

WEANING OFF OPIATES



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DISCLOSURE

- No disclosures



OBJECTIVES

- Summarize the basics of how to wean patients off of opiates and who is at risk of withdrawal.
- Review the signs and symptoms of withdrawal from chronic opioids.
- Summarize how providers can use medications to treat withdrawal symptoms
- Describe options and techniques for transitioning patients to addiction treatment



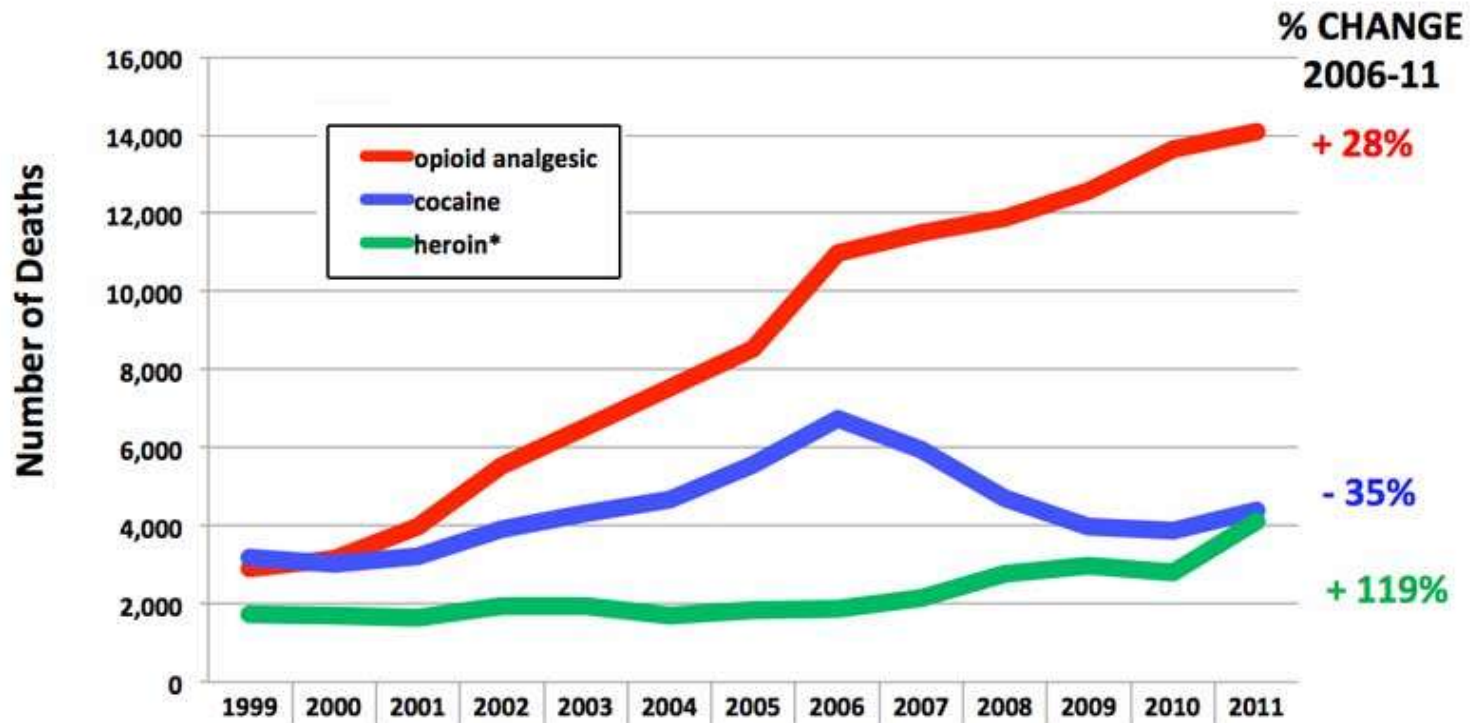
DISCLAIMERS

- This talk will not cover when to use opiates appropriately
- We will not seek to solve the opiate crisis
- Opiates have their place in pain management



THE OPIATE CRISIS

Unintentional Drug Poisoning Deaths Involving Opioid Analgesics, Cocaine and Heroin: United States, 1999–2011

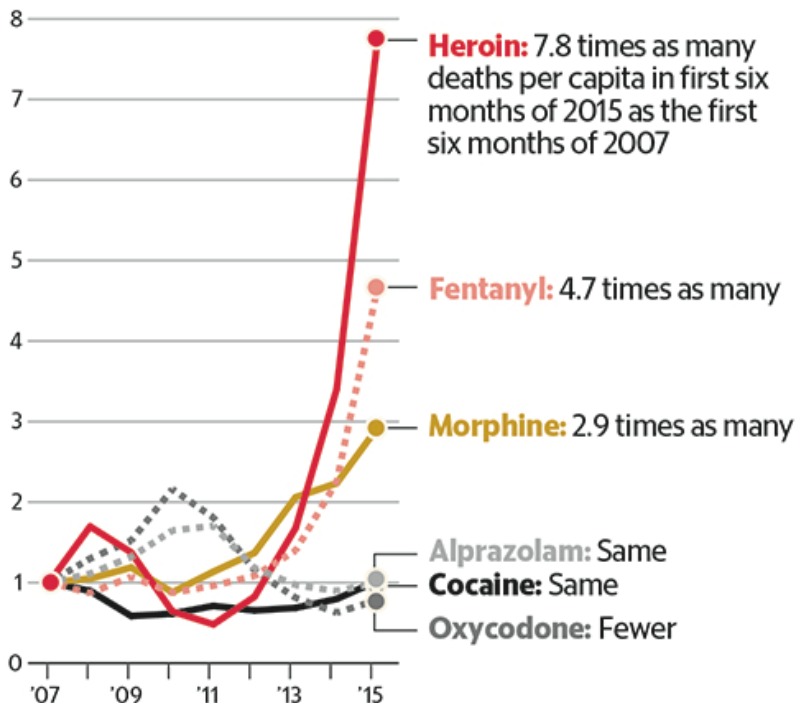


○ Source: National Vital Statistics

Heroin deaths surge in Florida

Deaths caused by heroin and fentanyl (a potent, synthetic alternative) have skyrocketed in Florida. During the first six months of 2015 — the latest data available — there were roughly six times as many deaths per capita as there were during same period in 2007.

