The Case of Conundrum Carl: He wants to withdrawal… now what?

March 2018 VIP Chat

March 21, 2018

Noon-12:30

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A VISN 19 – VA SLC Initiative

The Discussant has no conflict of interests to disclose

Vulnerable Veteran – Innovative PACT (VIP) & VIP Chats

- **VIP Goal:**
  - The VISN 19 VIP (Vulnerable Veteran – Innovative PACT) Initiative's over-arching goal is to improve the health of veterans who are particularly vulnerable due to medical disease and/or their social determinants in primary care environments
  - Veterans served by this Initiative include those with unhealthy alcohol and drug use, co-occurring pain and addiction disorders, social determinants of health including homelessness, and those who frequently use health care services
- **VIP Chat Goal:**
  - **To provide education, mentorship, and foster a learning collaborative to improve the knowledge and skills of health care providers in VISN 19**
  - **The chats are generally scheduled for the 3rd Wednesday of each month**
  - **All health care providers are welcome to join! – FUN!**

AGENDA

- Introduction and Case (10 minutes)
- “Bite Sized Teach” (BST or “Beast Mode”) (10 minutes)
- Discussion (10 minutes)
  - Extended discussion (optional) (30 minutes)

youtu.be/dJ_8QmHlNPw
medicine.emory.edu/education/academy-of-medical-educators/bst-mode.html

CASE: Conundrum Carl

- Carl is a 45 year old male Veteran who presents to your primary care clinic complaining of constipation
- He is new to your clinic
- He relates difficulty with constipation for some time
- He “goes” 2-3 times a week, but feels discomfort
- He has tried laxatives and stool softeners in the past

CASE: Conundrum Carl

- **Past Medical History:**
  - Lower back pain – “mild, and gets bad when I am cutting logs in the backyard”
  - Right leg amputation – In service
  - Hypertension – generally well controlled
  - Nicotine use disorder - He smokes cigars, 3 weekly
- **Social history:** Employed, works at the VA in shop keeping
  He is married, with three older children
  He drinks alcohol only socially
- **Family history:** hypertension and early dementia in family

CASE: Conundrum Carl

- **Allergies:** None
- **Medications:** Aspirin once a day
  Metoprolol 50 twice a day
  Gabapentin 300mg three times a day
  MS Contin 60 mg twice a day
  Percocet 5/325 mg every 6 hours as needed

