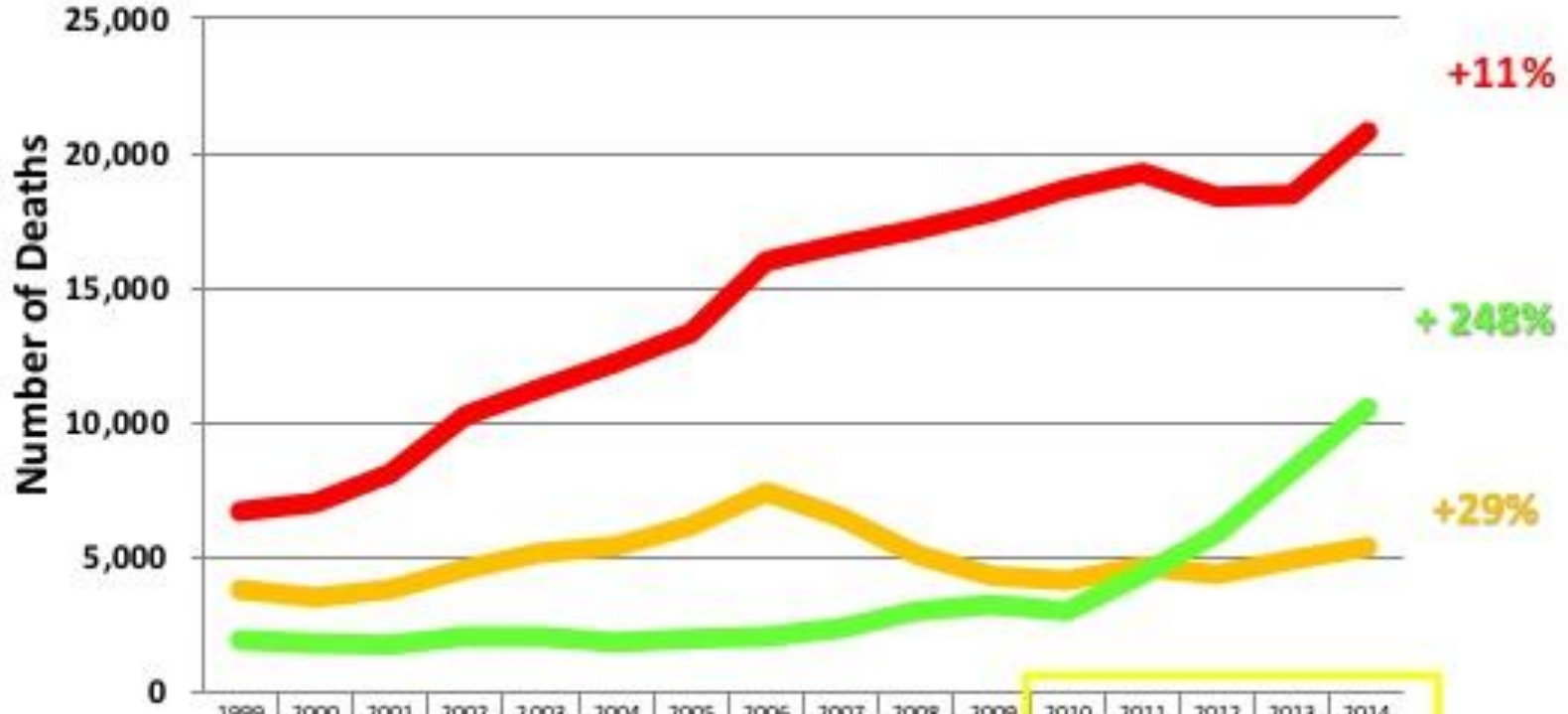
WEANING OFF OPIATES

David Gilchrist, MD, MBA, FAAFP, CPE

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

Drug Poisoning Deaths Involving Opioid Analgesics, Cocaine and Heroin: United States, 1999–2014



	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
opioid analgesic	6,731	7,053	8,132	10,297	11,295	12,243	13,355	16,009	16,624	17,184	17,841	18,690	19,286	18,389	18,483	20,808
cocaine	3,822	3,544	3,833	4,599	5,199	5,443	6,208	7,448	6,512	5,129	4,350	4,183	4,681	4,404	4,944	5,415
heroin*	1,963	1,843	1,784	2,092	2,084	1,879	2,010	2,089	2,402	3,041	3,279	3,038	4,397	5,927	8,260	10,574

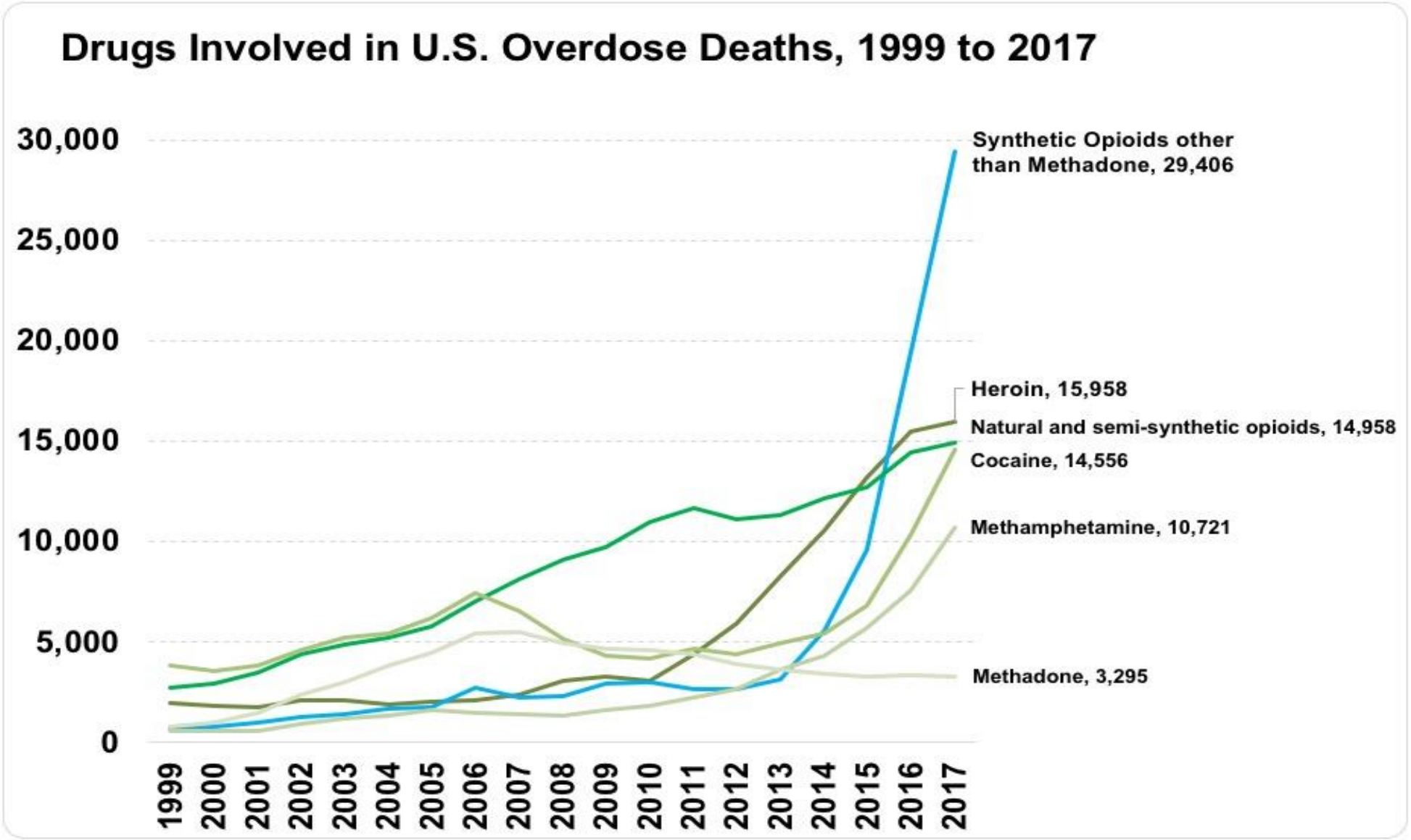
Note: Not all drug poisoning deaths specify the drug(s) involved, and a death may involve more than one specific substance. The rise in 2005-2006 in opioid deaths is related to non-pharmaceutical fentanyl (see http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5729a1.htm). *Heroin includes opium.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. *Multiple Cause of Death 1999-2014* on CDC WONDER Online Database, released 2015. Data were extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on Dec 9, 2015.

