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A collaboration of state agencies, working together to improve health care quality for Washington State citizens

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Tapering Opioids

- A little evidence
- A lot of experience

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A Patient Perspective

"I would personally go CT rather than draw it out by tapering..load up on some immodium, clonidine, benzos and it will make detox WAY more comfortable. But if you have extra opiates on hand I guess there is no reason to taper a little bit. Rather than a structured taper, I would cease use and only take a pill when withdrawals have become unbearable. And when you do take a pill, absolutely do not take enough to get high or it is counter productive. You want just enough to stave off withdrawals a little.. Not to maintain and feel dandy all day. Like every time you hit th epeak of withdrawals and are puking/whatever symptoms you exhibit, take a LITTLE oxycodone.. like 2.5mg, wait an hour and see if it has releived any symptoms.

Clonidine will absolutely not red flag you if you choose to get it. My bupe doctor said he presribed it for coke and nicotine withdrawal as well. But I mean its a blood pressure med as far as your insurance company knows.. they have no idea what off-label use your doc is prescribing for.

If you are worried about the red flag thing get clonidine prescribed for nicotine withdrawal. It is common. Clonidine will help your detox like crazy.. it does WONDERS for sweats and will let you get some sleep/releif from rls"

http://www.bluelight.org/vb/threads/620286-fastest-opiate-taper-possible
20-4-12

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When should opioids be stopped or tapered?

- Patient request
- After 3 months there is no clinically meaningful improvement in **FUNCTION**, (CMIF)
- Risk of continued treatment outweighs benefit
- Patient has experienced a severe adverse outcome or overdose event
- Patient has a substance use disorder
- Use is not in compliance with DOH pain management rules or consistent with AMDG guideline
- Patient exhibits aberrant behaviors

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Behavioral Considerations

Less suggestive for addiction but are increased in depressed patients	More suggestive of addiction and are more prevalent in patients with substance use disorder
Frequent requests for early refills; claiming lost or stolen prescriptions	Buying opioids on the street; stealing or selling drugs
Opioid(s) used more frequently, or at higher doses than prescribed	Multiple prescribers ("doctor shopping")
Using opioids to treat non-pain symptoms	Trading sex for opioids
Borrowing or hoarding opioids	Using illicit drugs, +UDT for illicit drugs
Using alcohol or tobacco to relieve pain	Forging prescriptions
Requesting more or specific opioids	Aggressive demand for opioids
Recurring emergency room visits for pain	Injecting oral/topical opioids
Concerns expressed by family member(s)	Signs of intoxication (ETOH odor, sedation, slurred speech, motor instability etc.)
Unexpected drug test results	
Inconsistencies in the patient's history	Adapted from Passik, S. 2006

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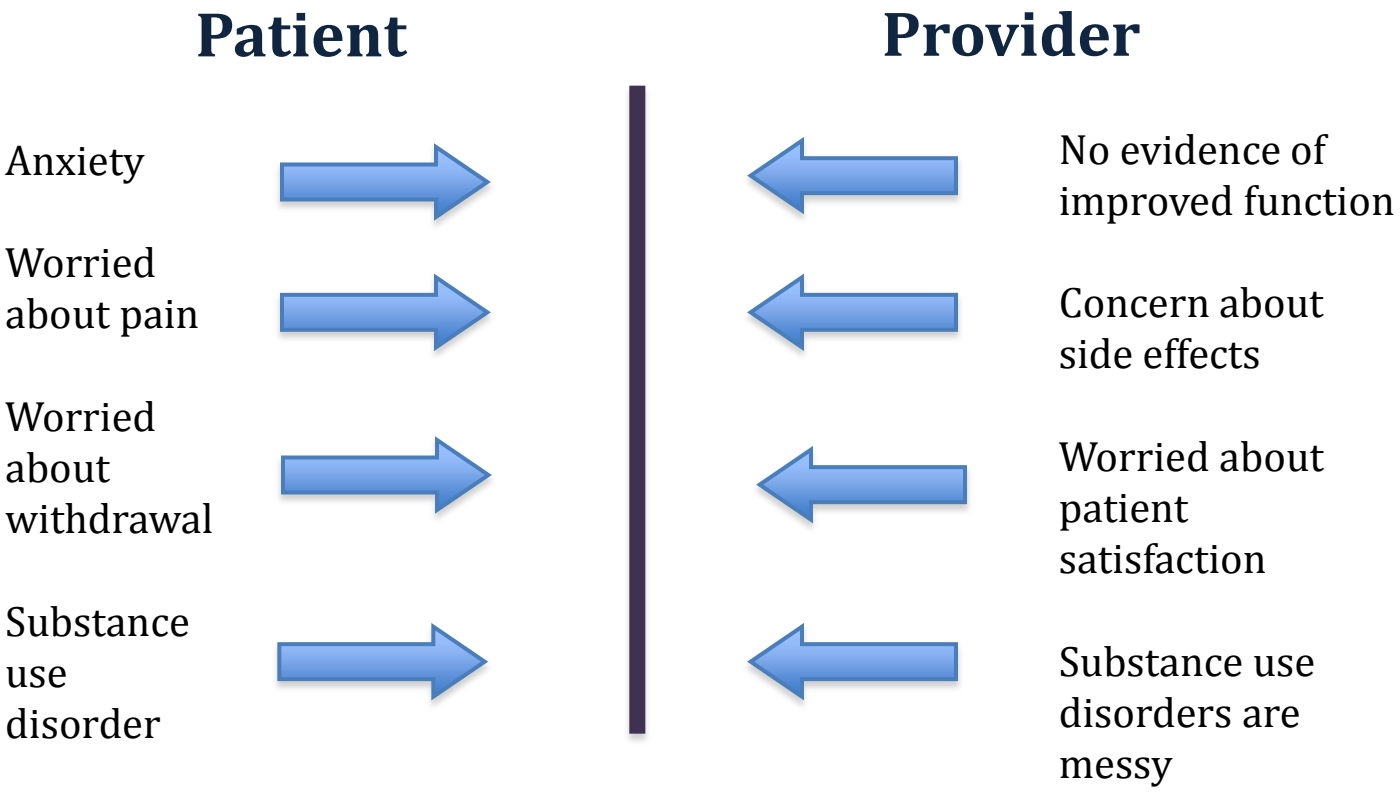
Conflicting Interests