Labs/Studies: Normal

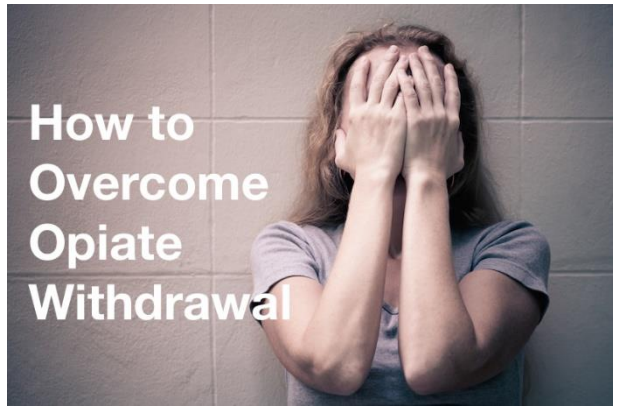
CASE: Conundrum Carl

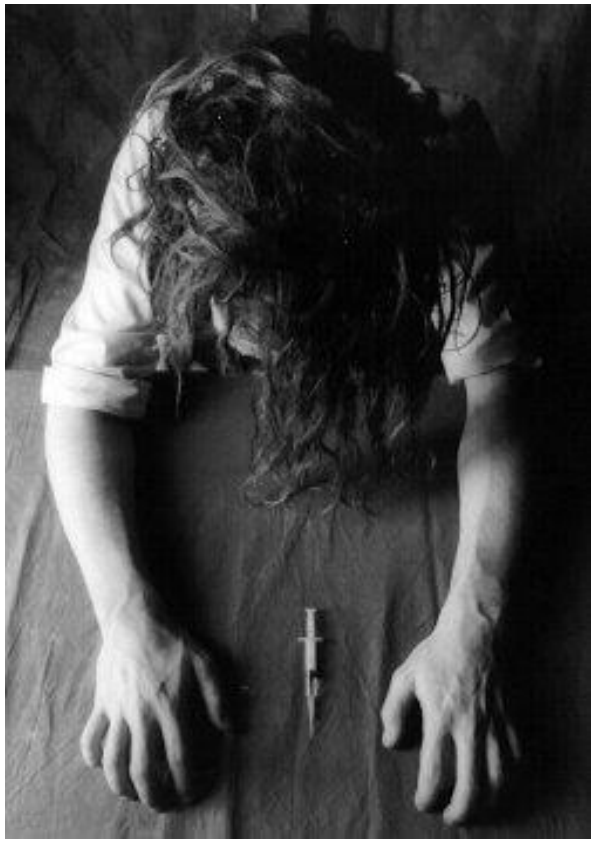
- **The rest of the story:**
  - You inquire about his opioid pain medications
  - Patient has been on long acting morphine since his leg amputation
    “The docs just prescribed it to me”
    “She told me it would be helpful for my back”
    “You know doc, when I try to wean myself down, I get bad feelings”
    “I don’t really need them for pain. I am doing well. I could come down.
- **Your consideration:**
  - Opioid induced constipation
  - Long term opioids without lasting benefit
  - Opioid withdrawal syndrome
- **Patient consideration:**
  - Let’s get these medications out of my system!

HOW DO YOU WITHDRAWAL PATIENTS FROM OPIOIDS WHO WANT TO BE WITHDRAWN?

Opioid Withdrawal
Want to avoid these…

- Severe flu-like symptoms
- Shaking chills
- Anxiety
- Hyperactivity
- Drooling
- Lacrimation/tearing
- Rhinorrhea
- Nausea and Vomiting
- Anorexia
- Diarrhea
- Myalgias and Muscle spasms





Not all people will have all these symptoms
Ask patients what THEY experience
Symptoms can be complicated by other medical conditions

Evidence of effect of opioid tapers…

Annals of Internal Medicine

REVIEW

Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy

A Systematic Review

Joseph W. Frank, MD, MPH; Travis I. Lovejoy, PhD, MPH; William C. Becker, MD; Benjamin J. Morasco, PhD; Christopher J. Koenig, PhD; Lilian Hoffecker, PhD, MLS; Hannah R. Dischinger, BS; Steven K. Dobscha, MD; and Erin E. Krebs, MD, MPH

Background: Expert guidelines recommend reducing or discontinuing long-term opioid therapy (LTOT) when risks outweigh benefits, but evidence on the effect of dose reduction on patient outcomes has not been systematically reviewed.

Purpose: To synthesize studies of the effectiveness of strategies to reduce or discontinue LTOT and patient outcomes after dose reduction among adults prescribed LTOT for chronic pain.

Data Sources: MEDLINE, EMBASE, PsycINFO, CINAHL, and the Cochrane Library from inception through April 2017; reference lists; and expert contacts.

Study Selection: Original research published in English that addressed dose reduction or discontinuation of LTOT for chronic pain.

Data Extraction: Two independent reviewers extracted data and assessed study quality using the U.S. Preventive Services Task Force quality rating criteria. All authors assessed evidence quality using the GRADE (Grading of Recommendations Assessment, Development and Evaluation) system. Prespecified patient outcomes were pain severity, function, quality of life, opioid withdrawal symptoms, substance use, and adverse events.

