Managing Chronic Pain

AN EXIT PLAN FOR OPIOIDS – WHO,WHEN AND HOW TO TAPER

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Conflict of Interest Disclosure
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- Medical Director, CPM Centres for Pain Management

Conflict of Interest Disclosure
Dr. Lori Montgomery

Program Title: An Exit Plan for Opioids – Who, When, How

DISCLOSURES (2 years)

- Grants/Research Support: none
- Speakers' Bureau/Honoraria/Consulting: none
- Medical Director: Alberta Health Services (Calgary) Chronic Pain Centre
- MI Slides developed with Todd Hill, DFM University of Calgary

Disclosure of Commercial Support

- None for this presentation

Mitigating Potential Bias

- Information/recommendations provided will be evidence- and/or guideline-based (where they exist) and opinions of the speaker and off-label uses will be identified as such.
- The Speakers have completed the CPFC Mainpro® Declaration of Conflict of Interest form evidencing compliance with Mainpro® requirements
- Any off-label uses will be identified as such

Learning Objectives

After attending this program, participants will be able to:

- Explain reasons for tapering or discontinuing opioid therapy in patients with CNCP
- Describe methods to safely and humanely taper or discontinue opioid therapy in patients with CNCP

When to Consider Tapering Opioid Therapy

- Patient request
- Pain condition resolved
- Risks outweigh benefits
  - Repeated out of bounds behaviours --? OUD
- Adverse effects outweigh benefits
  - High risk behaviours for overdose
  - ?Opioid hyperalgesia
- Medical complications
- Opioid not effective
  - No improvement in function / QOL
- Regulatory recommendation

Motivational Interviewing

A patient's motivation may be different than yours

- Cost
- Perceptions of family and friends
- Social stigma
- Fear of overdose/addiction
- Constipation
- Hyperhidrosis

Stages of Change

- **Pre-contemplation**
  - Low pressure + information + extended invitation
- **Contemplation**
  - Motivational Interviewing
- **Preparation**
  - Support + problem-solving + resource
- **Action**
  - Support + encouragement + encouragement
- **Maintenance**
  - Support + encouragement + 'next steps'

When to Consider Using M.I.

- Patient is in the contemplative stage of change
- Taper isn't urgent

Motivational Interviewing – Why should I?

- MI out performs traditional advice giving in 80% of studies
- Can show efficacy in 10-20 minutes
- More encounters over longer time period increase likelihood of an effect 6 – 12 months(perfect for Primary Care or services with continuity)
- Physicians, psychologists and other health providers can be effective at MI
- Effect of MI is enhanced when combined with other treatments such as education, self-management support, or "treatment as usual"

Rubak, S., Sandbaek, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: a systematic review and meta-analysis. *The British journal of general practice: the journal of the Royal College of General Practitioners*, *55*(513), 305–12.

Why MI for opioid tapering?

- Easier tapering (smoother course)
- More sustained results
- Insights gained can be useful for many other parts of pain treatment
- Time invested up front can result in long term time savings

Anne Zahradnik et al, Randomized controlled trial of a brief intervention for problematic prescription drug use in non-treatment-seeking patients, Addiction 104(1), January 2009

Evoking patient motivation

OARS

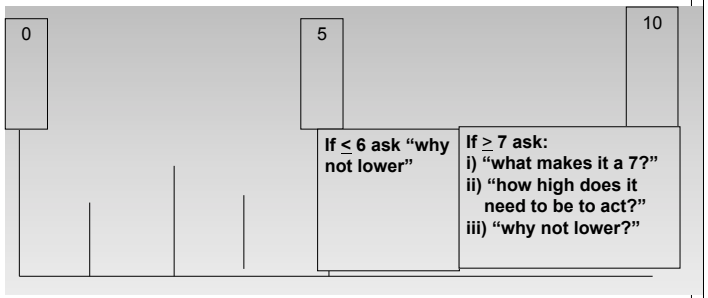
- O – Open-ended questions
- A – Affirmations
- R – Reflections
- S – Summaries

Evoking patient motivation

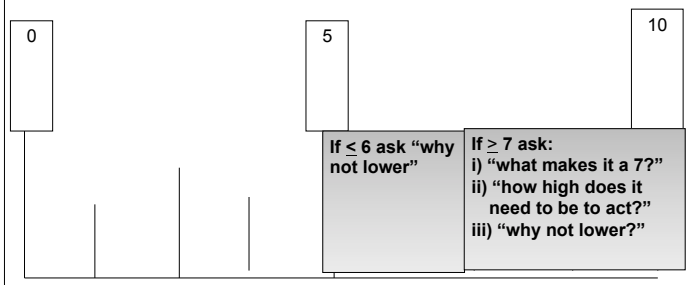
DEARS

- D evelop Discrepancy
- E xpress Empathy
- A im at Ambivalence
- R oll with Resistance
- S elf – Efficacy (i.e. evoking patient motivation)

How important is making this change to you – at present?

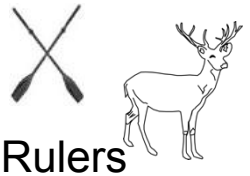


How confident are you that you could make this change – at present?



Evoking patient motivation

- 'Open'
- Listen more / Talk less
- OARS
- DEARS
- Readiness Rulers



"Centralization" Continuum

Peripheral — Centralized

Acute pain, Cancer pain, Osteoarthritis, RA, Low back pain, SC disease, Ehler's Danlos, Fibromyalgia, Tension HA, TMJD, IBS

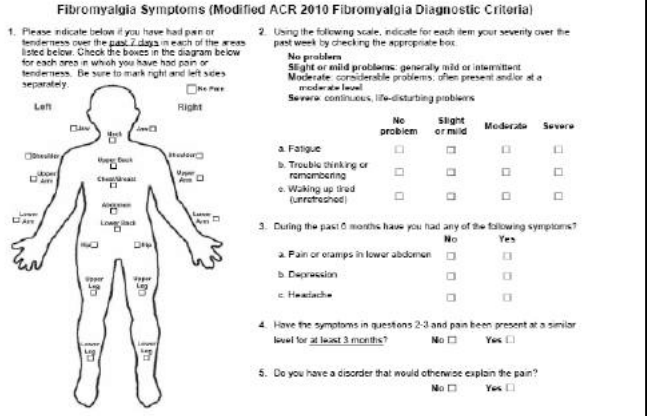
Clauw 2016

Clues to Central Sensitization

	Description
Patient history	Reports of pain that spread beyond the initial area of injury
Primary/secondary brush allodynia	Painful response to lightly brushing the skin inside the initial area of injury (primary) or outside of the area of injury (secondary)
Temporal summation with wind up	Repeated painful stimuli, like a pinprick (usually tested as 1 per second for 10 seconds) results in an augmented pain response so that following repetitive pinpricks the intensity of the pain rating at the end is graded much higher than a single stimulus
After pain	Describes the sensation when, after the pinprick is removed, patients continue to feel as if the pin is still in their skin

Latremoliere and Woolfe. J Pain. 2009;10(9)895-926.