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How to taper/discontinue opioids

- For most patients outpatient tapering is appropriate: (acute mental health issues, chronic high dose opioids or co-occurring substance use disorder)
- If using and want to taper both opioids and benzodiazepines, taper opioids first
- Avoid "ultra-rapid" detoxification methods
- Base the rate of taper on safety considerations:
  - Slow taper, no concerns: 10% per week, once at lower doses can go faster
  - Rapid taper, concern for SUD or severe adverse event: taper over 2-3 weeks
  - Immediate taper, concern for non-medical use, diversion
- Watch for signs of unmasked behavioral health conditions
- Adjust rate, amount based on response, (including withdrawal symptoms)
- Don't go backwards
- Don't treat withdrawal symptoms with benzodiazepines
- Don't start or resume opioids or benzodiazepines once discontinued

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Recommendations of others

Provider Action	APS/ AAPM	Utah	VA/ DoD	WA State	Canadian	ACOEM	NYC	ASIPP
Reason	Repeated aberrant behaviors, abuse/ diversion, no benefit, bad SE	Goals not met, harms> benefits, dangerous or illegal behavior	Misuse , abuse or SUD	No benefit, adverse effects, aberrant behaviors	Discontinue if pain remains unresponsive	Failure to improve, aberrant behaviors	Taper if signs of opioid misuse	No benefit, adverse effects or aberrant behavior
Taper Plan	10%/week to 25-50% every few days	10%/week over 6-8 week	20-50%/week may go faster or slower	10%/wk over 6-8 weeks	10%/day or 10% every 1-2 weeks	Not addressed	10%/day, 20% every 3-5 days, 25%/week	10%/week

http://www.cdc.gov/drugoverdose/pdf/common_elements_in_guidelines_for_prescribing_opioids-a.pdf

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Withdrawal Symptom Management

Restlessness, sweating, tremors: Clonidine 0.1-0.2mg orally every 6 hours or transdermal patch 0.1-0.2mg weekly (If using the patch, oral medication is required for the first 72 hours) during taper. Monitor for significant hypotension and anticholinergic side effects.

Nausea: Anti-emetics such as ondansetron or prochlorperazine

Diarrhea: Loperamide or anti-spasmodics such as dicyclomine

Muscle pain and myoclonus: NSAIDs or muscle relaxants such as cyclobenzaprine or methocarbamol

Insomnia: Sedating antidepressants (e.g. nortriptyline 25mg at bedtime or mirtazapine 15mg at bedtime or trazodone 50mg at bedtime. Do not use benzodiazepines or sedative-hypnotics.

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Additional Considerations

- Persons who smoke may have a harder time, in terms of increased opioid craving
  - Nicotine & Tobacco Research, Volume 15, Number 10 (October 2013) 1705–1713
- If multiple opioids are being used convert to one long-acting agent and use scheduled doses
- Pain should not worsen and for those on high dose opioids may get better
- Buprenorphine may be a good alternative for patients who have chronic pain and who had or develop opioid use disorder

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Treatment for Opioid Use Disorder

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University of Washington

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Saxon Disclosures

- Received royalties from UpToDate, Inc.