Data Synthesis: Sixty-seven studies (11 randomized trials and 56 observational studies) examining 8 intervention categories, including interdisciplinary pain programs, buprenorphine-assisted dose reduction, and behavioral interventions, were found. Study quality was good for 3 studies, fair for 13 studies, and poor for 51 studies. Many studies reported dose reduction, but rates of opioid discontinuation ranged widely across interventions and the overall quality of evidence was very low. Among 40 studies examining patient outcomes after dose reduction (very low overall quality of evidence), improvement was reported in pain severity (8 of 8 fair-quality studies), function (5 of 5 fair-quality studies), and quality of life (3 of 3 fair-quality studies).

Limitation: Heterogeneous interventions and outcome measures; poor-quality studies with uncontrolled designs.

Conclusion: Very low quality evidence suggests that several types of interventions may be effective to reduce or discontinue LTOT and that pain, function, and quality of life may improve with opioid dose reduction.

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For author affiliations, see end of text.
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So how do you taper?

- First thing, make sure you have identified a reason for a taper and that the patient is willing to taper
  - Involuntary tapers are a bit different in approach…
- **General considerations:**
  - Everyone is different
    - Don't rely on a "protocol"
  - Long duration of action of medications = long duration of taper
    - Thus the taper depends of the half-life of the medications you are dosing/tapering
    - 2-6 months sometimes
  - Consider adjusting the dose and the taper based on patient needs
    - Reconsider the risk/benefit at all times
    - This may take some trial and error but the secret is patience and willingness to adjust your taper schedule if necessary
  - The taper should be more gradual to allow for time to assess the pain level or physical dependence to adjust as the dose is reduced
    - If you have patient symptoms while tapering, perhaps the taper is going too fast

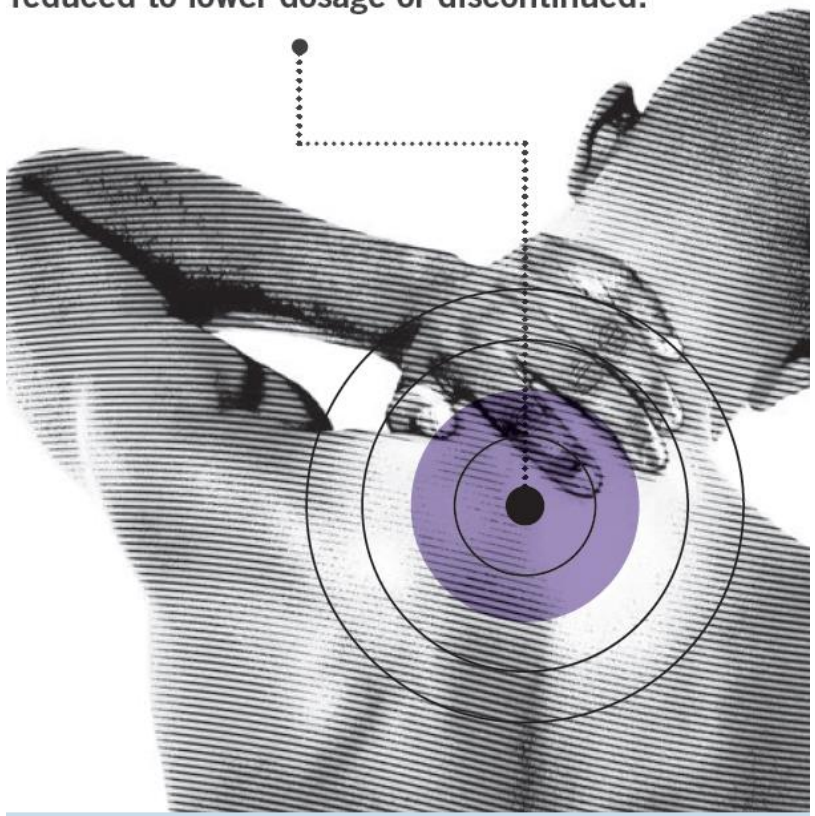
Some general guidelines:

1. Seek consultation from a pain management specialist or Structured Intensive Multidisciplinary Pain Program (SIMP) for patients who have 1) failed taper in an outpatient setting or 2) who are at greater risk for failure due to high dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or any active mental health disorder
   - If SIMP is not available, engage patients in activities that emulate the biopsychosocial approach of such a program
   - Rarely, inpatient management of withdrawal may be necessary
2. Refer patients with aberrant behaviors (opioid misuse or opioid use disorder) for evaluation and treatment

http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

POCKET GUIDE: TAPERING OPIOIDS FOR CHRONIC PAIN*

Follow up regularly with patients to determine whether opioids are meeting treatment goals and whether opioids can be reduced to lower dosage or discontinued.



GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

HOW TO TAPER

Tapering plans should be individualized and should minimize symptoms of opioid withdrawal while maximizing pain treatment with nonpharmacologic therapies and nonopioid medications. In general:

Go Slow

A decrease of 10% of the original dose per week is a reasonable starting point. Some patients who have taken opioids for a long time might find even slower tapers (e.g., 10% per month) easier.

Discuss the increased risk for overdose if patients quickly return to a previously prescribed higher dose.

Consult

Coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.

Use extra caution during pregnancy due to possible risk to the pregnant patient and to the fetus if the patient goes into withdrawal.

Support

Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.

Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

Encourage

Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.

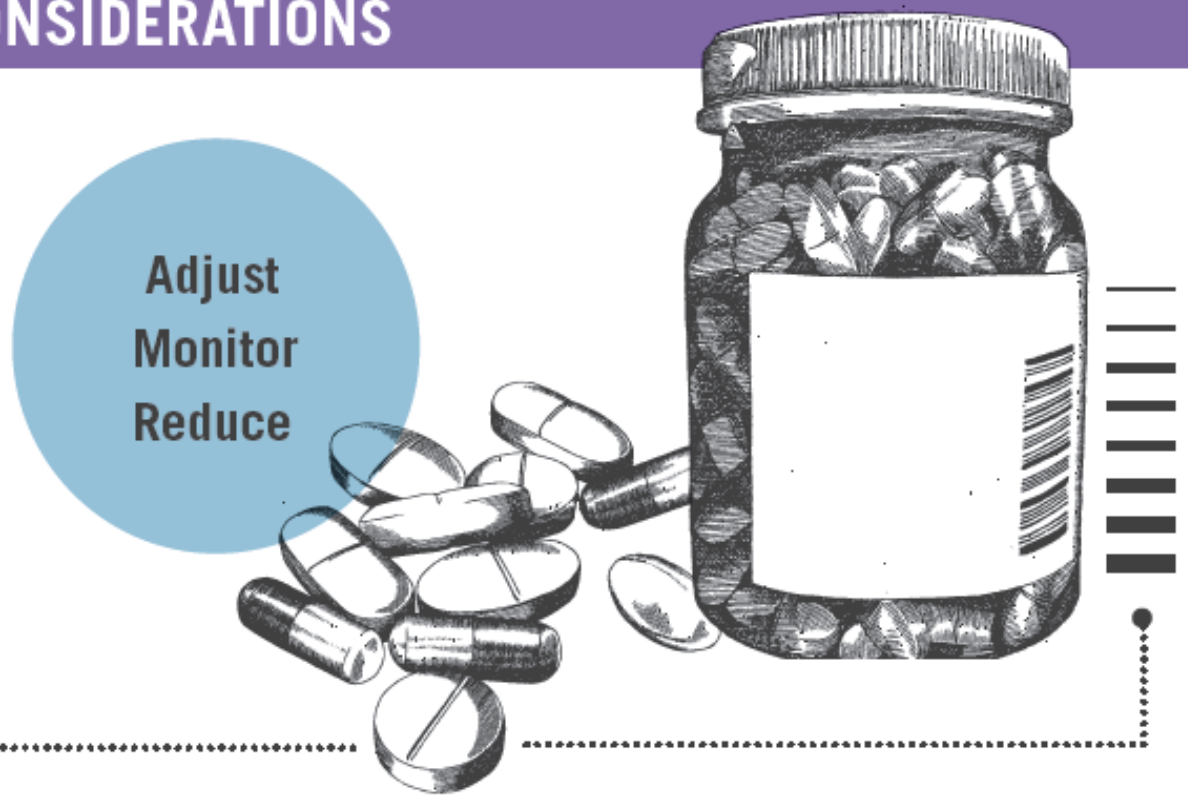
Tell patients "I know you can do this" or "I'll stick by you through this."