Deaths per capita during first six months of the year compared to same period in 2007

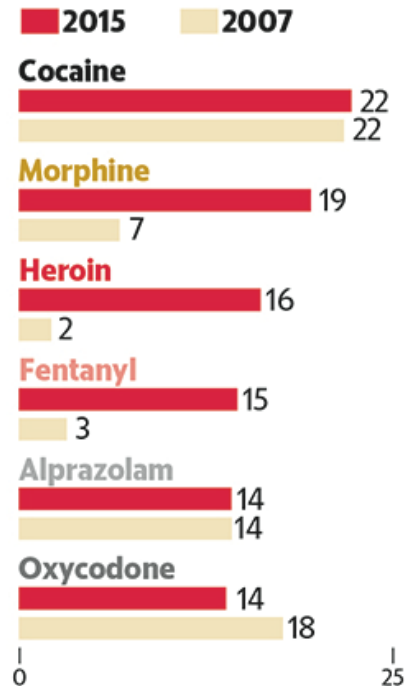


Note: Heroin is rapidly metabolized to morphine, which may lead to a slight over-reporting of morphine deaths.

Source: Florida Department of Law Enforcement Medical Examiners Commission

Floridians are now more likely to be killed by opioids like morphine, heroin and fentanyl than oxycodone or the state's lead benzodiazepine killer, alprazolam (generic Xanax).

Deaths per million Floridians in the first 6 months of the year

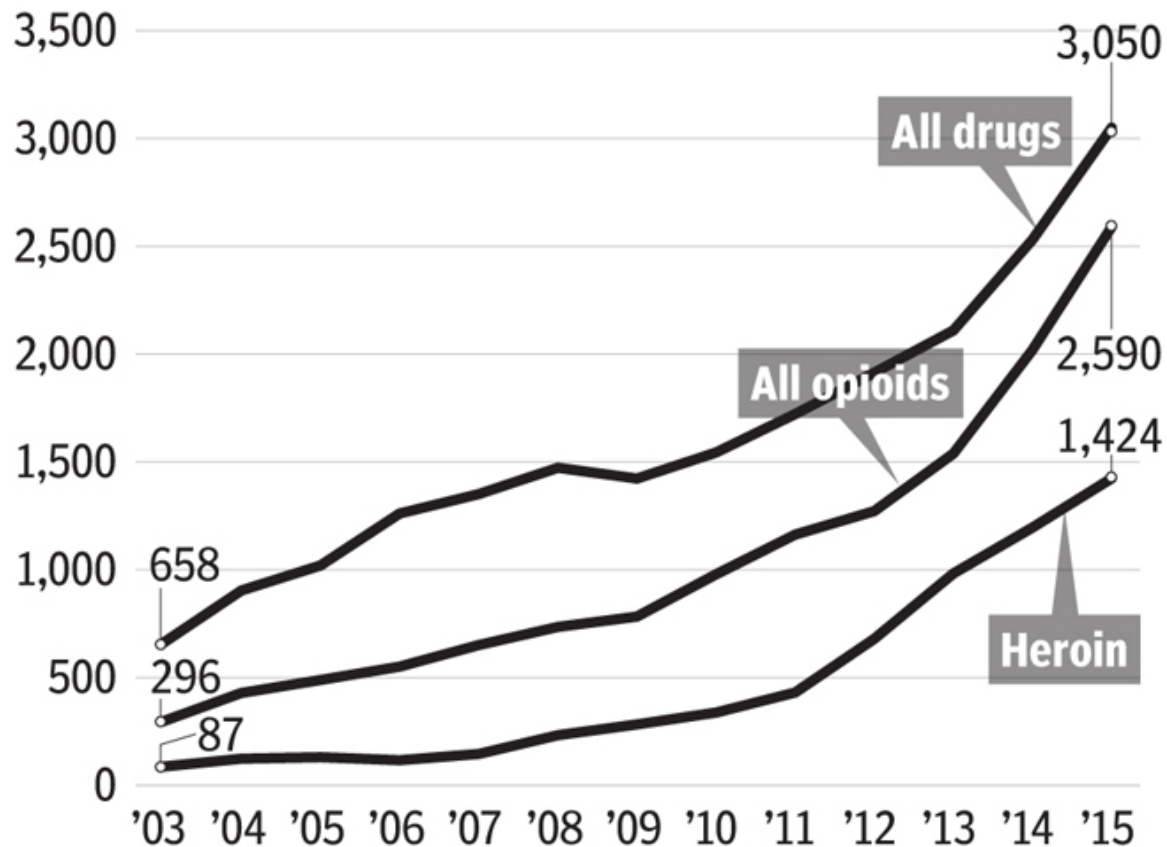


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Overdose deaths in Ohio

Overdose deaths caused by opioids, and specifically heroin, have risen dramatically since 2003.