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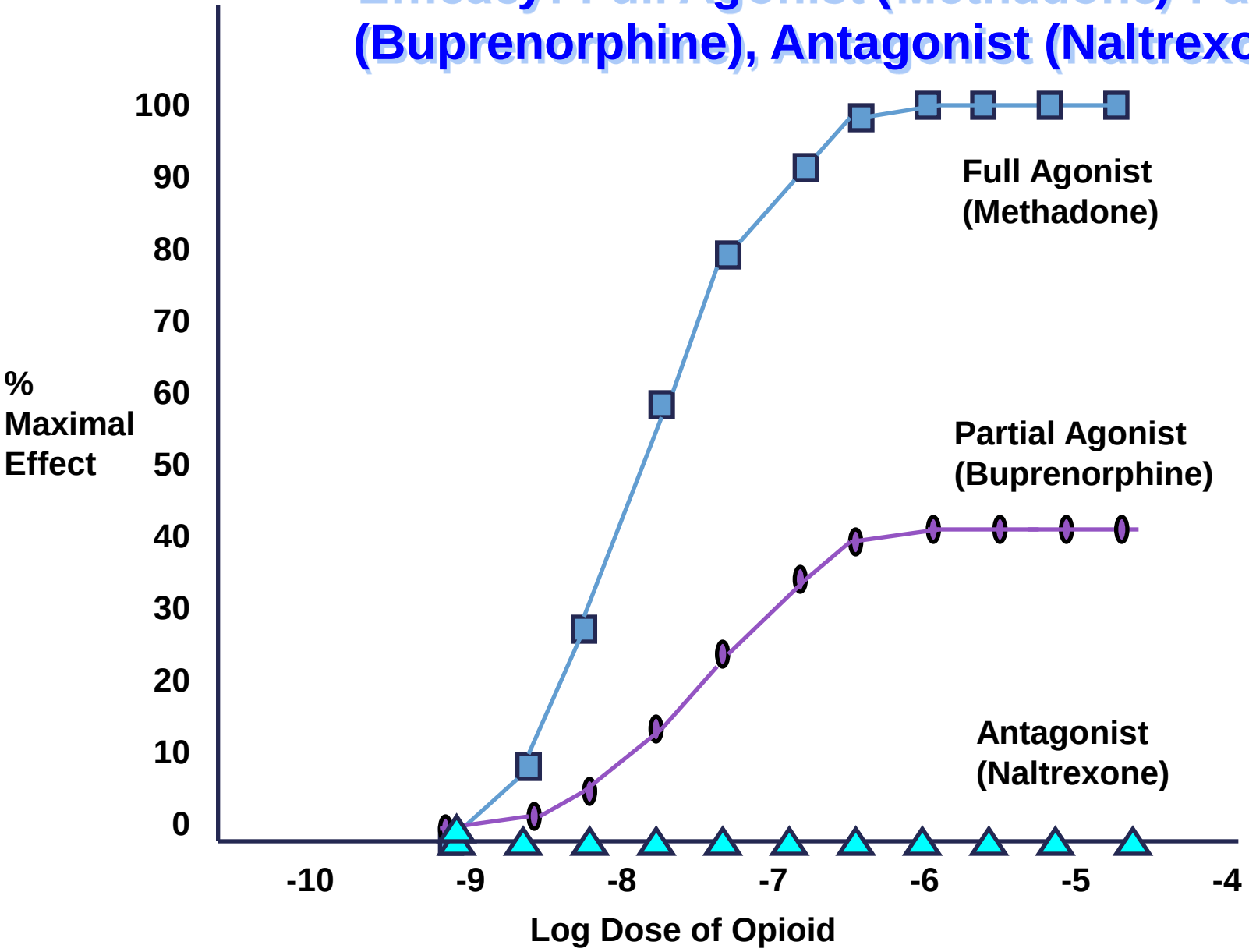
Medication Assisted Treatments for Opioid Use Disorder

- μ-OR full agonist: **Methadone**
- μ-OR partial agonist: **Buprenorphine**
- μ-OR antagonist: **Naltrexone**

Efficacy: Full Agonist (Methadone) Partial Ago (Buprenorphine), Antagonist (Naltrexone)



