The Geriatric Patient & Chronic Opioids

Patient-centered approach to chronic opioid management - Washington State AMDG

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Persistent Pain in Older Adults

- Pain is common: 67% report ≥ moderate pain in last month
- Painful conditions disproportionally affect elders
  - Chronically painful musculoskeletal disorders, malignancy, neuropathic
  - Typically multiple sites of pain
- Pain has a profound impact on older adults
  - Deconditioning, functional impairment, slower rehabilitation
  - Increased falls and fractures
  - Impaired cognition, worsening mood, increased isolation
  - Impaired sleep and appetite
  - Increased health care costs
  - Decreased quality of life

AGS, *JAGS*, 2009. Davies, *Nurse Pract*, 2017. Makris, 2014, *JAMA*. Malec, *MCNA*, 2015. Stubbs, *Arch Phys Med Rehab*, 2014.

Concerns: Pharmacological Management of Pain in Elders

- Pharmacodynamic & pharmacokinetic changes with aging
  - Decreased drug clearance & prolonged drug half life → Adverse drug rxt
  - Narrowed therapeutic window → Safety risks in prescribing
- Polypharmacy & multimorbidity
  - Increased risk of clinically significant drug interactions, and
  - Drug – disease interactions
- Focus on non-steroidal anti-inflammatory drugs (NSAIDs)
  - NSAIDs are potentially dangerous when used chronically in elders
  - "NSAIDs … may be considered *rarely and with extreme caution* in highly selected individuals." [AGS, 2009, p.1342]
  - NSAIDs "should be prescribed for the *shortest duration possible in the lowest effective dose* and with careful surveillance to monitor GI, renal, cardiovascular toxicity." [Wongrakpanich, 2018, p.148]

AGS. Pharm mngt of persistent pain in older persons. *JAGS* 2009; 57(8):1331-46. Wallace. Appropriate prescribing and important drug interactions in older adults. *MCNA.* 2015;99(2):295-310. Wongrakpanich. A comprehensive review NSAID use in the elderly. *Aging & Disease* 2018;9(1): 143-150.

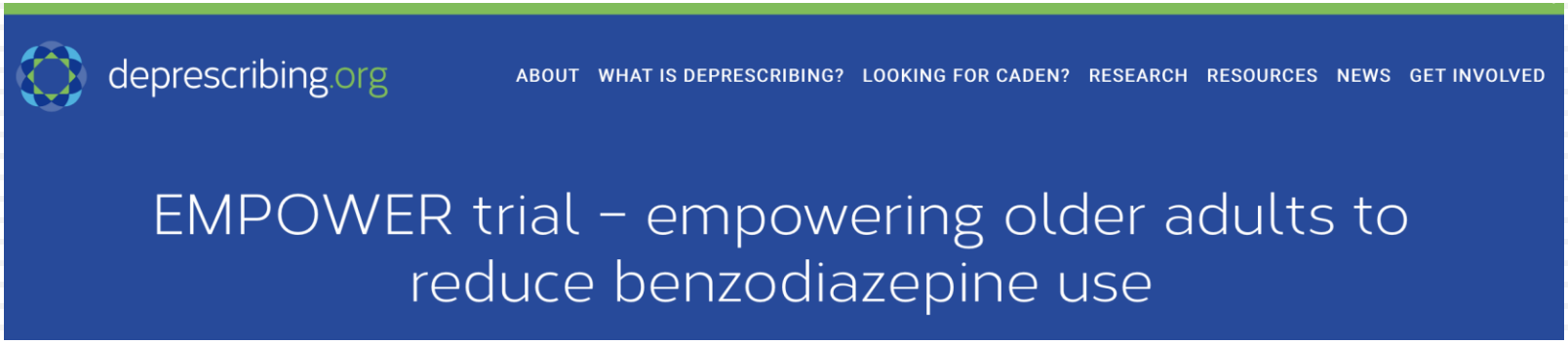
Chronic Opioid Therapy in Older Adults

- Opioids may be safer than NSAIDs in older adults [1]
  - AGS: Consider as part of a multimodal pain management strategy for those with moderate-severe pain, pain-related functional impairments, diminished QOL
- Nonetheless, chronic opioid tx remains concerning in elders [2, 3]
  - Falls, sedation, cognitive clouding, MVA, and unsafe polypharmacy
  - Older adults are particularly vulnerable to accidental opioid overdose
- The efficacy of opioids for chronic noncancer pain is uncertain
  - Reduced opioids were not clearly related to incr pain in veterans with OA [4]
- There is an **increased incidence of opioid misuse, opioid use disorder, and opioid-related overdose deaths in older adults** [5]
- The highest risk for opioid overdose in elders involve: [6]
  - **Concurrent sedative-hypnotics, higher opioid doses,** multiple prescribers/pharmacies, high opioid dose without a pain diagnosis