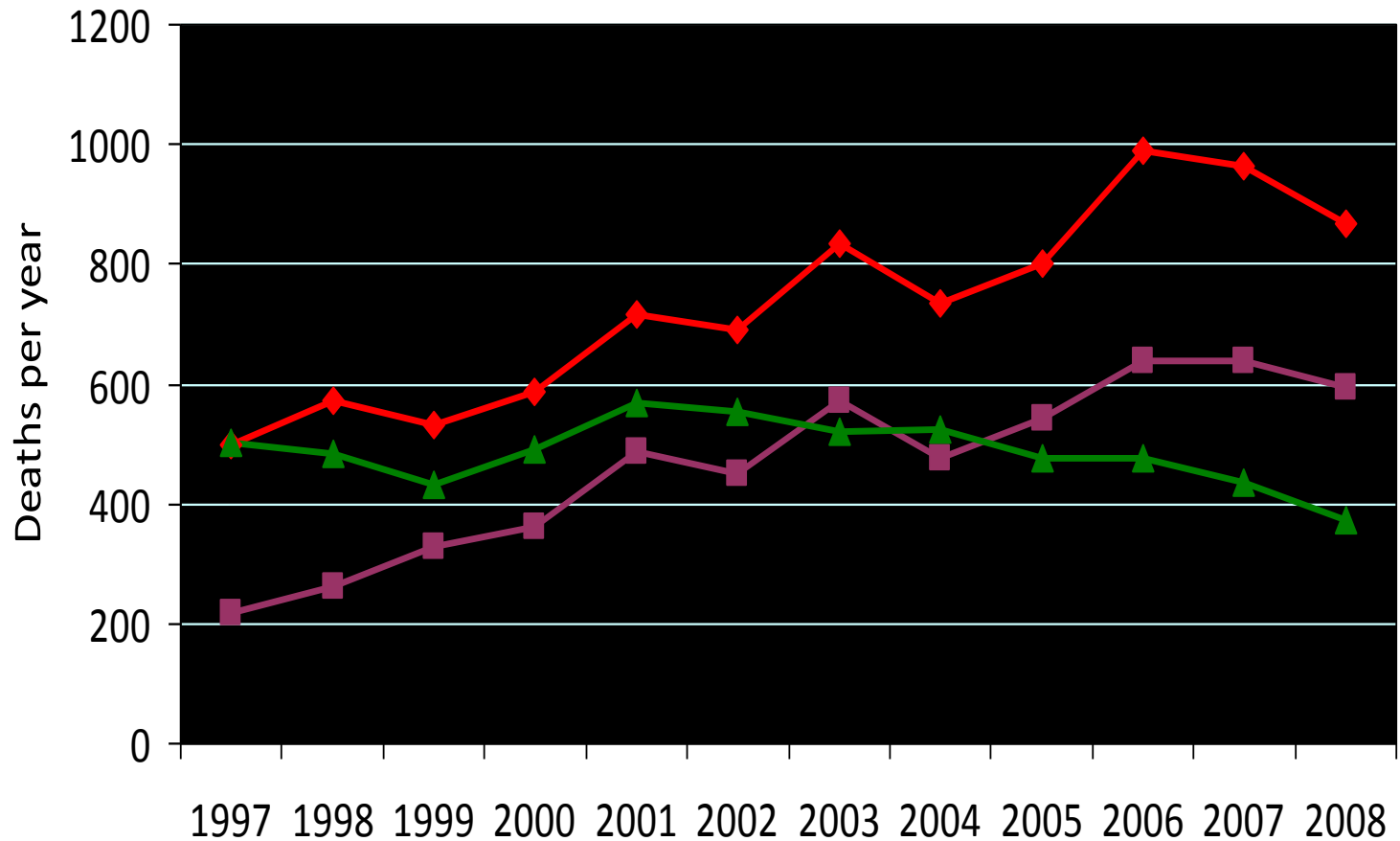


*Individual drugs do not add up to the total deaths because more than one drug was listed for the cause of death in some cases.

Source: Ohio Department of Health



Poisoning Deaths vs. Motor Vehicle-Related Injury Deaths, MA Residents (1997-2008)



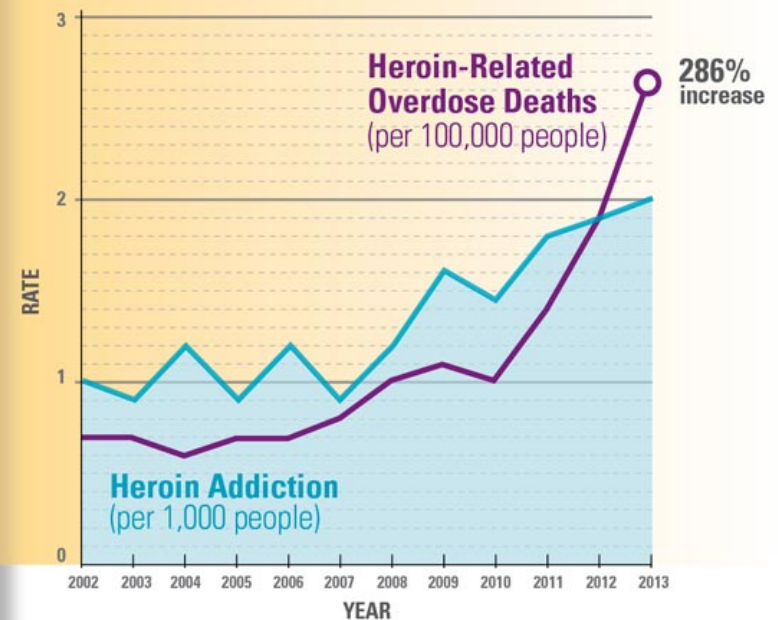
◆ All Poisoning Deaths ■ Opioid-related Poisoning Deaths ▲ Motor Vehicle-Related Injury Deaths



