

The background of the slide is a blurred image. On the left, there is a vertical strip showing a person's face, possibly a doctor, with a white coat and a stethoscope. The rest of the background is a dark teal color with a large, out-of-focus image of a pill bottle and several pills scattered around. The text is centered in a bold, white, sans-serif font.

OPIOID TAPERING FOR PEOPLE WITH CHRONIC NON-MALIGNANT PAIN

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Physical Medicine & Rehabilitation

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DECLARATION OF POTENTIAL CONFLICTS

Received research grants from Canadian Institutes for Health Research, Ontario Ministry of Health and Long-term care, and Health Canada

Past chair of WSIB Drug Advisory Committee

Youtube channel for patients with chronic pain, member of YouTube Partner Program.

Amazon affiliate marketing with links to products in the YouTube channel

Unrestricted educational grant from Canadian Generic Product Association to offer an online self-assessment program of Opioids for Chronic Non-Cancer Pain.

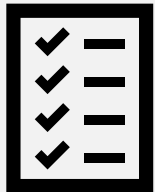


LEARNING OBJECTIVES

At the end of this presentation, participants will be able to:



Describe the recommendations about opioid tapering according to the Canadian guidelines (2017)



Explain the criteria for selecting patient for opioid tapering



List at least 3 facilitators for a successful opioid tapering

CANADIAN OPIOID GUIDELINE (2017)

Recommendations about opioid tapering

#9 For patients with chronic noncancer pain who are currently using 90 mg morphine equivalents of opioids per day or more, we suggest tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy (weak recommendation)

Remark: Some patients may have a substantial increase in pain or decrease in function that persists for more than one month after a small dose reduction; tapering may be paused or potentially abandoned in such patients.

#10 For patients with chronic noncancer pain who are using opioids and experiencing serious challenges in tapering, we recommend a formal multidisciplinary program (strong recommendation)

Remark: In recognition of the cost of formal multidisciplinary opioid reduction programs and their current limited availability/capacity, an alternative is a coordinated multidisciplinary collaboration that includes several health professionals whom physicians can access according to their availability (possibilities include, but are not limited to, a primary care physician, a nurse, a pharmacist, a physical therapist, a chiropractor, a kinesiologist, an occupational therapist, an addiction medicine specialist, a psychiatrist and a psychologist).

A male doctor in blue scrubs is looking down at a smartphone in his hands. He has a stethoscope around his neck. The background is a blurred hospital hallway with warm lighting. The text 'TAPERING OPIOID' is overlaid in large white letters, underlined with a thin orange line. Below that, a teal box contains the text 'It is NOT about the calculator' in orange italics.

TAPERING OPIOID

It is NOT about the calculator

Opioid Tapering Template

Centre for Effective Practice

Opioid Tapering Template

This tool is to support primary care providers in discussing the value of opioid tapering with adult patients already prescribed an opioid and to support their patients in reducing opioid dosage in a safe and effective way.

Section A: Important considerations for opioid tapering

- Clinicians should engage patients in shared decision-making, including consideration of the patient's values, goals, concerns and preferences for tapering.^{1,2}
- When possible, an interdisciplinary team approach is recommended for tapering, with the primary care provider complementing a primary care pharmacologist and pharmacological management.^{3,4}
- For patients starting or continuing an opioid trial, discuss and document patients' goals on a regular basis. **SMART** goals: Specific, Measurable, Agreed upon, Realistic, Time-based.⁵
- Consider the potential opioid use and safety concerns.

CAUTION: • Pregnancy, spontaneous abortion and/or return to use have been associated with opioid withdrawal and/or relapse.⁶
• When you have concerns about reports of suicidal thoughts, depression, delirium or an overdose, or if you are tapering a patient with a history of overdose or concurrent benzodiazepine use, a 50% morphine equivalent dose (MED) may have a history of overdose or concurrent benzodiazepine use.

Indications

- Tapering is a medication that can reverse the effects of an opioid overdose. It is recommended to keep naloxone on hand in case of an accidental overdose. This is particularly important for patients on doses of a 50 morphine equivalent dose (MED) day, those with a history of overdose or concurrent benzodiazepine use.
- Patients with a health condition or a higher tolerance for pain have a reduced risk of overdose. You can receive these and training on their use from pharmacies, community organizations and provincial correctional facilities.

For more information on evidence, links and where to use these tools, visit: <https://www.cep.ca/our-approach/our-approach-to-evidence-based-practice/>

Reasons to consider opioid tapering, reduction or discontinuation

- Patient requests dosage reduction
- Problematic opioid behavior (e.g. diversion, altering the route of delivery, accumulating opioids from other sources)
- Opioid use of opioid use disorder (OUD)

Tapering is not likely an effective treatment for OUD. It may require further assessment and possible consultation to identify the optimal therapeutic options.

- Lower the use assessment early warning signs for overdose risk (e.g. car, falls, isolation, suicidal speech)
- Medical complications (e.g. sleep apnea, hypotension and withdrawal mediated pain)
- Adverse effects (e.g. fatigue, functioning below baseline level)
- Patient does not tolerate adverse effects
- Opioid dosage > 90 MED/day
- Opioid dosage > 90 MED/day without benefit in improving pain and/or function
- Opioid is combined with benzodiazepine
- Other:

If pain and/or function are not improving despite opioid therapy, you should consider the potential harms of the current use of opioids, reduce opioid use and focus on other approaches.

Opioid use disorder criteria⁷

- Opioids use often or larger than intended
- Persistent desire or unsuccessful efforts to limit or control opioid use
- Spending a lot of time obtaining the opioids, using the opioids, or recovering from its effects
- Craving or a strong desire to use opioids
- Recent or current opioid use resulting in failure to fulfill major role obligations at work, school or home
- Continued use despite persistent or new medical condition or worsening personal problems (e.g. social, family, legal)
- Stopping or reducing important social, occupational, or recreational activities due to opioid use
- Recurrent use of opioids in physically hazardous situations
- Continued use of opioids despite acknowledgment of persistent or new medical condition or worsening personal problems (e.g. social, family, legal)
- Need for markedly increased amounts to achieve intoxication or desired effect
- Markedly diminished effect with continued use of the same amount

Withdrawal⁸ manifesting as either:

- Characteristic opioid withdrawal syndrome base feature C: Withdrawal symptoms (management)
- Baseline already related substance is taken to relieve or avoid withdrawal symptoms

• Mild: Presence of 2 to 3 criteria
• Moderate: Presence of 4 to 5 criteria
• Severe: Presence of 6 or more criteria

¹ Most commonly by the physicians who are providing opioid medications for analgesia without a tapering protocol in place.