"Fibromyalgia-ness" can be scored



Fibromyalgia Symptoms (Modified ACR 2010 Fibromyalgia Diagnostic Criteria)

1. Please indicate below if you have had pain or tenderness over the past 7 days in each of the areas listed below. Check the boxes in the diagram below for each area in which you have had pain or tenderness. Be sure to mark right and left sides separately.

Left Right

2. Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

No problem
Slight or mild problems: generally mild or intermittent
Moderate: considerable problems, often present and/or at a moderate level
Severe: continuous, life-disturbing problems

	No problem	Slight or mild	Moderate	Severe
a. Fatigue	☐	☐	☐	☐
b. Trouble thinking or remembering	☐	☐	☐	☐
c. Waking up tired (unrefreshed)	☐	☐	☐	☐

3. During the past 6 months have you had any of the following symptoms?

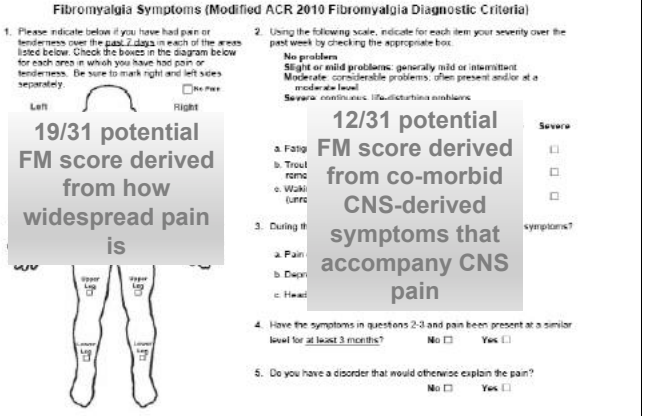
	No	Yes
a. Pain or cramps in lower abdomen	☐	☐
b. Depression	☐	☐
c. Headache	☐	☐

4. Have the symptoms in questions 2-3 and pain been present at a similar level for at least 3 months? No ☐ Yes ☐

5. Do you have a disorder that would otherwise explain the pain? No ☐ Yes ☐

1. Wolfe et. al. *Arthritis Rheum.* Jun 15 2009;61(6):715-716 2. Wolfe et. al. *J Rheumatol.* Feb 1 2011. 3. Clauw DJ. JAMA, 2014.

"Fibromyalgia-ness" can be scored



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Left Right

19/31 potential FM score derived from how widespread pain is

2. Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

No problem
Slight or mild problems: generally mild or intermittent
Moderate: considerable problems, often present and/or at a moderate level

12/31 potential FM score derived from co-morbid CNS-derived symptoms that accompany CNS pain

1. Wolfe et. al. *Arthritis Rheum.* Jun 15 2009;61(6):715-716 2. Wolfe et. al. *J Rheumatol.* Feb 1 2011. 3. Clauw DJ. JAMA, 2014.

Opioid-induced Hyperalgesia

- In some patients, opioids activate an endogenous "anti-opioid" system involving CCK, dynorphin A, spinal NK1 receptors, and TLR4 on glial cells
- This can manifest clinically as tolerance (loss of opioid analgesic effect)
  - May also manifest as inter-dose, withdrawal-mediated pain
- Increasing opioid dose will temporarily restore pain relief but loss of analgesic effect will recur

Ossipov MH, et al. *Biopolymers.* 2005;80(2-3):319-24.
Chang G, et al. *Med Clin North Am.* 2007;91(2):199-211.
Lee M, et al. Pain Physician 2011; 14:145-161

CCK, cholecystokinin.

Opioid Hyperalgesia vs. Tolerance?

- Can be a difficult call
- Pain characteristics change / more generalized
- May develop hyperalgesia +/- allodynia
- Opioid-induced hyperalgesia, may have associated features of neuroexcitation:
  - Agitation
  - Multifocal myoclonic jerks
  - Seizures
  - Delirium

Ossipov MH, et al. *Biopolymers.* 2005;80(2-3):319-24.
Chang G, et al. *Med Clin North Am.* 2007;91(2):199-211.
Lee M, et al. Pain Physician 2011; 14:145-161

Glial Cells and Opioids

- Glia disrupt the clinical efficacy of opioids
  - affect efficacy, tolerance, dependence, reward and withdrawal
- When you take opioids you suppress pain but you also activate glial cells that are pain enhancing - so the "net" analgesic effect is the balance between these two effects

Grace PM, Mair FM, Watkins LR. Headache 2015;55:475-489)

Glial Cells and Opioids

- Opioid isomers differ dramatically in clinical actions
- (-)isomers bind to the neuronal opioid receptor the (+) isomer does not
- Both (+) and (-) isomers can activate glial cells
- The (+)isomers of naltrexone and naloxone block the glial effects but doesn't bind to the neuronal opioid receptor → can potentiate morphine analgesia

Grace PM, Mair FM, Watkins LR. Headache 2015;55:475-489)

2017 Opioid Guidelines Recommendation #9 (weak)

For patients currently using 90 mg morphine equivalents of opioids per day or more

> We suggest tapering opioids to the lowest possible dose, potentially including discontinuation, rather than no change in opioid therapy

Some patients are likely to experience significant increase in pain or decrease in function that persists more than one month after a small dose reduction; tapering may be paused and potentially abandoned in such patients.

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

…but how do I actually do this?

SYMPOSIUM ON PAIN MEDICINE

MAYO CLINIC

Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice

Chantal Berna, MD, PhD; Ronald J. Kulich, PhD; and James P. Rathmell, MD

"…little specific and high-quality research has focused on guiding tapering from long-term opioid treatment and on specific support needed to manage risks and issues in this process. Important questions remain to be studied…"

Mayo Clin Proc. June 2015;90(6):828-842

2017 Opioid Guidelines Recommendation #10 (strong)

Patients using opioids and experiencing serious challenges in tapering

We recommend a formal multidisciplinary program

Recognizing 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 specialist, a psychiatrist, and a psychologist).

