PainWeek®

Is the Grass Always Greener On The Other Side? Clinical Controversies with Opioid Tapers

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Disclosure

- Tanya Uritsky: Advisory Board: AcelRx
- Jessica Geiger: Nothing

Learning Objectives

- Describe risks and benefits of opioid tapering
- Discuss rationale and current evidence based taper regimens
- Identify an appropriate patient specific opioid tapering plan

Case – Mr. P.

- 50 yo with chronic back pain s/p MVA.
- His PCP has been managing his pain for 15 years.
- PMH: scoliosis, chronic pain (2005), hyperlipidemia (2012); hypertension (2013); depression (2011)
- SH: Widowed, works for the local bar as a bartender
- FH: Mother with alcoholism, deceased from liver failure; Father living, has dementia, two siblings – estranged from one, lives with the other; one child living, no known medical problems (20 yo)
- Medications: Oxycodone extended release 40 mg PO q12h, oxycodone immediate release 5 mg PO q6h PRN, gabapentin 300 mg PO BID; duloxetine 40 mg PO daily; Lisinopril 10 mg PO daily; atorvastatin 40 mg PO daily

What Do You Do Now?

1. Continue to prescribe
2. Decline further prescribing
3. Taper him off opioids
4. Taper him to less than 90 MEDD

What do you want to know in order to decide?

What You Need To Know

- Urine toxicology
- ORT (baseline)
- COMM
- Pain assessment
- What else has he tried?
- Adverse effects to analgesics?
- Response to other analgesics?
- Other?

1. How would you describe this patient's potential risk for prescription opioid abuse?		
Abuse=any use or the intentional self-administration of a medication for a nonmedical purpose such as altering one's state of consciousness, eg, getting high.		
○ Low risk	○ Moderate risk	○ High risk
2. How would you describe this patient's potential risk for prescription opioid misuse?		
Misuse=use of a medication (with therapeutic intent) other than as directed or as indicated.		
○ Low risk	○ Moderate risk	○ High risk
3. How would you describe this patient's potential risk for prescription opioid diversion?		
Diversion=giving or selling their medication, or acquiring or obtaining of a controlled substance by an illegal method.		
○ Low risk	○ Moderate risk	○ High risk
4. Please describe the type of information that you have relied on to make this assessment? (Please check all that apply.)		
○ Past medical history	○ Prescription monitoring program	
○ History of treating/knowing the patient	○ Urine drug testing	
○ Interviewing the patient	○ Use of questionnaires to assess risk[a]	
○ Interviewing the patient's family member or guardian	○ Assessment of patient's behavior	
○ Physical signs and symptoms	○ Pill counts	

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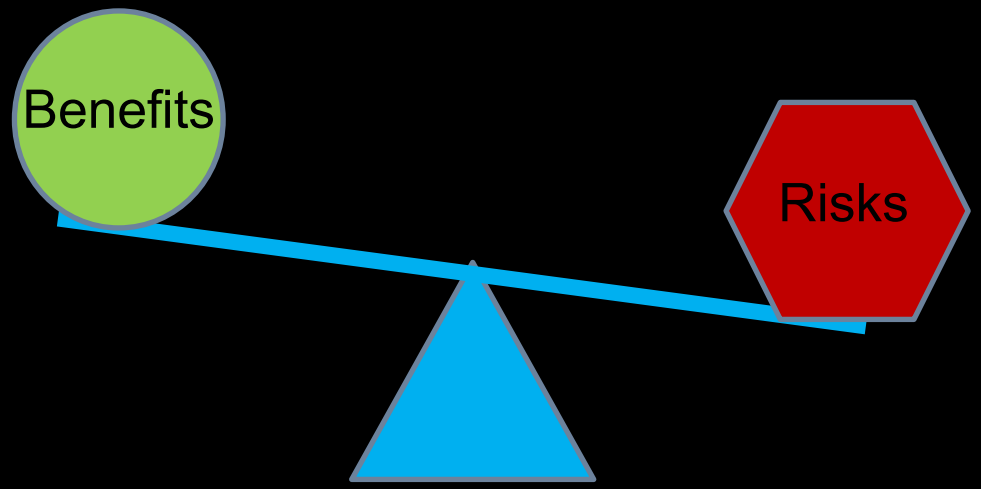
The Good, The Bad…And the Ugly? Risks and Benefits of Tapering

Why taper?