Talking Points

Provide information about tapering might be needed:

- "Chronic pain is a complex condition and opioids alone cannot adequately address all of your pain-related needs."
- "It may be a time to consider the opioid dose you are on and how it affects the rest of your life and the risk of overdose if you take more than you need."
- "Did you know that most of the evidence showing benefits from opioid use for chronic non-cancer pain support a relatively low dose (less than 120 MED/day)?"
- "In some people, opioids can make their pain worse rather than better - how happens resulting from an opioid use disorder makes one more sensitive to pain instead of less."

Ensure patients have clear expectations of tapering:

- "Some patients, after with opioids, when they're reduced their use of opioids."
- "Clear reduction or discontinuation of opioids frequently improves function, quality of life and pain control. This may take several days, and your pain may briefly get worse at first."

Address discrepancies between the patient's goals and their current pain management:

- "You're not sure if your pain management is as safe as you'd like it to be. It's important to know that your regular activities."
- Adjust to any resistance to opioid reduction by framing the conversation:
- "Opioids can have an effect on your central nervous system - it may be making you feel as if you're losing your ability to do daily activities. It is important to know that your regular activities will go down when the opioid dose goes up."
- "Since the your pain has not improved over with the high dose you have been taking, it may be time to consider a lower dose."

Consideration about tapering requires a carefully planned self-efficacy and should ideally be a joint decision. They may need to be revisited periodically depending on the patient's readiness. A risk process enables, continue to work with your patients to provide care in a safe way.

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Opioid Manager

OPIOID MANAGER

The Opioid Manager is designed to help family physicians and nurse practitioners (primary care providers) prescribe opioids for chronic non-cancer pain. It is based on the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain.

Section A: Before the First Script

Discuss and document patients' goals (SMART goals: Specific, Measurable, Agreed upon, Realistic, Time-based).

OVERDOSE RISK

- Opioids are associated, at very low doses (1-20 mg morphine equivalent dose (MED)/day), with a 0.2% risk of fatal overdose and a 0.2% risk of fatal overdose.
- Risk of overdose increases in patients with a history of prior substance use disorder and concurrent benzodiazepine use.
- Estimated annual fatal overdose rates were:
 - 0.1% in patients receiving < 20 mg MED/day of opioids
 - 0.34% in patients receiving 20-49 mg MED/day of opioids
 - 0.33% in patients receiving 50-99 mg MED/day of opioids
 - 0.23% in patients receiving > 100 mg MED/day of opioids
- Estimated annual fatal overdose rates were:
 - 0.4% in patients receiving < 20 mg MED/day of opioids
 - 0.7% in patients receiving 20-49 mg MED/day of opioids
 - 1.8% in patients receiving > 100 mg MED/day of opioids

INITIATION CHECKLIST

These are the key elements to consider before starting an opioid trial. See appendix 4 for a fillable version of this checklist that can be included into the patient medical record.

- Has your assessment been completed?
- Has non-opioid pharmacotherapy been optimized?
- Stable physical condition (no acute medical illness)?
- Current or past substance use disorder?
- Contraceptive?
- Explained to patient benefits?
- Explained adverse effects?
- Explained risk of relapse?
- Thorough baseline assessment conducted as needed?
- Informed consent obtained?
- Patient given information to consider?
- If pre-treatment agreement is needed?
- Urine drug screening needed?
- Medication prescription needed?

Non-opioid pharmacotherapy options:

- Analgesics: acetaminophen, aspirin
- Anti-inflammatory: non-steroidal anti-inflammatories (NSAIDs), celecoxib, ibuprofen, naproxen, diclofenac
- Antidepressants: tricyclic antidepressants (amitriptyline, nortriptyline, desipramine)
- Anticonvulsants: gabapentin, pregabalin, carbamazepine
- Muscle relaxants: methocarbamol, cyclobenzaprine, tizanidine

Non-pharmacotherapy options:

- Activities of therapist: walking, exercises, yoga, Tai Chi, etc.
- Physical modalities: cold, heat, electrotherapy (e.g. TENS), laser
- Complementary and alternative medicine: massage, manipulation, acupuncture
- Mind-based therapies: relaxation, mindfulness meditation, cognitive behavioral therapy, acceptance and commitment therapy
- Self-management
- Multidisciplinary program
- Interventional therapies: injections, nerve blocks, implants
- Surgery

Other considerations:

- Factors such as depression, anxiety disorders and post-traumatic stress disorder (PTSD) are not recommended. Patients with psychiatric disorders report chronic severe pain, pain is often reported or related if the psychiatric disorders are well managed.
- Opioids are not recommended for patients with current or past substance use disorder (e.g. alcohol use disorder, opioid use disorder)

Other Points

- Opioids may have similar effects on pain relief when compared to NSAIDs, tricyclic antidepressants or gabapentin.
- Opioids for chronic non-cancer pain may result in similar improvements in physical function when compared to NSAIDs, antidepressants, tricyclic antidepressants or gabapentin.
- Adding opioids to non-opioid therapy results in reduction in pain by 12.3%, and an increase in functional improvement by 10% vs. continuing established therapy without opioids.