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

Case 1: Serge

Serge: Patient Profile

- Male aged 38 years
- Chronic low back pain that failed to respond to previous discectomy and fusion
- Current medications:
  - CR oxycodone 80 mg three times daily
  - Oxycodone-acetaminophen, 8 tablets daily as needed
    - He usually takes all 8 tablets and some extras “occasionally”
- Wakes in the morning with severe pain
- Spends most of the day resting, watching TV:
  - “I’m in too much pain to do anything else”
  - “I am afraid of reinjuring my back”
- Significantly depressed mood
- Requests an increase in opioid dose

Serge: Chart Review

- His opioid dose has increased significantly over the past 2 years
- In spite of this, he has come in for early refills a number of times
- His Opioid Risk Tool assessment 3 years ago put him in the moderate risk category
- Urine drug tests recently have been positive for cannabis (“medical”) and cotinine (smokes 1 PPD)
- He ran out of meds early recently and came in smelling of alcohol (“helps the pain, doc”)

Serge: Current Status

- Despite opioids, no increase in functionality
- Pain is worse (8-10/10), mood has worsened
- BPI-I score is 62/70
- Current opioid dose is 240 mg + 40 mg = 280 mg oxycodone ~ 420mg ME
- Spouse is complaining that he is very irritable lately and is not participating in family activities
- Serge is complaining that his whole body hurts

Tolerance? Hyperalgesia? SUD?

BPI-I, Brief Pain Inventory-Interference.

Benefit to Harm Framework

Judge the treatment, not the patient
"I care about you…
…maximize benefit, minimize harm"

Don't abandon your patient simply because of opioid-related behaviours – but you can abandon a treatment that is no longer helping

Risks of Opioid Withdrawal

Careful: pregnancy, fragile medical or psychiatric condition
severe SUD / diversion & duration of a taper
risk of relapse → loss of tolerance → overdose

CASE REPORT

"Broken Heart Syndrome" After Separation (From OxyContin)

Juanita M. Rivera, MD; Adam J. Locketz, MD; Kevin D. Fritz, CNP; Terese T. Horlocker, MD; David G. Lewallen, MD; Abhiram Prasad, MD; John F. Bresnahan, MD; and Michelle O. Kinney, MD

Mayo Clin Proc. 2006;81(6):825-828

Tapering Opioid Therapy

- Discuss and document (with significant other?):
  - Withdrawal is rarely dangerous
  - Typical withdrawal symptoms and time course (? hand-out)
- Discuss an alternative treatment plan
- Careful with sedatives – withdrawal is more risky and has to be more gradual

Patients who are diverting or addicted may refuse to comply and leave your practice

Tapering Opioid Therapy

- Fast or slow (patient input)
  - 10% every 1-2 days, daily pharmacy dispensing OR
  - 5-10% per 1-2 weeks, weekly dispensing (blister pack)
  - When down to 30% of original dose – slow down the taper to 5% every 1-2 weeks
  - Can take months (or years!) in some people
- Use pharmacological aids for withdrawal symptoms
  - Clonidine, loperamide, NSAIDs, GPN/PGN, nabilone
- Methadone (buprenorphine) taper
  - Know info about your local methadone (buprenorphine) clinic
- Talking to the patient is the most effective treatment!

NSAID, non-steroidal anti-inflammatory drug.

Assess Stage of Change

- "Have you ever thought about making changes to they way you take the medication?"

Serge: - Discussion

- You have a good discussion with Serge and his wife and explain why, in your opinion, the opioid therapy is no longer working very well (risk vs benefit)
- Explain hyperalgesia / withdrawal-mediated pain
- You explain a trial of gradual tapering of his dose to see what happens to his symptoms
- You explain the possible withdrawal symptoms and strategies for managing

Serge: Taper

- You reduce Serge's opioid dose by ~10% every 2 weeks, with part fills every 2 weeks in blister packs
- You prescribe pregabalin, clonidine, and nabilone to help him manage withdrawal symptoms
- At 40 mg CR-oxycodone q8h plus 6 acetaminophen-oxycodone per day, he complains of great difficulty coping with withdrawal symptoms and a severe increase in pain
- He now tells you that he is also getting severe pain from his right ankle which he broke 10 years ago ???

WISP Syndrome

WITHDRAWAL-ASSOCIATED INJURY SITE PAIN (WISP): A DESCRIPTIVE CASE SERIES OF AN OPIOID CESSATION PHENOMENON

Launette Marie Rieb, MD, MSc[1,2]

OPEN

PAIN Publish Ahead of Print
DOI: 10.1097/j.pain.0000000000000710

A previously healed painful injury begins to hurt again during the course of opioid withdrawal
Typically lasts about 2 weeks

For Consideration

- What would you do now for Serge?
  - A. Leave well enough alone – he is at the watchful dose
  - B. Pause the taper, but continue again in 1 month
  - C. Continue the taper in spite of his complaints
  - D. Switch to Bup/Nx and stabilize, and then taper off slowly
  - E. Keep him on a stabile dose of Bup/Nx and reassess in the future
  - F. Other options?

3-day Switch to Bup/Nx and Taper

- Responsible other adult – that you meet in person, no benzos
- Explain the loading protocol – written materials
- Stop the Rx opioid at midnight
- On Day 1 wait until at least moderate to severe withdrawal
  - COWS > 14
- Take Bup/Nx 4mg s.l. and wait 3 hours
- Take Bup/Nx 2mg s.l. q 3h prn up to 12mg Day 1
- On Day 2 – take the total dose of Bup/Nx required on Day 1 and load again if required by 2mg q 3h up to max 24mg daily
- On Day 3 – take the total dose of Suboxone from Day 2 and split the total dose BID
- F/U with MD on Day 4 → stabilize then taper

Lee JD. J Gen Intern Med 2009; 24(2):226–32
Lee JD et al J Addict Med 2014; 8(5):299-308

Tapering Off of Bup/Nx

- Taper by ~2mg q 1-4 weeks (or faster if motivated)
- When you get to 2mg, pt. can break the pill in ½ or take q 2 days
- If difficult to stop Bup/Nx completely then:
- Leave them at the dose they stabilize on for a negotiated number of weeks then try again

OR

- Switch to 20ug/hr Bup patch x 1 week (off label)
  - then 15ug/hr x 1 week
  - then 10ug/hr x 1 week
  - then 5 ug/hr x 1 week then D/C

For Consideration

- **What if:**
  - Serge screened positive for cocaine on his next two urine drug tests?
  - Serge started using street sources of opioids and other drugs?
  - Serge voluntarily attended an addiction program for an assessment?