Heroin Use Has INCREASED Among Most Demographic Groups

	2002-2004*	2011-2013*	% CHANGE
SEX			
Male	2.4	3.6	50%
Female	0.8	1.6	100%
AGE, YEARS			
12-17	1.8	1.6	--
18-25	3.5	7.3	109%
26 or older	1.2	1.9	58%
RACE/ETHNICITY			
Non-Hispanic white	1.4	3	114%
Other	2	1.7	--
ANNUAL HOUSEHOLD INCOME			
Less than \$20,000	3.4	5.5	62%
\$20,000–\$49,999	1.3	2.3	77%
\$50,000 or more	1	1.6	60%
HEALTH INSURANCE COVERAGE			
None	4.2	6.7	60%
Medicaid	4.3	4.7	--
Private or other	0.8	1.3	63%

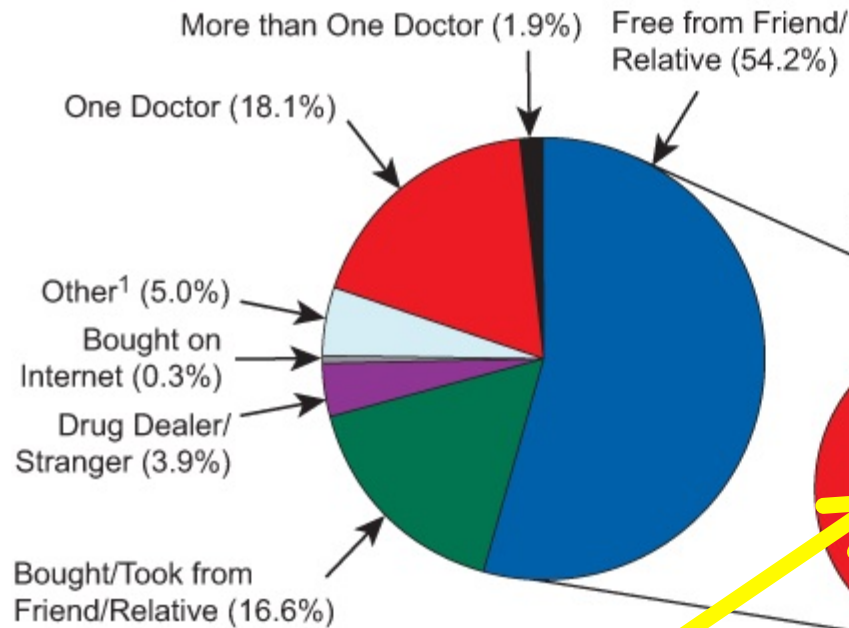
Heroin Addiction and Overdose Deaths are Climbing



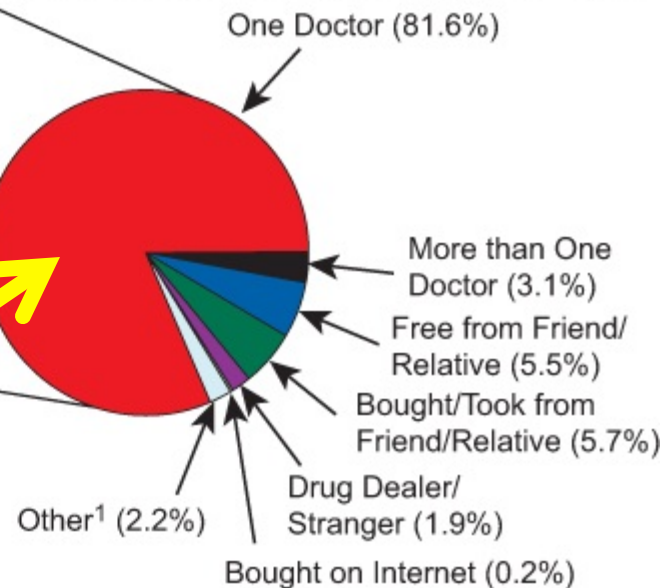
SOURCES: National Survey on Drug Use and Health (NSDUH), 2002-2013.
National Vital Statistics System, 2002-2013.

WHERE DO PATIENTS GET THEIR OPIATES?