[1] AGS. Pharm mngt persistent pain older persons. *JAGS* 2009; 57(8):1331-46. [2] Naples. Opioid analgesics in geriatric pain mngt. *Cl Ger Med. 2016;*32.4: 725-735. [3] Davies. Opioids for pain mngt in older adults: Strategies for safer prescribing. Nurse Pract. 2017;42(2):20-26. [4] Trentalange. Analgesic rx VA OA. *Pain*. 2019;160(6):1319-26. [5] Scholl. Drug & Opioid-Involved Overdose Deaths - US, 2013-2017. MMWR. 2018 Jan 4;67(5152):1419-1427.
[6] Rose. Effect of Age on Opioid Prescribing, Overdose, and Mortality in Massachusetts, 2011 to 2015. J Am Geriatr Soc. 2019 Jan;67(1):128-132.

Engaging Elders to Reduce Opioids ….
Follow the Canadians!

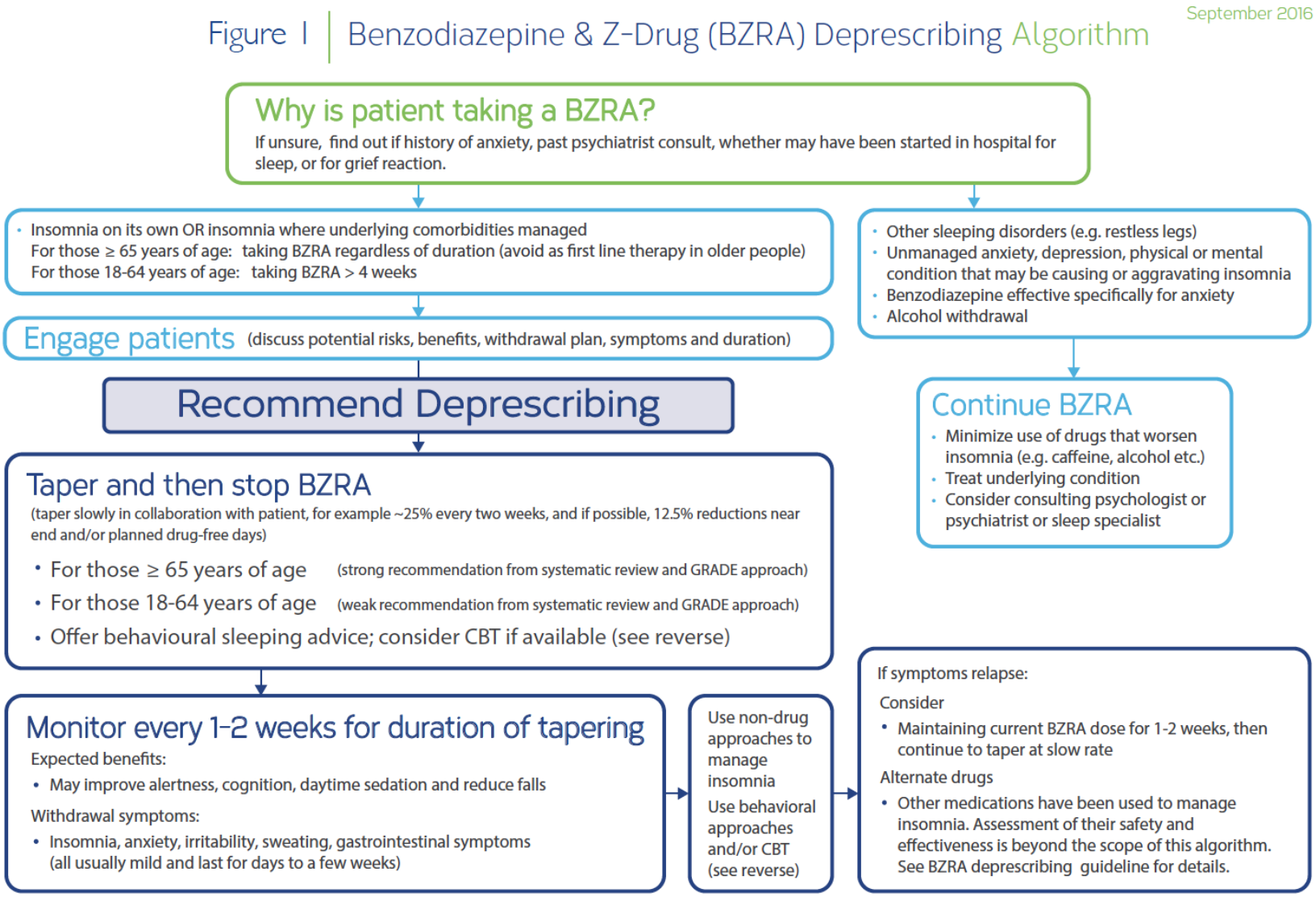
- Evidence-based clinical practice guidelines to reduce benzodiazepine receptor agonist use



