OPIOID TAPERING FOR PEOPLE WITH CHRONIC NON-MALIGNANT PAIN

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Chair, ECHO Ontario Chronic Pain and Opioid Stewardship

Scientist, Institute for Work & Health

DECLARATION OF POTENTIAL CONFLITS

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

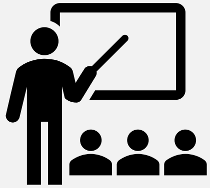
Youtube channel for patients with chronic pain, member of YouTube Partner Program.

Amazon affiliate marketing with links to products in the YouTube channel

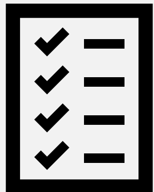
Unrestricted educational grant from Canadian Generic Product Association to offer an online self-assessment program of Opioids for Chronic Non-Cancer Pain.

LEARNING OBJECTIVES

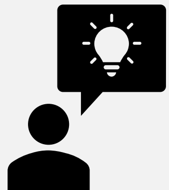
At the end of this presentation, participants will be able to:



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).

http://nationalpaincentre.mcmaster.ca/guidelines.html

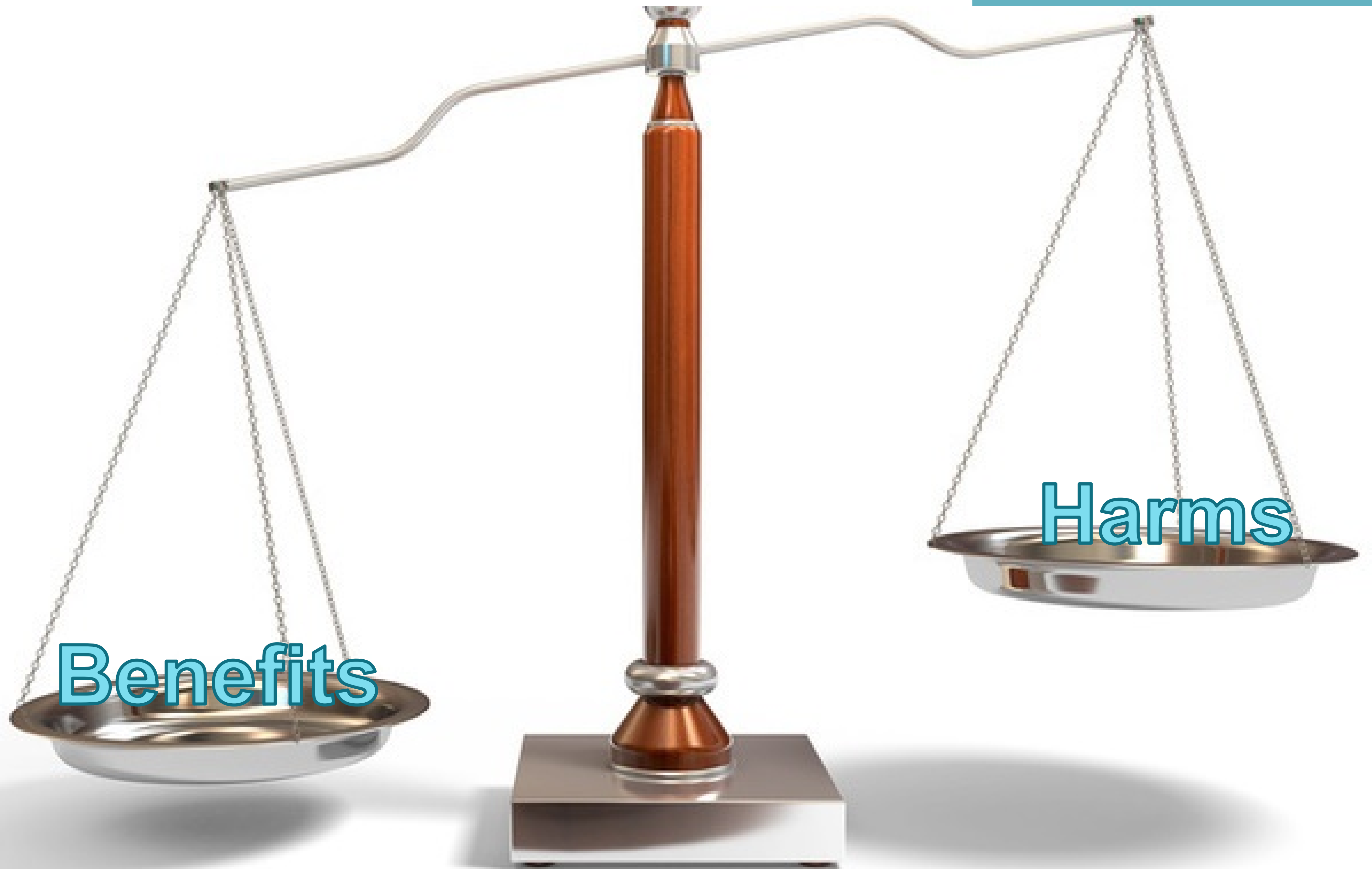
It is NOT about the calculator

Opioid Tapering Template

Opioid Manager

TOOLS

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


Harms
Benefits

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

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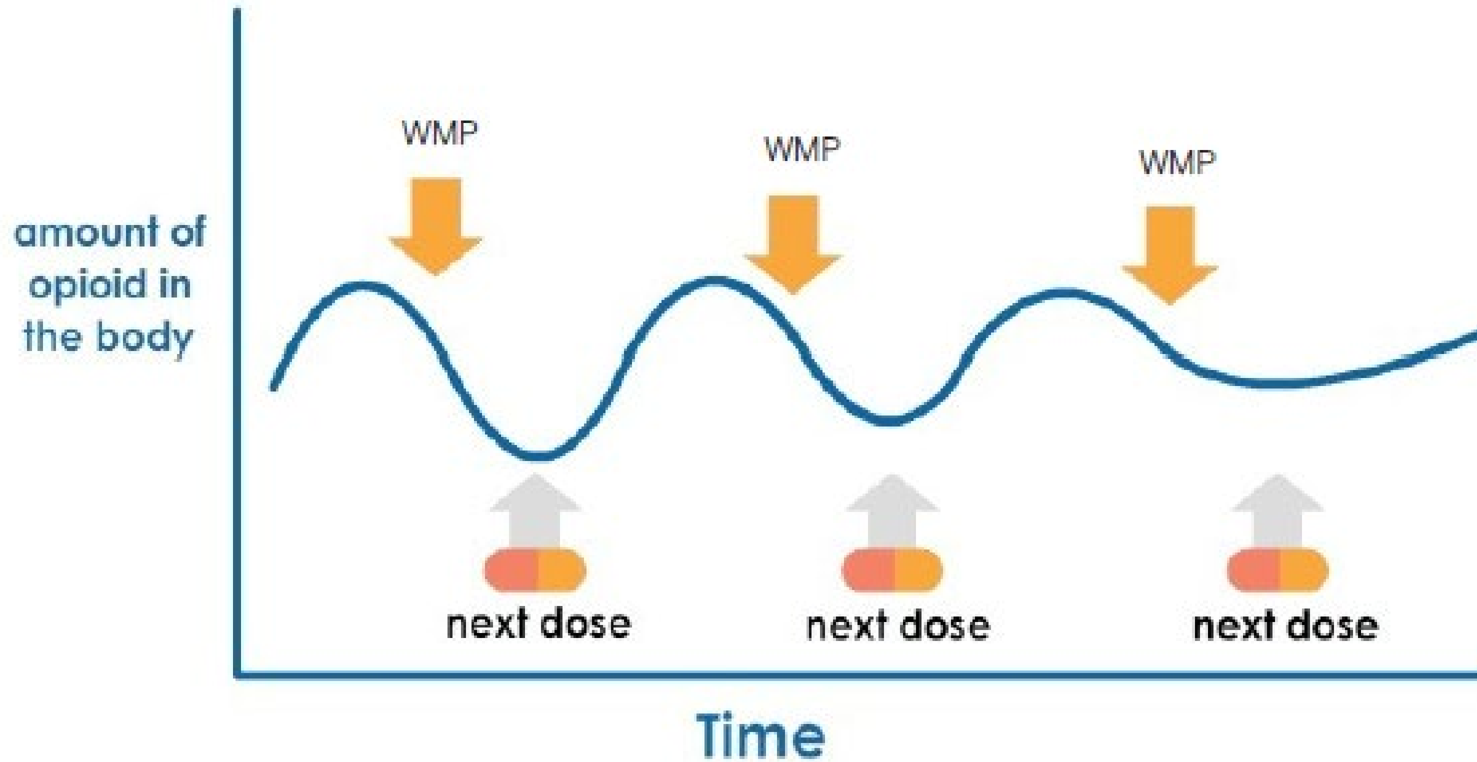
WITHDRAWAL MEDIATED PAIN