- Lack of efficacy
  - No improvement in function/failed trial
  - Inadequate analgesia
  - Failure to reach treatment goals
- Therapy not needed any longer
  - Acute pain resolving(ed)
  - Cancer survivorship?
- Unacceptable risk
  - Adverse effects
  - Opioid-induced hyperalgesia and glial cell activation
  - Stigma
  - Employer prohibits drugs that may affect motor coordination

The Scale



- The risks and benefits of what?
- Opioid use?
- Tapering?

…opioid analgesic prescribing changes, such as dose escalation, dose reduction or discontinuation of long-term opioid analgesics, have potential to harm or put patients at risk if not made in a thoughtful, deliberative, collaborative, and measured manner. – HHS 2017

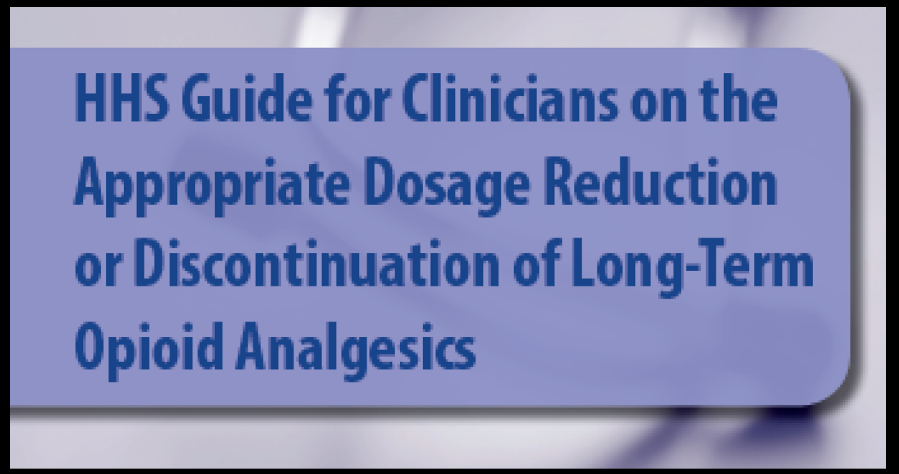
The Good

- Less prescription opioids in the community
  - Annual opioid prescriptions in the United States peaked at 255 million in 2012 and then decreased to 191 million in 2017.
- Reported improvements in function, sleep, anxiety, and mood
  - Patient-centered approach led to successful discontinuation and improved QOL
- Pain no worse, possibly even improved
  - 46% reduction in opioid doses over 12 months
  - 70% of patients had no change in pain or less pain
- Optimization of alternative analgesics
  - 70% of patients had an increase in prescribed adjuvants or no additional prescribed

Harden P, et al. Pain Med 2015; Frank JW, et al. Pain Medicine 2016; 17: 1838–1847

The Bad

- Uncontrolled Pain
- Withdrawal
- Decreased productivity
- Increased Illicit drug use
- Increased use of other CNS depressants



Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, HHS does not recommend abrupt opioid dose reduction or discontinuation.

The Ugly…

- Suicide
  - –Suicide decedents with chronic pain increased from 7.4% to 10.2%
    - Most commonly spine, musculoskeletal and cancer related pain
  - –No decrease in overdose rates despite deprescribing of opioids
  - –Rates due to tapering are undetermined

- We do know who to identify should probably be tapered but…
  - –We do not have tools to help us decide who should NOT be tapered

- Minimal evidence on the rate of taper

Boehnart ARG, Ilgen MA. N Engl J Med 2019;380:71-9.
Dowell D, Haegerich T, Chou R. No shortcuts to safer opioid prescribing. N Engl J Med. 2019;380:2285-2287

Now What Do You Do?

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How Would You Taper Mr. P?

A. Over days to 2 weeks

B. Over 3 weeks to 6 months

C. Over 6 months to a year