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

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]
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

Engaging Elders to Reduce Opioids ....

*Follow the Canadians!*

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

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Algorithm for Evaluation of BZRA Use

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

Figure 1 | Benzodiazepine & Z-Drug (BZRA) Deprescribing Algorithm

September 2016

Why is patient taking a BZRA?
If unsure, find out if history of anxiety, past psychiatrist consult, whether may have been started in hospital for sleep, or for grief reaction.

- Insomnia on its own OR Insomnia where underlying comorbidities managed
  For those ≥ 65 years of age: taking BZRA regardless of duration (avoid as first line therapy in older people)
  For those 18-64 years of age: taking BZRA > 4 weeks

Engage patients (discuss potential risks, benefits, withdrawal plan, symptoms and duration)

Recommend Deprescribing

Taper and then stop BZRA
(taper slowly in collaboration with patient, for example ~25% every two weeks, and if possible, 12.5% reductions near end and/or planned drug-free days)

- For those ≥ 65 years of age (strong recommendation from systematic review and GRADE approach)
- For those 18-64 years of age (weak recommendation from systematic review and GRADE approach)
- Offer behavioural sleeping advice; consider CBT if available (see reverse)

Monitor every 1-2 weeks for duration of tapering
Expected benefits:
- May improve alertness, cognition, daytime sedation and reduce falls
Withdrawal symptoms:
- Insomnia, anxiety, irritability, sweating, gastrointestinal symptoms (all usually mild and last for days to a few weeks)

Use non-drug approaches to manage insomnia
Use behavioral approaches and/or CBT (see reverse)

Continue BZRA
- Minimize use of drugs that worsen insomnia (e.g. caffeine, alcohol etc.)
- Treat underlying condition
- Consider consulting psychologist or psychiatrist or sleep specialist

If symptoms relapse:
Consider
- Maintaining current BZRA dose for 1-2 weeks, then continue to taper at slow rate
Alternate drugs
- Other medications have been used to manage insomnia. Assessment of their safety and effectiveness is beyond the scope of this algorithm. See BZRA deprescribing guideline for details.

### Specific Instructions for Engaging Patients, Behavioral Management & CBT

**Before and During the Taper Process**

#### BZRA Availability

<table>
<thead>
<tr>
<th>BZRA</th>
<th>Strength</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alprazolam (Xanax&lt;sup&gt;t&lt;/sup&gt;)</td>
<td>0.25 mg, 0.5 mg, 1 mg, 2 mg</td>
</tr>
<tr>
<td>Bromazepam (Lectapam&lt;sup&gt;t&lt;/sup&gt;)</td>
<td>1.5 mg, 3 mg, 6 mg</td>
</tr>
<tr>
<td>Chlordiazepoxide (Librax&lt;sup&gt;c&lt;/sup&gt;)</td>
<td>5 mg, 10 mg, 25 mg</td>
</tr>
<tr>
<td>Clonazepam (Rivotril&lt;sup&gt;t&lt;/sup&gt;)</td>
<td>0.25 mg, 0.5 mg, 1 mg, 2 mg</td>
</tr>
<tr>
<td>Clorazepate (Tranxene&lt;sup&gt;c&lt;/sup&gt;)</td>
<td>3.75 mg, 7.5 mg, 15 mg</td>
</tr>
<tr>
<td>Diazepam (Valium&lt;sup&gt;t&lt;/sup&gt;)</td>
<td>2 mg, 5 mg, 10 mg</td>
</tr>
<tr>
<td>Flurazepam (Dalmane&lt;sup&gt;c&lt;/sup&gt;)</td>
<td>15 mg, 30 mg</td>
</tr>
<tr>
<td>Lorazepam (Ativan&lt;sup&gt;1,3&lt;/sup&gt;)</td>
<td>0.5 mg, 1 mg, 2 mg</td>
</tr>
<tr>
<td>Nitrazepam (Mogadon&lt;sup&gt;t&lt;/sup&gt;)</td>
<td>5 mg, 10 mg</td>
</tr>
<tr>
<td>Oxazepam (Serax&lt;sup&gt;t&lt;/sup&gt;)</td>
<td>10 mg, 15 mg, 30 mg</td>
</tr>
<tr>
<td>Temazepam (Restoril&lt;sup&gt;c&lt;/sup&gt;)</td>
<td>15 mg, 30 mg</td>
</tr>
<tr>
<td>Triazolam (Halcion&lt;sup&gt;t&lt;/sup&gt;)</td>
<td>0.125 mg, 0.25 mg</td>
</tr>
<tr>
<td>Zopiclone (Imovane&lt;sup&gt;, Rhovane&lt;sup&gt;s&lt;/sup&gt;&lt;/sup&gt;</td>
<td>5 mg, 7.5 mg</td>
</tr>
<tr>
<td>Zolpidem (Sublinox&lt;sup&gt;s&lt;/sup&gt;)</td>
<td>5 mg, 10 mg</td>
</tr>
</tbody>
</table>

*<sup>T</sup> = tablet, <sup>C</sup> = capsule, <sup>S</sup> = sublingual tablet

#### 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://sleepwellins.ca/](http://sleepwellins.ca/)

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**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 you 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.

**You May Be at Risk**
You are taking one of the following sedative-hypnotic medications:
- Alprazolam (Xanax®)
- Diazepam (Valium®)
- Temazepam (Restoril®)
- Promazine (Zydelig®)
- Triazolam (Halcion®)
- Trazodone (Desyrel®)

**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, repeated use of sedative-hypnotic medication is not the best long-term solution for insomnia. This is because it can help you fall asleep, but it doesn’t address the underlying causes of your sleep problem, and can lead to a cycle of dependence and reduced quality of sleep. It is important to seek professional help to address the root causes of your sleep issues.
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

References