http://bit.ly/Withdrawal_Mediated_Pain



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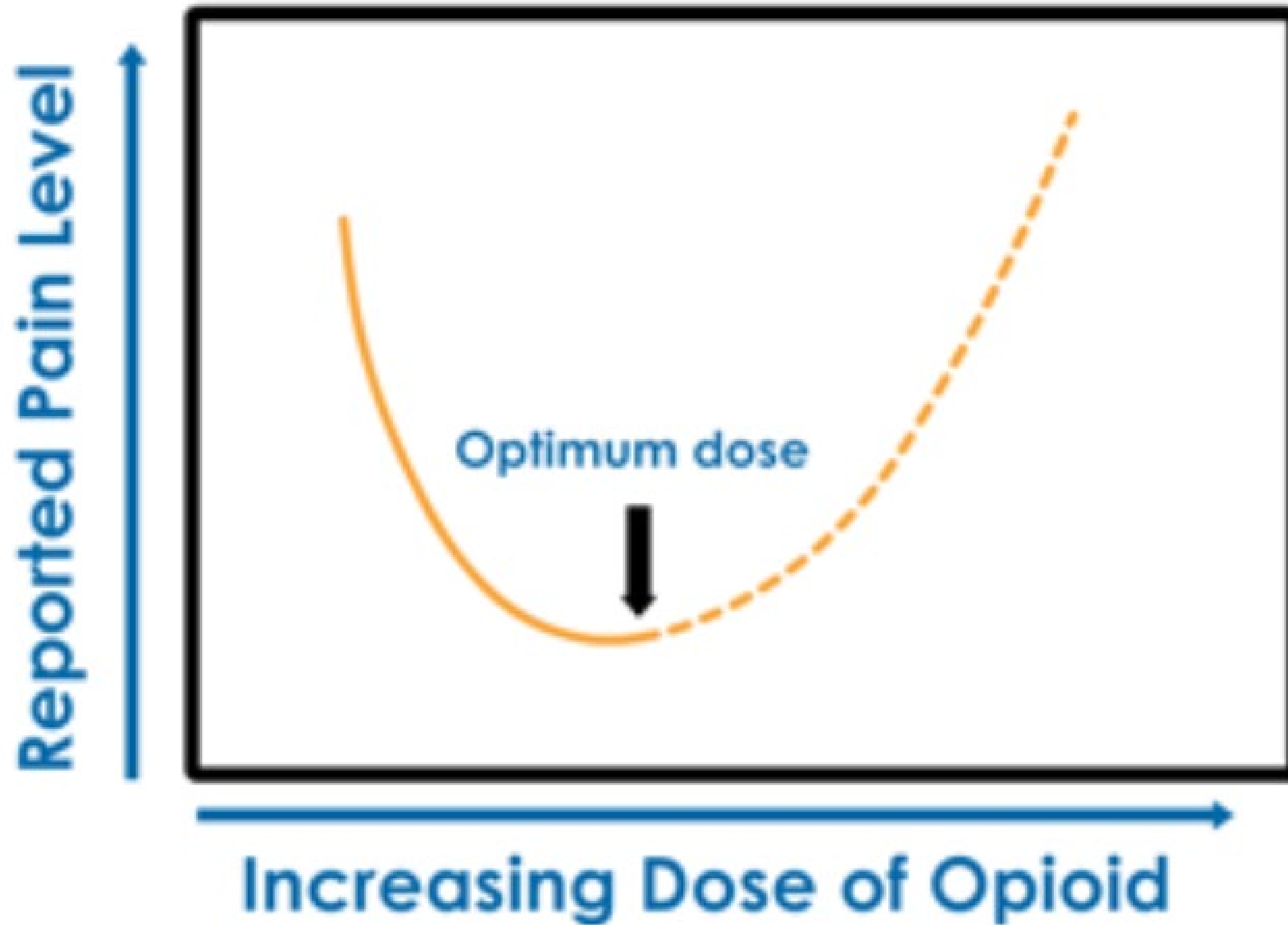
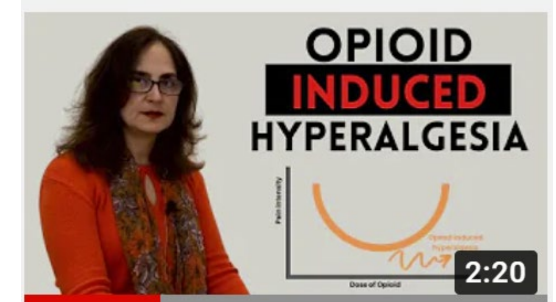
OPIOID INDUCED HYPERALGESIA