12/2015

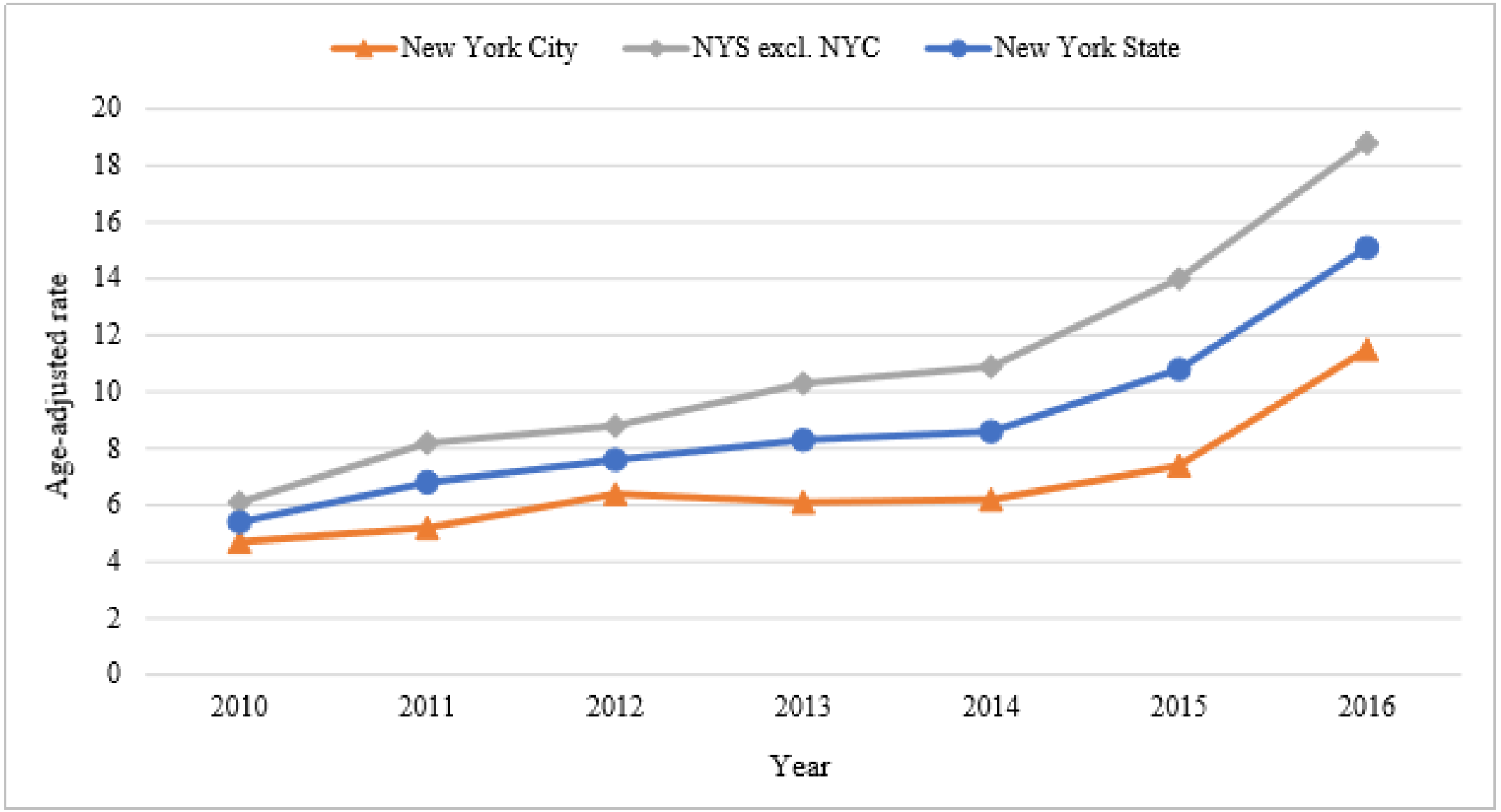
#RxSummit

NATIONAL RX DRUG ABUSE & HEROIN SUMMIT



Source: National Institute on Drug Abuse

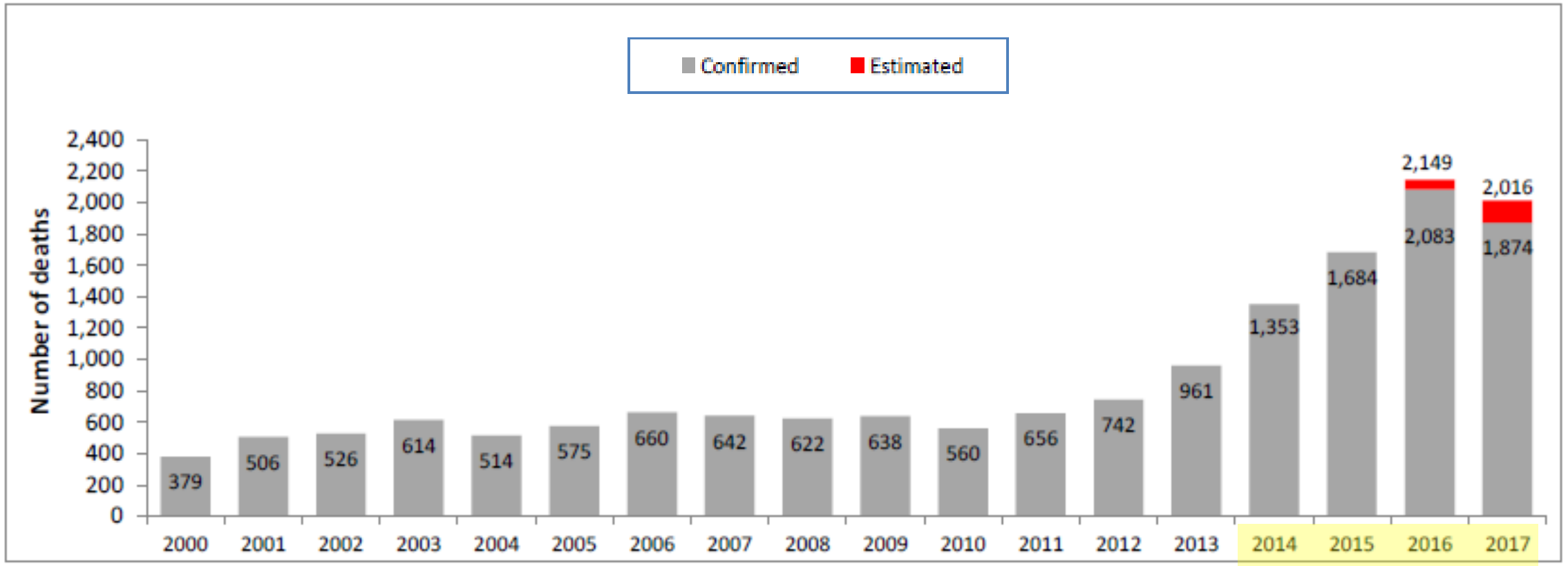
Figure 1.5 Overdose deaths involving any opioid, age-adjusted rate per 100,000 population, by region, New York State, 2010-2016



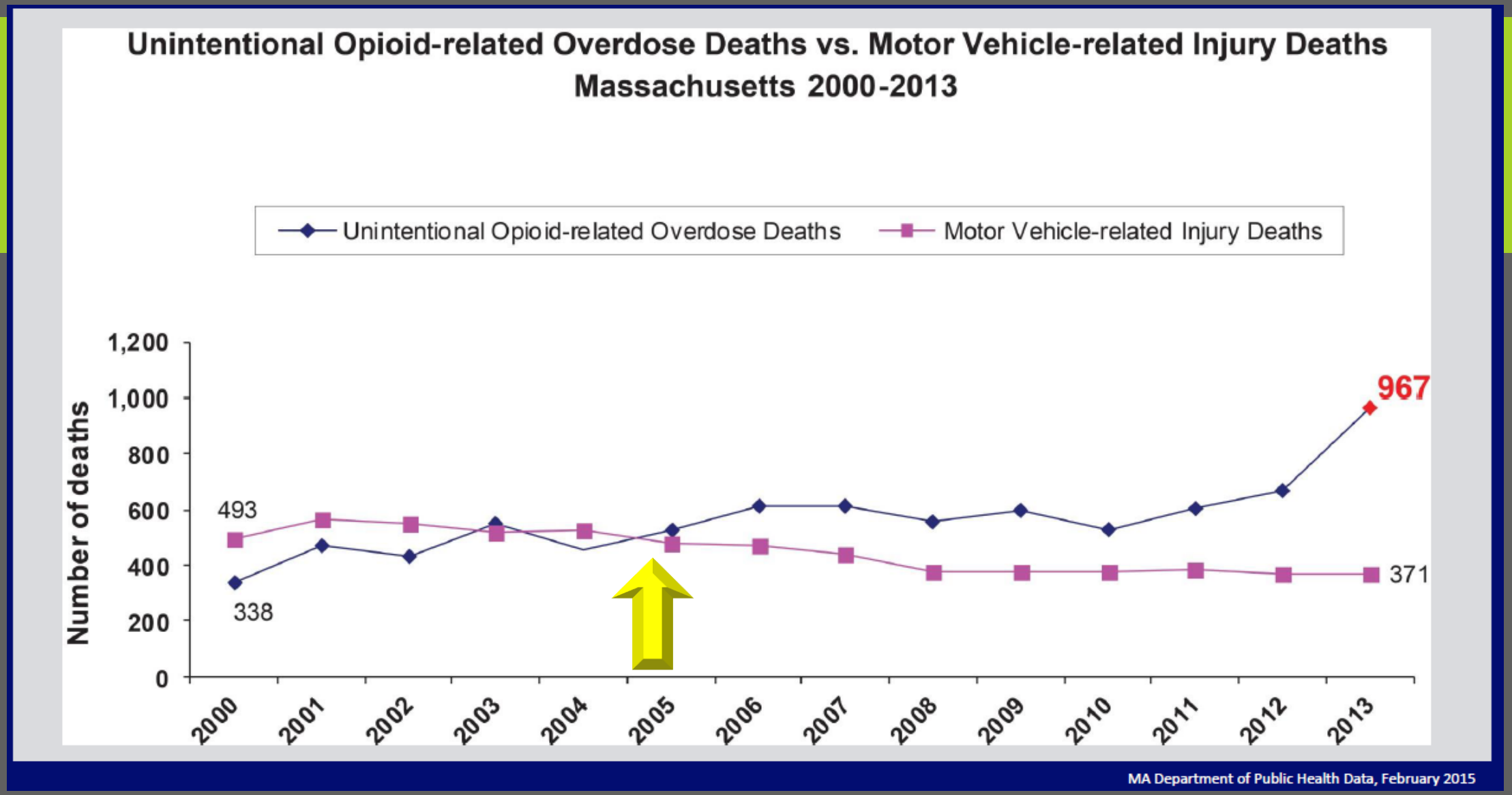
Data source: CDC WONDER; Data accessed August 2018

For complete data, see Appendix: Data Table 1.5.

Figure 2. Opioid[1]-Related Deaths, All Intents Massachusetts Residents: 2000 - 2017