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Methadone Pharmacology

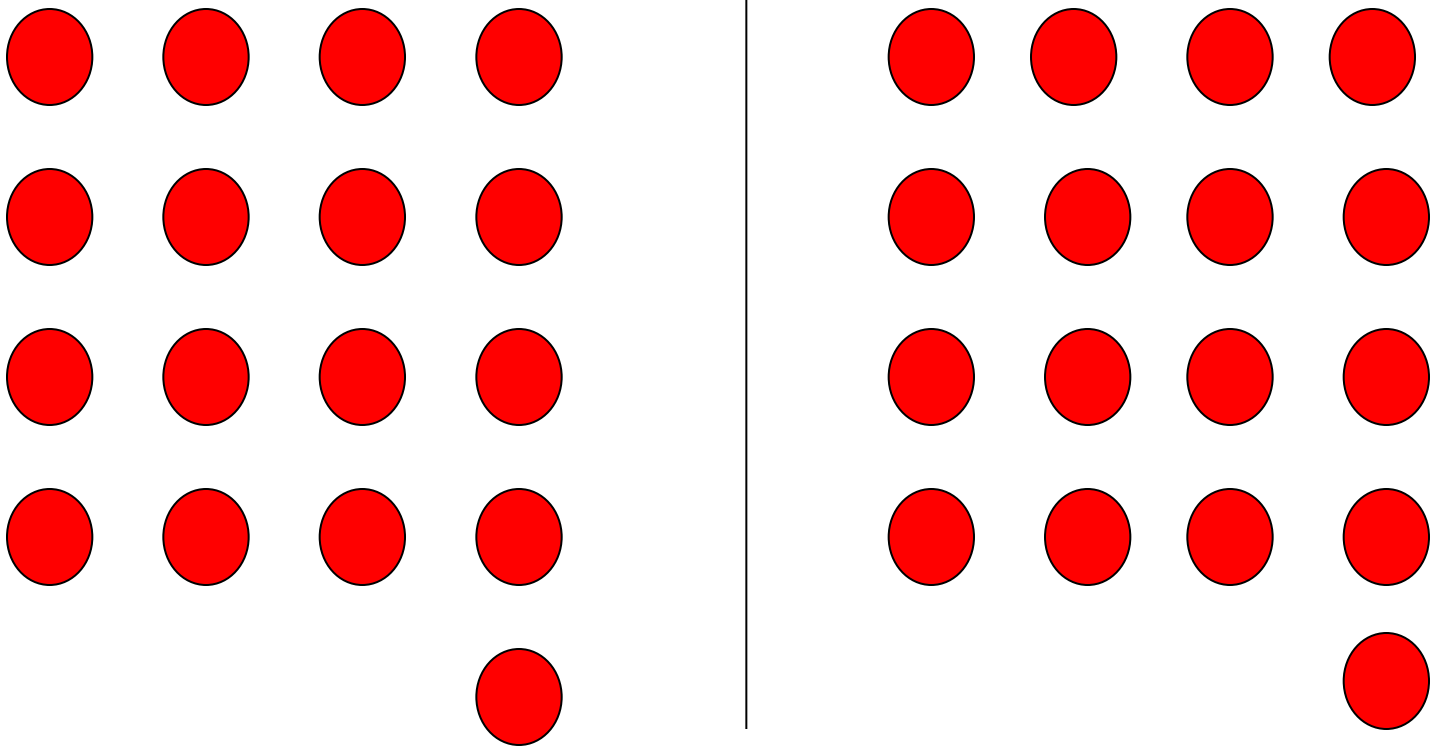
- Rapidly absorbed orally
- Peak Levels in 4 hours
- Half-life=24 hours
- Metabolized in liver
- Doses should be individualized but higher doses generally more effective
- **Boxed Warnings**
  - Respiratory depression
  - QT prolongation on ECG

Swedish Methadone Study

Before

Experimental Group
(Methadone)