Case 2: Renee

Patient Profile: Renee

- Female aged 55 years
- Bilateral knee pain with moderate osteoarthritic changes
- Orthopedic review – "conservative therapy"
- Obesity; onset 6 years ago after her daughter's suicide
  - Current BMI 31 kg/m^2
- Chronic anxiety and mild to moderate depression
- On disability for 1 year following a difficult cholecystectomy complicated by several episodes of *Clostridium difficile*

BMI, body mass index.

Current Treatments: Renee

- Seeing a bariatric physician
  - With an appropriate weight loss strategy, has lost 30 pounds in the last 6 months
- Escitalopram 30 mg once daily
- Clonazepam 1 mg twice daily for anxiety
- Zopiclone 7.5 mg at bedtime for insomnia
- CR hydromorphone 24 mg three times daily
- IR-Oxycodone 20 mg three times daily as needed for breakthrough pain (but takes it regularly)

Renee's Visit Today

- In to see you because IR-OC not helping anymore
- Tried 40 mg dose and found it more effective
- Requesting increased dose of oxycodone "so she can walk more"

What is the morphine equivalent of Renee's current opioid use?

How would you handle this request?

HM 24mg x 3 = 72mg x 5 = 360mg ME
OC 20mg x 3 – 60mg x 1.5 = 90mg ME
Total = 450mg ME

Handling Renee's Request

- The Canadian Opioid Guideline advises a trial of tapering opioids when ME dose is >90 mg a day
- You agree to reassess her current situation and ask that she complete some evaluations and book a follow-up counselling visit to review the results

Follow-up Evaluation: Renee

- Knee pain: Standing radiographs of both knees and physical examination
- Assess pain and functionality: Brief Pain Inventory
- Assess mood: GAD-7, PHQ-9, HADs (or other mood evaluations)
- Assess for opioid side effects:
  - Screen for sleep apnea: sleep diary and overnight oximetry
  - Hormonal effects: order appropriate lab tests +/- bone density
  - Inter-dose withdrawal: by history
  - Sedation: Epworth Sleepiness Scale
  - Cognitive impairment: by history
- Addiction, misuse, abuse, diversion: urine drug test, list of aberrant behaviours in past, physical examination
- Assess for coping strategies

GAD-7, Generalized Anxiety Disorder 7-item scale. PHQ-9, Patient Health Questionnaire 9-item scale, HADs, Hospital Anxiety Depression Scale.

Follow-up Evaluation: Renee

- Physical examination:
  - Both knees stable, no significant bony enlargement
  - Pain-free hip range of motion
  - Evidence of muscle tenderness with trigger points in vastus medialis and vastus lateralis
  - Quadriceps weakness
  - Patellofemoral pain with patellar compression and quads activation
  - No abnormal sensitivity to light touch
- X-rays: mild to moderate OA – no change from prev

Follow-up Evaluation: Renee

- Average pain score is 8/10, increasing to 10/10 with prolonged walking, generally proportional to activity
- Brief Pain Inventory Interference score: 68/70 – indicating severe interference with daily life activities
- Mood stable: PHQ-9 score is 9 (mild depression), GAD-7 score is 15 (moderate anxiety)
- Sleep apnea screening: initial insomnia (anxious thoughts) and severe sleep apnea

GAD-7, Generalized Anxiety Disorder 7-item scale. PHQ-9, Patient Health Questionnaire 9-item scale. TSH, thyroid-stimulating hormone. UDT, urine drug test.

Coping Strategies: What to Ask About

1. Does the patient have a "pain team" and a pain plan?
   - Renee thinks this is you and your prescribing of medication
2. Pacing
   - Renee does pace her activities, but spends most of her day resting at home; she can complete her own activities of daily living but requires help to get groceries
3. Prioritizing
   - Renee hadn't thought about this
4. Goals
   - Renee's sees that more oxycodone is the only way to achieve functional improvement and her goal of additional weight loss

Coping Strategies: What to Ask About (2)

5. Plan to manage a pain flare
   - Take more oxycodone
6. Relaxation skills
   - Used to walk for relaxation but can't due to pain, admits she doesn't cope as well with pain when anxiety is bad (and this cues her to use oxycodone)
7. Keeping a diary of progress, recording positive changes
   - Renee couldn't think of anything to write down
8. Pain self-management program
   - Renee has never attended one

Chronic Pain & Suffering Is Like a Layer Cake

Psychosocial stress: Moderate – still grieving
Mood: Moderate anxiety, mild depression
Sleep: Impaired by anxiety, pain, and sleep apnea
Pain: Mild-moderate OA, myofascial pain, deconditioning
What the pain means: Loss of independence
Pain bothers her a lot – on her mind all day
Abnormal pain processing: None
Genetic factors: ?

Is pain the primary cause of Renee's suffering?

OA, osteoarthritis.

Renee: Summary

- There is little evidence that opioids are still helping Renee, based on high pain scores and BPI (her assessment, not yours) – BUT she has recently tried increasing the dose and found it helpful
- She has developed significant opioid tolerance but no symptoms/signs of OIH
- She has severe sleep apnea and is using both opioids and benzodiazepines

BPI, Brief Pain Inventory.

Assess Stage of Change

- "What do you love about the medication?"
- "If you could wave a magic wand and change anything about the opioid, what would it be?"

The Plan for Renee

1. Discuss risks of combining opioids and benzodiazepines, especially given severe sleep apnea
2. Give her the option to choose which to taper first, the benzodiazepines or opioids
   - Renee reluctantly agrees to try tapering the opioid first
3. Reassure her that the plan will be a very gradual withdrawal
4. Discuss typical withdrawal symptoms and how to manage

Options for Reducing Opioids: Renee

Option 1

- Stay on CR HM 24 mg q 8h
- Gradually reduce IR OC first, then start reducing CR HM
  - Reduce oxycodone 20 mg three times daily by 10 mg every 2 weeks

Option 2

- Convert IR opioid to same medication as CR, then gradually reduce
  - 60 mg OC ~ 18 mg HM + (24 mg x 3) = 72 + 18 = 90
  - Total HM = 90 mg ÷ 3 = 30 mg q8h
    - Start by reducing ~10 mg every 2 weeks: 27 mg / 27 mg / 27 mg X 2 weeks, then 24 mg – 24 mg – 24 mg x 2 weeks …

LA, long acting. SA, short acting.

The Plan for Renee (2)

- The goal is to find the lowest effective dose of opioids
  - No opioids, less opioids, or intermittent opioids
  - Offer alternative strategies for reducing pain AND increasing coping (CBT, Mindfulness, CPSMP)
  - Targeted exercise to strengthen quadriceps
  - Trigger point injections, intra-articular injections
  - Refer for assessment re: Tx of sleep apnea

Bi-PAP, Biphasic Positive Airway Pressure. CPAP, Continuous Positive Airway Pressure.