Source Where User Obtained



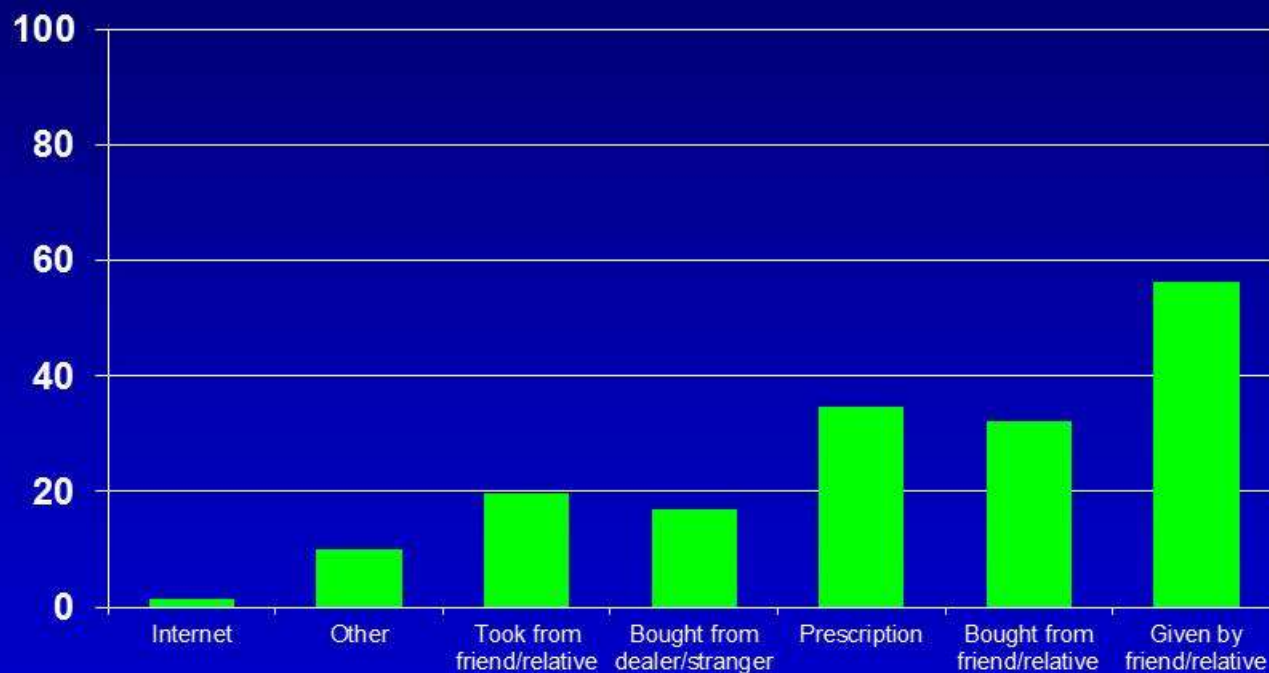
Source Where Friend/Relative Obtained



This is where we can intervene



Source of Prescription Narcotics Among Those Who Used in the Past Year, 12th Grade*



*Categories not mutually exclusive

SOURCE: University of Michigan, 2015 Monitoring the Future Study

NIDA (1969). High School and Youth Trends. Retrieved November 1, 2016, from <https://www.drugabuse.gov/publications/drugfacts/high-school-youth-trends>

WHO NEEDS TO BE TAPERED OR DISCONTINUED FROM OPIOIDS?

- Patients not improving with opioid treatment – inadequate analgesia
- Side effects or medical complications
- Chronic pain patients who need surgery
- Patients on high doses of opioids (>90MME/day)
- Patients you are concerned about opioid abuse or diversion