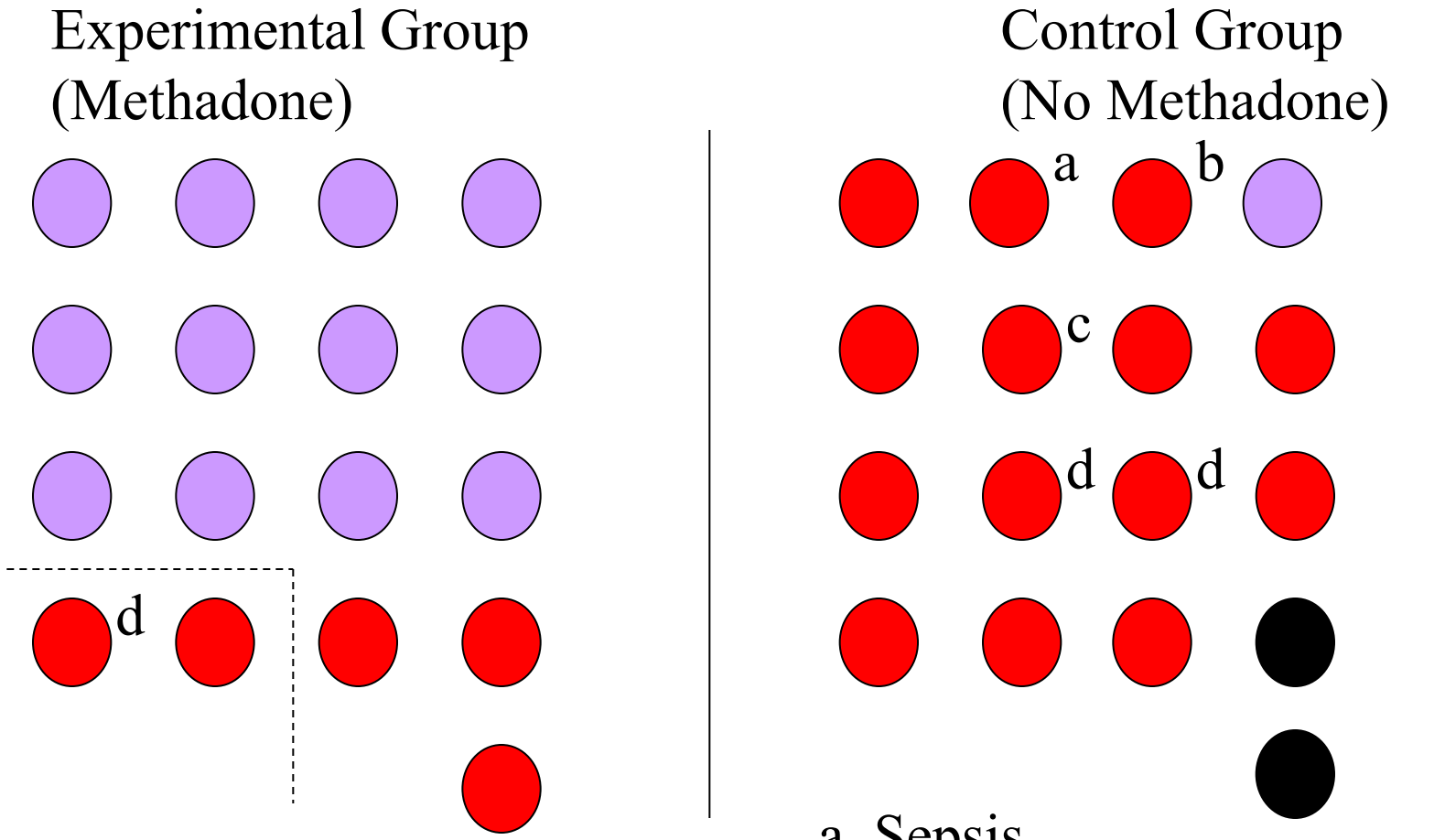
Control Group
(No Methadone)



Gunne & Gronbladh, 1981

Swedish Methadone Study

After 2 Years



a Sepsis
b Sepsis and Endocarditis
c Leg Amputation
d In Prison

Gunne & Gronbladh, 1981

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Properties of Buprenorphine, a μ-Opioid Partial Agonist

- Ceiling effect on respiratory depression
- High affinity for μ-opioid receptor
- Slowly dissociates from μ-opioid receptors
- Ameliorates withdrawal once underway
- Can precipitate withdrawal if given in temporal proximity to full agonist opioids