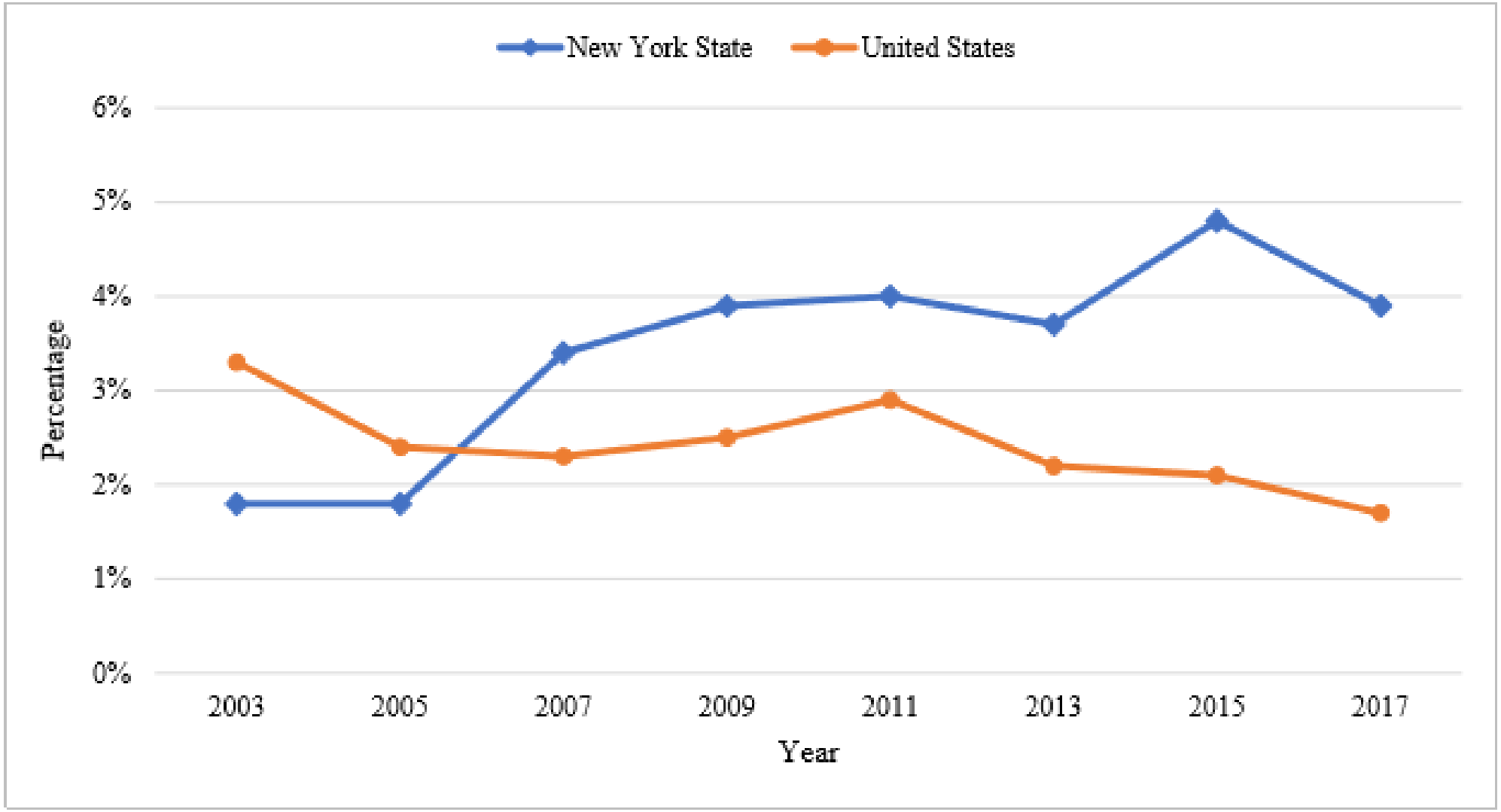


Source: Massachusetts Department of Public Health Posted August 2018



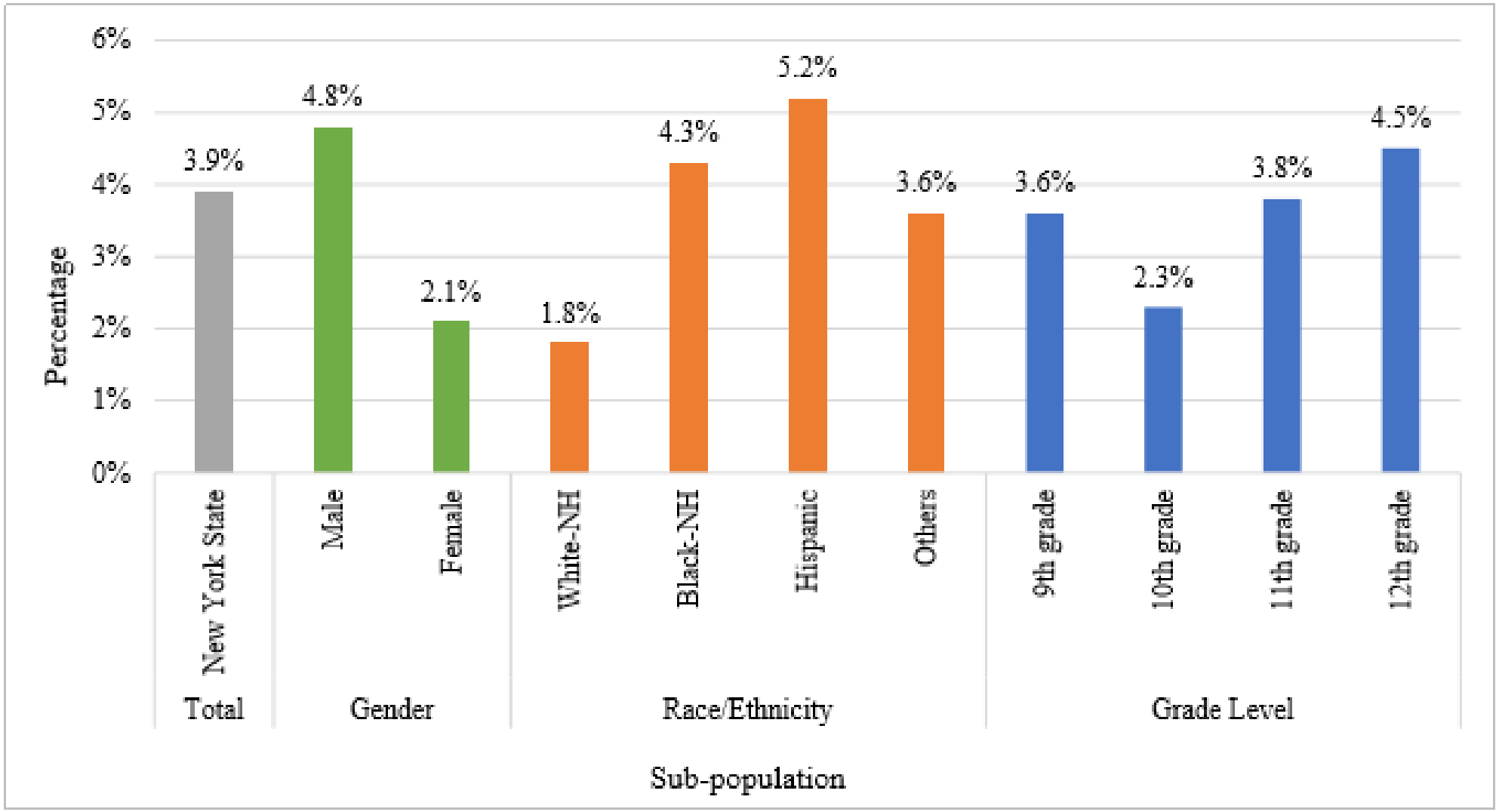
Source: Massachusetts Department of Public Health Data, February 2015

Figure 6.1 Percentage of high school students reporting ever using heroin, New York State and United States, 2003–2017

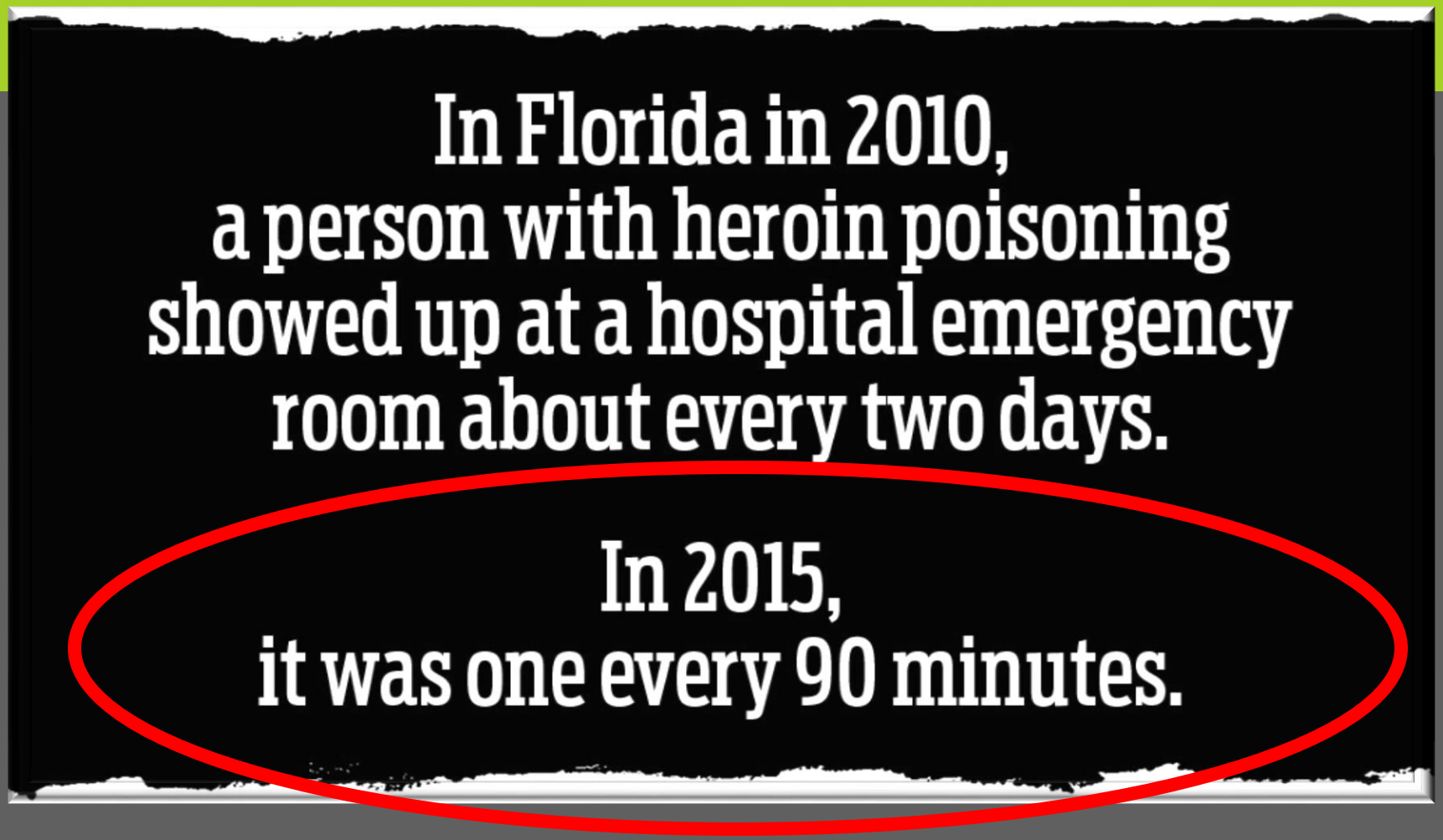


Data source: Youth Risk Behavior Surveillance System (YRBSS); Data accessed August 2018
Survey Question: During your life, how many times have you used heroin (also called smack, junk, or China White)?
For complete data, see Appendix: Data Table 6.1.

Figure 6.2 Percentage of high school students reporting ever using heroin, by subpopulation, New York State, 2017



Data source: Youth Risk Behavior Surveillance System (YRBSS); Data accessed August 2018
Survey Question: During your life, how many times have you used heroin (also called smack, junk, or China White)?
For complete data, see Appendix: Data Table 6.2.