YouTube

http://bit.ly/Opioid_Induced_Hyperalgesia



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PATIENT SELECTION FOR OPIOID TAPERING

- Type of pain (headache, fibromyalgia, functional pain, emotional pain)
- Pain has resolved

•OIH
•Hypogonadism
•Immunesupression
•Sleep apnea
•Side effects
•Withdrawal mediated pain

Indication

Harms

Risks

Patient's preference

- Overdose
- Misuse
- Oud
- Overdose
- Death

- Patient's request

http://bit.ly/Opioid_Tapering

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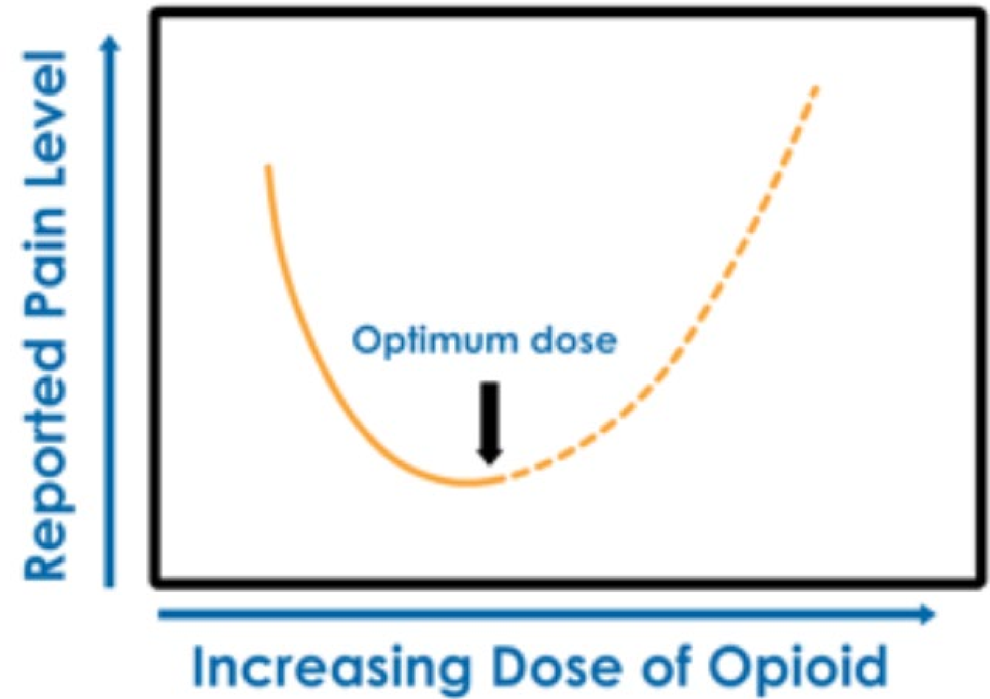
PERCIVAL

