OPIATES AND TAPERING

WHAT DO I DO NOW?

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CONFLICT OF INTEREST

All presenters have signed a conflict of interest form and have declared that there is no conflict of interest and nothing to disclose for this presentation.

WHY IS IT SO IMPORTANT TO FIGURE THIS OUT?

- The concept of tapering is frightening for most patients, and often just as frightening for the provider, especially in a resource poor environment
- If we can't engage the patient in this process, there are no good outcome options.
  - Continued use at an unsafe dose which endangers the patient and the provider;
  - cutting off/abandoning a patient who will suffer unnecessarily and may turn to heroin or other illegal drugs to fill this gap;
  - the patient may seek another provider who is less skilled or less scrupulous in "safer" pain management.
- Having the patient walk out of your office upset and looking for another provider is not a win for anyone.

PREPARING FOR THE CONVERSATION

- Know your facts—Calculate MEDs on all patients. Check overnight oximetry, bone density, QT intervals (if on methadone), CURES reports, and urine toxicology on all pain management patients.
- Change the way you think—use an "informed consent for opiate therapy" instead of a "pain management contract/agreement"
- Prepare your office staff on what to expect

WHO TO TAPER

- Pick your battles
  - Also on benzodiazepines?
  - Nocturnal hypoxia in a heavy smoker?
  - In a situational crisis? Remember it is difficult to differentiate between suffering and physical pain.
  - Are you concerned about a component of SUD?

WHO TO TAPER

- Patients on a high MED (>100, >120)
- Nocturnal hypoxia
- Osteoporosis and/or fractures
- QT prolongation with methadone
- Patient prompts
  - I think I'm developing "Old Timers"
  - I'm falling a lot
  - Its getting harder for me to breath
  - My pain is getting worse/spreading all over
  - I'm really depressed

STARTING THE CONVERSATION

- Put up posters about the side effects of opiate therapy in exam or waiting room.
- Use a screening tool to check for side effects at every visit.
- Prioritize patients by highest risk and/or greatest chance of success.
- If you aren't going to start tapering someone right away, plant the seeds anyway.
- Own our mistakes.

BONUS TIPS

- New-to-you patients with ongoing prescriptions: set expectations on the first phone call and at the first visit.
- Surgery: set expectations before referral appointment and contact surgeon's office about post-op pain management
- Acute Injury: set clear limits for any additional interventions

KEYS TO SUCCESS

- You must exhibit empathy/compassion. If you can't, find an MA/nurse/SW you work with who can.
- A sense of control is important for patients too.
- Figure out what local resources you can use creatively (chiro, PT, LCSW, yoga class at the local senior center, etc.). If you do have limited access to PM, are they willing to do a one-time medication management consult?
- This is not a race, it may take longer than you expect or be less successful than you hoped. Take a break if you need to.
- Don't set yourself up for failure. I rarely taper between Thanksgiving and mid-February.

WHO I DON'T TAPER

- Patients with clear co-morbid SUDs. Offer referral to appropriate treatment or transition onto buprenorphine.
- Patients using </= 50 MED daily with no high risk findings and no physical complaints related to their opiate use.
- When it is more appropriate to have a palliative care discussion. (Patients with advanced COPD, CHF, etc.)

CASE STUDY: LP

- Mid-50's with chronic low back pain following multiple surgeries.
- Obese (BMI >40) and a 1-2ppd smoker.
- Bipolar disorder (on medication) and a history of alcohol overuse, but is not currently drinking.
- On pain medication 10+ years, previously on 650 MED (methadone 60mg, hydrocodone/APAP 10/325 5 tablets)
- Tapered down to 360 MED daily over 14 months (methadone 40mg, hydrocodone/APAP 10/325 3 tablets).
- She was motivated and doing well to this point.

CASE STUDY: LP (CONT.)

- After 14 months, we stalled out. She began developing severe abdominal pain. Her previous L knee surgery with cadaver grafting failed and she developed osteonecrosis.
- She relapsed briefly with alcohol due to her increasing pain, and her depression got worse. Because of our close working relationship, we were able to get her into support for her drinking and she had stopped drinking entirely within 2 weeks. Her psychiatrist adjusted her bipolar meds which helped with the worsening depression.
- Abdominal pain was NSAID-induced gastritis and resolved with PPI/stopping NSAIDs.
- It took nearly 9 months to get her through the process of a total knee replacement--during which time we weren't able to taper at all. Her surgeon told her to double up on the methadone and added oxycodone postoperatively. It took 8 weeks following surgery to get her back to her pre-surgery dosing. Its now been 4 months and she is down to 340 MED

CASE STUDY: TJ

- 43 y/o male with LS spine DDD and arthritis of the hands and knees. Worked as a manual laborer for years.
- PMHx: mild intermittent asthma and GAD. He is disabled and his anxiety and severe panic attacks are so bad that he rarely leaves the house.
- Meds: Hydrocodone/APAP 10/325 12 tablets daily, lorazepam 1mg TID, albuterol inhaler prn
- Trial transition to morphine ER, and then oxycodone ER, both made him feel sick. Refused to try methadone.
- "What is the most you are willing to give me?"
- We agreed to try 6 tablets per day, but I told him I didn't expect this to work for him and I would see him back in 1 month to reconsider. He didn't keep the appointment.

CASE STUDY: TJ (CONT.)

- About a year later, he showed up on my schedule for a "med refill" appointment.
- He asked for albuterol, and never brought up the pain medication.
- "When you cut my pain medication down, my anxiety got so much better. I could go to the store and stand in line with other people—so I decided to stop it all. I still hurt, but its not worse and I can go to the grocery store now."
- I followed him for several years after that and he never asked for another pain pill, and even turned them down a few years later when I offered a prescription for a week following a serious injury.

CASE STUDY: GR

- 72 y/o female with severe DDD of the LS—several back surgeries for spinal stenosis—and fibromyalgia.
- Meds: oxycodone ER 10mg BID, oxycodone/APAP 5/325mg 2-4/day (45-67.5 MED daily). Alprazolam 0.5 mg BID-TID, ran out early several times. Sees an alternative medicine specialist for her fibromyalgia and takes a variety of vitamins and supplements for this.
- Hx: GAD, panic attacks, bipolar disorder. Significant social stressors.
- Came in for a check-up with a three page list a friend helped her prepare detailing all the issues she was having with memory and confusion. She believed she was developing dementia and was very anxious about this, particularly as she lives alone.

CASE STUDY: GR (CONT.)

- We talked about both opiates and benzos being high risk medications in older patients, which often lead to confusion, memory impairment, and falls. We had tried to taper her dosing several times in the past. We agreed that she would taper off her alprazolam over a 6 week period and she would come back in for a check up in 8 weeks. She scheduled with the LCSW to help with her anxiety during the process.
- After 2 weeks, her memory was so much better, she decided to stop her pain meds as well. She did it on her own before her next appointment with me and had 3-4 days of withdrawal symptoms which were not too severe.
- She now takes 4-8 tablets of acetaminophen with codeine per month for severe breakthrough pain, no other opiates and no benzos. Her memory problems and confusion have not returned and she is still able to live independently.

QUESTIONS

- If you would like an ear to bounce your plan/questions off of, you can reach me by email cstockton@shingletownmedcenter.org . It usually takes me 2-3 days to respond to emails, so please be patient with me.
- Thank you for your time. This is a very important issue for your patients.