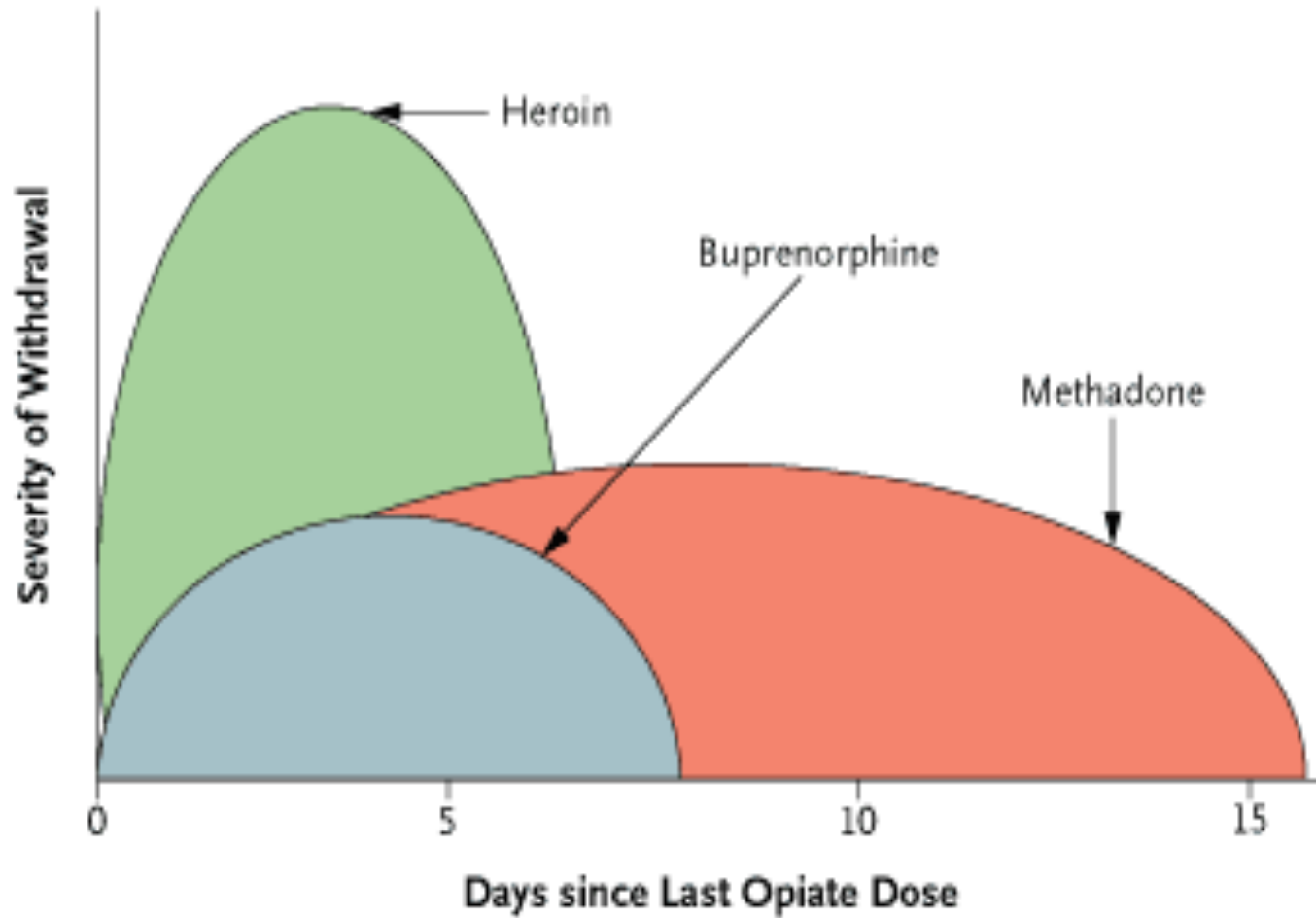


DETERMINANTS OF WITHDRAWAL RISK

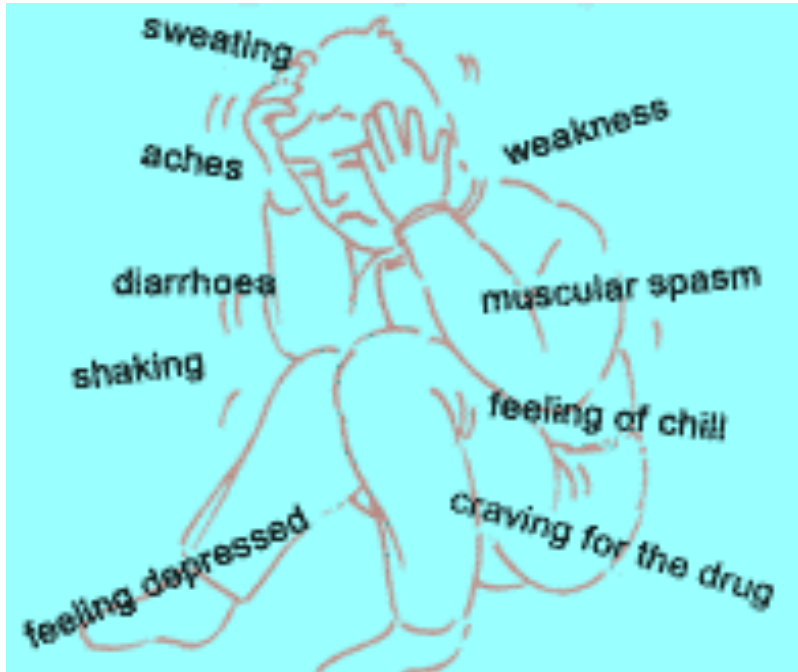
- Exposure to steady state level of medication
 - Neuro-adaptation to opioids
- Higher intensity withdrawal from:
 - Higher steady state levels
 - Longer term exposure
 - Faster rate of medication clearance
 - Long vs. short half life agents



OPIOID WITHDRAWAL TIMING/INTENSITY



CLINICAL OPIOID WITHDRAWAL SCALE (COWS)



5-12	Mild
13-24	Moderate
25-36	Moderately severe
≥ 36	Severe

- Pulse rate
- Sweating
- Restlessness
- Pupil Size
- Bone/joint aches
- Runny nose/tearing
- GI upset
- Tremor
- Yawning
- Anxiety/irritability
- Gooseflesh



TAPERING LONG-ACTING OPIOIDS

- Consider tapering long acting first
- Decrease by 10-20% each week
 - Long acting pill formulations dictate increments of dose decrease that are possible
 - Rate of decrease determined by circumstances of withdrawal: Emergency vs. controlled taper
- Allow supply of short acting medications to treat “breakthrough” symptoms
 - Build up alternative pain treatment modalities
 - Comfort medications
- Rotate patients on fentanyl to a different long-acting opioid



TAPERING SHORT-ACTING OPIOIDS

- Decide if you need a taper at all (is there physiological dependence?)
- Decrease strength of tablets each week
- Decrease by a specific number of tablets each week
- Consider substitution with long acting medication, then taper???



**KEEP
CALM
AND
TAPER
OFF**

MANAGE PATIENT EXPECTATIONS

- Ask the patient about prior experience tapering down or off opiates?
- Have they tried to do detox at home?
- What barriers do they perceive in reducing their dose or discontinuing their opioid?
- How long will they experience withdrawal symptoms?



TREATMENT: CLONIDINE

Oral Dosing

- Initial dosing: 0.1 mg po
Watch BP carefully
- Titrate up to 0.1 to 0.3 mg po q4-6 hours, then taper
- Risk: HYPOTENSION
- Effective adjuvant to other meds listed

Transdermal (Patch)

- more steady levels of med; avoid cyclic hypotension and rebound.
- Dosed one patch per week (\$10/patch).
- Dose range: 0.1-0.4 mg
- 24-48 hours to start to work-- can use oral clonidine initially while waiting for effect.



“COMFORT MEDS” (1)

Analgesics

- NSAIDS: Ibuprofen, Naproxen
- Acetaminophen
- **Avoid Tramadol:** it is opioid

Antispasmodics (abd cramps)

- Dicyclomine (Bentyl)
 - 20 mg 4 times per day
- Decongestants
- Pseudoephedrine
 - 30-60 mg 4 times daily
- Phenylephrine
 - 10 mg 4 times daily

Antiemetics

- Prochlorperazine (Compazine)
 - 5-10 mg 3 times daily
- Promethazine (Phenergan)
 - 25 mg 4 times daily
- Metochlopramide (Reglan)
 - 10 mg 4 times daily

Antidiarrheals:

- Kaolin with Pectin;
- PeptoBismol (Bismuth HCL)
- Loperamide (Immodium)



“COMFORT MEDS” (2)



Muscle relaxants:

- Cyclobenzaprine (Flexeril)
 - 5-10 mg 3 times daily
- Methocarbamol (Robaxin)
 - 1000-1500 mg up to QID
- Do not prescribe SOMA (Carisoprodol)
 - metabolized to barbiturate
 - Overdose, dependence and withdrawal risks

Sleep aids

- Diphenhydramine (Benadryl)
 - 50 mg
 - Trazodone
 - 50-100 mg
 - Amitriptyline
 - 50mg
 - Melatonin
 - ?Zolpidem?
-
- Avoid Benzodiazepines