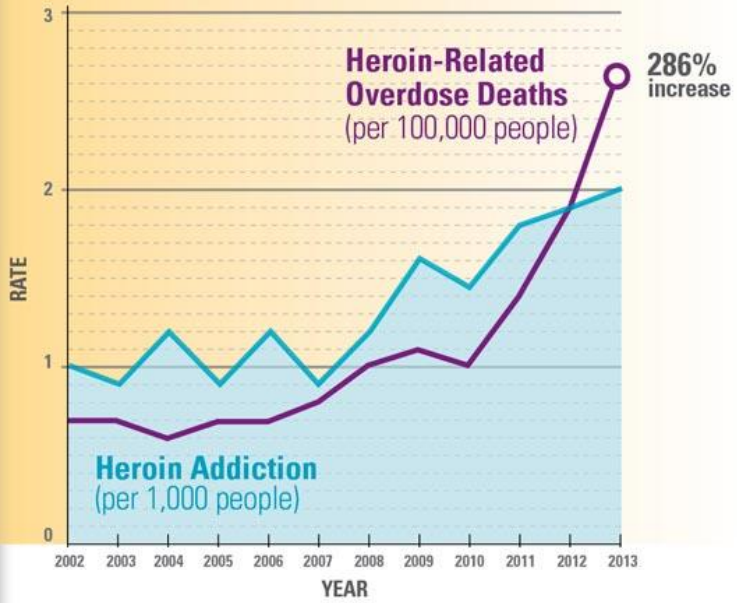


Source: https://www.palmbeachpost.com/wall/?ecmp=newspaper_email/##

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%

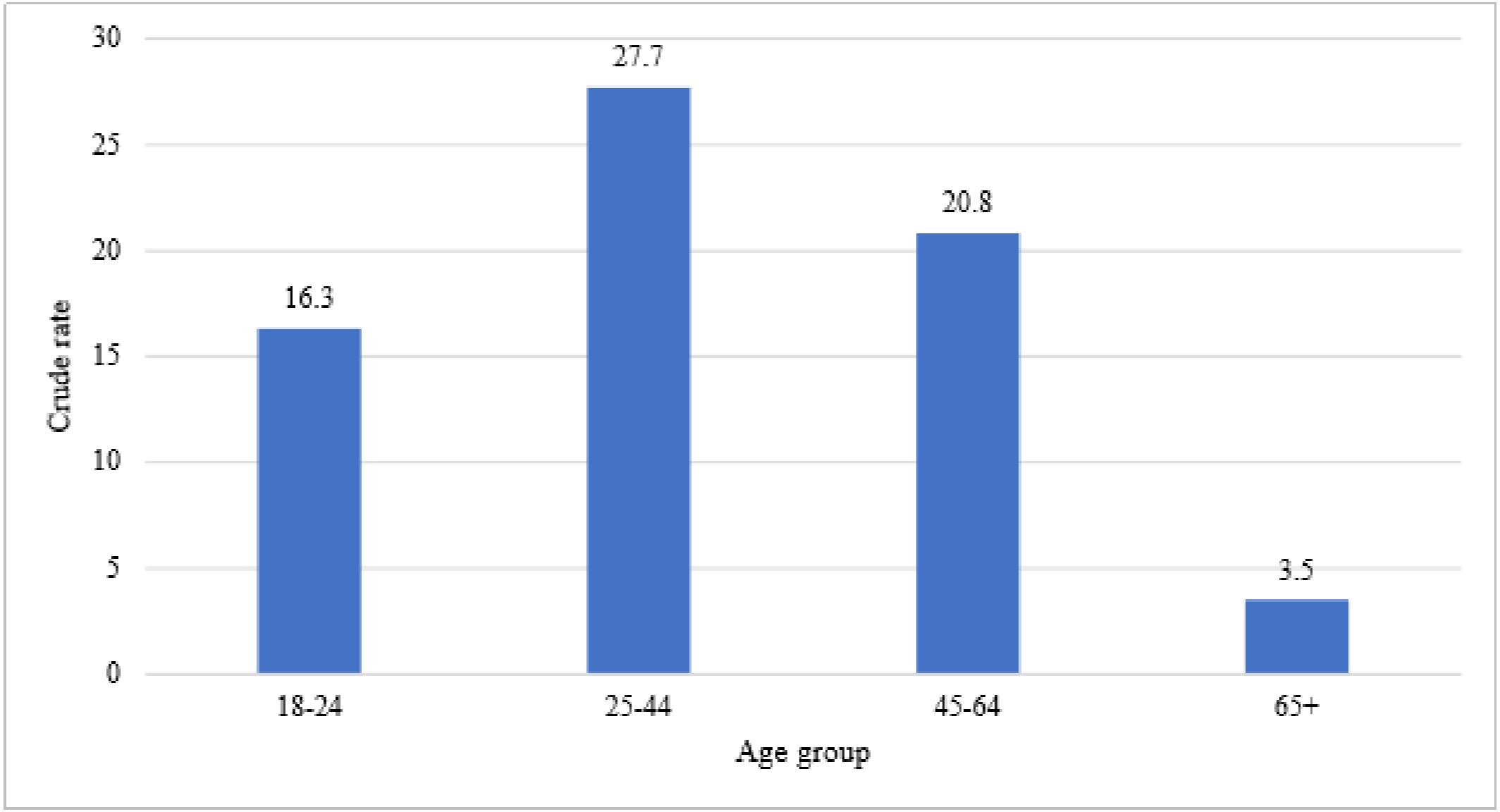
Heroin Addiction and Overdose Deaths are Climbing



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

WHO HAS BEEN HIT BY THE OPIATE EPIDEMIC?

Figure 1.8 Overdose deaths involving any opioid, crude rate per 100,000 population, by age group, New York State, 2016



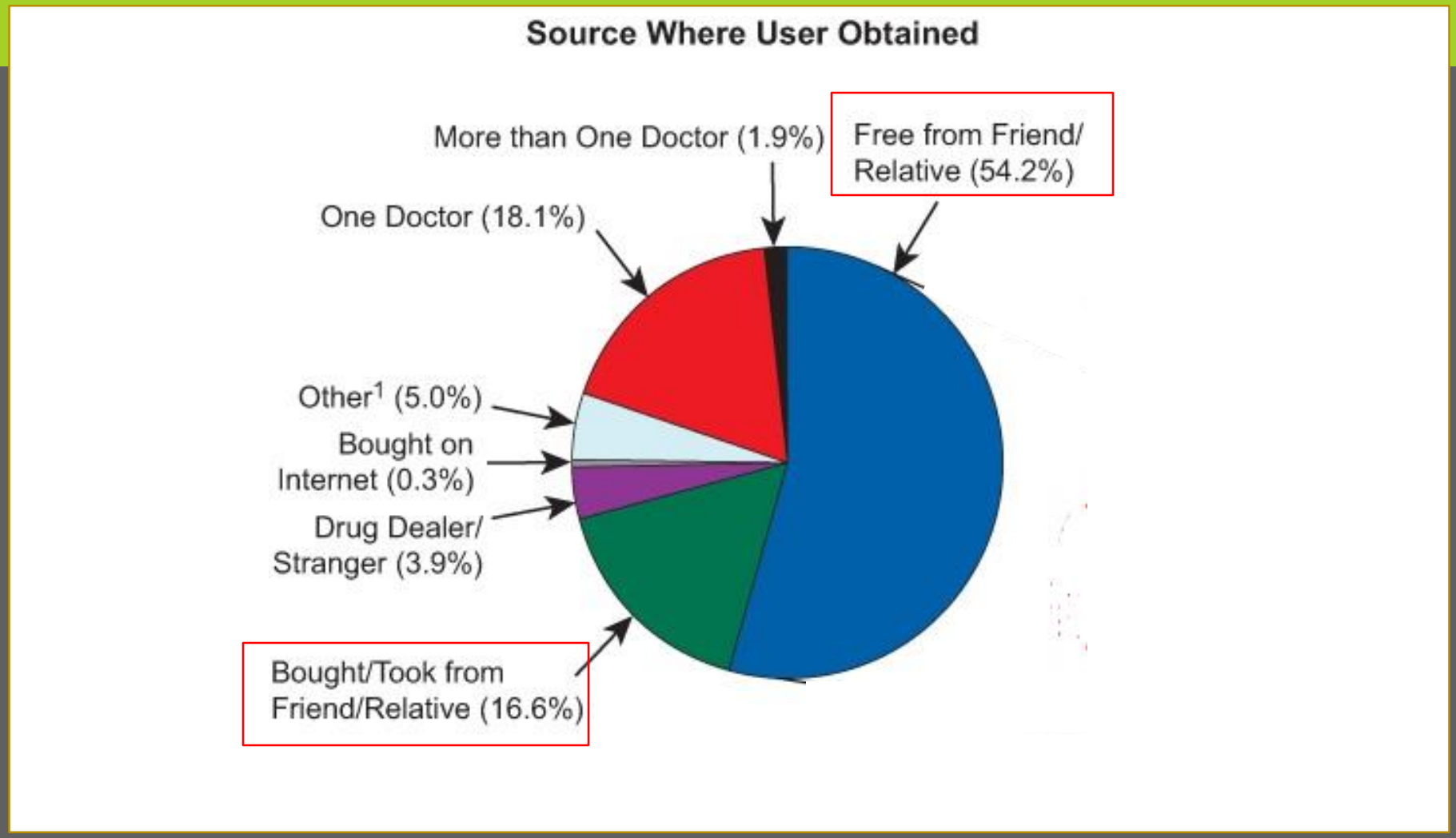
Data source: CDC WONDER; Data accessed August 2018

For complete data, see Appendix: Data Table 1.8.

- "In 2016, the average lifespan was 78.6 years in the U.S., a drop of one-tenth of a year from 2015. This marks the second year in a row that life expectancy has fallen, and the first two-year decline since the early 1960s."