The Plan for Renee (3)

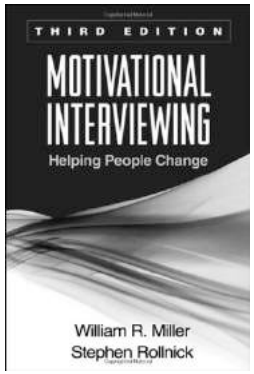
- Once opioids are rationalized, work on the benzodiazepines
  - Use nabilone and/or GPN or PGN during taper
  - Resource: *The Ashton Manual*, a book otherwise known as "Benzodiazepines: How They Work and How to Withdraw":
    - Official website with content from the book:
      - http://www.benzo.org.uk/manual/
      - PDF: http://lonelylinks.com/ashton.htm
      - e-book: http://www.theashtonmanual.com/order.html
      - Order online: http://www.benzobookreview.com/ashton.html

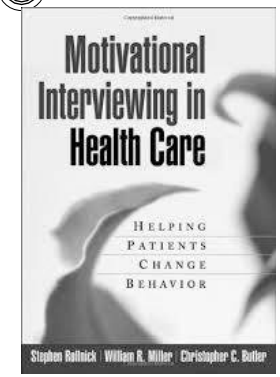
Bi-PAP, Biphasic Positive Airway Pressure. CPAP, Continuous Positive Airway Pressure.

Plan: Tips for Success

- Predict (100% guaranteed) pain will be worse the first week after reducing dose (hyperalgesia) but should stabilize to baseline by the end of the second week
- Reduce slowly: 5-10% every 1- 4 weeks
- Interval dispensing q 1-2 weeks (?blister packs)
  - Helps keep people on schedule
- Manage side effects of withdrawal
- See the patient regularly to review status and discuss other strategies for pain flares
- Do what you do for the good of the patient

Motivational Interviewing





References

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  - https://www.youtube.com/watch?v=7Na2m7lx-hU&feature=youtu.be
- Opioid Taper Template & related materials at: www.RxFiles.ca
  Opioid Manager tool from Canadian CNCP guideline group:
  http://nationalpaincentre.mcmaster.ca/opioidmanager/
- CDC Guideline for Prescribing Opioids for Chronic Pain
  www.cdc.gov/drugoverdose/prescribing/guideline.html
- Washington State Opioid Taper Plan Calculator
  www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf
- Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain
  www.mayoclinicproceedings.org/article/S0025-6196(15)00303-1/fulltext

This presentation and some supplementary info is on the FMF website Handout area

Questions?

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Useful Pain Resources for Patients and Health Care Professionals

The Mind-Body Connection in Chronic Pain

Explain Pain by David Butler and Lorimer Moseley. NOI Group Australia, 2003. www.noigroup.com

Understanding Pain in < 5 minutes: http://www.youtube.com/watch?v=4b8oB757DKc

Psychological Pain Management Techniques

Managing Pain Before It Manages You by Margaret Caudhill. Guilford Publications, 2002.

The Happiness Trap (ACT) by Dr. Russ Harris. Exisle Publishing, 2007

Online relaxation exercises: www.allaboutdepression.com/relax

Sleep Problems

60-Second Sleep Ease by S.R. Currie & K.G. Wilson. (2002) New Horizon, Far Hills N.J.

Mindfulness Based Pain Programs

Mindfulness Meditation for Chronic Pain by Dr. Jackie Gardner-Nix. For more information go to: www.neuronovacentre.com

Fibromyalgia

Fibromyalgia & Chronic Myofascial Pain - A Survival Manual, 2nd Edition. by Devin Starlanyl and Mary Ellen Copeland. New Harbinger Publications Inc. Oakland California, 2001

FibroGuide: http://fibroguide.med.umich.edu

Pain Awareness / Support / Advocacy : www.canadianpaincoalition.ca

Chronic Pain Anonymous: www.chronicpainanonymous.org

Exercise for Health: http://parc.ophea.net/walkthisway
23 ½ Hours: http://www.youtube.com/watch?v=aUaInS6HIGo &feature=g-all&context=G13f5

Pain BC Pain Toolbox: www.painbc.ca/support-and-education

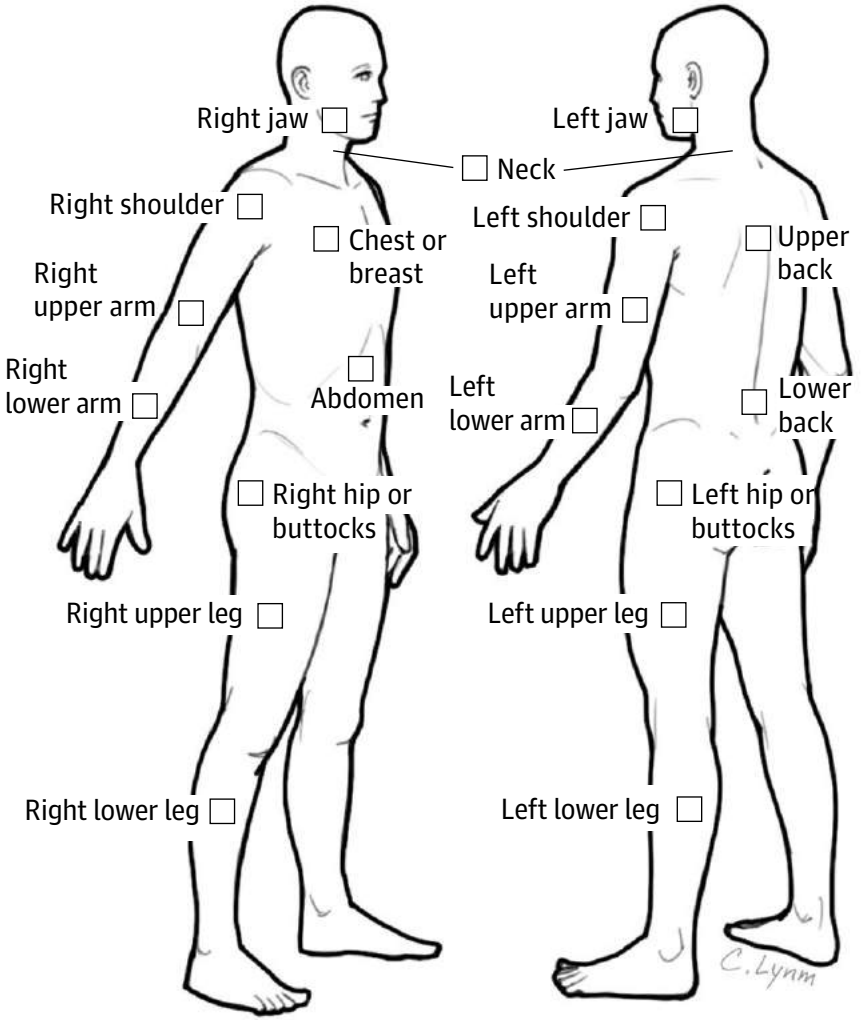
Chronic Pain Self-Management Toolkit: www.pipain.com

