by taper completion but does not increase pain.

METHODS: Of 364 references, 20 fulfilled inclusion/exclusion criteria. These studies were type 3 and 4 (not controlled) but reported pre/post-taper pain levels. Characteristics of the studies were abstracted into tabular form for numerical analysis. Studies were rated independently by two reviewers for quality. The percentage of studies supporting the above hypothesis was determined.

RESULTS: No studies had a rejection quality score. Combining all studies, 2,109 CPPs were tapered. Eighty percent of the studies reported that by taper completion pain had improved. Of these, 81.25% demonstrated this statistically. In 15% of the studies, pain was the same by taper completion. One study reported that by taper completion, 97% of the CPPs had improved or the same pain, but CPPs had worse pain in 3%. As such, 100% of the studies supported the hypothesis. Applying the Agency for Health Care Policy and Research Levels of Evidence Guidelines to this result produced an A consistency rating.

CONCLUSIONS: There is consistent type 3 and 4 study evidence that opioid tapering in CPPs reduces pain or maintains the same level of pain. However, these studies represented lower levels of evidence and were not designed to test the hypothesis, with the evidence being marginal in quality with large amounts of missing data. These results then primarily reveal the need for controlled studies (type 2) to address this hypothesis.

Several areas that need more research should be prioritized owing to their potential to influence policy and system interventions. First, there is concern that opioid tapering has resulted in patients’ transitioning to heroin use or resulted in uncontrolled pain, which increases suicidality. However, evidence for these relationships, beyond case reports, is lacking. As noted above, a study involving patients at Veterans Affairs facilities showed that higher prescribed dosages are associated with greater suicide risk than lower dosages. This same study also showed that rates of suicide among patients who were prescribed opioids for any length of time and stopped were similar to those among patients in ongoing treatment at low dosages (1 to 20 morphine milligram equivalents) and lower than rates among patients receiving higher dosages (≥21 morphine milligram equivalents). The findings of this study are not suggestive of suicide-related harm from discontinuation.

It is premature to conclude that discontinuation of prescription opioids leads to suicide or heroin use independent of risk factors that predated (or directly caused) the decision to discontinue. Nonetheless, abrupt discontinuation is physically unpleasant and potentially distressing. Protocols to reduce opioid withdrawal and provide alternative pain management are critical.
Risk-Benefit Calculation

• No quality published evidence to suggest that the benefits of high-dose LTOT exceed the risks.

• No quality published evidence to suggest that the risks of tapering high-dose LTOT patients exceed the benefits.

• Tapering high-dose LTOT patients generates difficult conversations that are uncomfortable and effect your Press-Ganey scores negatively.
Addiction Happens

• In our practice at Salem Health 51 of our 1st 239 high-dose patients ultimately required a transition to buprenorphine.
• Edlund* has estimated the addiction rate in high-dose - ≥ 120MED - LTOT patients to be ~1 in 17.
• Our data at Salem Health suggest that the addiction rate diminished to ~1 in 4 when the MED ≥ 240.
• If you treat high-dose LTOT patients get your X-Waiver and learn how to use it.
• Be careful about your definition of ‘success’ when tapering. 16 of our 51 buprenorphine patients successfully tapered to 90MED or below.

*https://www.ncbi.nlm.nih.gov/pubmed/24281273
Velocity Matters

• 10% per week is much too fast for high-dose LTOT patients.
• 10% per month is appropriate for patients ≤ 300MED.
• Delaying a taper for a month or two is reasonable in new patients without aberrancy or florid opioid use disorder.
• Pausing a taper is permissible during stressful times: weddings, holidays, deaths in the family, etc.
• Once started tapers for high-doe LTOT patients should NEVER go backwards.
• Sometimes – not always – the litmus test for opioid use disorder is the inability to taper slowly.
Other Strategies.

- Most high-dose LTOT patients will tell you they have tried the other strategies.
- Most high-dose LTOT patients have significant comorbid: depression, anxiety, PTSD, Bipolar Disorder, Borderline-Personality Disorder, and/or SUD. These worsen under stress/tapering so prepare.
- Supportive behavioral therapy – even by you or your MA – can help diffuse the stress associated with tapering.
- Don’t buy into the narrative that you are obligated to replace the opioid you taper with an alternative that ‘works’.
Tapering High Dose LTOT Is Distressing For Both Parties.

Reasons for opioid use among patients with dependence on prescription opioids: the role of chronic pain.