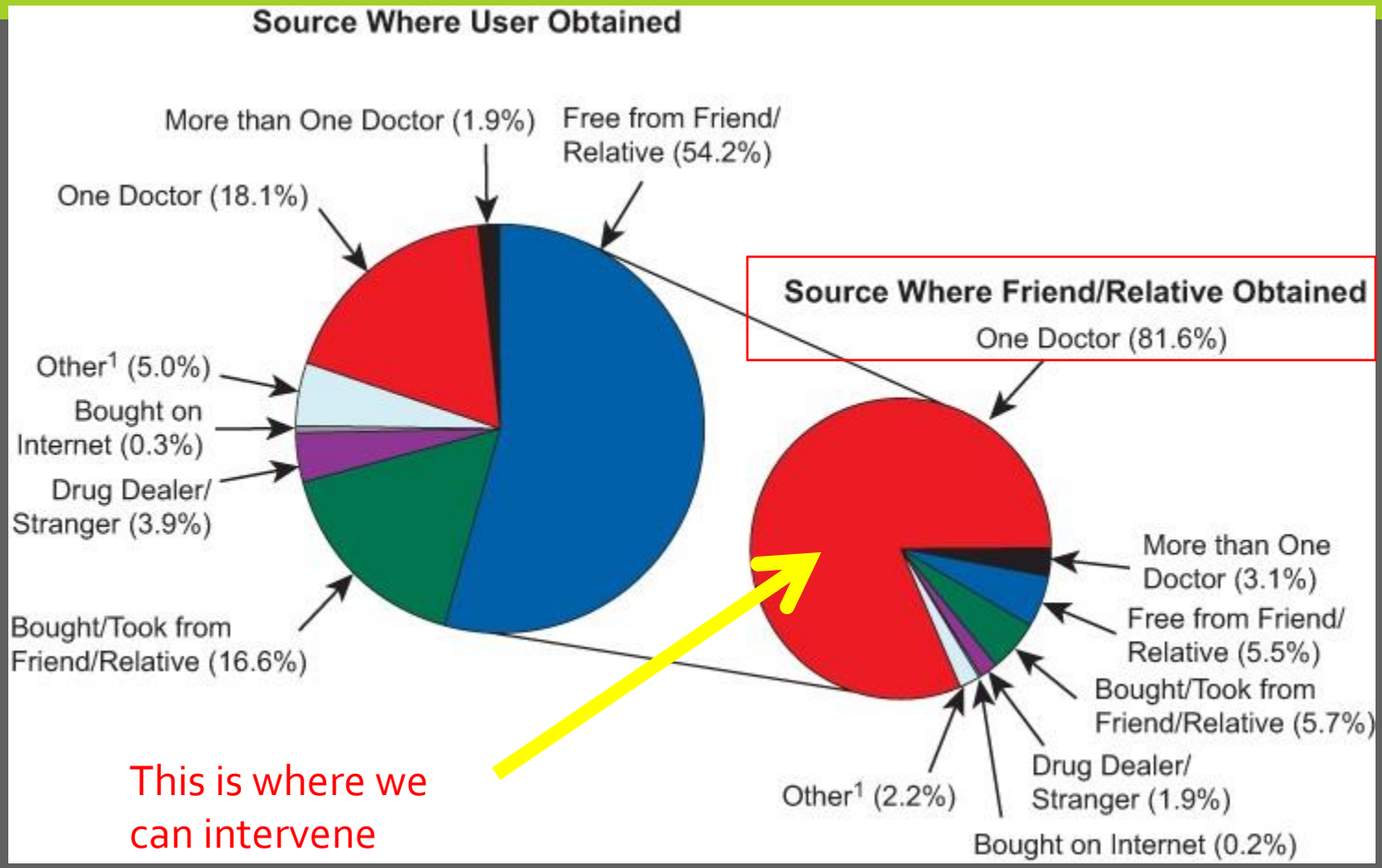
https://www.consumerreports.org/drug-use/opioid-overdoses-life-expectancy-decline/

WHERE DO PATIENTS GET THEIR OPIATES?



Source: www.samhsa.gov **Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings**

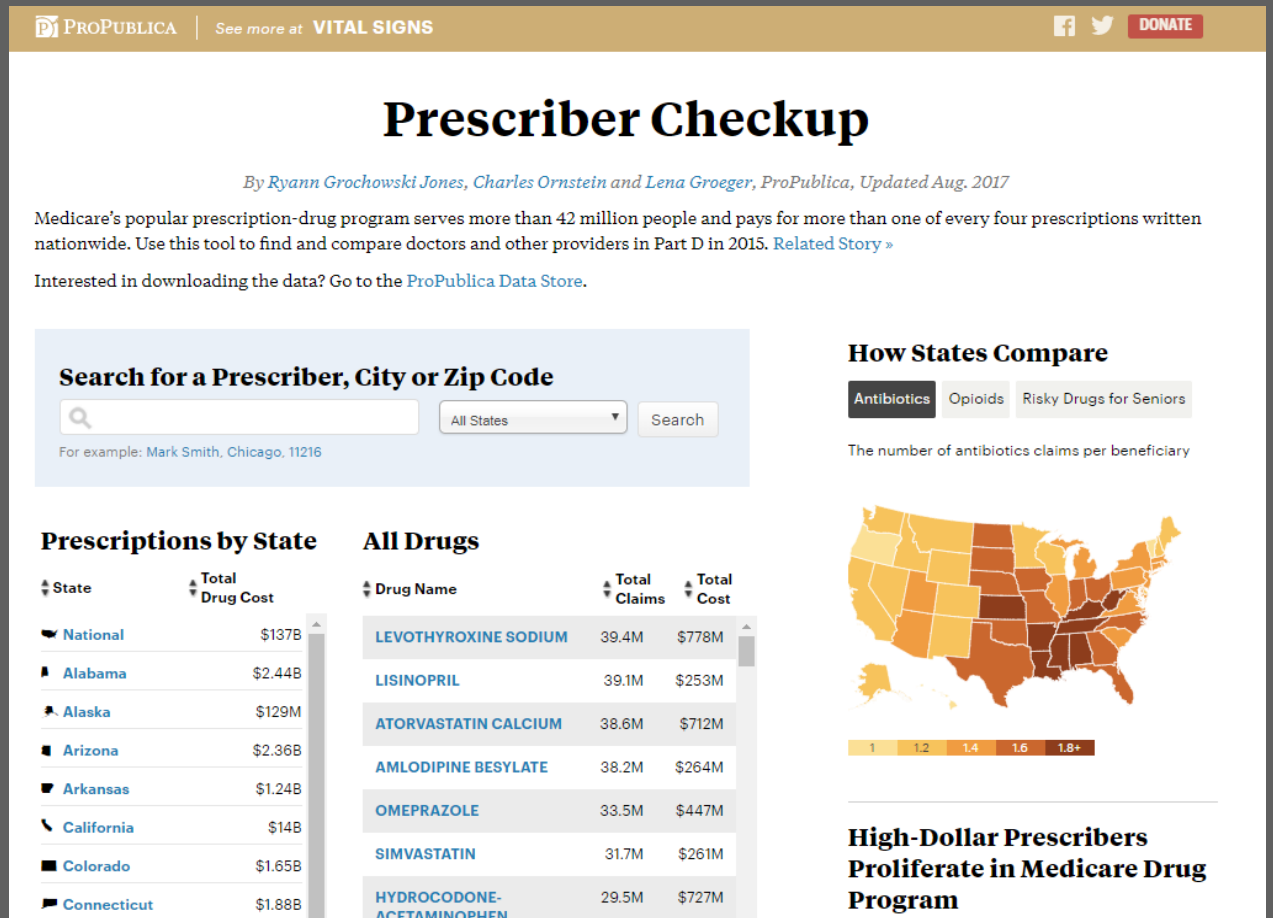
WHERE DO PATIENTS GET THEIR OPIATES?



Source: www.samhsa.gov **Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings**

PROPUBLICA

- https://projects.propublica.org/checkup/



ProPublica | See more at VITAL SIGNS

DONATE

Prescriber Checkup

By Ryann Grochowski Jones, Charles Ornstein and Lena Groeger, ProPublica, Updated Aug. 2017

Medicare's popular prescription-drug program serves more than 42 million people and pays for more than one of every four prescriptions written nationwide. Use this tool to find and compare doctors and other providers in Part D in 2015. Related Story »

Interested in downloading the data? Go to the ProPublica Data Store.

Search for a Prescriber, City or Zip Code

All States | Search

For example: Mark Smith, Chicago, 11216

Prescriptions by State

State	Total Drug Cost
National	$137B
Alabama	$2.44B
Alaska	$129M
Arizona	$2.36B
Arkansas	$1.24B
California	$14B
Colorado	$1.65B
Connecticut	$1.88B

All Drugs

Drug Name	Total Claims	Total Cost
LEVOTHYROXINE SODIUM	39.4M	$778M
LISINOPRIL	39.1M	$253M
ATORVASTATIN CALCIUM	38.6M	$712M
AMLODIPINE BESYLATE	38.2M	$264M
OMEPRAZOLE	33.5M	$447M
SIMVASTATIN	31.7M	$261M
HYDROCODONE-ACETAMINOPHEN	29.5M	$727M

How States Compare

Antibiotics | Opioids | Risky Drugs for Seniors

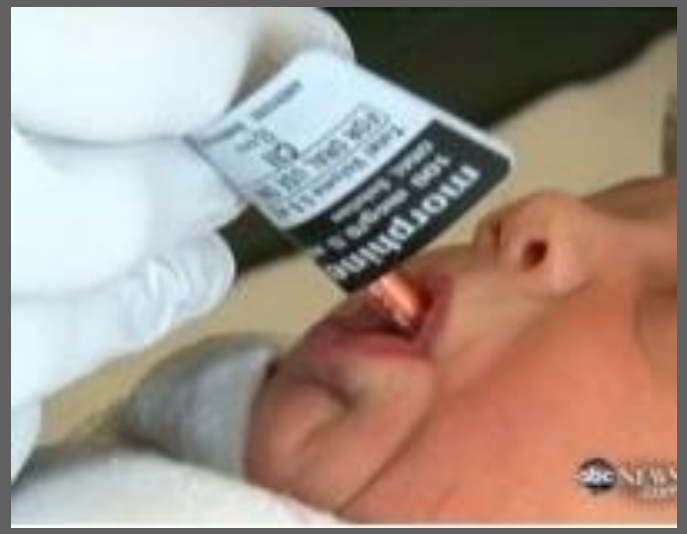
The number of antibiotics claims per beneficiary

1 1.2 1.4 1.6 1.8+

High-Dollar Prescribers Proliferate in Medicare Drug Program

In the US, a baby is born dependent on opioids every 19 minutes.