Section B: Initiation Trials

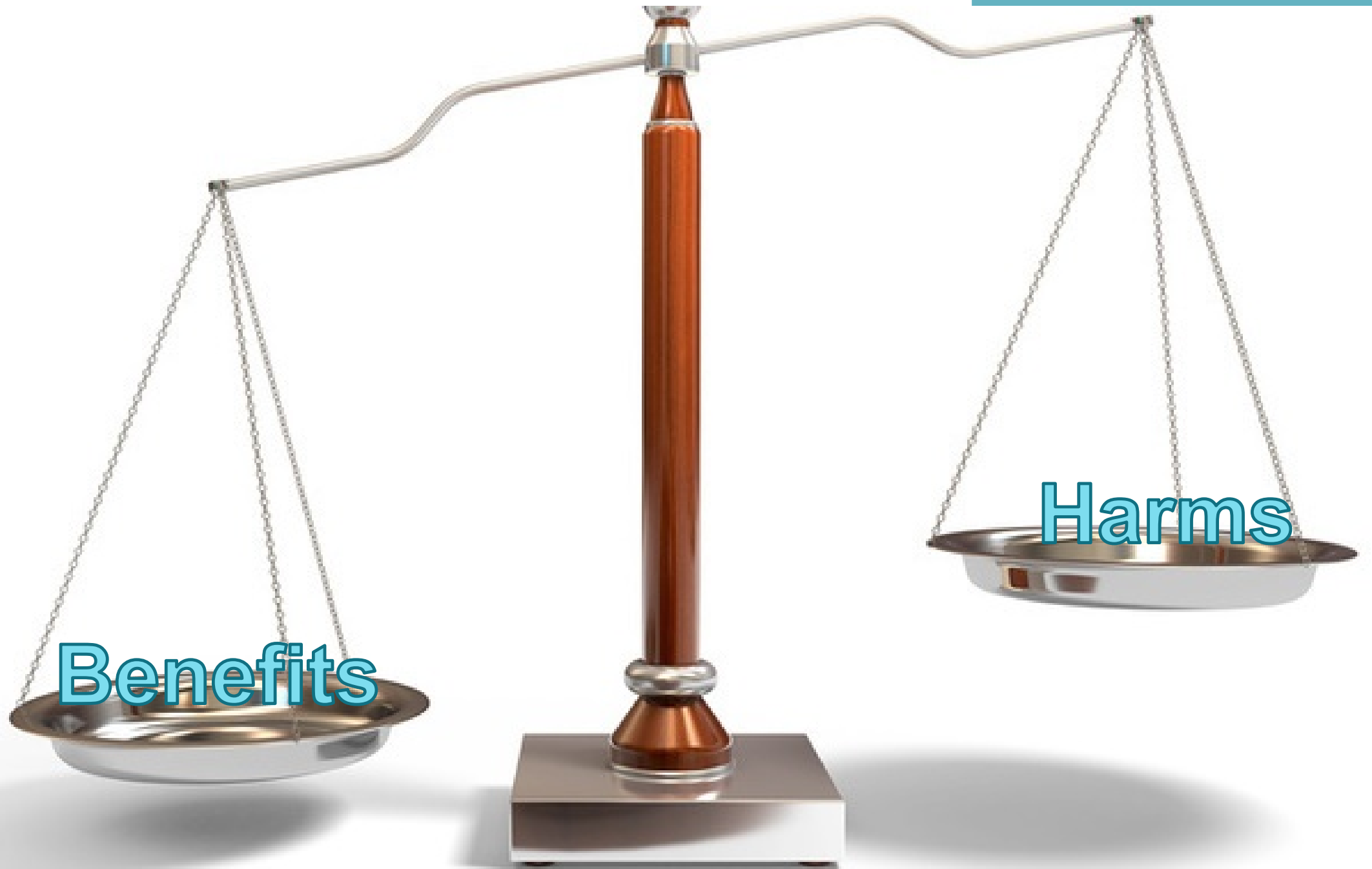
A reasonable trial of the therapy should be accomplished within 3-6 months, after which time pain relief after 3 months.

Other Points

- Start at lowest available dose of the opioid
- In patients with continuous pain (waking pain at rest), clinicians can prescribe controlled-release opioids for both comfort and simplicity of treatment during therapy
- Activity with pain might not require sustained-release treatment and opioid therapy may be initiated with immediate-release opioids
- Opioids (OAT) recommended for initiating a trial of therapy include fentanyl, morphine, oral hydromorphone
- Opioids that are recommended are listed in the Suggested Initial Dose and Titration Table
- Oral preparations preferred
- Prescriptions should be provided by the primary treating physician only, for no more than 28 days at a time

September 2017 www.health.ca/cep/cep-templates www.cep.ca/cep-templates www.cep.ca/cep-templates www.cep.ca/cep-templates Page 1 of 6

<https://cep.health/clinical-products/opioid-tapering-template/>



Benefits

Harms



Benefits

Harms

RISK:BENEFIT ASSESSMENT

Benefit

- ❑ Type of pain is responsive to opioids
- ❑ Patient reported improvement in pain intensity > 30%
- ❑ Patient reported improvement in function > 30%
- ❑ Adverse events are minimal or manageable