Weiss RD¹, Potter JS², Griffin ML³, McHugh RK³, Haller D⁴, Jacobs P⁵, Gardin J 2nd⁶, Fischer D⁷, Rosen KD⁸

Author information

Abstract

The number of individuals seeking treatment for prescription opioid dependence has increased dramatically, fostering a need for research on this population. The aim of this study was to examine reasons for prescription opioid use among 653 participants with and without chronic pain, enrolled in the Prescription Opioid Addiction Treatment Study, a randomized controlled trial of treatment for prescription opioid dependence. Participants identified initial and current reasons for opioid use. Participants with chronic pain were more likely to report pain as their primary initial reason for use; avoiding withdrawal was rated as the most important reason for current use in both groups. Participants with chronic pain rated using opioids to cope with physical pain as more important, and using opioids in response to social interactions and craving as less important, than those without chronic pain. Results highlight the importance of physical pain as a reason for opioid use among patients with chronic pain.

Tapering High-Dose LTOT Is Distressing For Both Parties.

Withdrawal symptoms predict prescription opioid dependence in chronic pain patients.

**Coloma-Carrona A**, **Carballo JL**, **Rodriguez-Marin J**, **Pérez-Carbonell A**

**Abstract**

**BACKGROUND:** The last version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes substantial changes for prescription opioid-use disorder (POUD). After its removal as a criterion, the goal of this study was to estimate the prevalence of withdrawal symptoms in long-term users of prescription opioids and its association with the new DSM-5 POU D classification.

**METHODS:** Data were collected from 215 long-term consumers of opioid medication who were chronic non-cancer pain patients. Participants completed sociodemographic, Adjective Rating Scale for Withdrawal (ARSW), opioid treatment characteristics, POU D criteria (DSM-5), and pain intensity measurements.

**RESULTS:** 26.6% of the participants were classified with moderate to severe POU D. Higher intensity of withdrawal symptoms was found in patients with moderate/severe POU D, younger age, and higher pain intensity (p < .01). Anxiolytics (p < .01) and antidepressants use (p < .05) and percentage of smokers (p < .05) were significantly higher in patients with severe withdrawal. Logistic regression analyses suggested moderate [odds ratio (OR) = 3.25] and severe (OR = 10.52) withdrawal as the strongest predictor of POU D. Age, anxiolytics use, and smoking were also associated with POU D, but multilevel analysis showed that these variables do not moderate the association between withdrawal intensity and POU D.

**CONCLUSION:** Escalation of withdrawal intensity during opioid treatment can be used to identify patients with POU D. Further studies are needed to assess the clinical implications of these findings during long-term opioid therapy for chronic pain.
Tools to Monitor Distress When Tapering

- COWS: Clinical Opioid Withdrawal Scale
- ARSW: Adjective Rating Scale for Withdrawal
- *SOWS: Subjective Opioid Withdrawal Scale
- Pain scales may not reliably capture the distress and suffering some patients experience.

*https://www.slideshare.net/101N/subjective-taper-distress-scale
Ruth is a 36y/o young woman with psoriatic arthritis. She is a married mother of two children. She has an associates degree and works full-time as a case manager. She does not smoke, drinks Alcohol in moderation, and she has no history of addiction. She is prescribed Oxycontin 60mg BID And oxycodone 10mg eight QD total MED 300. Ruth has been compliant with her care and has no History of aberrant behavior. PCS 12, FSQ 18.

At her first visit I agreed to take over Ruth’s prescribing. At the first refill visit I did not make any changes But I mentioned that at the second visit we would negotiate a taper schedule. I prescribed nasal naloxone.
Sample Case: Ruth 1\textsuperscript{st} F/U

Ruth returned for her first follow-up and refill. I refilled her existing regimen – Oxycontin 60mg BID and Oxycodone 10mg eight QD sig 224.

We negotiated a taper from 300MED to 90 MED with a tempo of: 300-90 = 210/15mg oxycodone (22MED)/mo. = 9mo.
Sample Case: Ruth F/U

Ruth subsequently tapered to 90MED - by a 15mg oxycodone/mo. decrement - without aberrancy or pause.

6mo post taper we negotiated a wean off of opioids and this was accomplished over 4mo by another 4mo of tapering 15mg oxycodone/mo.
Salem Health 30mo Taper Data

- 239 High-Dose Patients
  - 105 – 3200 MED
  - 106 Tapered ≤ 90 MED
  - 11 Taper Drop-Outs
  - 71 One Consult Only
  - 44 Buprenorphine > 12wks
  - 7 Buprenorphine Drop-Outs

- 239 Low-Dose Control Patients
<table>
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<th>Demographics</th>
<th>106 High-Dose LTOT Pts</th>
<th>239 Low-Dose LTOT Pts</th>
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<tr>
<td>Sex</td>
<td>57% Female</td>
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<td>Median Age</td>
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<tr>
<td>Payer</td>
<td>52% Medicare, 17% Medicaid</td>
<td>49% Medicare, 23% Medicaid</td>
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Thank you!