Non-CME Webinar Series
designed with the trainee in mind
first Tuesday of the month

ASRA PAIN MEDICINE
THE ASSOCIATION OF PAIN PROGRAM DIRECTORS

Opioids: Indication-Getting On-Staying On-Getting Off

Tuesday, November 1, 2022

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Opioid Tapering

Matthew Meroney, MD
Assistant Professor
Pain Medicine
Department of Anesthesiology, University of Florida

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Disclosures:

- None

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Objectives:

- Realize the Indications for Opioid Tapering
- Understand the Risks of Opioid Tapering
- Apply Strategies for Opioid Tapering
- Know Options for Safe Opioid Disposal
- Identify Future Research Topics in Opioid Tapering

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Some thoughts to start:

- Opioids are a high-risk intervention…..they may be beneficial for a subgroup of patients…..or not…

→ Consider opioids as a tool in your toolbox for the right patient…..and failure of the therapy is an option…for various reasons…..

Indications for Opioid Tapering:

- **Patient** Initiated (minority of cases)
  - Concerns given the opioid crisis
- **Physician** Initiated (majority of cases)
  - Unsatisfactory pain control and/or functional improvements
  - Polypharmacy, especially with additional sedating medications
  - Co-morbidities, e.g. respiratory, kidney, liver, or mental disease
  - Non-compliance with opioid therapy and monitoring
  - Overdose event

Indications for Opioid Tapering:

- Daily morphine-equivalent doses above the recommendation of the CDC's *Guideline for Prescribing Opioids for Chronic Pain* alone is not an immediate indication for opioid tapering…. But the dose and therapy should be reviewed…..
- Consider vulnerable populations such as adolescents and pregnant patients.

Benefits

- Highest quality of evidence of opioid efficacy is for short time periods (12 weeks)
- Patients are not motivated generally to taper due by overdose risk
  - Decrease in side effects (constipation/nausea/energy level/sense of well being
- Sexual dysfunction (hypogonadism), falls, fracture, hyperalgesia, testosterone
- Opioid related mortality
  - 50-99 MED - OR 1.92
  - 100-199 MED – 2.04
  - 200+ MED - OR 2.99 (Gomes et al)

Risks Associated with Opioid Tapering:

- Abrupt discontinuation of opioids in patients who are physically opioid-dependent is not recommended unless there are life-threatening issues.
- Abrupt discontinuation/fast taper of opioids in opioid-dependent patients is associated with withdrawal symptoms and psychological stress.
- Patients may seek alternatives in the form of illicit and unsafe opioids.
- Risk of overdose if uncontrolled dose (re-) escalation.
- Loss of pain control in patients who benefit from opioid therapy.

Risks Associated with Opioid Tapering:

- Discuss and treat withdrawal symptoms!
  - Untreated withdrawal symptoms can jeopardize the taper.
- Withdrawal symptoms and timeline:
  - Initial symptoms of withdrawal may include anxiety, watery eyes, and headaches, and symptoms at withdrawal's peak can include nausea, muscle aches, and insomnia.
  - Onset: Initial: 8-24 hours after last opioid dose, peak 36-72 hours, some symptoms lasting for weeks to months.
- Treatment of opioid withdrawal symptoms:
  - Most are off label: Alpha-2 adrenergic agonists, antiemetics, antidiarrheal agents, muscle-relaxing agents, acetaminophen, and NSAIDs.
  - Consider adjusting the opioid taper.

Strategies for Opioid Tapering:

- Shared Decision-Making:
  - Engage the patient in the decision to attempt opioid tapering
  - Explain the reasons
  - Explain what to expect and the process
  - Optimize non-opioid-based pain strategies
  - Don't abandon the patient
  - "Buy in from the patient" has demonstrated improved adherence and outcomes → consider "agreement to taper"
  - Frequent follow-ups, at least during the initial phase of a taper

Strategies for Opioid Tapering:

- Abrupt or ultra-fast discontinuation only in life-threatening situation(s)
- So:
  - Fast or slow taper?
  - Use an individualized approach
  - Some evidence indicates that patients on opioids for more than 12 months should undergo a slower taper.

Strategies for Opioid Tapering: Examples

- CDC Pocket Guide to Opioid Tapering:
  - A decrease of 10% per month is a reasonable starting point if patients have taken opioids for more than a year.
  - A decrease of 10% per week may work for patients who have taken opioids for a shorter time (weeks to months).
- Department of Veterans Affairs and the Department of Defense:
  - Slower tapering schedule (for chronic opioid users): Dosage reductions of 5% to 20% of the original dose every 4 weeks.
  - Faster tapering schedule (for acute/postoperative opioid users): Daily decreases of 20% to 50% of the initial dose down to a threshold dose; this is followed by a decrease every 2 to 5 days.