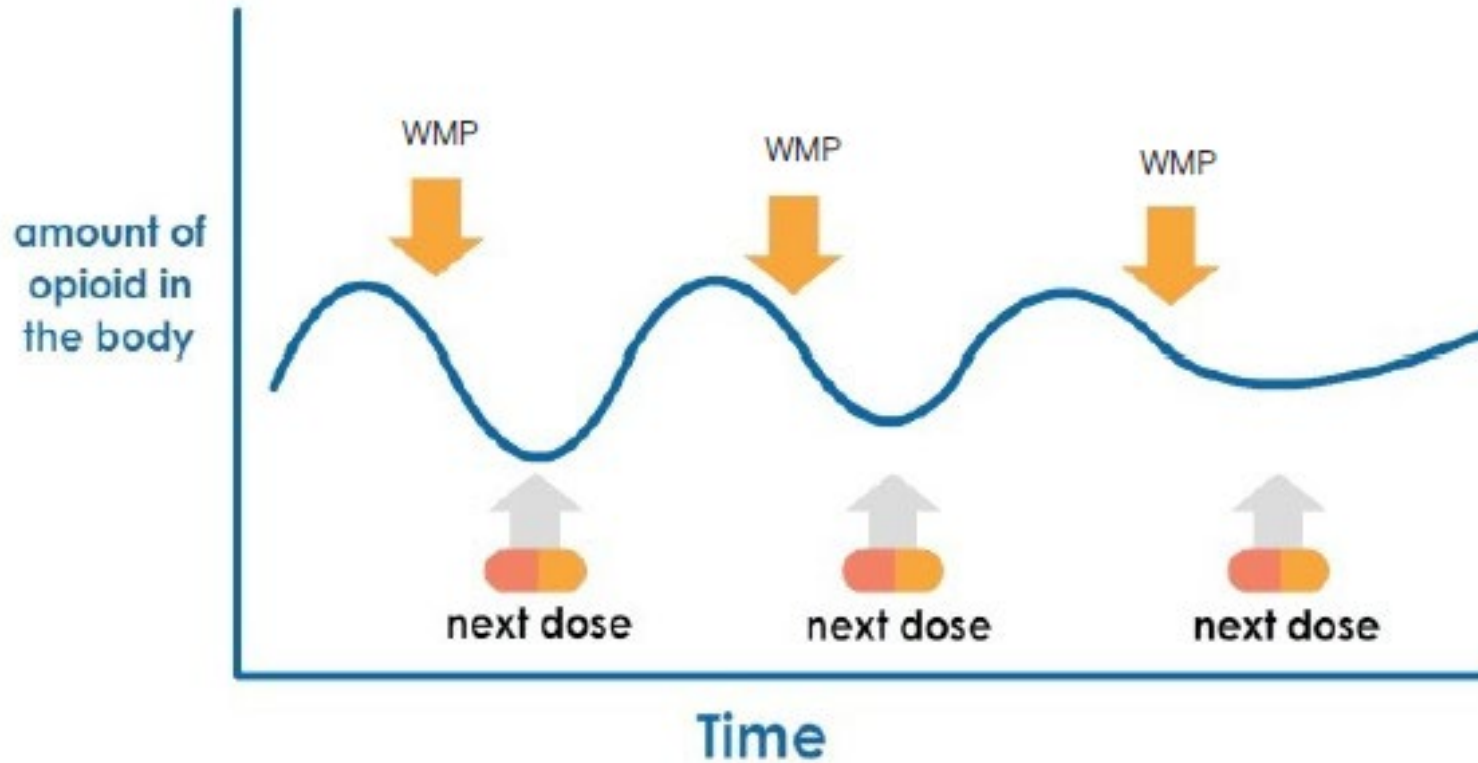
Risks

- ❑ Type of pain that gets worse with opioids
- ❑ Patient develops hyperalgesia, sleep apnea immunosuppression, hypogonadism, withdrawal mediated pain
- ❑ Factors that puts patient at higher risk of sedation, falls, overdose
- ❑ Higher probability of opioid use disorder

WITHDRAWAL MEDIATED PAIN



http://bit.ly/Withdrawal_Mediated_Pain

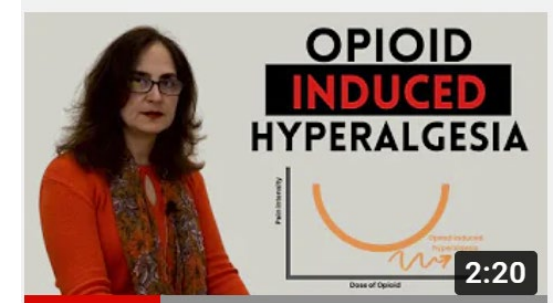
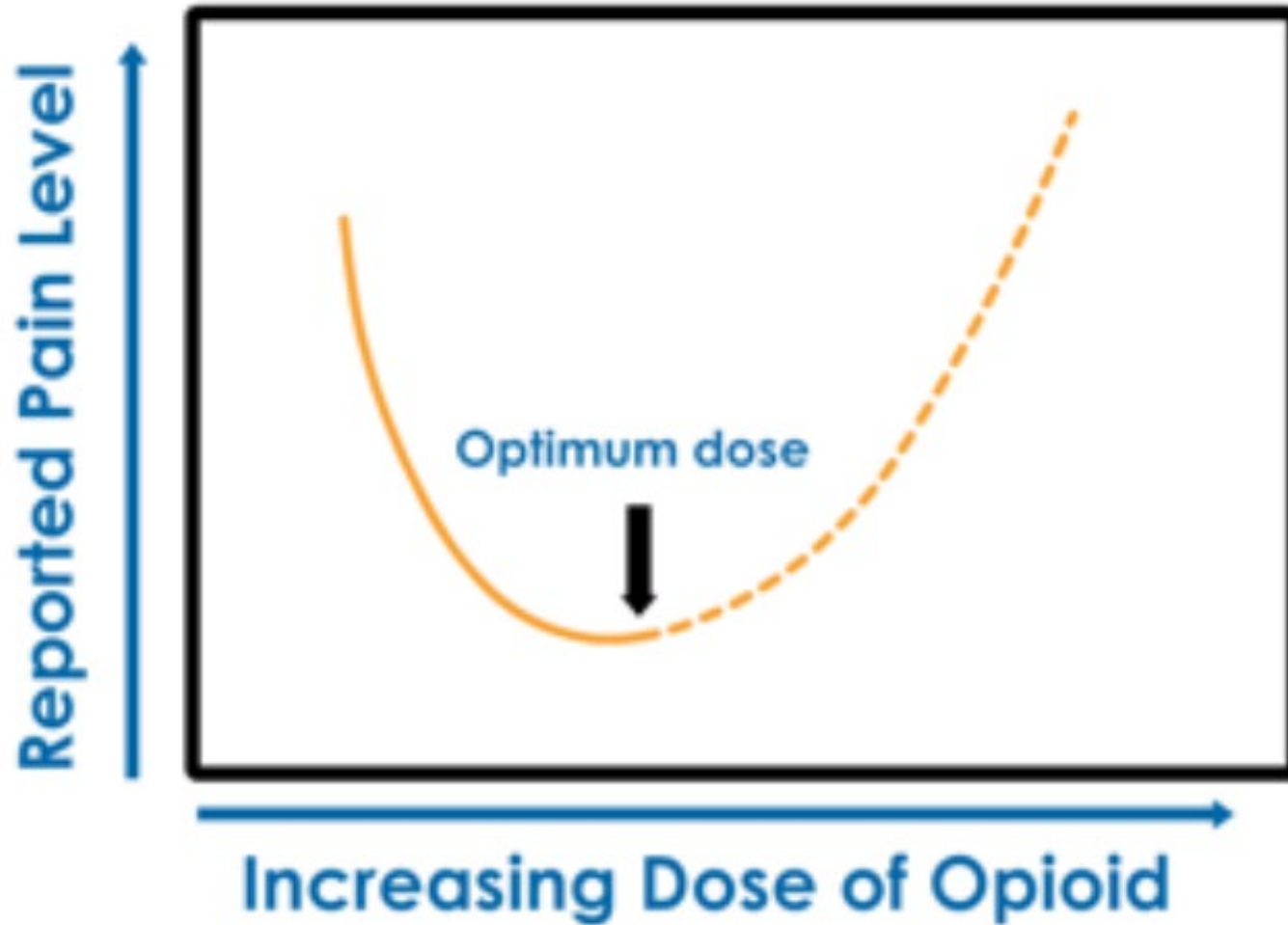