CHALLENGES

- Involuntary Withdrawal
 - Set a reasonable schedule and stick to it
- Emergency Termination
- Recurrence of pain
 - Overlap of pain and withdrawal symptoms
 - Assess withdrawal intensity with scale
- Psychiatric instability
 - Overlap of pain and psychiatric symptoms
 - Suicidality
- Threatening behavior
 - “if you don’t prescribe this for me I will just have to get it on the street”
 - “I’m calling my lawyer”



AVOIDING “ABANDONMENT”

- Documentation of risk/benefit discussion and why treatment discontinued
 - *Allow for medically appropriate taper*
- Restate commitment to continue to work with patient on pain and addiction if needed
 - Refer to specialty pain treatment providers
 - Alert patient to addiction treatment resources
- See patient frequently and monitor for progress and safety
- Copy to patient and to chart



Patient example 1:

JOHN IS A 52 YO MALE WHO TRANSFERRED CARE TO YOU FROM A COLLEAGUE WITH FIBROMYALGIA AND OSTEOARTHRITIS. HE IS NOT ENGAGED IN ANY TREATMENT OTHER THAN OPIATES AND DOESN'T WANT TO BE. REVIEW OF HIS CHART SHOWS IMAGING WITH NO EVIDENCE OF OA. HE IS CURRENTLY ON 60MG OF MS CONTIN BID.



HOW SHOULD WE MANAGE THIS PATIENT?

- A – Continue on current medication regimen since patient is stable.
- B – Wean down the dose but continue with current opiate treatment.
- C – Patient has no indication for opiate treatment and is new to you so discontinue medications.
- D – Taper off the medication.



PLAN: WEAN OFF MS CONTIN

- Week 1: MS Contin 45mg BID
- Week 2: MS Contin 30mg BID
- Week 3: 15mg qAM, 30mg qPM
- Week 4: 15mg BID
- Week 5: 15mg daily
then discontinue



ALTERNATIVE WEANING PLAN

- Week 1+2: MS Contin 45 mg BID with 1 tablet of oxycodone 5mg for mid-day breakthrough symptoms – provide for each week
- Week 3+4: MS Contin 30mg BID
- Weeks 5+6: MS Contin 15mg qAM, 30mg qPM
- Weeks 7+8: MS Contin 15mg BID
- Week 9: MS Contin 15mg daily
- Week 10: Oxycodone 5mg BID
- Discontinue medications



PATIENT EXAMPLE 2:

- Lucy is a 33 yo female who underwent an orthopedic surgery and is now 8 weeks out from her procedure date. She is ready to taper off her hydrocodone/acetaminophen. She is taking 2 tabs every 6 hours as needed for pain and typically takes 8 tablets per day.



PLAN: WEAN OFF HYDROCODONE/ ACETAMINOPHEN

- Option 1: slow taper over 3 weeks by reducing 1 tablet per day every 3 days until off
- Option 2: rapid taper over 10 days
 - 1 tab every 6 hours for 1 day (4 tablets/day), then
 - 1 tab every 8 hours for 3 days (3 tablets/day), then
 - 1 tab every 12 hours for 3 days (2 tablets/day), then
 - 1 tab every day for 3 days (1 tablet/day), then
 - Discontinue



PATIENT EXAMPLE 3:

- Doris is a 70 yo female with spinal stenosis, degenerative disc disease at multiple levels and severe OA of her knees which all limit her function. She is on Oxycontin 60mg BID and oxycodone for breakthrough pain 5mg TID. Pain score is always 6-7/10.



HOW SHOULD WE MANAGE THIS PATIENT?

- A – Patient is elderly so we should taper her off the medication.
- B – Taper down the dose to get below 90MME per day.
- C – Make sure a medication agreement is signed and continue on her current dose.
- D – Discontinue the medication at this time and provide comfort medications.



PLAN: WEAN DOWN

- Month 1: Oxycodone 40mg BID and oxycodone 10 mg TID PRN pain
- Month 2: Oxycodone 40mg BID and oxycodone 5mg TID PRN pain
- Month 3: Oxycodone 30mg BID and oxycodone 5mg TID PRN pain
- Month 4: Oxycodone 30mg BID and oxycodone 5mg in the afternoon PRN pain
- Month 5: Oxycodone 30mg BID and 10 tablets per month of oxycodone 5mg as needed for breakthrough pain



PATIENT EXAMPLE 4:

- David is a 25 yo male who started using oxycodone after knee surgery as a high school senior. He continued to use opiates sporadically after he had recovered from surgery but more recently has used oxycontin 10mg for 6 months. He is taking 8-10 tablets per day and when he misses a day, he feels very sick. He wants to stop using opiates.



HOW SHOULD WE (PCP) MANAGE THIS PATIENT?

- A – Taper the patient off of oxycontin slowly with comfort medications available.
- B – Prescribe methadone to treat his addiction.
- C – Refer him to a detox facility for inpatient treatment.
- D – Avoid long acting opiates and treat him with a lower dose short acting opiate as needed for pain.