10% per week TO 10% per month!

Watch for:
Anxiety
Depression
Opioid Misuse

VIP

CONSIDERATIONS



1. Adjust the rate and duration of the taper according to the patient's response.
2. Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day.

Tapering guidance – more specifi

Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice

Chantal Berna, MD, PhD; Ronald J. Kulich, PhD; and James P. Rathmell, MD

Abstract

Increasing concern about the risks and limited evidence supporting the therapeutic benefit of long-term opioid therapy for chronic noncancer pain are leading prescribers to consider discontinuing the use of opioids. In addition to overt addiction or diversion, the presence of adverse effects, diminishing analgesia, reduced function and quality of life, or the absence of progress toward functional goals can justify an attempt at weaning patients from long-term opioid therapy. However, discontinuing opioid therapy is often hindered by patients' psychiatric comorbidities and poor coping skills, as well as the lack of formal guidelines for the prescribers. The aim of this article is to review the existing literature and formulate recommendations for practitioners aiming to discontinue long-term opioid therapy. Specifically, this review aims to answer the following questions: What is an optimal opioid tapering regimen? How can the risks involved in a taper be managed? What are the alternatives to an opioid taper? A PubMed literature search was conducted using the keywords *chronic pain* combined with *opioid withdrawal*, *taper*, *wean* and *detoxification*. Six hundred ninety-five documents were identified and screened; 117 were deemed directly relevant and are included. On the base of this literature review, this article proposes evidence-based recommendations and expert-based suggestions for clinical practice. Furthermore, areas of lack of evidence are identified, providing opportunities for further research.

 ■ Mayo Clin Proc. 2015;90(6):828-842

Berna C et. al. Mayo Clin Proc. 2015;90(6):828-842

Tapering guidance – more specific Recommendations

- Prevention of Taper Failure (Drop out)
- Withdrawal symptom management
- Pain Management
- Psychological Management and Interdisciplinary programs
- Management of Medico legal risks
- Alternatives to tapering
- Opioid maintenance
- Risk reduction programs

Berna C et. al. Mayo Clin Proc. 2015;90(6):828-842

Tapering guidance – more specific
Final thoughts…

There is mounting concern regarding the use of long-term opioid therapy for patients with CNCP, and increasing numbers of physicians are contemplating tapering for their patients. Although some evidence can be translated from the field of SUD to inform care in patients with CNCP, little specific and high-quality research has focused on guiding tapering from long-term opioid treatment and on specific support needed to manage risks and issues in this process. Important questions remain to

Berna C et. al. Mayo Clin Proc. 2015;90(6):828-842

POSSIBLE SOLUTION: Conundrum Carl

- **Current:**
  - MSContin 60 mg twice a day
  - Percocet 5/325 mg every 6 hours as needed
- **Plan and reassessment**
  - Either reduce long acting or short acting first, patient could choose
  - Consider:
    - Reduce MSContin 15 mg every other week/month
    - Once MSContin 15 mg is off…(over months)
    - Reduce Percocet PRN, q8, q12, then once a day then off
    - Consider symptomatic treatment
- **Reassure and reassess**
  - Change this up based on patient needs
  - Consider non-pharmacologic treatment
  - Consider buprenorphine to assist with final taper (evidence for this…)
  - Consider symptomatic treatment of any opioid withdrawal syndrome

Remember …

10% per week TO 10% per month!

DISCUSSION

Next VIP CHAT!

Wednesday, APRIL 25, 2018, noon-12:30 PM **(Switching to the 4th Wednesday of the month)**

The Case of Orwell – What is Opioid Use Disorder and what it is not