- 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

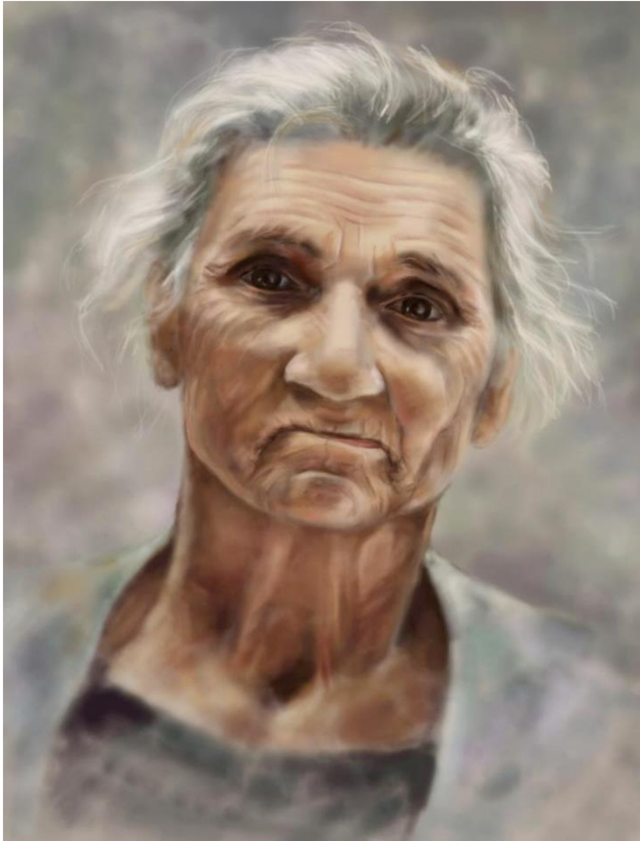
JOANA

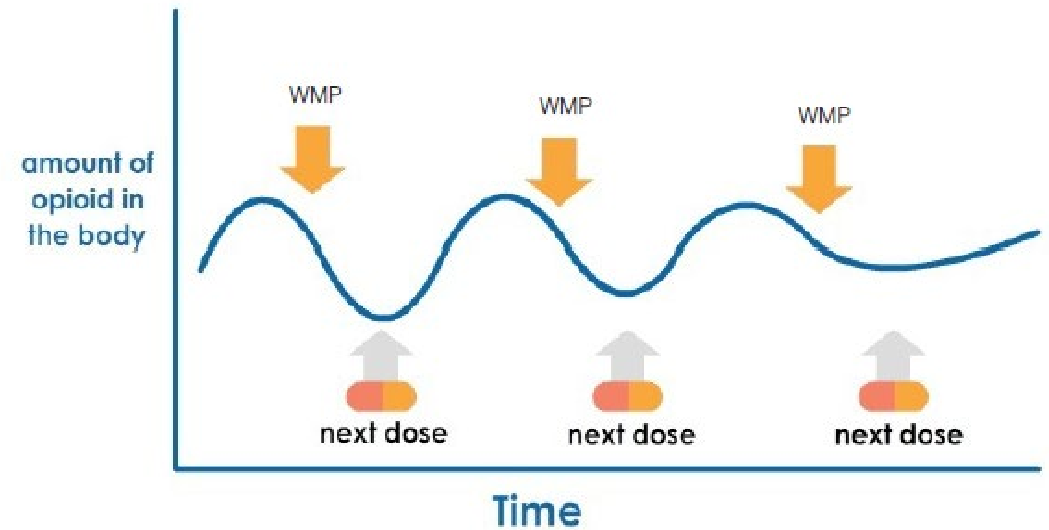
JOANA

- 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





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 ilicit opioids to supplement what doctor doesn’t give her.
- Equivalent MED = unknown
- Smokes marijuana to relax and sleep

TABLE 1	Summarized DSM-5 diagnostic categories and criteria for opioid use disorder
Category	**Criteria**
Impaired control	• 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	• 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	• 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	• 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/

LUCY

Opioid Use Disorder:

mild (2-3)

moderate (4-5)

severe (6-)

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

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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

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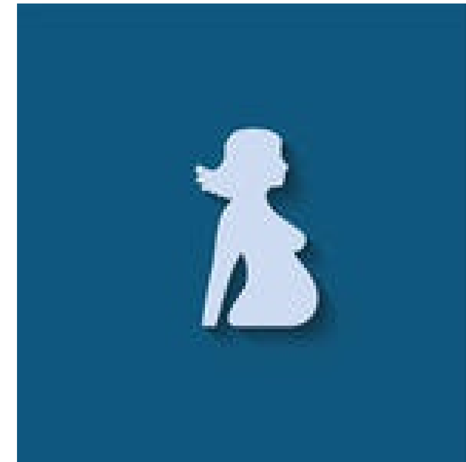
CONTRA-INDICATIONS FOR OPIOID TAPERING

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



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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

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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**