Back Pain Information: www.backcarecanada.ca/
Get Back at It: **http://www.youtube.com/watch?v=lkPv72O9ums**
Interprofessional Spine Assessment and Education Centre: ***http://www.isaec.org/***
Gentle Chair Yoga: https://www.youtube.com/watch?v=KEjiXtb2hRg

PATIENT VERSION

Patient Self-report Survey for the Assessment of Fibromyalgia

(1) Please indicate if you have had pain or tenderness **during the past 7 days** in the areas shown below.
Check the boxes in the diagram for each area in which you have had pain or tenderness.



(2) For each symptom listed below, use the following scale to indicate the severity of the symptom **during the past 7 days**.

- **No problem**
- **Slight or mild problem:** generally mild or intermittent
- **Moderate problem:** considerable problems; often present and/or at a moderate level
- **Severe problem:** continuous, life-disturbing problems

	No problem	Slight or mild problem	Moderate problem	Severe problem
A. Fatigue	☐	☐	☐	☐
B. Trouble thinking or remembering	☐	☐	☐	☐
C. Waking up tired (unrefreshed)	☐	☐	☐	☐

(3) During the **past 6 months** have you had any of the following symptoms?

A. Pain or cramps in lower abdomen	☐ **No**	☐ **Yes**
B. Depression	☐ **No**	☐ **Yes**
C. Headache	☐ **No**	☐ **Yes**

(4) Have the symptoms in questions 2-3 and pain been present at a similar level for at **least 3 months**?

☐ **No** ☐ **Yes**

(5) Do you have a disorder that would otherwise explain the pain?

☐ **No** ☐ **Yes**

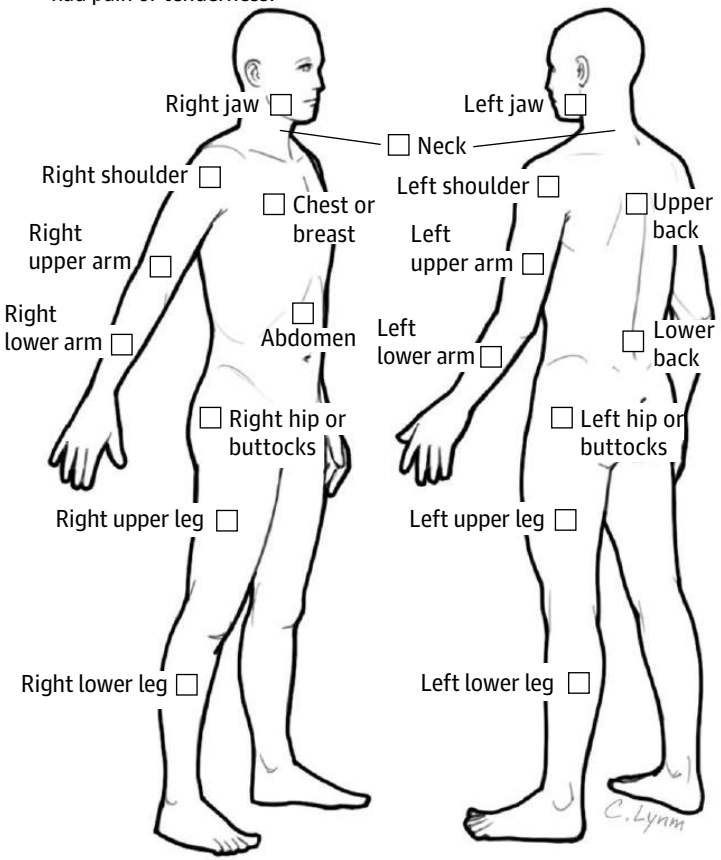
Available from: https://jamanetwork.com/journals/jama/fullarticle/1860480

Example of a Patient Self-report Survey for the Assessment of Fibromyalgia Based on Criteria in the 2011 Modification of the ACR Preliminary Diagnostic Criteria for Fibromyalgia[a]

CLINICIAN VERSION

Widespread Pain Index (1 point per check box; score range: 0-19 points)

(1) Please indicate if you have had pain or tenderness **during the past 7 days** in the areas shown below.
Check the boxes in the diagram for each area in which you have had pain or tenderness.



Widespread Pain Index Total (maximum, 19 points) _____

Symptom Severity (score range: 0-12 points)

(2) Using the following scale, indicate for each item your severity over the past week by checking the appropriate box.

No problem

Slight or mild problem: generally mild or intermittent

Moderate problem: considerable problems; often present and/or at a moderate level

Severe problem: continuous, life-disturbing problems

	No problem	Slight or mild problem	Moderate problem	Severe problem
A. Fatigue	☐ =0	☐ =1	☐ =2	☐ =3
B. Trouble thinking or remembering	☐ =0	☐ =1	☐ =2	☐ =3
C. Waking up tired (unrefreshed)	☐ =0	☐ =1	☐ =2	☐ =3

Subtotal (maximum, 9 points) _____

(3) During the **past 6 months** have you had any of the following symptoms?

A. Pain or cramps in lower abdomen	☐ **No** =0	☐ **Yes** =1
B. Depression	☐ **No** =0	☐ **Yes** =1
C. Headache	☐ **No** =0	☐ **Yes** =1

Subtotal (maximum, 3 points) _____

Symptom Severity Score Total (maximum, 12 points) _____

The following questions do not receive a score, but are criteria to be considered as part of the diagnostic assessment.

(4) Have the symptoms in questions 2-3 and pain been present at a similar level for at **least 3 months**?

☐ **No** ☐ **Yes**

(5) Do you have a disorder that would otherwise explain the pain?