WMP = withdrawal mediated pain

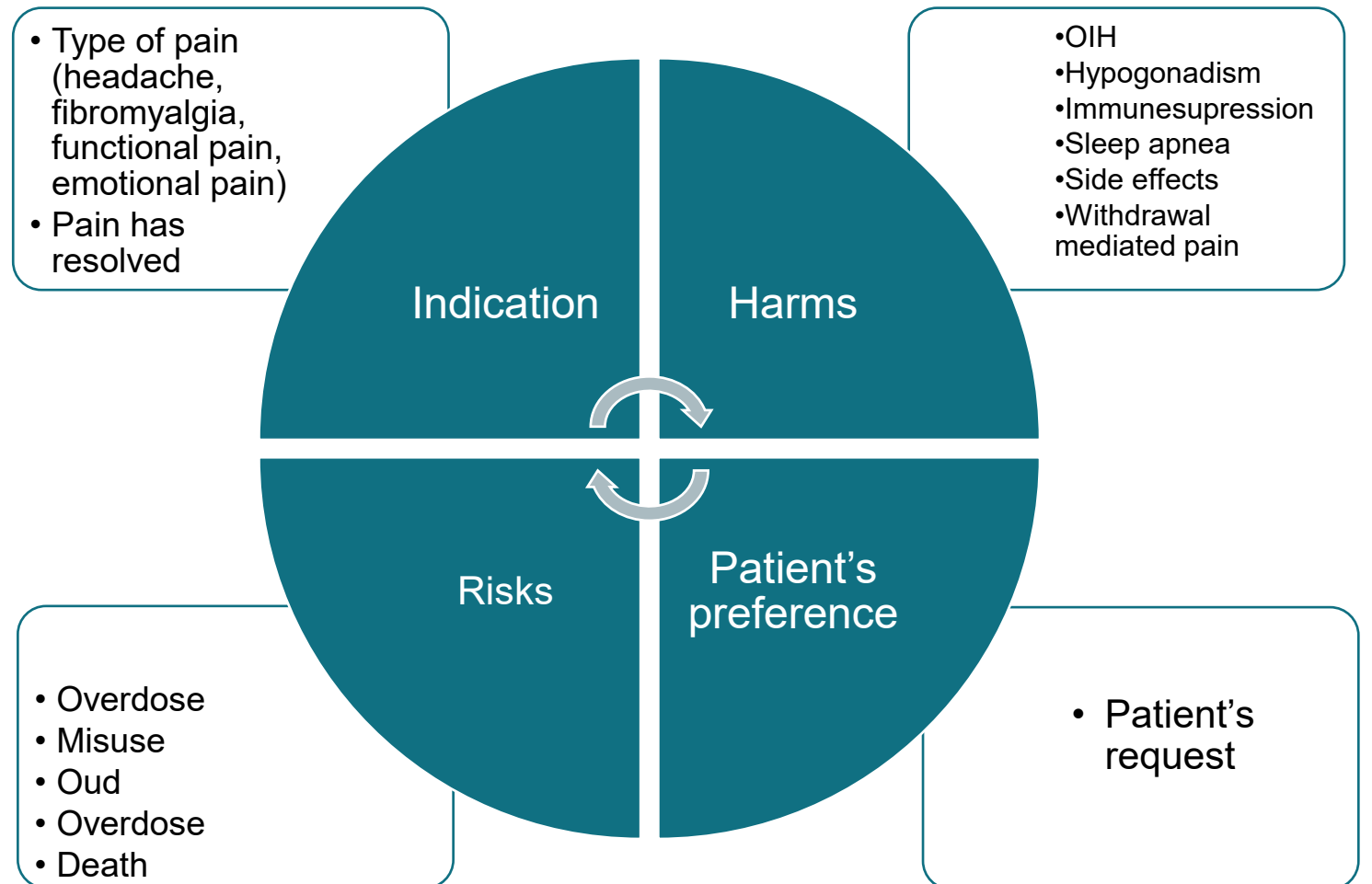


OPIOID INDUCED HYPERALGESIA

http://bit.ly/Opioid_Induced_Hyperalgesia



PATIENT SELECTION FOR OPIOID TAPERING



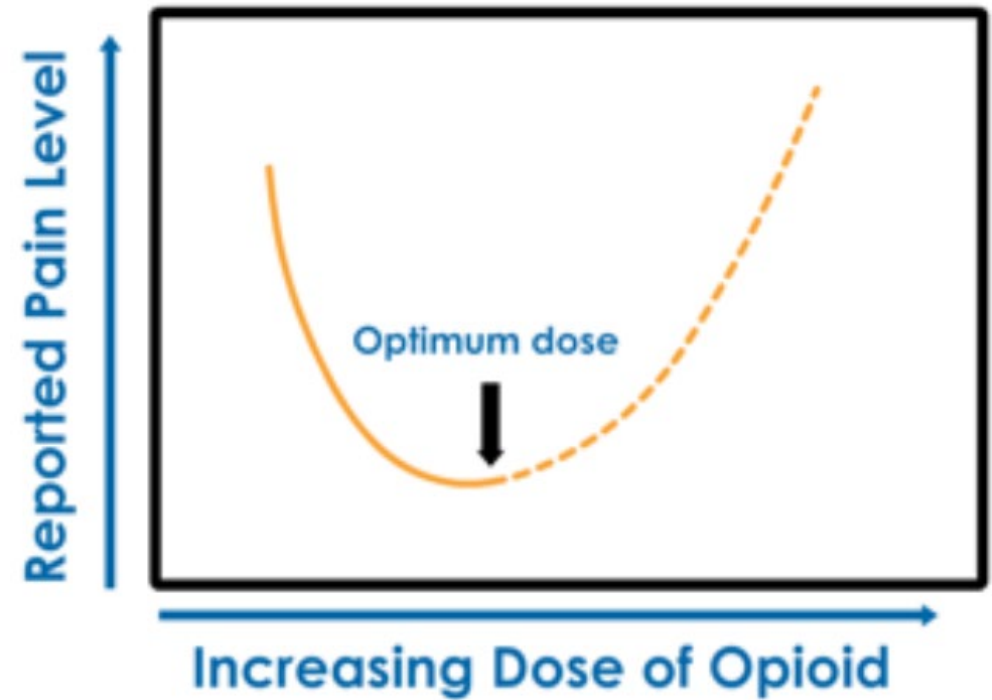
http://bit.ly/Opioid_Tapering

PERCIVAL

- 64 year-old male, married, disability
- 9 years ago lymphoma, radiotherapy/chemotherapy → cured
- Fentanyl patch 50 mcg/h q72 h
- Oxycodone CR 40mg bid
- Equivalent to ~320mg MED
- Pain 6-9/10 constant, neck, back
- Fatigue, low mood, no libido, loss muscle mass



