Date: May 15, 2018

Clinical Protocol: Opioid Taper & Discontinuation

Preamble

- Note: this preamble will also serve to inform our "Avoid-Opioid" policy in the CCDP
    - There is no evidence for the efficacy of stronger opioids in fibromyalgia (FM) and related Central Sensitivity Syndromes
        - Level D evidence
        - *JAMA. 2014;311(15):1547-1555*
        - *Pain Res Manag. 2013;18(3):119-126*
    - Tramadol has shown efficacy for FM in 2 RCT
        - *Int J Clin Pharmacol Res. 1998;18:13-19*
        - *Am J Med. 2003;114:537-545*
        - Different mechanisms of action and low potency opioid
        - Even this agent should be reserved for moderate to severe pain unresponsive to other treatment modalities
            - Level D evidence
            - *JAMA. 2014;311(15):1547-1555*
            - *Pain Res Manag. 2013;18(3):119-126*
- Despite recommendations against their use, evidence suggests widespread and increasing use in this patient population
    - *J Pain. 2009;10:777-791*
- In one study, more than 80% of patients were using opioids
    - *Pain Pract. 2011;11:204-216*
- Even more disturbing, the same study showed treatment using approved medications not only does **not** reduce this trend, but tends to **increase** opioid utilization rates
- Part of the problem is perceived efficacy among patients
    - First, patients mistake the pain of opioid withdrawal with efficacy
        - When a dose is missed, pain increases (due to withdrawal)
        - When the missed dose is taken, pain improves
            - Patients assume the missing dose is relieving their pain
            - In fact, it is relieving the pain of induced withdrawal
        - In chronic pain, one of the very first symptoms of opioid withdrawal is increased pain
    - Second, is the non-analgesic central reward effects
        - *BMC Musculoskelet Disord. 2007;8:27*
- In addition to the lack of efficacy, strong theoretical and practical concerns exist for the use of opioids in patient with Central Sensitivity Syndromes
- Opioid-induced hyperalgesia and opioid tolerance are primarily thought to be the result of central sensitization of pro-nociceptive pathways
    - *Clin J Pain. 2008;24:479-496*

    - FM is a syndrome of central pain amplification that could be facilitated or augmented by opioid effects
        - *J Clin Rheumatol 2013;19: 72-77*
- Sensitization of pain transmission pathways involves activation of microglia and astrocytes, which leads to a pro-inflammatory phenotype that can be induced by opioids
    - *Trends Neurosci. 2005;28: 661-669*
- The mechanism underlying this phenomenon appears to involve opioid-induced signaling and increase pro-nociception or central pain amplification
    - *Pharmacol Rev. 2011;63:772-810*
- Opioids may also be less effective in patients with Central Sensitivity Syndromes
    - FM exhibit decreased mu-opioid receptor availability in areas of the brain key to pain and nociception processing
    - *J Neurosci. 2007;27:10000-10006*
- Increased risk for misuse also exist in this population due to an increase prevalence of risk factors
    - *J Holist Nurs. 2009;27:232-240*
    - Risks:
        - Anxiety
        - Mood disorder
        - Low self-rated health status
- Finally, opioids may complicate other aspects of the syndromes by causing:
    - Non-restorative sleep
    - Fatigue
    - Sedation and mental clouding (brain fog)
    - Constipation (especially in IBS)
    - *J Clin Rheumatol 2013;19: 72-77*
- From a practical perspective
    - Not starting opioid treatment in FM and related disorders is the preferred approach
    - Should rescue analgesics be required, tramadol is the agent whose efficacy is best supported by the literature and is least likely to cause opioid-induced hyperalgesia
        - However, even with tramadol, dose escalation should be avoided
        - This should be part of the contract with the patient for its use
    - The CCDP will be involved in promoting the idea of "no further increase" for patients on opioids and a discussion of opioid taper
    - The CCDP may also need to be involved in opioid taper/discontinuation but does not write prescriptions for opioids
    - Patient education is key
- Some Opioid Taper & Discontinuation protocols suggest a fixed schedule. In my experience, such protocols are less likely to be successful – and in one case it was lethal
- I prefer to only take one step at a time and go more slowly

  - I explain to patients that the opioids are now only preventing withdrawal and are not providing any benefit for their underlying pain
  - I tell them that with each decrease in dose we, can expect their pain to come back to baseline over weeks to months
  - The amount of each decrease in dose depends on the size of their current dose – with larger doses, patients are able to tolerate a larger decrease in dose
  - As the dose gets smaller, so does the size of decrease in dose
  - Patients are highly variable in the speed of the taper; some patients may take 1 – 2 years, and sometimes more
  - Patient buy is important. It is key to listen and to work with the patient and adjust the plan as needed
  - In my discussions with patients, I use the metaphor of removing a band-aid. I ask them if they prefer to pull it off quickly or slowly
  - For patients on long-acting opioids, I decrease the long-acting opioid until a smaller size tablet is not available or the decrease in dose is too large using long-acting tablets; I then switch them to an equivalent dose of short-acting opioids. My preference is hydromorphone, but any short acting opioid can be used
  - I make the switch from long-acting to short acting opioids without decreasing the dose; I wait until they are back to baseline before tapering any further
- Provide patient with information/dose adjustment handout; there is also a useful video
- It is expected that physicians would educate themselves about these drugs beyond the outline provided below
- Screen for additional comorbidities: depression, anxiety
- The treatments described below may occur one-on-one or in a group setting depending on resources