Pottie. Deprescribing benzodiazepine receptor agonists: Evidence-based clinical practice guideline. *Canadian Family Physician* 64.5 (2018): 339-351.

Algorithm for Evaluation of BZRA Use

Ask Why → Engage → Recommend Stop or Continue → Close Follow up for Taper



Pottie. Deprescribing benzodiazepine: Evidence-based clinical practice guideline. *Canad Fam Phys* 64.5 2018;64(5):339-351. p. 346

Specific Instructions for Engaging Patients, Behavioral Management & CBT Before and During the Taper Process

deprescribing.org | Benzodiazepine & Z-Drug (BZRA) Deprescribing Notes

September 2016

BZRA Availability

BZRA	Strength
Alprazolam (Xanax®) T	0.25 mg, 0.5 mg, 1 mg, 2 mg
Bromazepam (Lectopam®) T	1.5 mg, 3 mg, 6 mg
Chlordiazepoxide (Librax®) C	5 mg, 10 mg, 25 mg
Clonazepam (Rivotril®) T	0.25 mg, 0.5 mg, 1 mg, 2 mg
Clorazepate (Tranxene®) C	3.75 mg, 7.5 mg, 15 mg
Diazepam (Valium®) T	2 mg, 5 mg, 10 mg
Flurazepam (Dalmane®) C	15 mg, 30 mg
Lorazepam (Ativan®) T,S	0.5 mg, 1 mg, 2 mg
Nitrazepam (Mogadon®) T	5 mg, 10 mg
Oxazepam (Serax®) T	10 mg, 15 mg, 30 mg
Temazepam (Restoril®) C	15 mg, 30 mg
Triazolam (Halcion®) T	0.125 mg, 0.25 mg
Zopiclone (Imovane®, Rhovane®) T	5mg, 7.5mg
Zolpidem (Sublinox®) S	5mg, 10mg

T = tablet, C = capsule, S = sublingual tablet

BZRA Side Effects

- BZRAs have been associated with:
  - physical dependence, falls, memory disorder, dementia, functional impairment, daytime sedation and motor vehicle accidents
- Risks increase in older persons

Engaging patients and caregivers

Patients should understand:
- The rationale for deprescribing (associated risks of continued BZRA use, reduced long-term efficacy)
- Withdrawal symptoms (insomnia, anxiety) may occur but are usually mild, transient and short-term (days to a few weeks)
- They are part of the tapering plan, and can control tapering rate and duration

Tapering doses

- No published evidence exists to suggest switching to long-acting BZRAs reduces incidence of withdrawal symptoms or is more effective than tapering shorter-acting BZRAs
- If dosage forms do not allow 25% reduction, consider 50% reduction initially using drug-free days during latter part of tapering, or switch to lorazepam or oxazepam for final taper steps

Behavioural management

Primary care:
1. Go to bed only when sleepy
2. Do not use bed or bedroom for anything but sleep (or intimacy)
3. If not asleep within about 20-30 min at the beginning of the night or after an awakening, exit the bedroom
4. If not asleep within 20-30 min on returning to bed, repeat #3
5. Use alarm to awaken at the same time every morning
6. Do not nap
7. Avoid caffeine after noon
8. Avoid exercise, nicotine, alcohol, and big meals within 2 hrs of bedtime

Institutional care:
1. Pull up curtains during the day to obtain bright light exposure
2. Keep alarm noises to a minimum
3. Increase daytime activity & discourage daytime sleeping
4. Reduce number of naps (no more than 30 mins and no naps after 2 pm)
5. Offer warm decaf drink, warm milk at night
6. Restrict food, caffeine, smoking before bedtime
7. Have the resident toilet before going to bed
8. Encourage regular bedtime and rising times
9. Avoid waking at night to provide direct care
10. Offer backrub, gentle massage