☐ **No** ☐ **Yes**

Total (maximum, 31 points) _____

Scoring information is shown in blue. The possible score ranges from 0 to 31 points. A score equal to or greater than 13 points is consistent with a diagnosis of fibromyalgia. In addition to a cutpoint of 13 points, diagnostic criteria in the 2011 Modification of the ACR preliminary diagnostic criteria for fibromyalgia[a] specify the presence of the following 3 conditions: [1] Widespread Pain Index ≥7 and Symptom Severity ≥5 or Widespread Pain Index between 3 and 6 and Symptom Severity ≥9; [2] Presence of symptoms at a similar level for at least 3 months; [3] The patient has no other disorder to explain the pain.

[a]Reference: Wolfe F, Clauw DJ, Fitzcharles MA, et al. Fibromyalgia criteria and severity scales for clinical and epidemiological studies: a modification of the ACR preliminary diagnostic criteria for fibromyalgia. *J Rheumatol*. 2011;38(6):1113-1122.

Opioid Tapering- Information for Patients

Why should I taper or decrease my opioid medication?

Taking high doses of opioids may not provide good pain relief over a long period of time. The amount of pain relief from opioids can become less at higher doses because of tolerance. Sometimes, opioids can actually cause your pain to get worse. This is called "opioid induced hyperalgesia".

The many side effects of opioids increase with higher doses. Sometimes people using opioids do not connect certain side effects to the medication. That is why many people who try a gradual taper to lower doses, report less pain, and better mood, function and overall quality of life. Sometimes, it is only after such a taper that patients appreciate how opioids were not helping as much as they thought.

What are the side effects of opioid therapy over the long term?

Some of the adverse effects of opioid therapy over the long term include:

- *Tolerance*- The medication becomes less effective over time with patients needing higher doses of opioid to achieve the same level of pain control. By itself, this does not mean patients are addicted, although in some patients it is part of addiction.
- *Physical dependence* –If you abruptly stop or decrease your opioid dose by a large amount, you may experience unpleasant symptoms called withdrawal. This is an expected response to regular opioid therapy that is not the same as addiction. *One of the early symptoms of withdrawal is an increase in pain, which is temporarily improved by taking more opioid*. *Many people on long-term opioids believe that this proves that the opioid is working, rather than being a symptom of withdrawal that will lessen with time.*
- *Constipation*- leading to nausea and poor appetite and less commonly, bowel blockage.
- *Drowsiness causing falls, broken bones, and motor vehicle accidents*
- *Fatigue, low energy, depression* -This can significantly affect your function and ability to work or do day-to-day activities.
- *Sleep apnea or impaired breathing while sleeping* – This can contribute to daytime fatigue and poor thinking ability. It increases your risk for many health conditions and also increases your risk of having a car accident.
- *Low testosterone hormone levels in men* – This can lead to low sex drive, low energy, depressed mood, slower recovery from muscle injuries and decreased bone density (thinning of the bones).
- *Low estrogen and progesterone hormones in women*- leading to decreased bone density and low energy.
- *Pain can get worse in some people, especially at higher doses (opioid-induced hyperalgesia)*

What can I expect when tapering or decreasing my opioid medication?

1. *Pain*- One of the first symptoms of opioid withdrawal is increased pain. This pain may be the same pain that you are being treated for, as well as total body joint and muscle aches. Some people will complain of a recurrence of pain at the site of an old healed injury, such as a broken

bone. Taking a dose of opioid reduces all of the above pains – but only temporarily. The pain associated with withdrawal generally passes in most people within 1-2 weeks, and is lessened by tapering doses very slowly. Many people report that the pain that the opioid was originally being taken for does not worsen when opioids are reduced.
In order to manage any withdrawal mediated pain, prior to reducing your opioids, you and your doctor should develop a plan to deal with this pain. This can include non-drug strategies such distraction, activity, stretching, meditation, and heat or the use of some non-opioid medications. Treating withdrawal pain with opioids delays the taper process.

2. *Withdrawal symptoms*- Opioid withdrawal symptoms can be very unpleasant but are generally not life threatening. However, they sometimes cause people to seek opioids from non-medical sources, which can be very dangerous. Therefore, it is advisable to talk with your doctor regarding a safe approach to gradual tapering. Withdrawal symptoms are similar to a flu-like illness and can begin 6-36 hours after your last dose of opioid. If you stop most opioids quickly or suddenly, withdrawal is most severe 24-72 hours after the last dose, and will diminish over 3-7 days. Some people will feel generally tired and unwell for several weeks and may feel "down" or not quite themselves for several months, particularly if they have been taking very high doses of opioids. If you choose to decrease your dose slowly (over several weeks or months), withdrawal symptoms are usually much less severe. Your doctor may prescribe some non-opioid medications (such as clonidine and others) to help reduce the severity of withdrawal symptoms. You may experience some or all of the following during withdrawal:
    - Sweats, chills, goose flesh
    - Headache, muscle aches, joint pain
    - Abdominal cramps, nausea, vomiting, diarrhea
    - Fatigue, anxiety, trouble sleeping

    These withdrawal symptoms usually resolve with time. A severe increase in your pain that results in a decrease in your daily function that does not reduce over 3-4 weeks is less likely to be due to withdrawal and should be re-evaluated by your doctor.

How do I taper?

Preparation

1. Enlist support from family, friends and all your healthcare team.
2. Make a plan to manage any withdrawal related pain.
3. Make a plan to manage any withdrawal symptoms including anxiety and trouble sleeping.
4. Learn and practice non-drug pain management strategies.
5. There may be times when the withdrawal symptoms have been really severe, and you are not ready to take the next step. Formulate a plan with your doctor and pharmacist for when you may need to pause or slow down a taper. It is OK to take a break, but the key point is to try to move forward with the taper after the pause.
6. Remember that the long term goal is improved pain control and quality of life while reducing potential harms of treatment.

Reductions in opioids can be carried out in many ways

1. Fast – Simply stopping your opioids immediately, or reducing rapidly over a few days or weeks will result in more severe withdrawal symptoms, but the worst will be over in a relatively short period of time. This method is best carried out in a medically supervised withdrawal center. Ask your doctor if such a center exists in your community.
2. Slow – Gradual dose reductions of 5 to 10% of the dose every 2-4 weeks with frequent follow-up with your doctor is the preferred method for most people. If you are taking any short- acting opioids it may be preferable to switch your total dose to long acting opioids taken on a regular schedule. This may make it easier for you to stick to the withdrawal plan. A pharmacist can help lay out a schedule of dose reductions.
3. Methadone or buprenorphine-naloxone – Another strategy that may result in less severe withdrawal is a switch to methadone or buprenorphine-naloxone and then gradually tapering off. This requires a doctor trained to use these medications but can be an alternative to the "Slow" method noted above.