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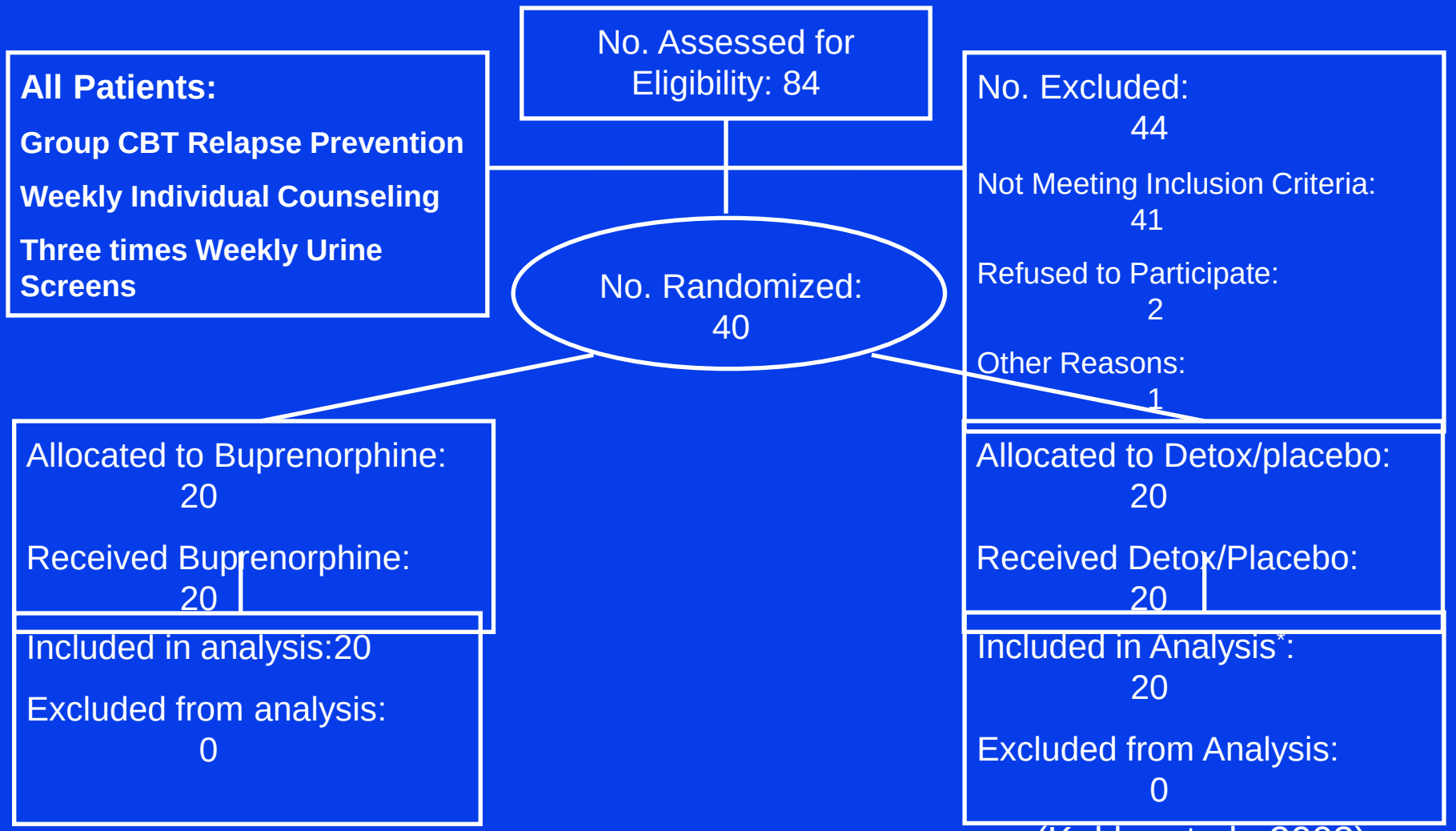
Buprenorphine Pharmacology

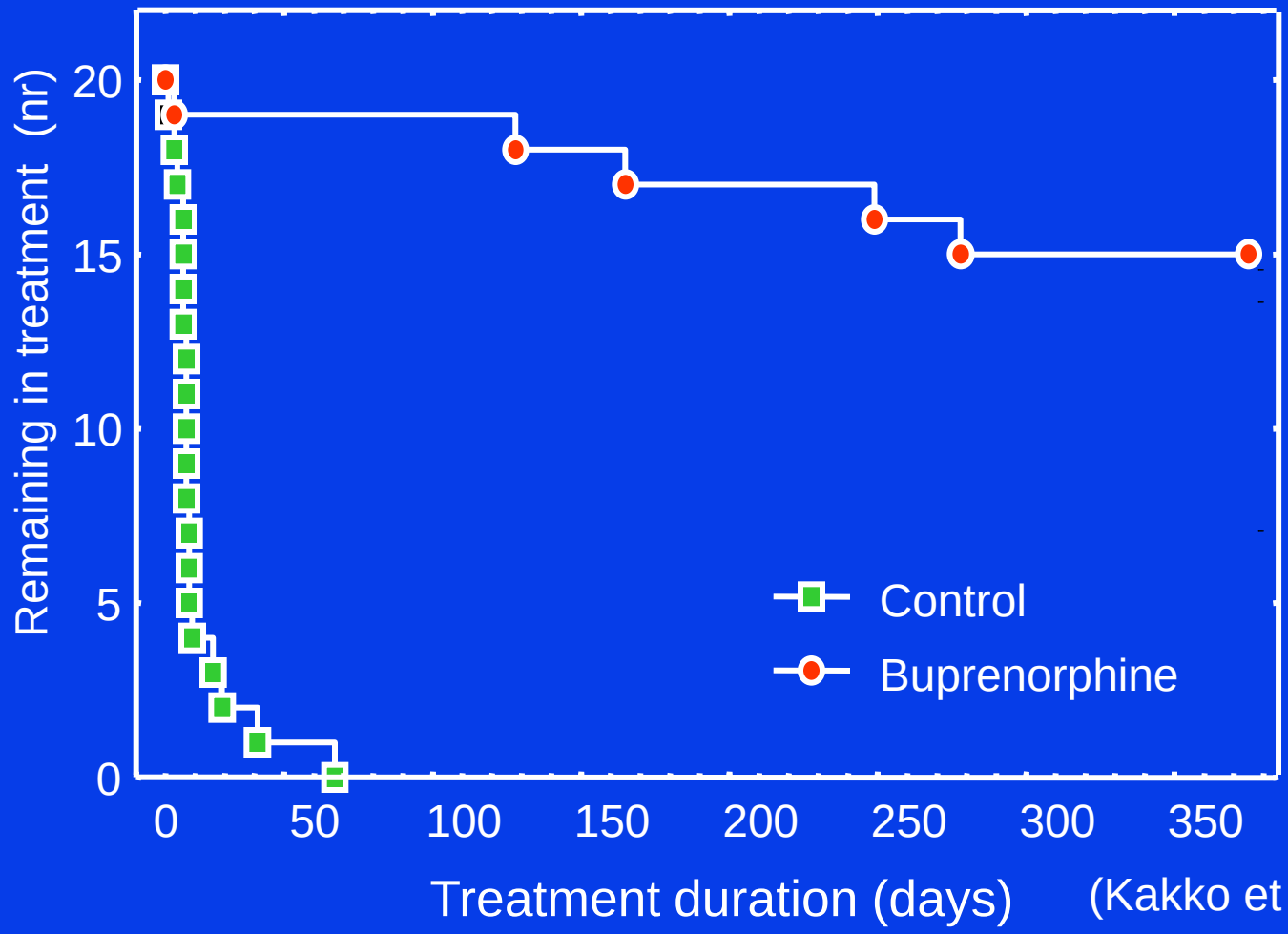
- Extensive 1st pass metabolism; given Sub-lingually
- Slow onset, long duration (24 - 48 hours)
- Slow offset
- Half life > 24 hours
- Once a day or every other day dosing