Using CBT

What is cognitive behavioural therapy (CBT)?
- CBT includes 5-6 educational sessions about sleep/insomnia, stimulus control, sleep restriction, sleep hygiene, relaxation training and support

Does it work?
- CBT has been shown in trials to improve sleep outcomes with sustained long-term benefits

Who can provide it?
- Clinical psychologists usually deliver CBT, however, others can be trained or can provide aspects of CBT education; self-help programs are available

How can providers and patients find out about it?
- Some resources can be found here: http://sleepwellns.ca/

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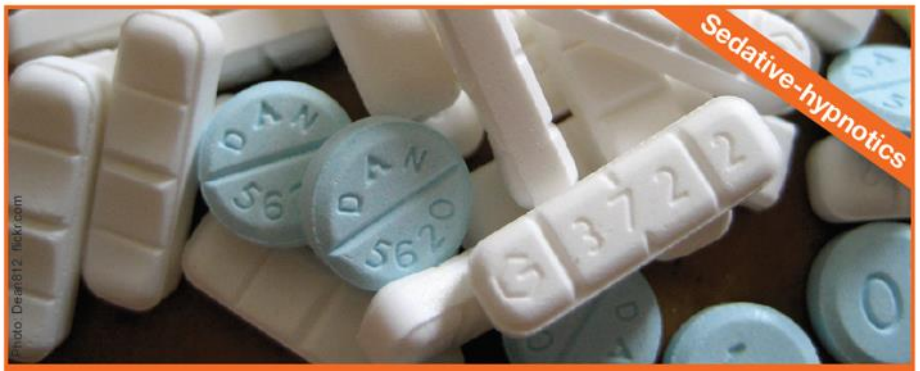
EMPOWER Brochure
Engagement through Education



You May Be at Risk

You are taking one of the following sedative-hypnotic medications:

- ◯ Alprazolam (Xanax®)
- ◯ Diazepam (Valium®)
- ◯ Temazepam (Restoril®)
- ◯ [illegible]
- ◯ [illegible]
- ◯ [illegible]

QUIZ

Sedative-hypnotic medication

1. The medication I am taking is a mild tranquilizer that is safe to take for long periods of time. ◯ True ◯ False

1. FALSE

Although it is effective for a short time, re
hypnotic medication is not the best long-t
insomnia. This is because it covers up th
solving the problem — while causing ma
reading to learn more about how you can develop healthier sleep patterns and lessen your stress and anxiety.

Did you know?

Sedative-hypnotic medication can be highly addictive and can cause many side effects. Except in special cases, these medications should never be taken.

As you age

Many changes take place in your body as your age, including:

- Changes in how your body processes medications.
- Decreases in your liver and kidney function.
- Changes related to illnesses you may have had.

This means that medications stay in your body longer as you get older, and your risk of side effects increases.

Other ways to help you sleep

- Try to get up in the morning and go to bed at night at the same time every day.

Other ways to deal with stress and anxiety

- Consider talking to a therapist or joining a support group. Both are proven to help people work out stressful situations and deal with what makes them anxious.

Strategies for Safer Prescribing in Older Adults When Opioids Are Determined to Be Appropriate

- Use a multi-modal approach
  - Maximize non-pharmacological and non-opioid therapies, consider interventional options
- Individualize the plan of care - there is significant inter-individual variability
  - Monitor for renal impairment and adjust dose and frequency – this is a dynamic process
- Screen for opioid misuse, opioid and other substance use disorder
  - Assess for risks for accidental overdose on an ongoing basis – especially new RX (benzos)
  - Regularly monitor the Prescription Drug Program
- Opioid selection
  - Hydromorphone, oxycodone and hydrocodone are preferred over morphine
  - Fentanyl TD and methadone have no active metabolites, and thus better in renal impairment, but are long acting, which may accumulate
- Opioid prescribing
  - Primarily utilize short-acting opioids, indicate maximum tablets/day on the label
  - Use PRN prescribing (rather than scheduled) especially in frail elders
  - **Avoid or use extreme caution in prescribing opioids concurrently with benzodiazepine and other sedative-hypnotics**
- Regularly reassess the risk/benefit of opioid therapy and consider a trial taper to a lower dose, when appropriate

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