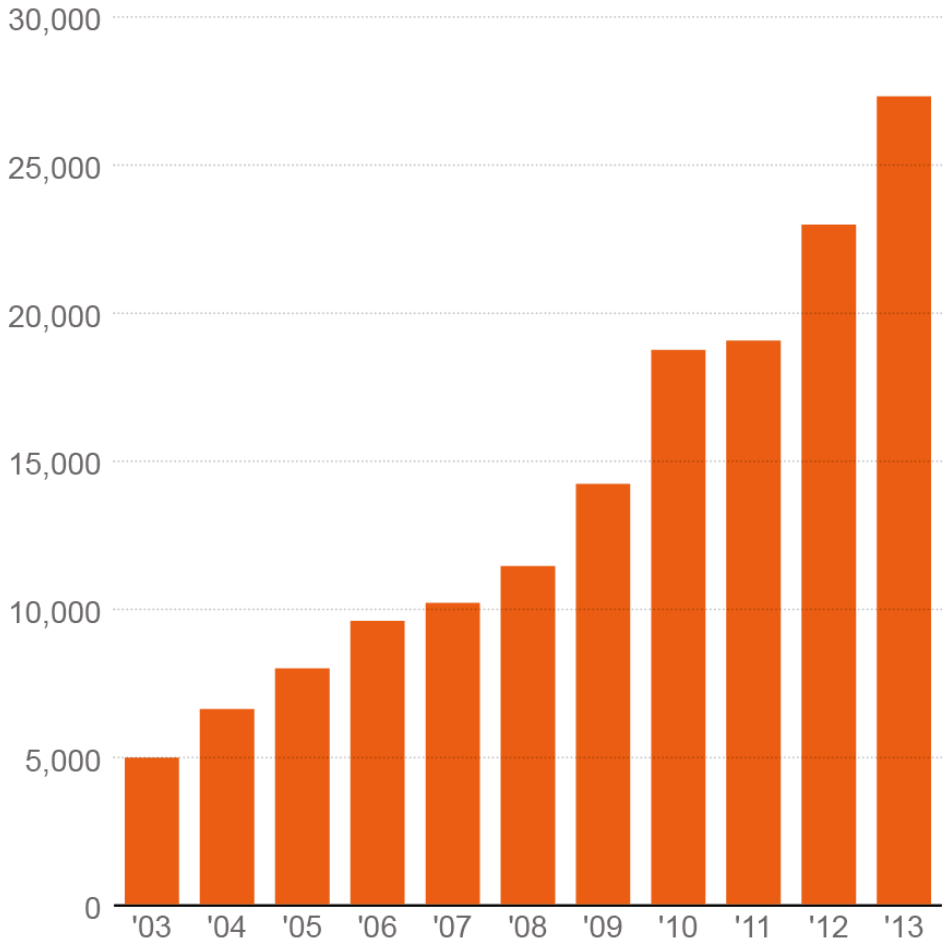
EVEN OUR MOST VULNERABLE PATIENTS ARE EFFECTED



Rise in drug-dependent newborns

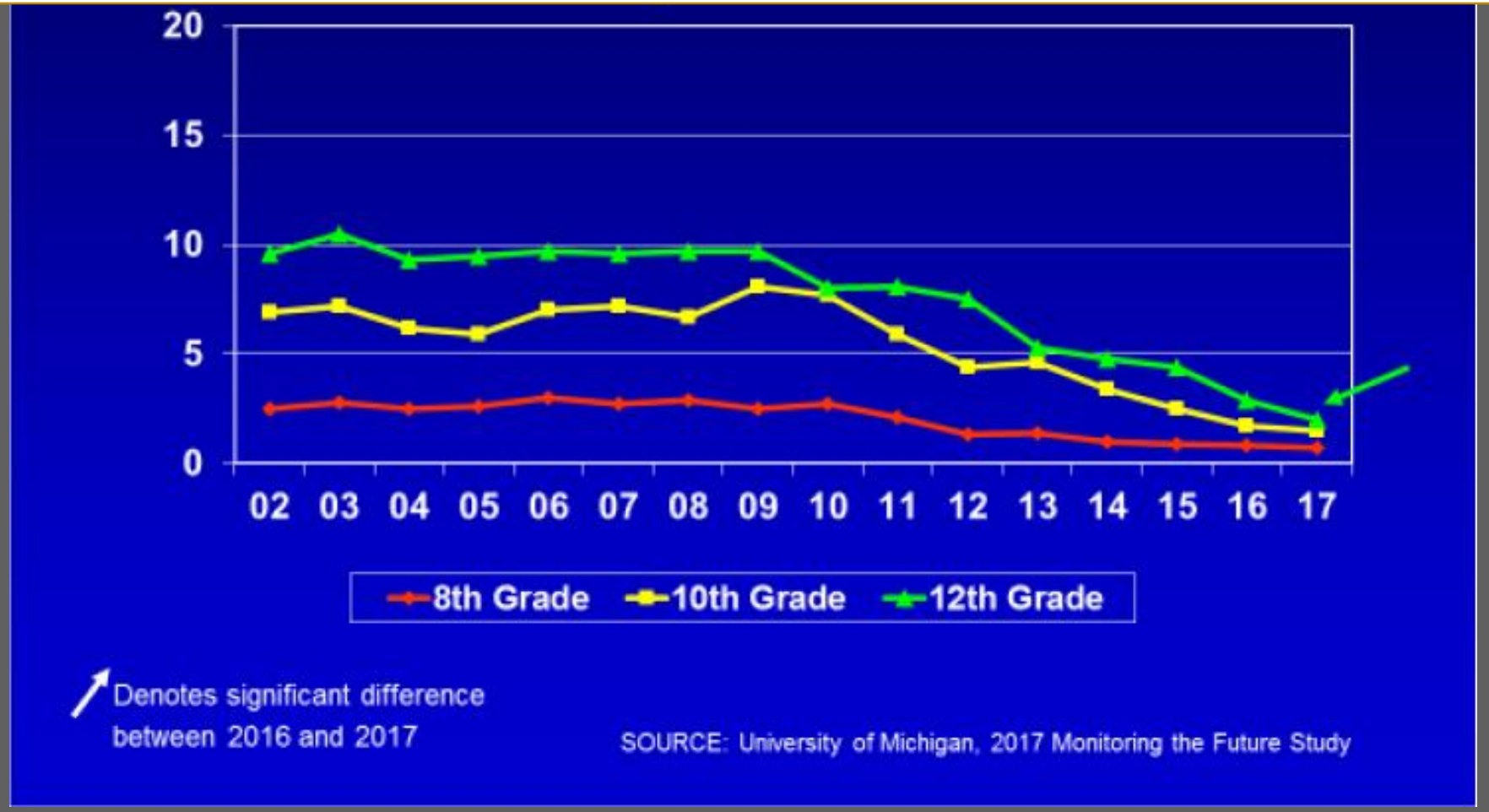
Since 2003, when Congress called on states to intervene in cases of drug-dependent babies, diagnoses of Neonatal Abstinence Syndrome, also known as newborn drug withdrawal syndrome, have increased dramatically.

NUMBER OF BABIES DIAGNOSED WITH NEONATAL ABSTINENCE SYNDROME (NAS)



Source: Reuters analysis of U.S. Department of Health and Human Services data

Percent of Students Reporting Nonmedical Use of Hydrocodone in Past Year, by Grade



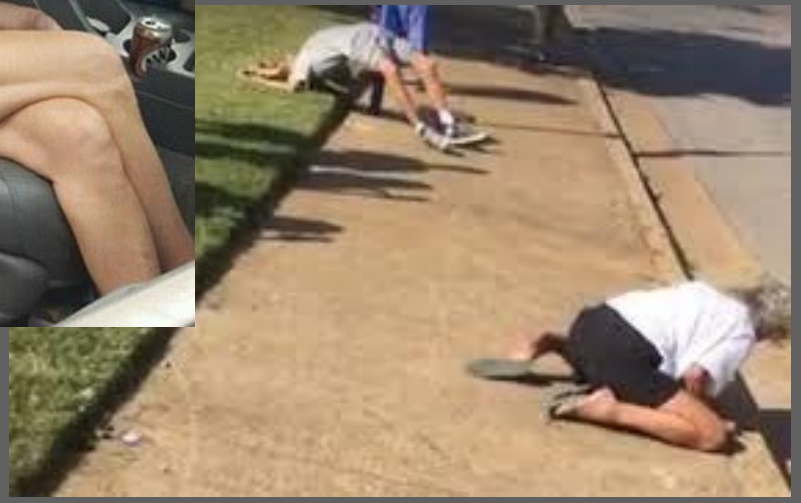
DIVERSION OF PRESCRIPTION PAINKILLERS IS THE SINGLE MOST COMMON ROUTE TO ADDICTION:

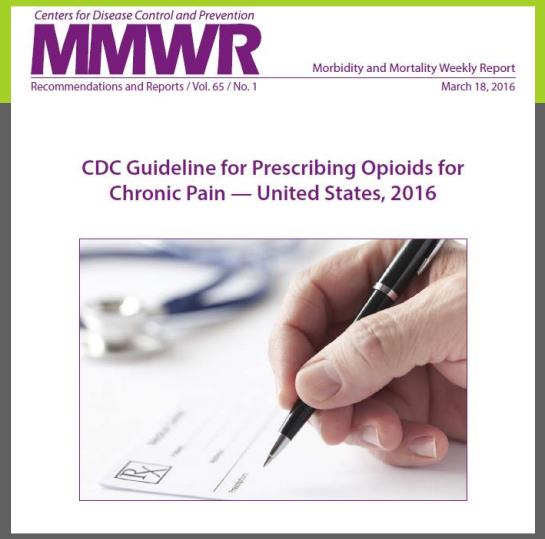
Source of Pain Relievers for Most Recent Nonmedical Use
Users Age 12+

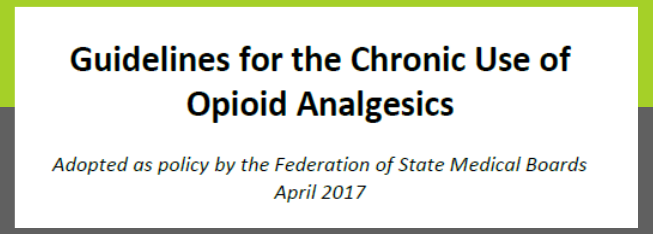
Free or bought from friend/relative	**61.5%**
Took from friend/relative without asking	**4.4%**
Prescribed by one doctor	22.1%
Drug dealer/stranger	4.8%
Other	4.1%
Prescribed by more than one doctor	3.1%

Source: Lipari, Rachel N., Ph.D., and Hughes, Arthur, M.S., "How People Obtain the Prescription Pain Relievers They Misuse,"The CBHSQ Report, www.samhsa.gov, January 12, 2017


