Tapering Long-Term Opioids Can Be Both Patient-Centered and Evidence-Based

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Tapering Long-Term Opioids

In 2018 Washington State dispensed 49.3 opioid prescriptions per 100 residents (for comparison, Texas 47.2, California 35.1).[2] Many of these opioid prescriptions were for chronic non-cancer pain (CNCP) despite limited evidence of benefit and abundant evidence of harm.[1] Pain management is challenging, and it is easy to prescribe opioids for a suffering patient from a desire to help. However, we must be certain when we prescribe opioids that they are part of the solution instead of part of the problem, and at the very least that we are prescribing the "lowest effective dose" referred to in the Bree (AMDG 2015 guidelines), CDC (2016 guidelines) opioid prescribing guidelines and in Washington State law (WAC). This may entail tapering of opioid prescriptions in some patients to lower, safer and perhaps more effective doses, or changing to buprenorphine. Recently, a number of evidence-based guidelines have been published to help prescribers with the difficult task of tapering opioid medications in CNCP (Bree, HHS and National Academy of Medicine).

How do we help people like a 54 year-old man on long-term opioids for chronic back pain that continues to have widespread pain and is too disabled to even vacuum his house? My clinic has had early success in actively addressing our CNCP opioid panel. This patient is now having minimal pain and more functional than he's been in over a decade on buprenorphine.

During October 2019, Neighborcare Health prescribed long term opioids to 673 patients, mostly for CNCP. Common issues for all our CNCP opioid patients were variations in evaluating and managing CNCP, as well as knowledge gaps on how to have an effective opioid risk/benefit discussion.

Our Approach

We piloted changes at my clinic with 45 CNCP opioid patients. By simply listing to them, taught us a lot. The most common indications for opioids were back pain/osteoarthritis (47%) or fibromyalgia (18%). Morphine equivalent daily doses (MEDD) were 5-300mg (mean 45mg) and age 33-80 years (mean 62).

We came to consensus as a group about when to continue opioids for CNCP and when to taper, by specifically agreeing on a set of principles for when risks were likely to outweigh benefits (Figure 1). The process occurred through a series of meetings, e-mails and evidence review.[3,4] We agreed everyone would use the PEG scale (Pain, Enjoyment of life, General Activity) for better longitudinal assessment of pain (Figure 2) and adopted the Bree Collaborative's 2020 Long Term Opioid Therapy Report for our standard of care.[5] By establishing clinic consensus, we were able to provide more consistent care for our patients.

Over a period of three months, we scheduled a 30-minute visit with every CNCP patient to do a full opioid re-evaluation and risk/benefit discussion. My initial conversations broaching the subject and counseling when an opioid taper was indicated lasted 30-45 minutes, and over half ended in a positive patient experience and optimism for some improvement. I found most patients had never been counseled on non-overdose risks of opioids, hyperalgesia, or withdrawal.

I use Stanford's BRAVO method to initiate these challenging CNCP opioid discussions.[6-8] Broach the subject (B) of a taper with extra time and up-front acknowledgment of the fear, anxiety and strong negative reactions this discussion brings. Have a risk/benefit conversation (R) about the patient's use of opioids, highlighting what we now know from decades of study that is different from when they first started. Acknowledge addiction happens (A) to some people exposed to opioids, even for those with legitimate pain conditions. This helps prevent stigma and allows providers to be optimistic about treatment because opioid use disorder (OUD) will become apparent in many patients while tapering. (V) is for Validating how difficult tapering can be, and for pointing out that velocity matters, as some patients on long-term opioid therapy may take months and even years to taper off opioids. For example, 40mg/day oxycodone taken by a patient with opioid dependence and chronic pain might be reduced by 5mg a day per month, with a goal of being off opioids in 12-18 months. (O) stands for other skills to manage pain providers can teach within a 15-minute visit. Discussing concerns about CNCP opioids is a dreaded conversation that is easy to avoid. I don't feel this way anymore. The BRAVO method has been a practice-changer.

35 patients (78%) were recommended to taper off opioids due to poor benefit and excessive risk. Continued uncontrolled pain and low functioning are reflected as high PEG scores. Opioid tolerance and withdrawal between doses of short-acting opioids like oxycodone, or the phenomenon of opioid-induced hyperalgesia are possible explanations for persistent pain on long-term opioids. Patients often interpret myalgias, fatigue, dysphoria or insomnia as their underlying pain condition and the opioid helping it. However, improvement with opioid dosing is more likely relieving opioid withdrawal. Though only four (9%) met DSM-5 criteria for opioid use disorder (OUD), most of their lives were adversely impacted by opioids to a similar degree.