Opioid Taper:

What It Can Look Like

Slowest Taper (over years)	Slower Taper (over months or years)	Faster Taper (over weeks)****	Rapid Taper (over days)****
Reduce by 2 to 10% every 4 to 8 weeks with pauses in taper as needed *Consider for patients taking high doses of long-acting opioids for many years*	Reduce by 5 to 20% every 4 weeks with pauses in taper as needed **MOST COMMON TAPER**	Reduce by 10 to 20% every week	Reduce by 20 to 50% of first dose if needed, then reduce by 10 to 20% every day
Ex: morphine SR 90 mg Q8h = 270 MEDD **Month 1:** 90 mg SR qam, 75 mg noon, 90 mg qpm [5% reduction]* **Month 2:** 75 mg SR qam, 75 mg noon, 90 mg qpm **Month 3:** 75 mg SR (60 mg+15 mg) Q8h **Month 4:** 75 mg SR qam, 60 mg noon, 75 mg qpm **Month 5:** 60 mg SR qam, 60 mg noon, 75 mg qpm **Month 6:** 60 mg SR Q8h **Month 7:** 60 mg SR qam, 45 mg noon, 60 mg qpm **Month 8:** 45 mg SR qam, 45 mg noon, 60 mg qpm **Month 9:** 45 mg SR Q8h**	Ex: morphine SR 90 mg Q8h = 270 MEDD **Month 1:** 75 mg (60 mg+15 mg)SR Q8h [16% reduction] **Month 2:** 60 mg SR Q8h **Month 3:** 45 mg SR Q8h **Month 4:** 30 mg SR Q8h **Month 5:** 15 mg SR Q8h **Month 6:** 15 mg SR Q12h **Month 7:** 15mg SR QHS, then stop***	Ex: morphine SR 90 mg Q8h = 270 MEDD **Week 1:** 75 mg SR Q8h [16% reduction] **Week 2:** 60 mg SR (15 mg x 4) Q8h **Week 3:** 45 mg SR (15 mg x 3) Q8h **Week 4:** 30 mg SR (15 mg x 2) Q8h **Week 5:** 15 mg SR Q8h **Week 6:** 15 mg SR Q12h **Week 7:** 15 mg SR QHS x 7 days, then stop***	Ex: morphine SR 90 mg Q8h = 270 MEDD **Day 1:** 60 mg SR (15 mg x 4) Q8h [33% reduction] **Day 2:** 45 mg SR (15 mg x 3) Q8h **Day 3:** 30 mg SR (15 mg x 2) Q8h **Day 4:** 15 mg SR Q8h **Days 5-7:** 15 mg SR Q12h **Days 8-11:** 15 mg SR QHS, then stop***