PERCIVAL



PERCIVAL

Hypogonadism





JOANA

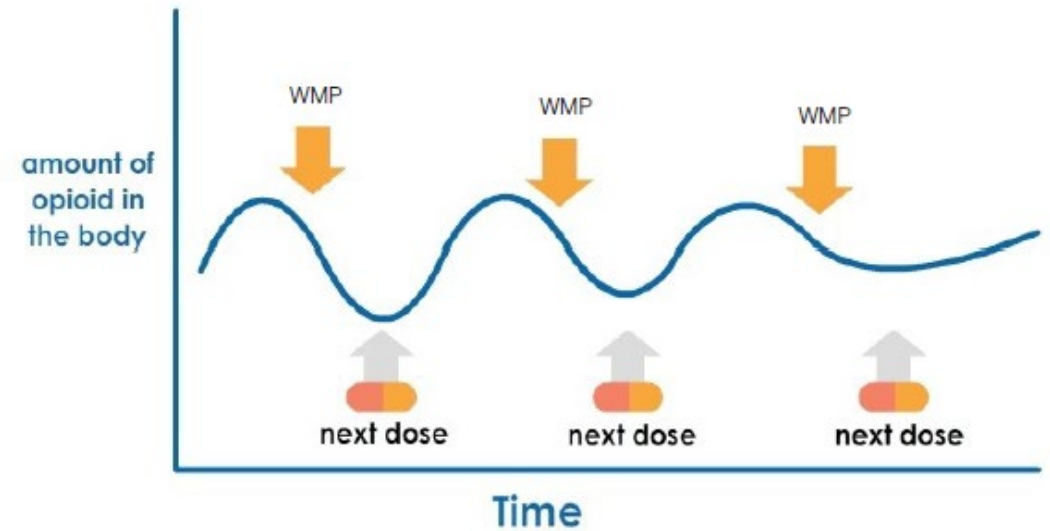
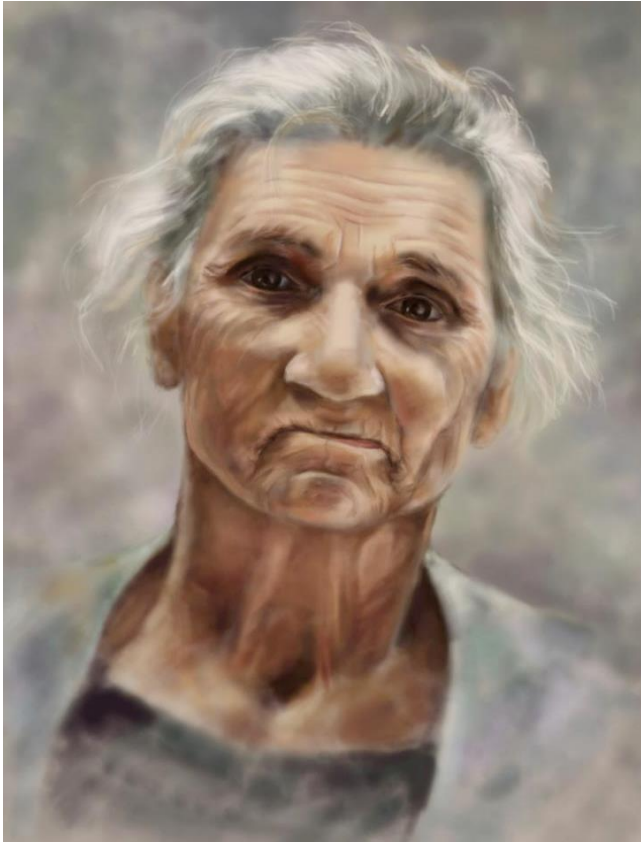
JOANA

- 81 years old, Crohn's disease, ileostomy, chronic pancreatitis
- Pain abdomen and back +/- 20 years. Worse at night
- Anxiety, depression, diabetes, hypertension, CAD
- Hydromorphone CR: 18mg + 18mg + 27mg
- Hydromorphone IR: 4mg, 32 tablets per day, q3h including middle of the night (chills and tremors)
- Equivalent to 955mg MED
- Clonidine: average 3 tab/day



JOANA

Withdrawal mediated pain



WMP = withdrawal mediated pain

LUCY

- 47 years old, married, 2 children, works full time, but misses work frequently
- Spondylolisthesis L5-S1, lumbar spinal stenosis, degenerative disc disease
- Tried TCAs, SNRIs, gaba, NSAIDs, physiotherapy, massage: “nothing helps”
- Rx: 100 tablets of oxycodone 5mg per month. (“All that my family doctor would give me”)
- Buys illicit opioids to supplement what doctor doesn’t give her.
- Equivalent MED = unknown
- Smokes marijuana to relax and sleep





LUCY

Opioid Use Disorder:
mild (2-3)
moderate (4-5)
severe (6-)

TABLE 1 Summarized DSM-5 diagnostic categories and criteria for opioid use disorder

Category	Criteria
Impaired control	<ul style="list-style-type: none">• Opioids used in larger amounts or for longer than intended• Unsuccessful efforts or desire to cut back or control opioid use• Excessive amount of time spent obtaining, using, or recovering from opioids• Craving to use opioids
Social impairment	<ul style="list-style-type: none">• Failure to fulfill major role obligations at work, school, or home as a result of recurrent opioid use• Persistent or recurrent social or interpersonal problems that are exacerbated by opioids or continued use of opioids despite these problems• Reduced or given up important social, occupational, or recreational activities because of opioid use
Risky use	<ul style="list-style-type: none">• Opioid use in physically hazardous situations• Continued opioid use despite knowledge of persistent physical or psychological problem that is likely caused by opioid use
Pharmacological properties	<ul style="list-style-type: none">• Tolerance as demonstrated by increased amounts of opioids needed to achieve desired effect; diminished effect with continued use of the same amount• Withdrawal as demonstrated by symptoms of opioid withdrawal syndrome; opioids taken to relieve or avoid withdrawal

<http://www.psychiatrictimes.com/>

BARRIERS TO OPIOID TAPERING

Healthcare Professional

- Lack of knowledge
 - rationale “Why should I taper?”
 - skills “How do I do it?”
- Lack of confidence “I am not sure I can do it”; “I can’t say no to my patients”
- Lack of willingness “It is too stressful to do it”
- Lack of time → It takes 5 minutes to say yes and 30 minutes to say no
- Other excuses “It is not my fault, I didn’t start this”

Patient

- Fear of pain getting worse
- Fear of withdrawal symptoms
- Fear of dying
- Drug liking
- Drug diversion
- Addicted

OPIOID WITHDRAWAL

Symptoms

- **PAIN:** headaches, muscle aches, joint aches, abdominal cramps
- **SLEEP:** insomnia, fatigue
- **FLU-LIKE:** Sweats, Chills, malaise
- **GASTRO-INTESTINAL:** Diarrhea, nausea and vomiting

