Exit Strategies for Opioid Therapy

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Disclosures

- Douglas Gourlay – no commercial disclosures
Exit Strategies for Opioids

- Key Elements of this talk are
  - Examine the CDC Guidelines
    - Especially around dose limits
  - Distinguishing between rational and irrational pharmacotherapy
  - Approaching the problematic medication user
  - Developing a rational approach to medication rotation and taper/discontinuation
CDC Guidelines Summary*

- Non-pharmacotherapy/non-opioid therapy preferred
- Before opioids, establish realistic treatment goals (pain/function)
- Risk/benefits assessment/discussion with patient
- Begin with IR rather than SR opioid preparations
- Start at lowest effective dose (avoid doses > 90MME/Day)
- Acute pain <3 days (rarely >7 days)

*http://www.cdc.gov/drugoverdose/prescribing/guideline.html

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CDC Guidelines Summary

- Evaluate benefits/harms after 1-4 weeks after starting opioid therapy (then q 3/12 or more frequently as needed)
- Evaluate risk factors – including possible naloxone rescue
- Review the PDMP program, if it exists in your state
- Patient UDT – frequency?
- Avoid concurrent prescription of sedatives e.g. benzodiazepines
- Offer/obtain evidence based assessment/treatment of patients with opioid SUD
Where is the controversy?

- Well, most of the CDC Guidelines are pretty straightforward
  - The really contentious point is the arbitrary “line in the sand” drawn at 90MME/day
  - Is it even useful to “compare” different members of the opioid class of drug in terms of equivalency to morphine?
Where is the controversy?

- Why 90? Why not 120 mg morphine equivalents per day? Why not 200 mg MME/day?

  —Well, all those numbers have been proposed at some point as being the “line in the sand” that should be drawn...
Where is the controversy?

- What we know is
  - 1) As MME dose rises, risk increases – 100mg MME seems to be a dose where this increase becomes problematic
  - 2) As doses become excessive, the likelihood of achieving acceptable treatment outcomes in terms of pain relief and function decrease
    - Much more likely to be “desperation” pharmacotherapy than “rational” pharmacotherapy
  - 3) Polypharmacy, especially with sedative class of drugs increases risk
    - Multiple agents from same class appears to be problematic
- Amy S. B. Bohnert, PhD; Marcia Valenstein, MD; Matthew J. Bair, MD; et al
  Association Between Opioid Prescribing Patterns and Opioid Overdose-Related Deaths JAMA. 2011;305(13):1315-1321
What’s missing from the CDC Guidelines?

- The guideline is clearly oriented toward “new” patients, rather than giving guidance to clinicians as to what to do with patients who were placed on opioids prior to our awareness of these risks.
  - What do you do with the “inherited pain patient” who is already on doses well in excess of the 90MME/day dose recommendations?
What’s missing from the CDC Guidelines?

- How do you determine who might be “exceptions” to these guidelines?
  - How do you document these exceptions?
- How to you take a patient “from where they are to where they need to be?” in terms of medication management?
  - Concept of readiness to change – both for the patient AND for the prescriber
  - Optimizing pharmacotherapy, including taper/discontinuation
    - The stalled taper
    - Minimizing physiologic/psychologic consequences of withdrawal
Documentation Requirements

- The importance of documentation can’t be overstated
  - Your medical record must clearly establish the thought process used to come to the proposed treatment plan
  - Detox ≠ Tapering as a legal concept

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Documentation Requirements

- If your treatment plan departs from currently accepted guidelines, it must be clear WHY this departure is appropriate or if this departure is part of a longer term plan to bring the patient into compliance.

  - Many of these cases are going to be “inherited” I.E. initiated under the old model of “no ceiling means no limit” in terms of acceptable agonist dose.
The signs of pharmacological instability

- Multiple members of the same class of drug
  - Poly opioids
  - Poly benzodiazepines
  - Addition of controlled substances to offset adverse effects of analgesics/sedatives
    - Stimulant class of drugs

- Excessive “pill loads” with each prescription written
  - Reliance on many tablets per day vs. using a tablet strength to limit total number of tablets dispensed
    - With large number of daily unit doses, the total number of pills per prescription can become excessive – e.g. 3 tablets per day q30 days = 90 tablets vs 10 tablets per day q30 days = 300 tablets per script