Managing Opioid Withdrawal – Information for Clinicians

Roman D. Jovey, MD and Pam Squire, MD

1. Reassure the patient that withdrawal from opioids is **uncomfortable but rarely life threatening.** Each dosage reduction may result in symptoms similar to a severe, flu-like illness beginning within 12-36 hours and, peaking at 48-72 hours, and then tapering off after 1-2 weeks. Some people experience a period of vague dysphoria for 1-2 weeks after initial withdrawal. (Methadone withdrawal may peak later with less intensity but can go on for 4-6 weeks in some people.) More caution is required in pregnancy and in those with fragile medical or mental health conditions, where an inpatient chemical withdrawal would be safer.

2. The patient and physician can agree to withdraw more quickly (over 10-14 days) resulting in a more severe but shorter overall period of symptoms, or to taper over weeks to months and experience a milder but more prolonged withdrawal. Reduce the dose by 10% at the agreed upon interval. Use interval dispensing for every dose reduction. Consider blister packs to help the patient stay on schedule. High-risk patients may require daily dispensing. Once-daily opioid formulations (i.e., Kadian) may make the withdrawal process simpler. A methadone taper allows for a less intense but longer period of withdrawal symptoms. This requires a Federal methadone prescribing authorization. A switch to BUP-NX followed by a taper is another option – especially for a rapid opioid taper. This is available through physicians who have methadone for addiction exemptions and is also offered in some private detox clinics. A suggested 4-day BUP-NX loading protocol is attached.

3. Clonidine has been used the longest to decrease some of the autonomic symptoms of opioid withdrawal. The main side effects are orthostatic hypotension and sedation.

> *Prescribe 0.1-0.2 mg po q6h prn maximum 6 tabs per day. The dose may have to be lowered if the patient reports orthostatic symptoms or has a BP less than 90/60 mmHg, 1 hour after a dose. Continue clonidine until off of opioids for 3-5 days, then taper over next 3-5 days.*

4. One of the early symptoms of opioid withdrawal is increased pain – the patient's usual pain plus additional arthralgias and myalgias. This may persist longer than other withdrawal symptoms, but will eventually settle. Acetaminophen, NSAIDs, or tramadol may be helpful. If attempting to re-evaluate a patient's pain off of opioids, the opioids need to be discontinued for at least 4-6 weeks to get through withdrawal pain and to allow opioid receptors to "reset." It can take a while for an individual's endogenous opioids to begin production again.

5. Loperamide (OTC) can help decrease abdominal cramping and diarrhea if these occur.

6. Acupuncture or TENS have been shown in some studies to decrease symptoms of opioid withdrawal.

7. Short-term use of pregabalin (75-150mg bid), and/or the cannabinoid nabilone (0.5 – 1mg bid) for the first 1-2 weeks may help with pain as well as sleep and anxiety.

References:

Brands B (Ed.), Kahan M, Selby P, Wilson L. *Management of Alcohol, Tobacco and Other Drug Problems. A Physician's Manual.* Toronto, Ontario: Centre for Addiction and Mental Health, 2000.

Fishbain D, Rosomoff HL, Cutler R.. Opiate detoxification protocols – a clinical manual. *Ann Clin Psych* 1993;5(1):53-65.

Ashburn MA, Lipman AG, Carr D, Rubingh C. *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain* (5th Edition). Chicago, IL: American Pain Society, 2003.

Gowing LR, Ali RL. The place of detoxification in treatment of opioid dependence. *Curr Opin Psychiatry* 2006 May;19(3):266-70.

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BUP-NX = Buprenorphine-naloxone sl tablets

A Suggested Outpatient Protocol for BUP-NX Induction and Taper

This protocol is for use with opioids other than methadone, in a patient who is not at high risk for addiction and should not be utilized if there are also benzodiazepines involved. Arrange a daily pickup of meds from the pharmacy for the first 4 days.

1. Make sure there is a responsible other adult present during the switchover and that you have met and discussed the protocol with them in person. Explain the possibility of precipitated withdrawal after the first dose of BUP-NX.

2. Explain the BUP-NX loading protocol and provide written materials. Discuss the common opioid withdrawal symptoms and provide a handout that describes what to expect.

3. Stop the prescription opioid at midnight.

4. The next day (Day 1) wait until the withdrawal symptoms are at least moderate to severe. The longer the patient waits, the less the risk of precipitated withdrawal. If using the COWS questionnaire to assess severity of withdrawal, aim for a total score of 14-20.

5. Take the first dose of BUP-NX 4mg s.l. and wait 3 hours.

6. Take BUP-NX 2mg s.l. q 3h prn up to a maximum dose of 12mg in the first 24 hours. If there are still some severe withdrawal symptoms, use the other meds (clonidine, loperamide, PGN or nabilone) to get through the first 24 hours.

7. On the morning of Day 2 (or 24 hours after the first dose of BUP-NX) – take the total dose of BUP-NX required on Day 1 (max 12mg) in one dose. Wait 3 hours. If withdrawal symptoms are at least moderate to severe, start loading again if by 2mg s.l. q 3h up to max 24mg daily on Day 2. **The patient should never exceed 24 mg in any 24 hour period.**

8. On Day 3 (48 hours after starting BUP-NX)– take the total dose of BUP-NX from Day 2 and split the total dose BID. Repeat this dose on the morning of Day 4.

9. On Day 4 follow-up with the MD to reassess. If the patient has had a relatively easy transition then begin the taper process. The speed of taper depends on the motivation (and stamina) of the patient. One can taper by 2mg daily or 2mg weekly. Reassess the patient weekly to offer support and be prepared to pause when required. Use interval dispensing no longer than 1 week apart during this time.

10. When you get to 2mg daily, you can either split the pill into 1mg doses or take a 2mg pill every 2 days and then stop.

11. If the patient is still having great difficulty stopping the last 1mg of BUP-NX then switch them to the Buprenorphine patch and taper. A 20ug/hr BUP patch is roughly equivalent to a s.l. dose of 0.5 mg buprenorphine per day. Therefore one can use a 20ug/hr patch for 1 week, then 15ug/hr for 1 week, then 10ug/hr for 1 week then 5ug/hr for 1 week then stop.

This protocol was adapted by Dr. R. D. Jovey, MD using the following references:

Lee JD, Vocci F, Fiellin DA. Unobserved "home" induction onto buprenorphine. J Addict Med. 2014 Sep-Oct;8(5):299-308.
Lee JD, Grossman E, DiRocco D, Gourevitch MN. Home buprenorphine/naloxone induction in primary care. J Gen Intern Med. 2009 Feb;24(2):226-32.