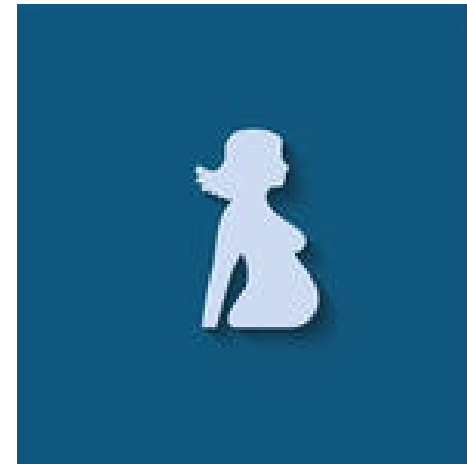
Signs

- Psychomotor agitation
- Irritability
- Goose bumps

Can last weeks,
months or years

CONTRA-INDICATIONS FOR OPIOID TAPERING

- Pregnancy
- Unstable coronary artery disease
- Unstable mental health disorder



MANAGEMENT OF OPIOID WITHDRAWAL

Non-pharmacological

- Education
- Reassurance (Not life-threatening)
- Ongoing support and encouragement
- Involve the pharmacist
- Relaxation
- Mindfulness
- Exercises, walks
- Distraction

Pharmacological

- Melatonin for insomnia
- Muscle relaxants for aches and sleep problem
- Clonidine for anxiety, jitters, sweats and chills
- NSAIDs or acetaminophen for muscle pain
- Loperamide for diarrhea and stomach cramps
- Scopolamine for abdominal pain
- Oxybutynin for sweating
- Quinine sulphate for muscle cramps
- Gabapentin or pregabalin for severe anxiety
- Nabilone for nausea/vomiting
- Do not use benzos or alcohol

CANNABINOIDS AND OPIOIDS

A meta-analysis of 5 RCTs and 12 observational studies:

⊗⊗⊗⊗
(high)

Adding cannabis had little or not effect on **pain relief** or **sleep disturbance**

⊗⊗○○
(low)

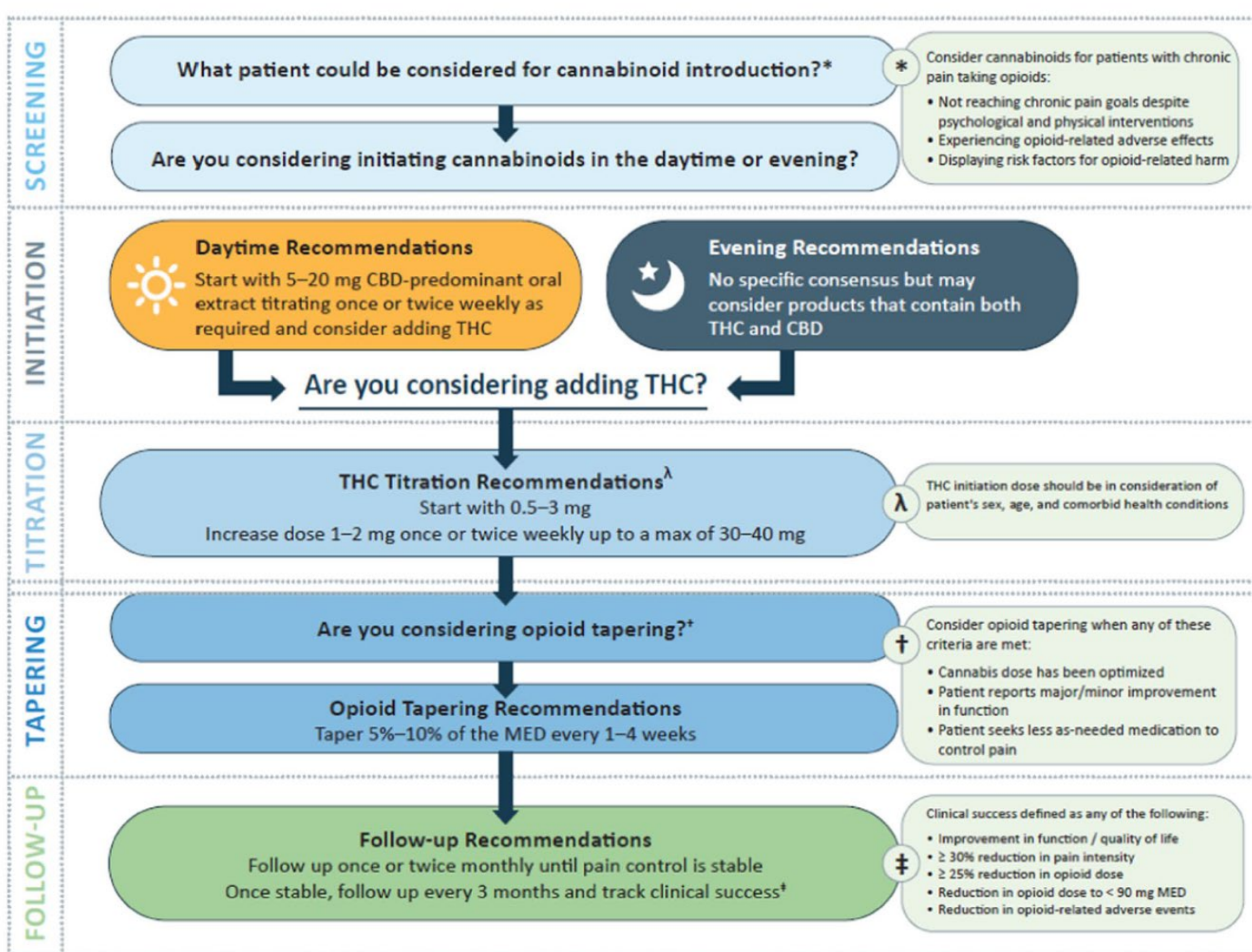
Adding cannabis likely increases **nausea and vomiting**, no effect on **constipation**

⊗○○○
(low)

Adding cannabis reduced **opioid use**

- 52% (32 of 61 patients) stopped all use of opioids at a median follow-up of 6.4 years
- CBD hemp extract → 53% were able to decrease their opioids at 8 weeks
- 0.5g medicinal cannabis for each 10% reduction in opioid dose → 55% had 30% reduction

CANNABINOIDS AND OPIOIDS



CONSENSUS
PRIMARY CARE

THE INTERNATIONAL JOURNAL OF
CLINICAL PRACTICE WILEY

Consensus-based recommendations for titrating cannabinoids and tapering opioids for chronic pain control

Aaron Sihota¹ | Brennan K. Smith² | Sana-Ara Ahmed³ | Alan Bell⁴ | Allison Blain⁵ | Hance Clarke⁶ | Ziva D. Cooper⁷ | Claude Cyr⁸ | Paul Daeninck⁹ | Amol Deshpande¹⁰ | Karen Ethans¹¹ | David Flusk¹² | Bernard Le Foll^{13,14,15,16,17,18,19} | M-J Milloy^{19,20} | Dwight E. Moulin²¹ | Vernon Naidoo²² | May Ong²⁰ | Jordi Perez²³ | Kevin Rod²⁴ | Robert Sealey²⁵ | Dustin Sulak²⁶ | Zachary Walsh²⁷ | Colleen O'Connell²⁸