From the

Opioid Taper Decision Tool

U.S. Department of Veterans Affairs

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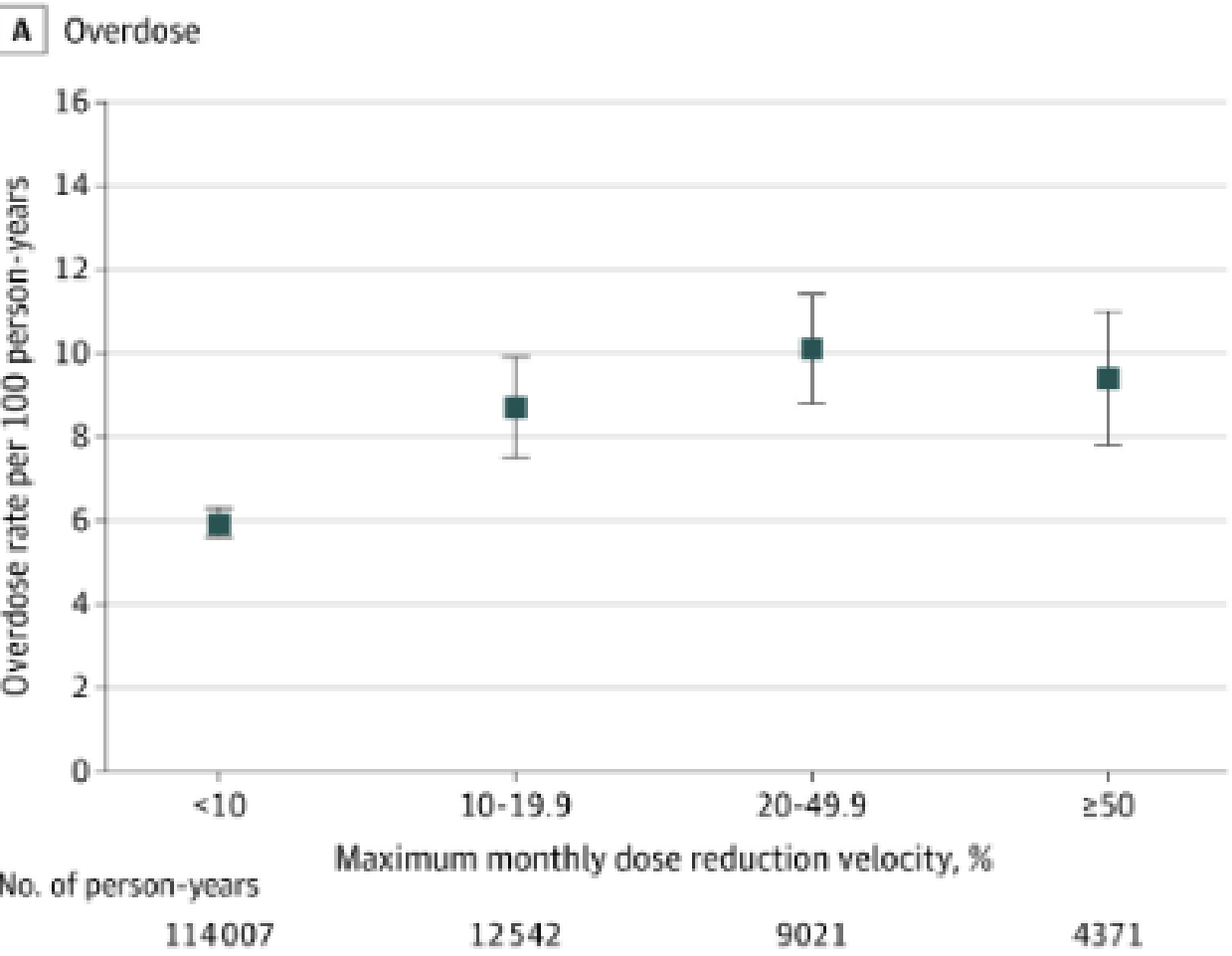
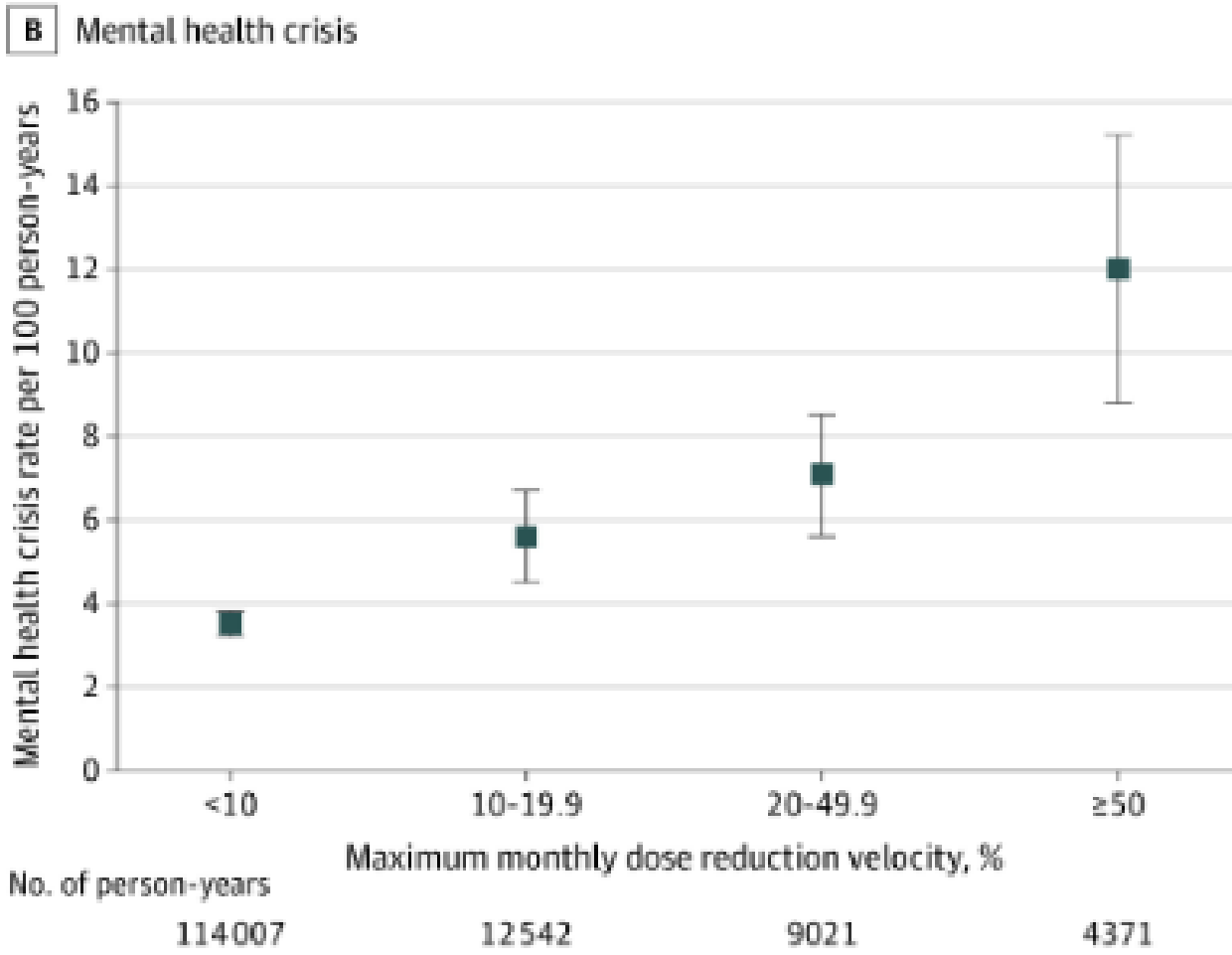
Strategies for Opioid Tapering:

- Most commonly, tapering will involve a dose reduction of 5% to 20% every 4 weeks.
- The slowest tapers take place over years and may need to be stopped intermittently…
- Again, plans need to be individualized …

- Consequences





- Consideration of Testosterone replacement?
  - Mu Agonists produce central hypogonadism in men. (Rajagopal et al)
  - Systematic review – reduces pain by 2 points (0-10)
  - Improved emotional functioning
  - No help with sleep, social functioning
  - Low quality evidence – unclear if improves successful tapering (AminiLari et al)

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Strategies for Opioid Tapering: Special Populations

Opioid use disorder (OUD)

If unable to wean/or weaning is challenging, assess for OUD

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Opioid Use Disorder (OUD) – DSM -5

"Problematic pattern" of use leading to "clinically significant impairment or distress" manifesting with 2 or more of 12 criteria

- Take larger amounts or use over longer period than intended
- Persistent desire/unsuccessful efforts to cut down/gain control over use
- Great deal of time spent procuring opioids
- Craving or strong desire to use
- Recurrent use problems at work, school, home, interpersonal/legal issues
- Recurrent use in hazardous scenarios
- Tolerance defined as need for "markedly increased amounts" or "markedly diminished effect" from same amount
- Withdrawal syndrome

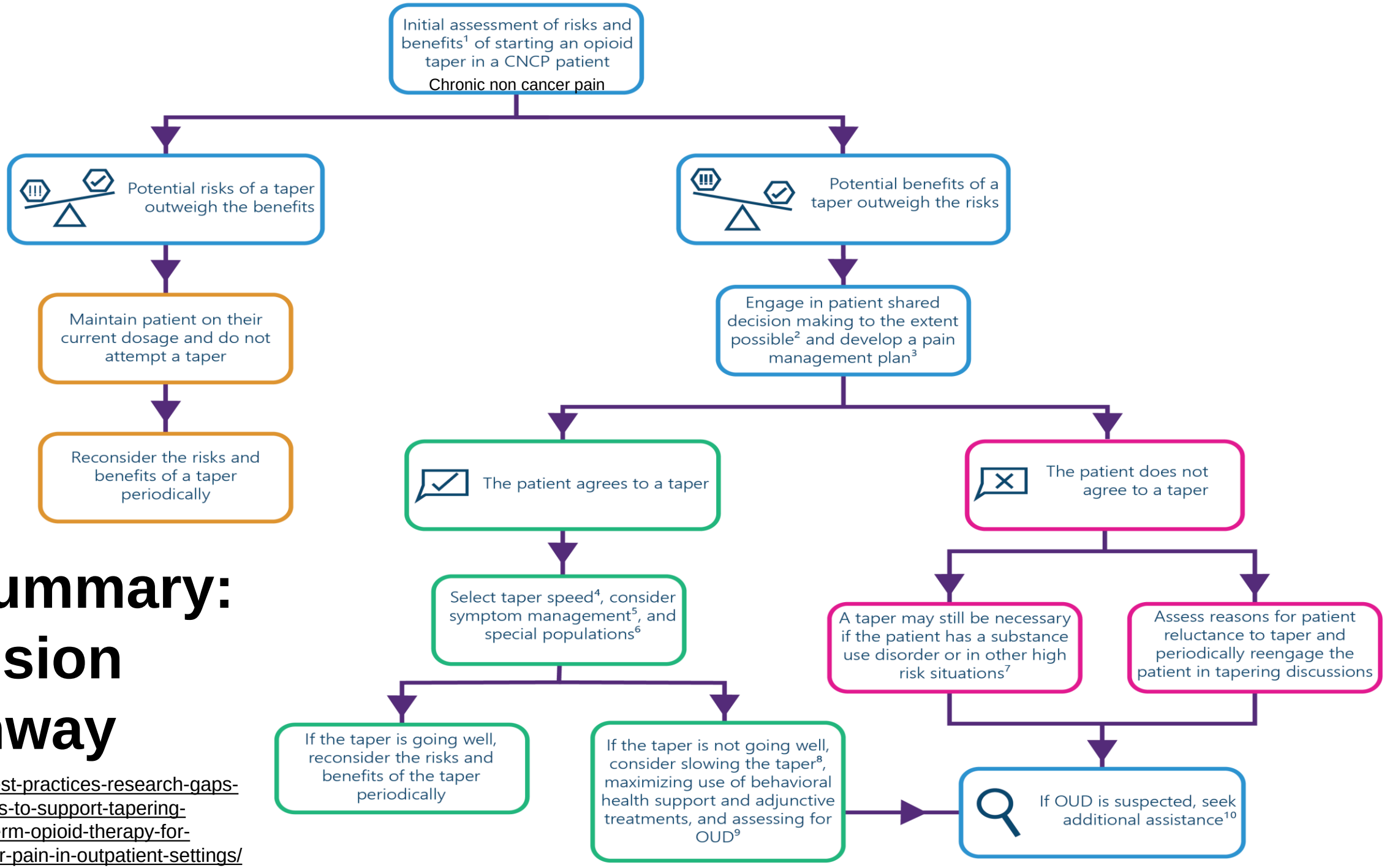
Severity: mild (2-3 symptoms), moderate (4-5), severe (≥ 6)

https://image4.slideserve.com/394761/opioid-use-disorder-oud-dsm-5-l.jpg

Strategies for Opioid Tapering: Special Populations

- Unable to wean, high opioid dose, polypharmacy:
  - Risk mitigation including naloxone prescription, Addiction Medicine Consultation
  - Consider buprenorphine
    - If prescribing buprenorphine for OUD, YOU need a DATA* Waiver (DEA X-number)
      - Required only if treating over 30 patients

(*DATA: Drug Addiction Treatment Act – Under the Act, physicians may apply for a waiver to prescribe buprenorphine for the treatment of opioid addiction or dependence outside of an opioid treatment program (OTP).



In Summary: Decision Pathway

https://nam.edu/best-practices-research-gaps-and-future-priorities-to-support-tapering-patients-on-long-term-opioid-therapy-for-chronic-non-cancer-pain-in-outpatient-settings/

Safe Disposal of Opioids:

- Patients should not have unused opioids in their homes.
- Resources for disposal and locations:
  - Contact local pharmacies and law enforcement agencies.
  - Review FDA webpages for options and locations.
  - If garbage is the only option, please mix with an unpalatable substance (kitty litter, dirt, or used coffee grounds) before throwing in the trash. Place the mixture in a container such as a sealed plastic bag. Remember to delete all personal information.
  - Opioids are included on the FDA list of medications that may be flushed when there is no other option. If flushing opioid patches down the toilet, fold each patch in half with the sticky sides together before flushing.

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Research Topics in the Field of Opioid Tapering:

- When and speed of opioid taper
- Taper in patients with opioid use disorder (OUD) and/or polypharmacy
- Interventions to assist with opioid tapering

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Questions?

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