Buprenorphine Maintenance/Withdrawal



(Kakko et al., 2003)

Buprenorphine Maintenance/Withdrawal: Retention



(Kakko et al., 2003)

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Buprenorphine Maintenance/Withdrawal: Mortality

	Placebo	Buprenorphine	Cox regression
Dead	4/20 (20%)	0/20 (0%)	χ^2=5.9; p=0.015

(Kakko et al., 2003)

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Clinical Use of Buprenorphine/Naloxone

- Supplied as
  - 2/0.5 mg and 8/2mg sublingual tablets
  - 2/0.5 mg, 4/1mg, 8/2mg, and 12/2.5 mg sublingual film
- Prescribing physician must have buprenorphine waiver
- Advise pt. to go 12-24 hrs. off short acting opioids, 48-72 hrs. off methadone
- **Pt. must have objective *signs* of opioid withdrawal prior to starting medication**

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Clinical Use of Buprenorphine/Naloxone

- First dose 2/0.5-4/1 mg
- Repeat doses every 1-2 hours until withdrawal signs and sx abate
- Total first day dose generally 8/2 mg but OK to go higher if needed
- Titrate upward until dose
  - Suppresses withdrawal signs and symptoms
  - Eliminates cravings
  - Achieves sufficient tolerance to block effects of illicit opioids
  - Minimizes side effects

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Naltrexone for Opioid Use Disorder

- Most ideal pharmacologic treatment
- Requires complete withdrawal before initiation or severe withdrawal will be precipitated
- In general poor patient compliance with oral form but superb treatment for selected patients
- **Now available in long acting injection**

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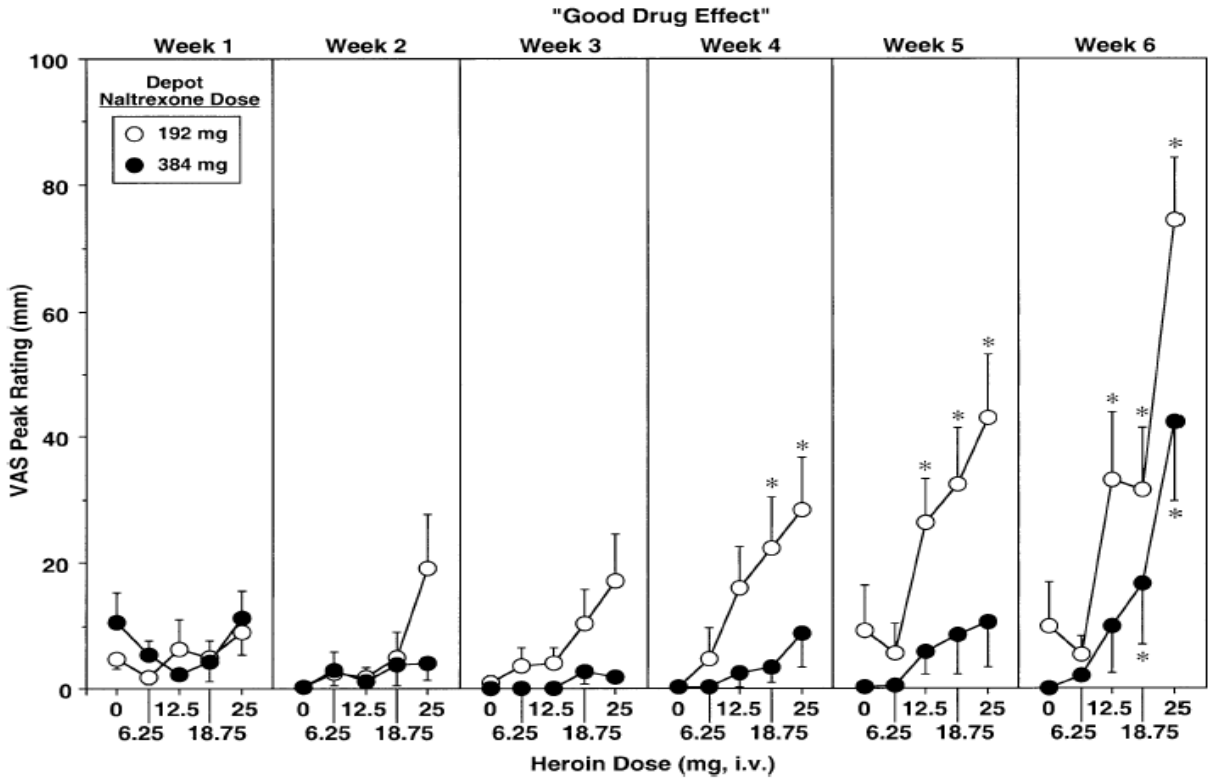
Depot Naltrexone to Block Heroin Effect