FACILITATORS FOR A SUCCESSFUL TAPER

Prescriber

- Book longer appointments
- Provide education, videos, books, testimonials
- Mobilize interprofessional team (Pharm, Nurse, SW, psych)
- Use motivational interviewing techniques
- Clear goals for tapering
- Available by phone, email
- Slow taper, protocol-based
- Manage withdrawals
- Switch to another opioid before start tapering
- Buprenorphine

Patient

- Clear goals
- Support network
- Slow taper
- Manage withdrawals using non-pharmacological techniques
- Focus on function, not pain

TOOLBOX OF SELF-MANAGEMENT (5M IS)



Movement

Mind-body

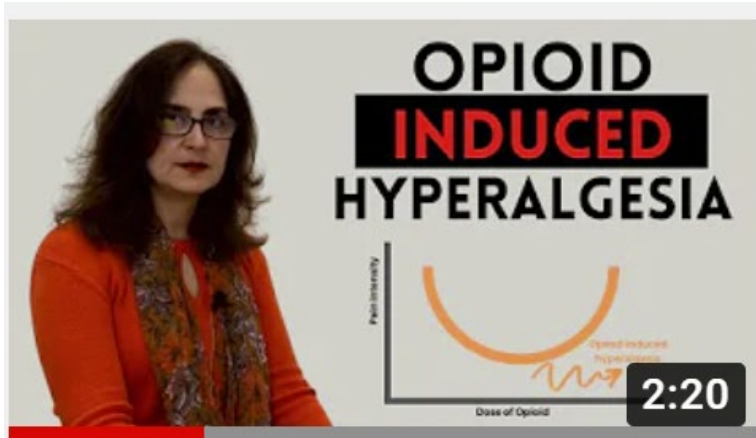
Modalities

Manual therapies

Medications

Interventional/Injections

Surgery



RESOURCES FOR PATIENTS

YouTube videos www.youtube.com/c/DrAndreaFurlan

Self-management www.selfmanagementontario.ca/

FREE book to download → My Opioid Manager

<https://www.opioidmanager.com/my-opioid-manager>

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- Self-paced
- Up-to-date tools and resources
- Interactive learning
- Assessment Activities
- Applies 2017 Canadian Opioid Guideline



CME CREDITS

- Royal College of Physicians and Surgeons of Canada: CPD Accreditation for Section 3 (Specialists= 3credits/ hour)
- College of Family Physicians of Canada: Mainpro+ (Family Physicians = 1 credit/hour)

REGISTER TODAY: WWW.OPIOIDASSESSMENT.CA



CONTACT:
Info@opioidassessment.ca

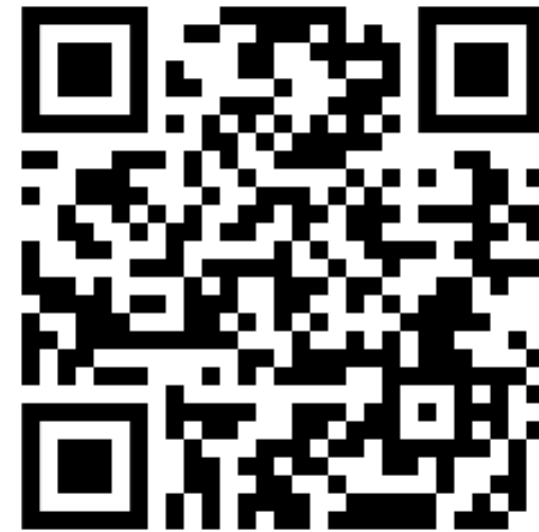
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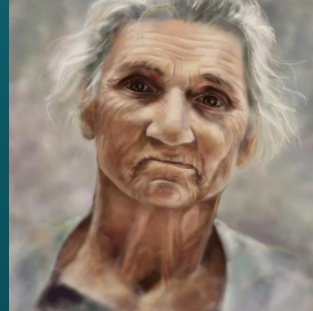
Email: echooem@iwh.on.ca

CASES



Percival

Opioid Induced
hyperalgesia (OIH)
Hypogonadism



Joana

Withdrawal
mediated pain
(WMP)



Lucy

Opioid Use
Disorder (OUD)

PERCIVAL



BEFORE

Oxycodone 80mg
Fentanyl patch 50
mcg
(MED 320 daily)
Pain constant 9/10



SWITCH

Switched to
morphine SR
once a day (160
MED)



TAPER

Slow taper
9 years = 9
months



GOAL

100% elimination of
all opioids



AFTER

Pain 2/10, occasionally
No fatigue, no low
mood
Still has low muscle
mass (frailty)

Success with patience

JOANA (I)



BEFORE

Hydromorphone
(MED 955 mg daily)



SWITCH

No switch



TAPER

Slow taper
Started with
immediate
release 32 → 20
tabs per day



GOAL

Improve withdrawal
mediated pain



AFTER

IR = 20 tables per day
Improved quality of
life (sleep)
Patient wanted to
stop taper
MED (715 mg daily)

Partial success

JOANA (II)



BEFORE

Hydromorphone
(MED 715 mg daily)



SWITCH

Buprenorphine/
Naloxone
induction

(sublingual
advantage due to
ileostomy)

Admitted to
hospital



TAPER

Bup/NLX 24mg
daily

(~ 130 MED)

No more
hydromorphone



GOAL

Reduce risk of
overdose,
complications,
polypharmacy,
improve quality of life



AFTER

Sleep much improved

Pain: can manage
with non-
pharmacological

Walks 3 km/day

Friends noticed
difference

Surprising Success

LUCY



BEFORE

Oxycodone IR
(37 MED)
Pain BPI 32/40
Interference BPI
60/70



SWITCH

Switched to
buprenorphine
patch 10
mcg/hour → 20
mcg/h patch



TAPER

Not possible
because of
ongoing spinal
stenosis



GOAL

Decrease risk of
immediate release
opioids – losing
control – opioid use
disorder



AFTER

Excellent pain relief
with buprenorphine
patch 20 mcg/h
Low risk OUD
(too expensive)

Expensive Success

THE TEAM



Dr. Andrea Furlan

Pain Specialist



Laura Murphy

Pharmacist



Joyce Lee

Nurse



Lucy Ruggiero

Social Worker



Andrew Smith

Addiction Medicine, CAMH

THANK YOU

Email: Andrea.Furlan@uhn.ca

Twitter [@adfurlan](https://twitter.com/adfurlan)

www.opioidassessment.ca

www.youtube.com/c/DrAndreaFurlan