© East Liverpool Police Department





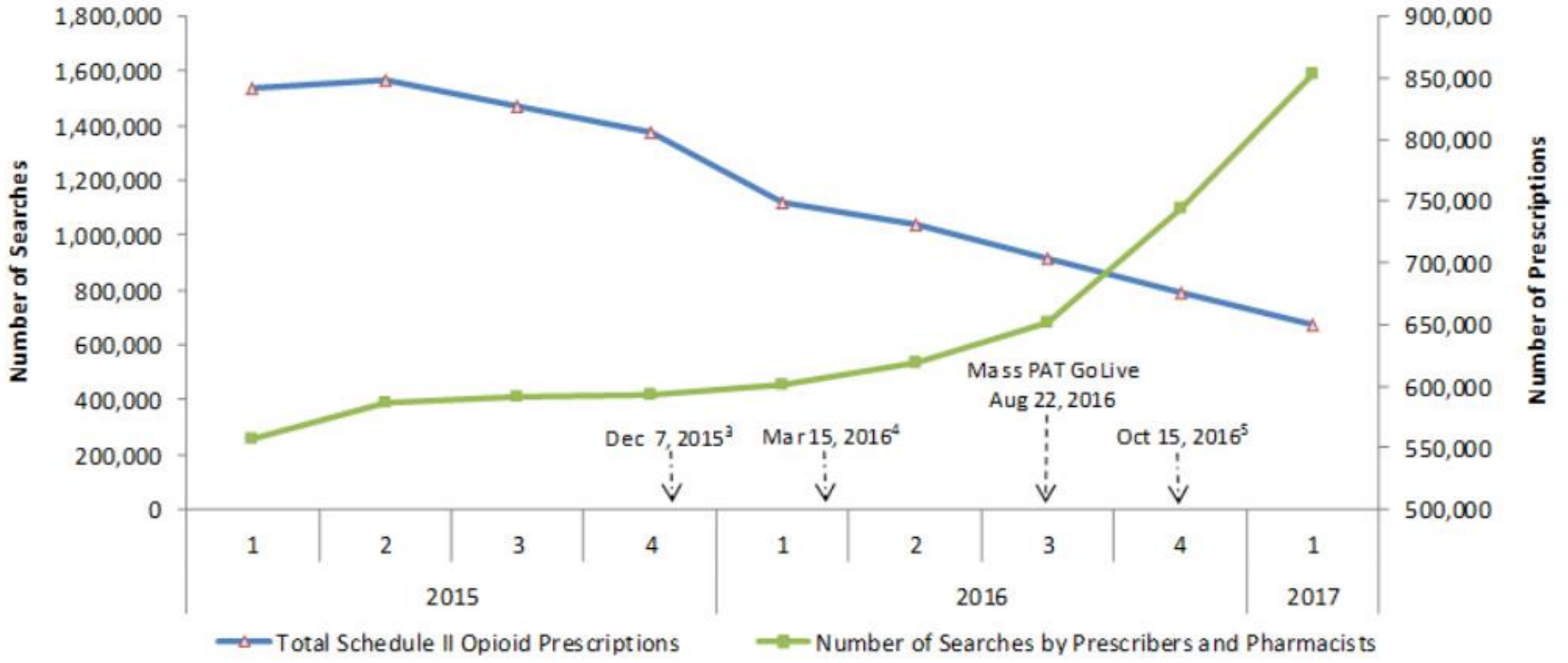


KNOW YOUR GUIDELINES

SAFE PRESCRIBING OF OPIATES

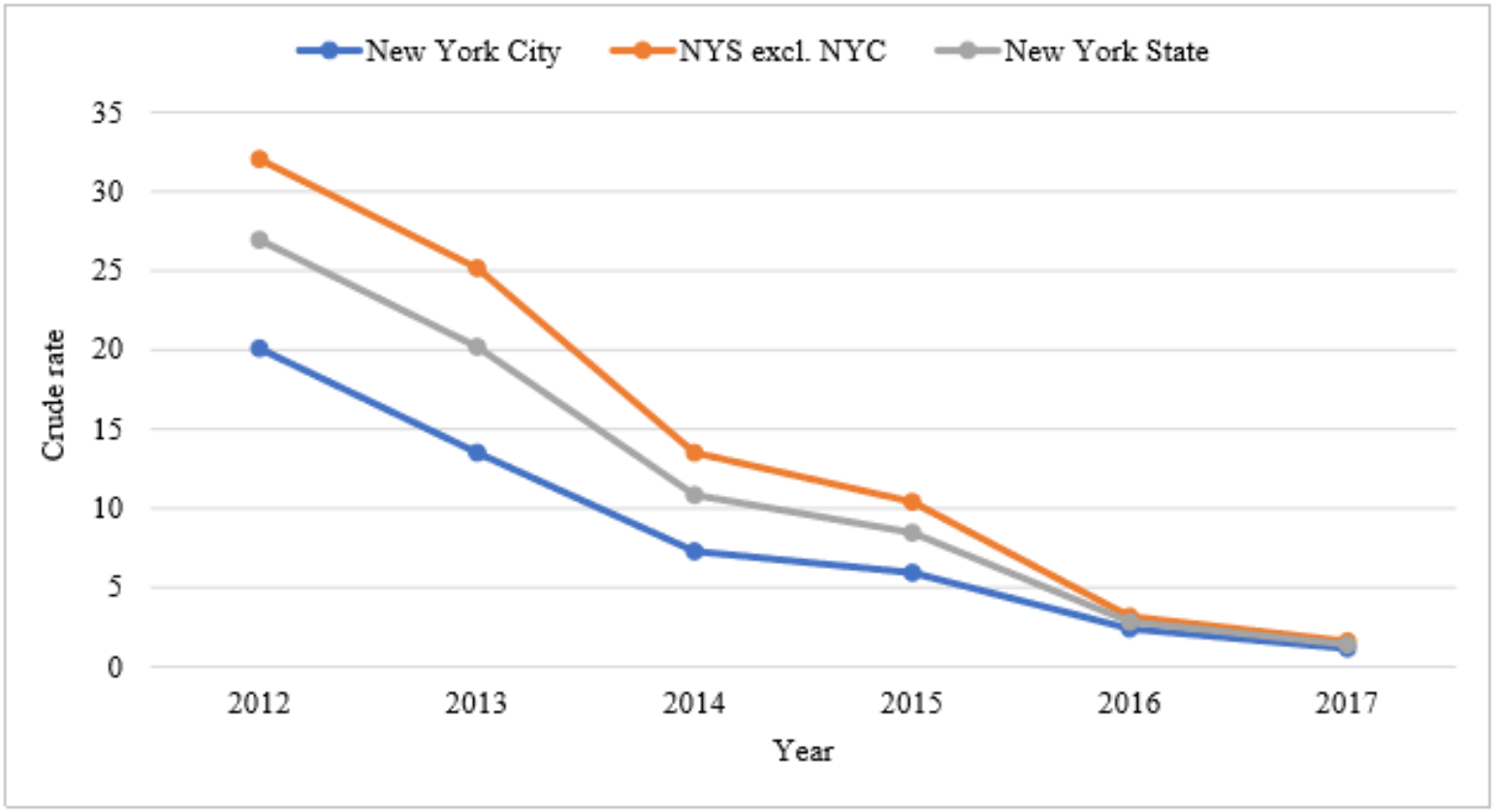
- Be familiar with the CDC Opioid prescribing guidelines and your state regulations
- Consider a standard form and/ or processes in your office
- Check your state PDMP
- Perform full initial assessments and every 3 months at a minimum. Document functional goals.
- Consider UDS and random pill counts
- Watch for diversion of other controlled substances.
- Justify MME doses above 90MME
- Avoid concurrent benzo prescribing

Figure 1. Schedule II Opioid Prescriptions and MassPAT[1] Search Activity[2] Trends
MA: 2015 - Q1 2017



[1] MassPAT is the Massachusetts Prescription Awareness Tool (Online PMP)
[2] Search activity includes prescribers, delegates, and pharmacists registered in MassPAT
[3] Pharmacies required to report daily
[4] STEP bill signed into law (7-day supply requirements go into effect)
[5] MA prescribers required to look up patient when prescribing a Schedule II or III opioid medication

Figure 5.5 Patients with prescribed opioid analgesics from five or more prescribers and dispensed at five or more pharmacies in a six-month period, crude rate per 100,000 population, by region, New York State, 2012-2017



The data exclude buprenorphine prescriptions for the treatment of substance use disorder.
Data Source: NYS Prescription Monitoring Program; Data as of April 2018
For complete data, see Appendix: Data Table 5.5.

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

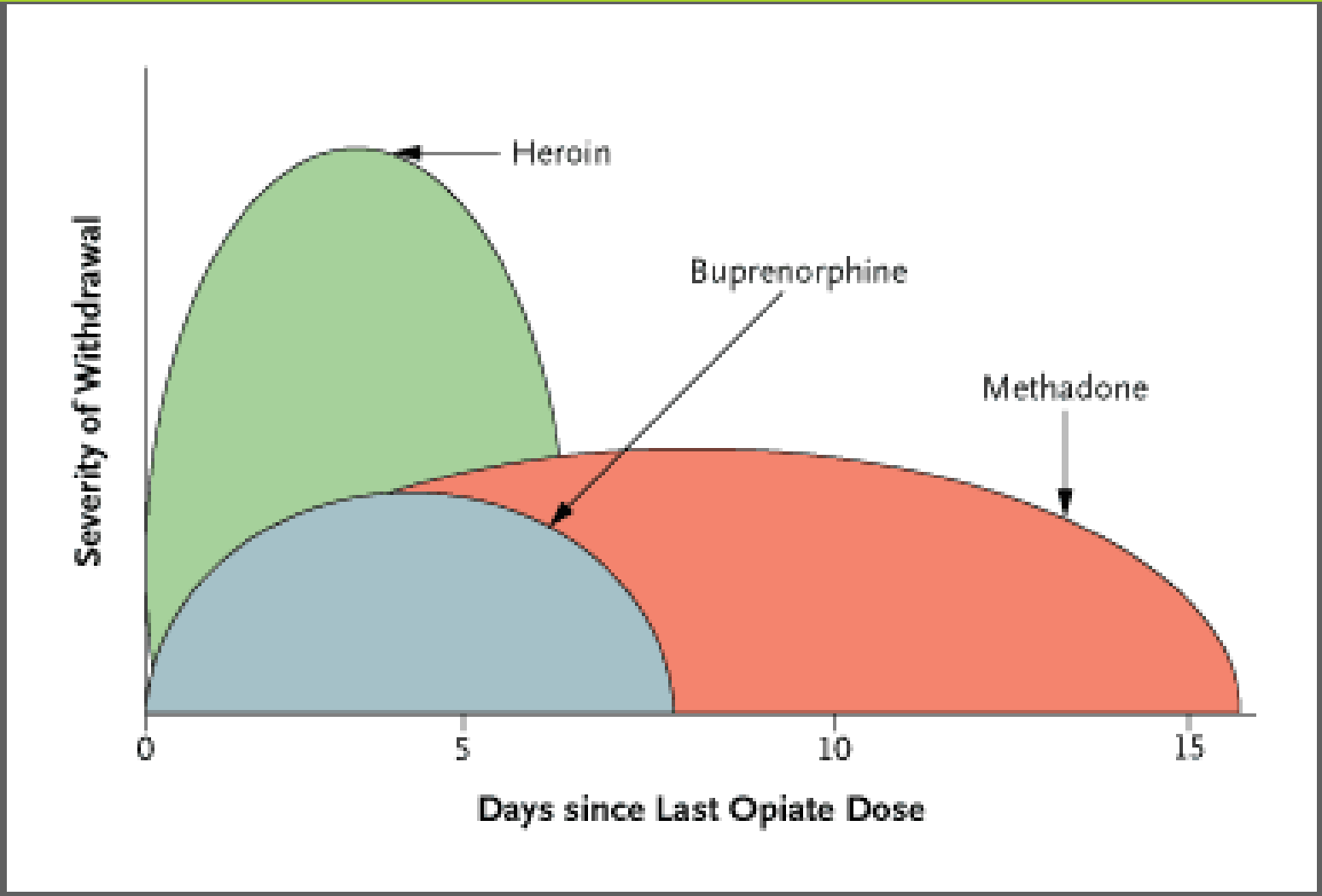
Patients that request it

WHO NEEDS TO BE TAPERED OR DISCONTINUED FROM OPIOIDS?

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



Kosten and O'Connor, NEJM 348;18, May 1, 2003

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

Wesson DR, Ling W, J Psychoactive Drugs. 2003 Apr-Jun;35 (2):253-9.