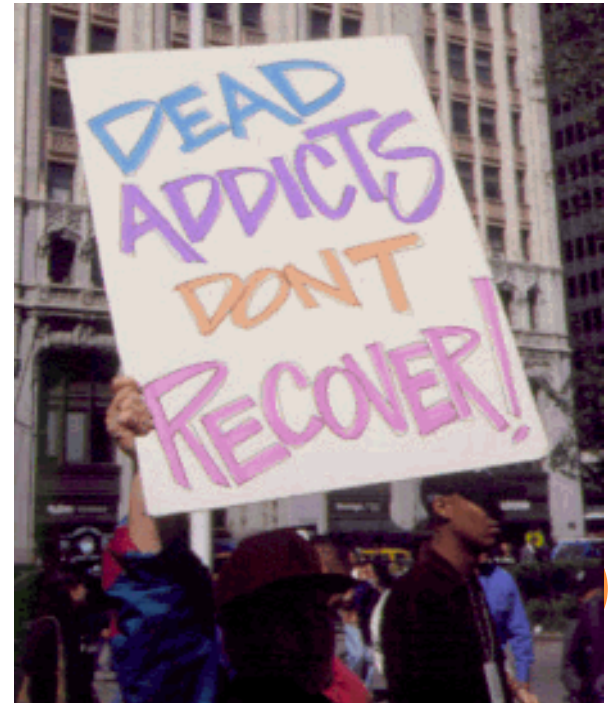
INPATIENT DETOXIFICATION

- Usually patient initiated and voluntary
- Short length of stay: 4-5 days
 - Insurance coverage varies
- Diagnosis of opioid addiction, not just physiological dependence
 - Addiction focused, not pain
- Nursing managed
 - No labs/Xrays/Pharmacy
- ***Reserve for the most unstable or unsafe***
 - May be difficult to place patients with serious mental health or medical co-morbidities



OPIOID AGONIST TREATMENT METHADONE PROGRAM (OTP)

- Daily observed dosing of opioid medication
- Monitoring for drug and alcohol use
- Dosing titrated to withdrawal symptoms
- Gradual taper over time
- Mandated behavioral tx

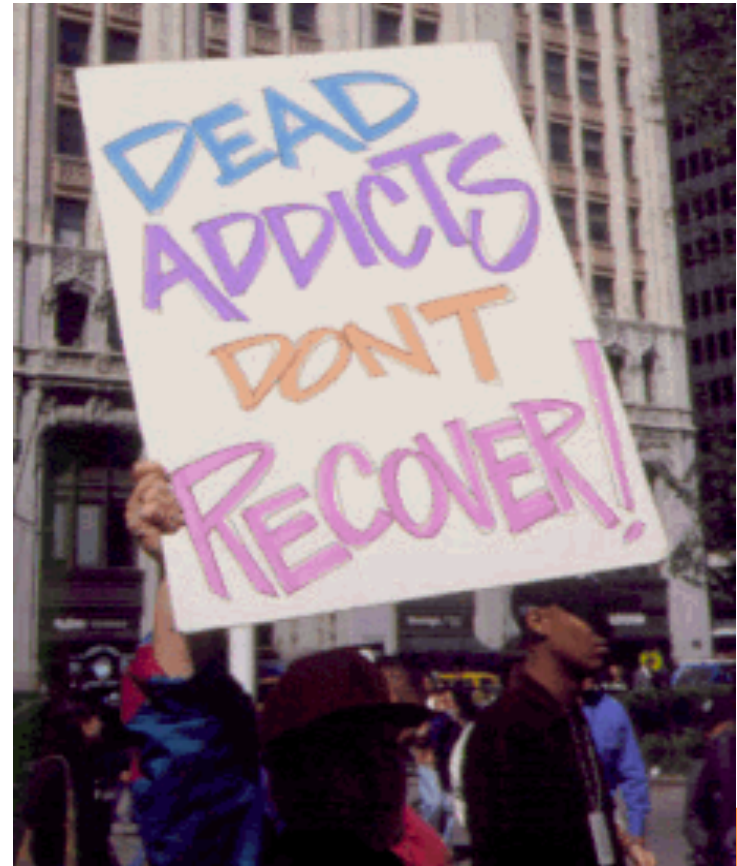


WHY METHADONE MAINTENANCE?

BECAUSE IT WORKS...

- 80-90% relapse to drug use without it
- Increased treatment retention
- 80% decreases in drug use, crime
- 70% decrease all cause death rate

NIH Consensus Statement
JAMA 1998



OPIOID AGONIST THERAPY: BUPRENORPHINE

“PROS”

- Partial opioid agonist
 - Lower overdose risk
 - ? Lower intensity withdrawal
- Mixed with naloxone
- Office-based treatment
- Patients control dosing times
- No “take home” restrictions
- Maintain or detox

“CONS”

- Weaker agonist activity
- Blocks out other opioids
- 8 mg and 2 mg tabs only
- Sublingual formulation only
- Limited prescriber availability
- Limited insurance coverage
- Must be in withdrawal to initiate treatment



Suboxone Tablets 8mg. and 2mg



TRANSITIONING PAIN PATIENTS TO OAT: OTHER CAVEATS

Not pain treatment

- Patients should not expect analgesia
- Addiction recovery focused, not pain focused treatment environment
- Must meet DSM IV criteria for ***opioid addiction***
 - not just abuse of other drugs
- Required behavioral treatment/drug testing
- Concomitant opioid pain meds not allowed

No direct transfer of care or dosing

- Most patients must be in withdrawal (Bup)
- Must start from low dose and gradually build up (methadone)



FINDING TREATMENT

- SAMHSA Treatment Facility Locator
 - <http://dasis3.samhsa.gov/>
- Massachusetts State Helpline 800-327-5050
 - www.helpline-online.com
- Buprenorphine Treatment
 - MA State hotline: 617-414-6926
 - <http://buprenorphine.samhsa.gov/>
 - www.naabt.org



SUMMARY

- Identify patients who need to be tapered or discontinued from opioids.
- Utilize the weaning methods as discussed
- Recognize and treat withdrawal symptoms with “comfort meds”.
- Refer patients for inpatient detox or to an addiction specialist as needed for additional support



REFERENCES

- CDC. “CDC Guidelines for Prescribing Opioids for Chronic Pain – United States, 2016” MMWR. 2016; 65 (1).
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