1. Patient Education

- Patient education is key because:
  - Opioid taper and discontinuation are not usually patient driven
  - Perceived efficacy of opioids among patients
  - Fear of pain getting worse with no patient recourse
  - Without patient buy-in, they may be looking for an opportunity for the taper/discontinuation plan to fail
  - Patients need an explanatory model to understand what is going on
- Important to tell patients what to expect
  - Your pain (and symptoms) will flare for the first week(s) after reducing dose
  - Your pain (and symptoms) will return to baseline in the within weeks to months
  - We can provide other medications to help with withdrawal

  - We will taper slowly at a rate that you can tolerate
  - Many patients tolerate the process without significant suffering
  - Most patients feel better overall after reducing or discontinuing opioid
  - The process is uncomfortable but not life threatening
  - Each dose reduction may result in flu-like symptoms beginning within 12 - 36 hours and peaking at 48 - 72 hours and then subside after 1 week
  - Some patients also experience mood changes
- Incorporated into multiple offerings (e.g., handouts, web-based resources)
  - Opioid Taper and Discontinuation Patient Resources
- Incorporated into core group: Living with Complex Chronic Diseases
- "Family and Friends" evening session
  - To register for the next event contact infoccdp@cw.bc.ca

2. Physical Activity

- Unknown

3. Sleep

- See Sleep Protocol for details

4. Diet

- Unknown

5. Alterative and Complementary Therapies

- Unknown

5.1 Acupuncture

- Has been shown in some studies to decrease symptoms of opioid withdrawal

6. Interventions

- Could decrease "need" for opioid by improving pain generators
  - May not make taper/discontinuation easier (see preamble)
- Maneuvers that target muscular trigger points, lengthen muscle contractures, and release painful scars and other connective tissue restrictions
- For example:
  - Trigger Point Injections
  - Intramuscular Stimulation (IMS)
  - Myofascial release
  - Nerve blocks
- Currently available:
  - At the CCDP

- Externally (outside referral):
  - Change Pain Clinic
  - Muscle MD
  - Myo Clinic (Victoria)
  - Other practitioners across the province

7. Psychological and Behavioural Interventions

- Incorporated in core group: Living with Complex Chronic Diseases
  - Combines Education, Pacing, CBT &, Mindfulness
  - 10 weeks
- One-on-one counselling
- Incorporated into other groups

8. Medications

Opioid Taper

- Reduce the dose of long-acting agents first
- Allow patients to keep breakthrough dose until the end of the taper
- Reduce dose of long acting by 5 – 10% at a time
- Do not plan more than one step at a time (i.e., you are more likely to successful with a flexible tapering schedule than a fixed one
- Provide education handout (and other resources)
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- See patient at regular intervals (e.g., 2 – 4 weeks) intervals to monitor progress
- Check Pharmanet to make sure other physicians are not prescribing opioids
- Be sure to discuss this with the patient and that they should let other Health Care Providers (e.g., their pharmacist) know they are trying to wean off opioids
- Wait until the patient's pain has come back to baseline before tapering the dose any more
- Note: withdrawal may last up to 3 months after last dose
  - Patients may benefit from clonidine, nabilone or loperamide (see below)
  - Peak withdrawal occurs at the end of taper

8.1 Clonidine (Catapres)

- Used to decrease risk of severe withdrawal and withdrawal symptoms
  - Also, very effective against nightmares and sweating
- Dose:
  - Initial: ½ tablet (0.05 mg) BID + QHS PRN
  - Increase to 0.1 mg BID + QHS PRN
    - Titrate based on duration of action (typically lasts 6-10 hours) and adverse effects

  - Maximum 0.2 mg QID
- Usually well tolerated
- Watch for: hypotension / dizziness, drowsiness, headache, fatigue, insomnia, dry mouth, blurry vision
- Practical considerations:
  - Prescribe 0.1 mg tablets
  - Clonidine reaches steady state at 2 to 3 days
  - Consider tapering if patient on clonidine > 2 weeks
  - Sudden discontinuation may cause rebound hypertension and tachycardia
  - Sample taper:
    - 100% clonidine total daily dose = _____ mg. Continue for 3 days after opioid discontinued
    - 75% initial dose x 3 days
    - 50% initial dose x 3 days
    - 25% initial dose x 3 days
    - Discontinue

8.2 Nabilone (Cesamet)

- Useful for withdrawal associated nausea, vomiting, anxiety, insomnia, and pain
- Has no street value, and can be discontinued abruptly without risk
- Assess for regular marijuana use
- Dose
  - Initial: 0.25 mg QHS
  - Increase frequency q2-7 days as tolerated
  - Maximum 2 mg TID
- Watch for: Drowsiness, dizziness, ataxia, headache, dry mouth, visual disturbances, hypotension, weight gain
- Practical considerations
  - 0.25 mg and 0.5 mg covered by Pharmacare
  - Nabilone should also be dispensed at 2-week intervals
  - Nabilone steady state at ~7 days
- Medicinal cannabis is also an option
  - greenleafmc.ca
  - www.cannabisclinics.ca

8.3 Loperamide (Imodium)

- Symptomatic management of abdominal cramping and diarrhea withdrawal symptoms
- Dose:
  - 4 mg x 1 at first loose stool then 2 mg after each loose stool thereafter
  - 4 mg x 1 at first loose stool then 2-4 mg QID taken 45 minutes before meals or PRN
  - Maximum 16 mg/day
- Watch for: constipation, cramping

- Available OTC

Patient Resources
http://www.bcwomens.ca/health-info/living-with-illness/living-with-complex-chronic-disease

Pharmacare coverage **(May 2015)**
Clonidine = yes
Nabilone = yes (max supply 35 days per fill)
Loperamide = no (covered only by palliative care or with special authority approval)