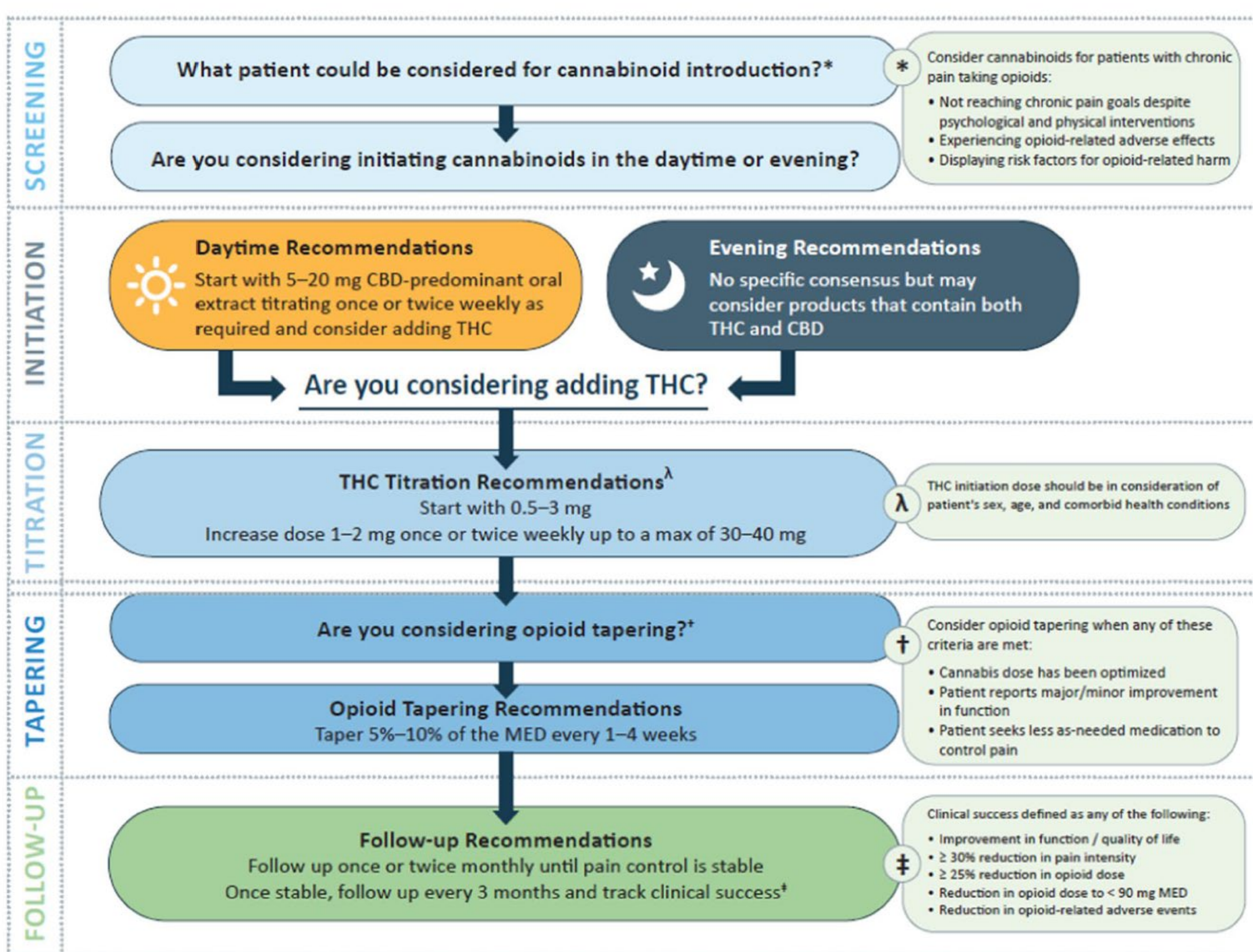
⨂⨂◯◯ (low) Adding cannabis likely increases **nausea and vomiting**, no effect on **constipation**

⨂◯◯◯ (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

Noori, BMJ Open, 2021

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 Sihota[1] | Brennan K. Smith[2] | Sana-Ara Ahmed[3] | Alan Bell[4] | Allison Blain[5] | Hance Clarke[6] | Ziva D. Cooper[7] | Claude Cyr[8] | Paul Daeninck[9] | Amol Deshpande[10] | Karen Ethans[11] | David Flusk[12] | Bernard Le Foll[13,14,15,16,17,18,19] | M-J Milloy[19,20] | Dwight E. Moulin[21] | Vernon Naidoo[22] | May Ong[20] | Jordi Perez[23] | Kevin Rod[24] | Robert Sealey[25] | Dustin Sulak[26] | Zachary Walsh[27] | Colleen O'Connell[28]