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Withdrawal Mediated Pain

- Three most important questions to ask in opioid pharmacotherapy
  - 1 what is your pain like first thing in the morning? (trough)
  - 2 what is your pain like ½ hr after your dose? (onset)
  - 3 what is your pain like 2-3 hrs after? (peak)
The signs of pharmacological instability

- Running out early
  - Failure to specify how long a prescription should last makes it very difficult to objectively assess “early refills”

- Excessive sedation/somnolence on current medication regimen
  - Consider 3rd party sources of information eg spouse/family

- Diminished rather than improved function
  - “continued use despite harm”

- Decreased duration of action +/- AM withdrawal symptoms associated with pharmacologic instability
  - Need to increase dosing frequency to achieve stability (eg once daily medication taken BID; TID; even QID)
Withdrawal Mediated Pain

- Opioid stability is largely a 24 hr event
  - If the patient wakes up complaining of generalized arthralgia/myalgia – the differential MUST include inadequate 24 hr opioid levels in a physically dependent patient
    - If these AM symptoms begin to improve after ½ hr and are largely resolved by 2-3 hrs – consider early withdrawal
  - If symptoms worsen with onset and become debilitating with peak – the unit dose may be too great (even if the total 24 hr dose is inadequate)
Opioid Myths

 “patients who no longer need opioids come off them easily” - NO

— For the most part, this is nonsense

— Physical dependency and accompanying withdrawal is largely person-specific but certain truths should be considered

• as dose goes up and duration on the drug increases, the degree of withdrawal *often* increases (but not always the case)

— the ease with which the taper goes at the beginning rarely predicts how easy/difficult the taper will be at the end (eg when they are finally off the medication altogether)
Opioid Myths

- “patients who no longer need opioids come off them easily” - cont
  
  - Any taper is a balance of tensions between time for optimal neuroadaptation to minimize withdrawal symptoms vs “prolonging the misery” of the process
  
  - unfortunately, for some, even the slowest of tapers will not totally eliminate withdrawal symptoms – in these cases, simply pushing through the taper is often the necessary and “best” approach
Practical Questions

- Should we taper the incumbent drug or substitute and taper?
  — Factors to consider
    - How long has the patient been on the drug to be tapered?
    - How many unsuccessful attempts have there been to taper this drug?
      — Does the patient feel, based on past history, beaten before they even start?
Practical Questions

- Should we taper the incumbent drug or substitute and taper?

  Factors to consider
  
  - How “malignant” has the relationship between the drug(s) and the patient been?
    
    - Frequently running out early?
    - Compromising the delivery system?
    - Multiple unsanctioned dose increases?
  
  - The nature of the drug
    
    - Is this a drug with a particularly bad reputation for withdrawal? Eg fentanyl/alprazolam
Where to start?

- If the rotation/substitution/consolidation is from a ‘reasonable’ opioid dose –
  - Equivalency tables may be useful places to start
- But if the dose of opioid is excessive
  - Equivalency tables make no sense
    - Why calculate an equivalency to an obviously excessive dose?
Where to start?

- When selecting an opioid to rotate to, the initial goal is not (always) ‘analgesic equivalency’
  - First, you want to be safe
  - Second, you want to mitigate withdrawal symptoms
  - Third, achieve ‘therapeutic intent’ I.E.
    - Reduced dose with adequate analgesia
    - Taper -> discontinuation etc
General Strategies

- Tapers of the order of 10% every 1-2 weeks until bottom 30%
  - Then, decrease to 5% every 2-4 weeks
- Difficulties are most often seen at the end of the taper
  - It is sometimes better to “push on” rather than to end with a stalled taper
Conclusions?

- The CDC guidelines can be challenging but also an opportunity to improve patient care
  - *Status quo* is not usually the best option
  - Use them to motivate change in current medication management

- Our past mistakes with opioids should not limit our future, rational use of these important drugs
References

- Karch, SB, Is it time to reformulate racemic methadone: J Addict Med 5(3), 2011
- Darpo B et al, Differentiation the Effect of an Opioid Agonist on Cardiac Repolarization From μ-Receptor-mediated, Indirect Effects on the QT Interval: A randomized, 3-way Crossover Study in Healthy Subjects: Clinical Therapeutics 38(2), 2016

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