Comer et al., 2002

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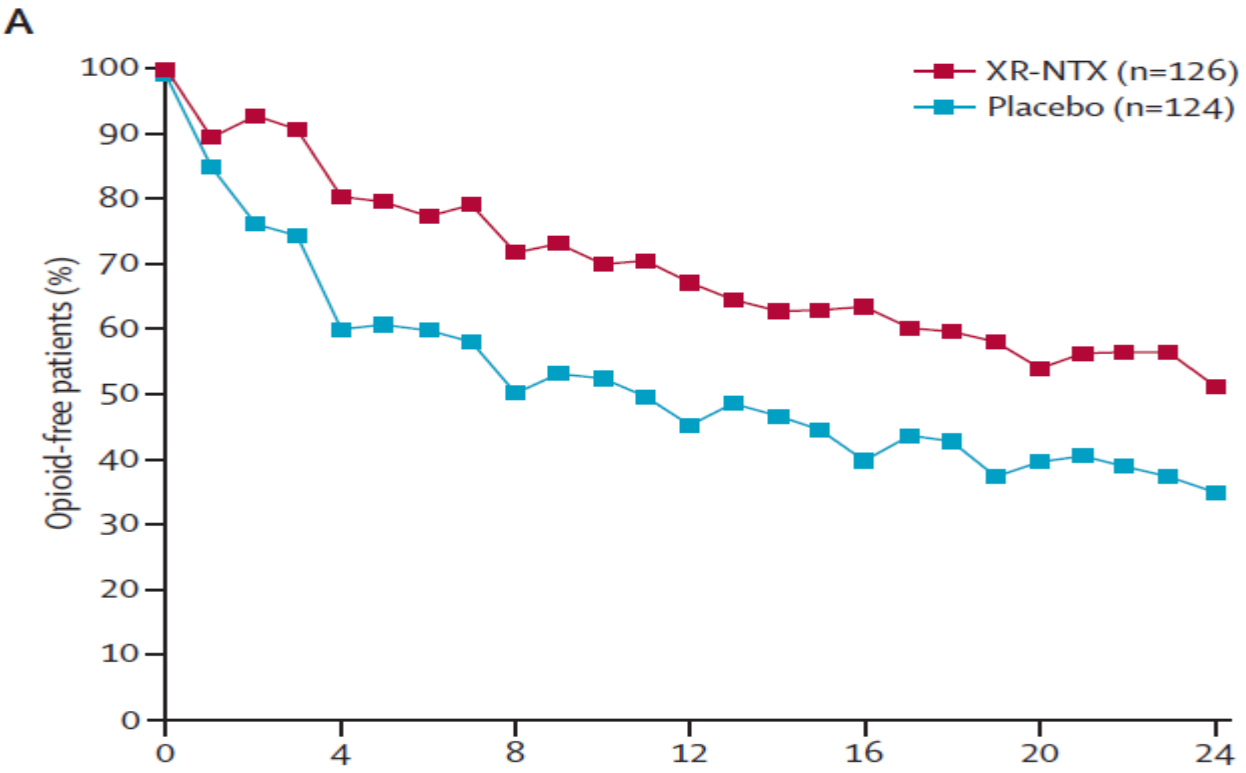
Injectable Extended Release Naltrexone for Opioid Use Disorder



Krupitsky, et al., 2011