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

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TOOLBOX OF SELF-MANAGEMENT (5M IS)

Movement

Mind-body

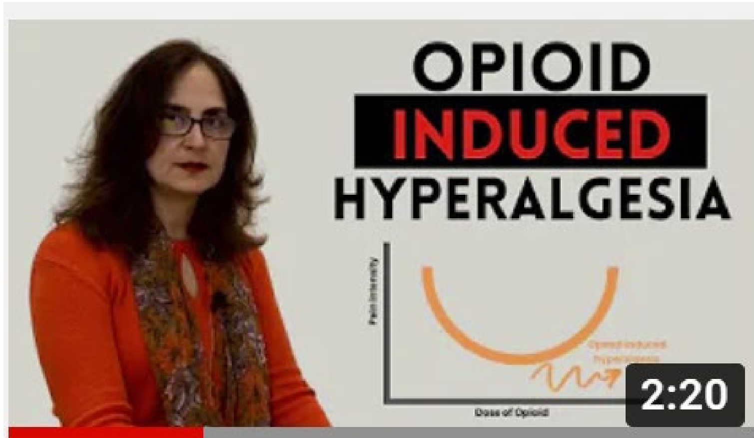
Modalities

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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INTERACTIVE ONLINE MEDICAL EDUCATION

Available ECHOs at UHN

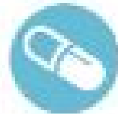
- **Chronic Pain & Opioid Stewardship**
- COVID-19
- Concussion
- Rheumatology
- Liver

Each session includes a didactic lecture by a content expert & real (anonymized) patient case discussions presented by participants.

Register at https://uhn.echoontario.ca/register

ONLINE SELF-ASSESSMENT PROGRAM FOR OPIODS FOR CHRONIC NON-CANCER PAIN

*Cost Free To All Leaners; $25 For Professionals



COURSE DETAILS

- Duration: 3 hours
- 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)

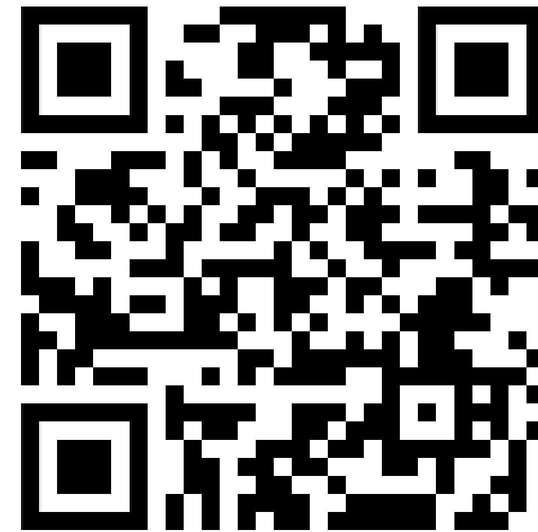
REGISTER TODAY: WWW.OPIOIDASSESSMENT.CA

CONTACT:
info@opioidassessment.ca

ECHO OCCUPATIONAL & ENVIRONMENTAL MEDICINE

Cycle 1: September 17 – December 3

Fridays at 1:00-2:30pm



Registration is ongoing!

Website: https://echooem.iwh.on.ca/

Email: echooem@iwh.on.ca

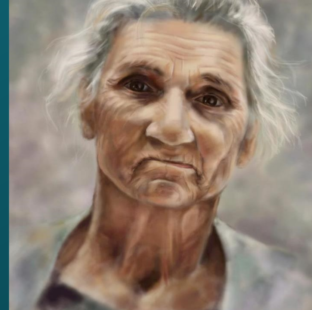
Institute for Work & Health

CASES

Percival

Opioid Induced hyperalgesia (OIH)

Hypogonadism



Joana

Withdrawal mediated pain (WMP)

Lucy

Opioid Use Disorder (OUD)

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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 – loosing 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

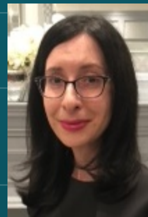
Pain Specialist

Laura Murphy

Pharmacist

Joyce Lee

Nurse



Lucy Ruggiero

Social Worker

Andrew Smith

Addiction Medicine, CAMH

THANK YOU

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www.opioidassessment.ca

www.youtube.com/c/DrAndreaFurlan

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