PAIN TREATMENT TOPICS
www.Pain-Topics.com

OPIOID TAPERING

Safely Discontinuing Opioid Analgesics

Author: Lee A. Kral, PharmD, BCPS
Editor: Stewart B. Leavitt, MA, PhD
Medical Reviewer: Jeffrey Fudin, BS, PharmD, DAAPM
Release Date: March 2006

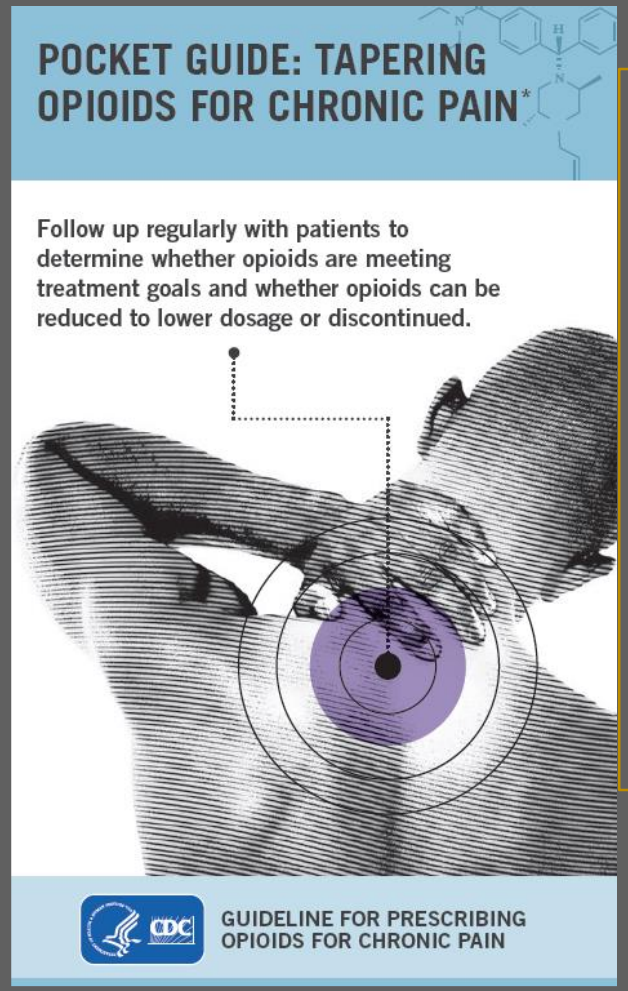
Introduction

Severe hurricanes in the Gulf Coast during 2005 caused many hardships for patients and healthcare providers alike. An important concern coming to light during this time of crisis was the inability to obtain prescription medications, including opioid analgesics. Patients with chronic pain and their healthcare providers faced the daunting task of either somehow procuring the opioids or, if this was not possible, tapering the medications to prevent onset of opioid withdrawal.

Safely discontinuing, or tapering, opioid analgesics is an ongoing concern, both in times of crisis and on a daily basis.

In response to the crisis in the Gulf Coast, a multi-organization Working Group published "Recommendations to Physicians Caring for Katrina Disaster Victims on Chronic Opioids" (AAPM et al. 2005). The National Pain Foundation also published information for patients regarding withdrawing from medications (NPF 2005). Safely discontinuing, or tapering opioid analgesics is not only a concern in times of natural disaster, but an issue that pain services and primary care providers confront daily as they try to balance the benefits and adverse effects of analgesics.

CDC POCKET GUIDE FOR TAPERING



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."

- https://www.pbm.va.gov/AcademicDetailingService/Documents/Pain_Opioid_Taper_Tool_IB_10_939_P96820.pdf

Intermountain Healthcare

CLINICAL GUIDELINE AUGUST 2015

Tapering Opioid Pain Medication

For Patients With Chronic Pain

The Functional Restoration/Chronic Pain Development Team developed these guidelines to assist providers with tapering patients' opioid pain medications. The Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain,[UTAH] Washington state's Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain,[WASH] and other peer-reviewed clinical guidelines[VA,CAN] were used to develop the guidelines.

WHY FOCUS ON OPIOID TAPERING?

Opioids play an important role in managing chronic pain; however, regular monitoring is essential to minimize these inherent risks:

- **Serious consequences** of long-term opioid use include death, accidents, and increasing disability. The Centers for Disease Control and Prevention described prescription pain medication overdose as a growing and deadly epidemic.
- **Adverse effects** associated with opioid use include functional limitations, apnea, anxiety, and depression.
- **Pain perception** can be altered by opioids, resulting in hyperalgesia. The long-term effectiveness of opioid pain medication is not clear.[KREB] Many patients report less pain when they discontinue opioids.
- **Abuse, addiction, and diversion** are all significant risks of opioids.

KEY RECOMMENDATIONS

Assess these factors:

- Patient's desire to discontinue opioids
- Pain and function
- Adverse effects
- Reasons for continuing use
- Abuse, addiction, or diversion

Consider these guidelines:

- Most patients tolerate a 10% dose reduction per week. Faster or slower tapering may be indicated.
- Abstinence syndrome may be treated with medications such as oral or transdermal clonidine.
- Patients should be regularly monitored and referred to specialists as needed.

MEASUREMENT & GOALS

- **Improve the quality of life for patients with chronic pain** in terms of overall function, work status, sleep, and activity levels.

GOALS OF TAPERING

- Reduce adverse effects of treatment
- Mitigate short and long-term risks
  - Short-term Risks:
    - Unmasking OUD
    - Increased Pain
    - Withdrawal syndrome
  - Long-term Risks:
    - Relapse
    - Declining Function
    - Medicolegal matters

TAPE…OIDS

- Consider t…
- Decrease …
  - Long act… are poss…
  - Rate of d… Emerger…
- Allow sup… symptom…
  - Build up…
  - Comfort…
- Rotate pa…

…ease that

…l:

…rough"

…oid

Table 1. Katrina Disaster Working Group Suggested Tapering Regimens [AAPM 2005]

- Reduction of daily dose by 10% each day, or…
- Reduction of daily dose by 20% every 3-5 days, or…
- Reduction of daily dose by 25% each week.

Table 2. VA Suggested Tapering Regimens for *Short-Acting* Opioids [USVA 2003]

- Decrease dose by 10% every 3-7 days, or…
- Decrease dose by 20%-50% per day until lowest available dosage form is reached (e.g., 5 mg of oxycodone)
- Then increase the dosing interval, eliminating one dose every 2-5 days.

Table 3. VA Suggested Tapering Regimens for *Long-Acting* Agents [USVA 2003]

Methadone

- Decrease dose by 20%-50% per day to 30 mg/day, then…
- Decrease by 5 mg/day every 3-5 days to 10 mg/day, then…
- Decrease by 2.5 mg/day every 3-5 days.

Morphine CR (controlled-release)

- Decrease dose by 20%-50% per day to 45 mg/day, then…
- Decrease by 15 mg/day every 2-5 days.

Oxycodone CR (controlled-release)

- Decrease by 20%-50% per day to 30 mg/day, then…
- Decrease by 10 mg/day every 2-5 days.

Fentanyl – first rotate to another opioid, such as morphine CR or methadone.

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???

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?
- Use a motivational interviewing

  approach with your patient.

LEANING IN

- Let patients know you care about them.
- Guidelines change just like pap smear frequency or lipid and blood pressure goals. Opioid guidelines have changed too.
- “I would be putting you at risk”, “I would not be a good doctor if we didn’t discuss this”
- Assure patients that you want to continue to care for them even if you taper them off, even if they are a new patient
- Address prior prescriber issue
- Give patients the time these visits deserve up front

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 (Aleve)
- Acetaminophen
- **Avoid tramadol (Ultram)**: it is opioid

Antispasmodics (abd cramps)
- Dicyclomine (Bentyl)
  - 20 mg 4 times per day
- Decongestants
- Pseudoephedrine (Sudafed)
  - 30-60 mg 4 times daily
- Phenylephrine (Neoynephrine Nasal)
  - 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 (Desyrel)
  - –50-100 mg
- Amitriptyline (Elavil)
  - –50mg
- Melatonin
- Zolpidem? (Ambien)

- 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

Fishbain DA Pain Medicine 2009

Patient example 1:

- Sam is a 58 yo male new patient on oxycodone 10mg TID with mild OA of the LS spine. He has been on oxycodone for 10 years now. He has intermittent low back pain with no radicular symptoms. He has no side effects from the oxycodone, has no inconsistencies in his urines and works full time. Given he is new to you, what is your plan to manage his pain?

Patient example 2:

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 without a taper.
D. Patient has no indication for opiate treatment. Taper off opioids.

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 3:

- 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 4:

- 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 to help with withdrawal symptoms.

PLAN: WEAN DOWN

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

PATIENT EXAMPLE 5:

- 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, which he buys from friends. 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 of short acting opiates as needed for pain.

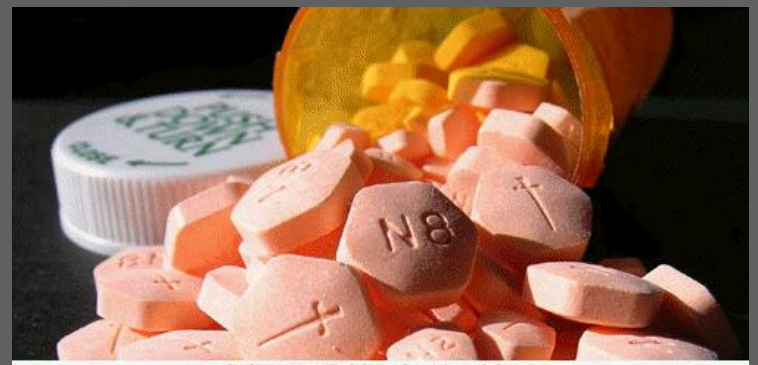
INPATIENT DETOXIFICATION

- 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 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

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

- Mendoza, Michael and Holly Ann Russell. "Is it time to taper that opioid? (And how best to do it)". The Journal of Family Practice. July/August 2019; Vol 68; No. 6: 324-331.
- CDC. "CDC Guidelines for Prescribing Opioids for Chronic Pain – Unitied States, 2016" MMWR. 2016; 65 (1).
- Suttner, J. et al. "Best Practices in Tapering Methods in Patients Undergoing Opioid Therapy". Advances in Pharmacology and Pharmacy. 2013;1(2); 42-57.
- Fishbain, D. A., J. E. Lewis, et al. "Alleged medical abandonment in chronic opioid analgesic therapy: case report." Pain Medicine. 2009;**10**(4): 722-9.
- Wesson, D. R. and W. Ling. "The Clinical Opiate Withdrawal Scale (COWS)." Journal of Psychoactive Drugs . 2003;**35**(2): 253-9.
- https://www.reuters.com/investigates/special-report/baby-opioids/

Questions?