PainWeek®

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

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Tapering Guidance

CDC

- DOES NOT recommend opioid discontinuation or taper when:
  - Benefits outweigh risks
  - Dose >90 MME

- DOES recommend continued risk assessment and documentation for continued opioid use

VA/DoD Pain management guidelines

- Guidelines were developed to provide information and assist with decision making
- Based on systematic reviews of evidence
- Tapering is only part of the guidelines

VA/DoD

- Consider tapering when:
  - Pain improves
  - Risks outweigh benefits
    - Especially when age <30
  - Active substance use disorder
  - When MME exceeds 90mg
- Avoid abrupt discontinuation unless immediate safety concerns

VA/DoD

- When a patient is identified as being appropriate for a taper
  - Perform a comprehensive biopsychosocial assessment
  - Include the patient when making decisions on length of taper
  - Follow up weekly-monthly after each change
    - This will depend on how fast or slow the taper will be.

VA/DoD

- Constructing the taper
  - 5-20% reduction every 4 weeks
  - Include interdisciplinary services as appropriate
  - Pauses are OK
- Goal
  - Improve balance of risks and benefits

Full guideline is available at:

https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf

HHS

"The HHS Guide for Clinicians on the Appropriate Dosage and Reduction or Discontinuation of Long-Term Opioid Analgesics provides advice to clinicians who are contemplating or initiating a reduction in opioid dosage or discontinuation of long-term opioid therapy for chronic pain. In each case the clinician should review the risks and benefits of the current therapy with the patient, and decide if tapering is appropriate based on individual circumstances."

HHS

- Consider tapering when:
  - Patient requests
  - Pain improves
  - Pain does not improve
  - Opioid misuse
  - Increased side effects
  - Increased risk for serious adverse effect
  - Unclear harm-benefit balance

HHS

- Additional considerations:
  - Avoid insisting a taper when opioid use is warranted
  - Avoid misinterpreting dosage thresholds
  - Coordinate with other providers when a patient is on both benzodiazepines and opioids
  - Avoid “firing” patients

HHS

- Constructing the taper
  - Decrease dose by 5-20% every 4 weeks
  - Slow taper
    - <10% per month
    - Better tolerated
    - Allows for patients to adjust to the new dose
    - When duration was >1 year
  - Fast taper
    - 10% dose reduction per week (or slower)
      - Until 30% of original dose is reached
    - Then 10% weekly reduction
    - When duration was weeks to months
    - Suspect opioid misuse

NAM Discussion Paper

- Identified a need for evidence-based tapering strategies
- Focuses on chronic non-cancer pain that do not have opioid or substance use disorder, outpatient
- Encourages shared decision making
- Encourages interdisciplinary team participation

NAM Discussion Paper

- Tapering indications:
  - Patient request
  - Provider suggestion
    - Risks outweigh benefits
    - Unresponsive pain
    - Unbearable side effects
    - Treatment is harming the patient's ADL's
    - On multiple medications that affect the CNS
    - Pt is unable to follow the terms of an opioid agreement
    - OUD or SUD is suspected

NAM Discussion Paper

- Fast tapers are generally not indicated
- The higher the dose, the longer the taper
- Taper should not be reversed without maximizing adjunct therapies
- Treat withdrawal symptoms

Taper plan for Mr. P

- Determine the length of the taper
- Taper plan
  - Should include education and monitoring for signs of withdrawal
  - Only start when the patient is ready
  - Decrease by ~10% of the total daily dose
    - Might find out that 10% is too big of a dose reduction and may need to consider smaller increments if possible.

Steps

1st decrease	• Total daily dose ↓ to 70mg • Oxycodone ER 30mg QAM and 40mg QPM
2nd decrease	• Total daily dose ↓ to 60mg • Oxycodone 30mg Q12H
3rd decrease	• Total daily dose ↓ to 50mg • Oxycodone ER 20mg QAM and 30mg QPM
4th decrease	• Total daily dose ↓ to 40mg • Oxycodone ER 20mg Q12H

Case – Ms. Q.

- 32 yo with chronic back pain s/p military injury.
- Pain has been managed by PCP at the VA for the past 5 years.
- PMH: Chronic low back pain (2015), PTSD (2015); depression (2011)
- SH: Single, unemployed, working with VA career services to try and find employment. Spends much of her time at the VFW with friends in the same situation.
- FH: Currently lives with mother who has struggled with substance use disorder, estranged from father; no children.
- Medications: Morphine extended release 60 mg PO q12h, hydrocodone/acetaminophen 7.5/325mg Q4H prn (uses all the doses), sertraline 50mg daily.

What You Need To Know

- Urine toxicology
- ORT (baseline)
- COMM
- Pain assessment
- What else has she 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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We find out that Ms. Q is diverting her prescription medications.

Now What Do You Do?

1. Continue to prescribe
2. Stop prescribing
3. Refer her to the pain clinic at the VA for further management
4. Taper without a referral

Faster taper

- Starting Morphine ER 120 mg/day
  - Decrease by 10% per dose
    - Faster rate than the slower taper
    - Goal would be to get the patient off the medication as fast AND safe as possible
    - Initially; may not be able to decrease weekly
  - This could still take a couple months…

Ms. T

- Ms. T is a 60 yo with chronic low back pain. She has been on opioids for the past 5 years as she tried many other therapies and did not do well.

Imaging shows some degenerative changes as well as bulging discs at L2-4 with minimal nerve root compression.

She presents today to clinic for a 3 month check in and opioid refill.

Medications: Morphine ER 30 mg PO q12h and morphine IR 15 mg PO q6h PRN; gabapentin 600 mg PO TID; duloxetine 30 mg PO daily; cyclobenzaprine 5 mg PO TID PRN

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What Do You Want to Do?

1. Continue to prescribe
2. Stop prescribing
3. Refer her to the pain clinic for further management
4. Taper without a referral

How do you want to do it?

Motivational interviewing

Continued use of risk mitigation strategies

Documenting function and assessment of risk versus benefits

Co-prescribe naloxone

Summary

- Understand the “why” behind the taper
- Work with the patient
- Be ready to be in this for the long haul…tapers are not always fast
- Consult pain management and substance use disorder specialists as needed

This is a team sport!

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