We use this clinical algorithm to make taper decisions (Figure 3), developed from published examples of modern pain care.[8-10] If CNCP is poorly controlled or risks are high, a slow medically supervised taper off opioids or rotation to buprenorphine is performed.[1] We rarely initiate a change during this initial visit, but do so during

a 30-minute visit the following month - to allow the patient time to review materials and process the change in their care plan. If a slow and carefully monitored taper is not tolerated, or they have OUD, we transition to buprenorphine.[11]

Further, I find patients focus their risk concerns on overdose death risk - "I've been taking these for 15 years and I haven't died yet." But linking their often-disparate symptoms to known effects of opioids creates understanding.[8] Brain fog, fatigue, sexual problems? Opioids can do that. "You've got such terrible pain you can't even get restful sleep. That must be exhausting. Based on what we now know about how opioids change the brain over time, I worry that what feels like pain relief is probably treating withdrawal from your last dose, rather than your underlying pain condition. To get out of this vicious cycle, we need to get you off opioids or on a longer acting medicine like buprenorphine, which has several potential benefits over what you're taking now."

Buprenorphine for Pain

Buprenorphine is best known for treating OUD but was first FDA approved as a potent opioid analgesic in 1981.[11] Most under appreciate how strong buprenorphine is. A Yale case series of CNCP patients without OUD on 105-390 MEDD stabilized them on 6-12mg/day of buprenorphine. [12] It has a long half-life - giving after repeated dosing more stable analgesia without withdrawal and perhaps fewer cognitive effects. Compared to traditional opioids, buprenorphine has a lower ceiling for its effects (a partial agonist), explaining how it has fewer undesirable effects like respiratory depression, euphoria, sedation, hyperalgesia, constipation, depression and risk of overdose.[11,13] However, buprenorphine is still an opioid and should probably still not be routinely given to opioid naïve patients with CNCP. Rather, it's a harm reduction strategy. Pain patients often need lower amounts (4-12mg/day in divided doses) compared to OUD patients, where 16-24mg daily doses are typical.

In our practice, most patients are doing well with a slow taper. We transitioned eight patients without OUD to buprenorphine. Six were happier with equal or better pain control and fewer side effects, like the case patient at the start. One chose to discontinue opioids completely and one could not finish the induction, due to symptoms. To increase successful inductions to buprenorphine, I recommend a technique called microdosing.

Despite the advantages, buprenorphine can be difficult to start as an outpatient because many regimens require a period of withdrawal. Microdosing involves beginning buprenorphine with tiny doses and increasing these doses slowly to avoid causing withdrawal (Figure 4). Because of its higher affinity for the opioid receptor, buprenorphine will gradually displace other opioids subclinically if started at a low enough dose. For example, starting at 0.5mg twice daily (1/4 tab or film) with slowly increasing increments over a week is one common approach.[12]

Patch-based regimens may be easier because it is more automatic. Transdermal buprenorphine's reliable delivery of low doses has been used in multiple case studies to bridge to sublingual buprenorphine. [14,15] For example, the use of the patch for five to seven days while tapering regular opioids over three to four days can be an effective start, followed by the introduction of sublingual buprenorphine on day three at 1mg BID. Then increasing the sublingual dose without the patch. Barriers for buprenorphine patches are the expense/poor insurance coverage, packaging (packs of four), and needing a pain diagnosis (not indicated for only OUD).

Document the indication for buprenorphine, because the FDA approved indications vary by route of administration. Buccal is approved for pain and available in small doses but has poor insurance coverage. Sublingual is not FDA approved for pain but is frequently used off-label. It is co-formulated with naloxone for OUD and broadly covered by insurance as 2/0.5 or 8/2mg tablets or films. If prescribing for pain, no DEA waiver is needed, but a waiver is required if OUD is diagnosed.

Putting it into Practice

These approaches to assessment and treatment greatly improved my group's confidence in managing CNCP. The clinical algorithm described above helped us apply the evidence to our practice using easy assessment tools like PEG.[1] BRAVO's structured approach to initiating difficult discussions about tapering off opioids for CNCP helped us start having these discussions. Knowledge about buprenorphine and the microdosing technique provided practical alternatives to a slow opioid taper, or when OUD became apparent.

Start the conversation: "I scheduled some extra time today to talk about a difficult subject. I've been thinking a lot about your pain and how best to help you with it. Your pain is still severe, and you're not very functional. Based on what we now know about opioids and pain, I worry it's causing you more harm than good now. This is a scary thing to talk about, but we can figure this out. And know I'll be with you every step of the way."

Figure 1. Our Approach: Situations Where Risks of Opioids May Outweigh Benefits for Pain
Pain remains significant
PEG scores >15/30 consistently
Low functioning
Persistent depression or anxiety
Presence drugs/conditions that increase risk overdose (ex sedatives)
Central/Visceral Pain syndrome that opioids typically worsen (ex fibromyalgia)

Figure 2. PEG Scale Assessing Pain Intensity and Interference (Pain, Enjoyment, General Activity

1. What number best describes your pain on average in the past week?

0 1 2 3 4 5 6 7 8 9 10

No Pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

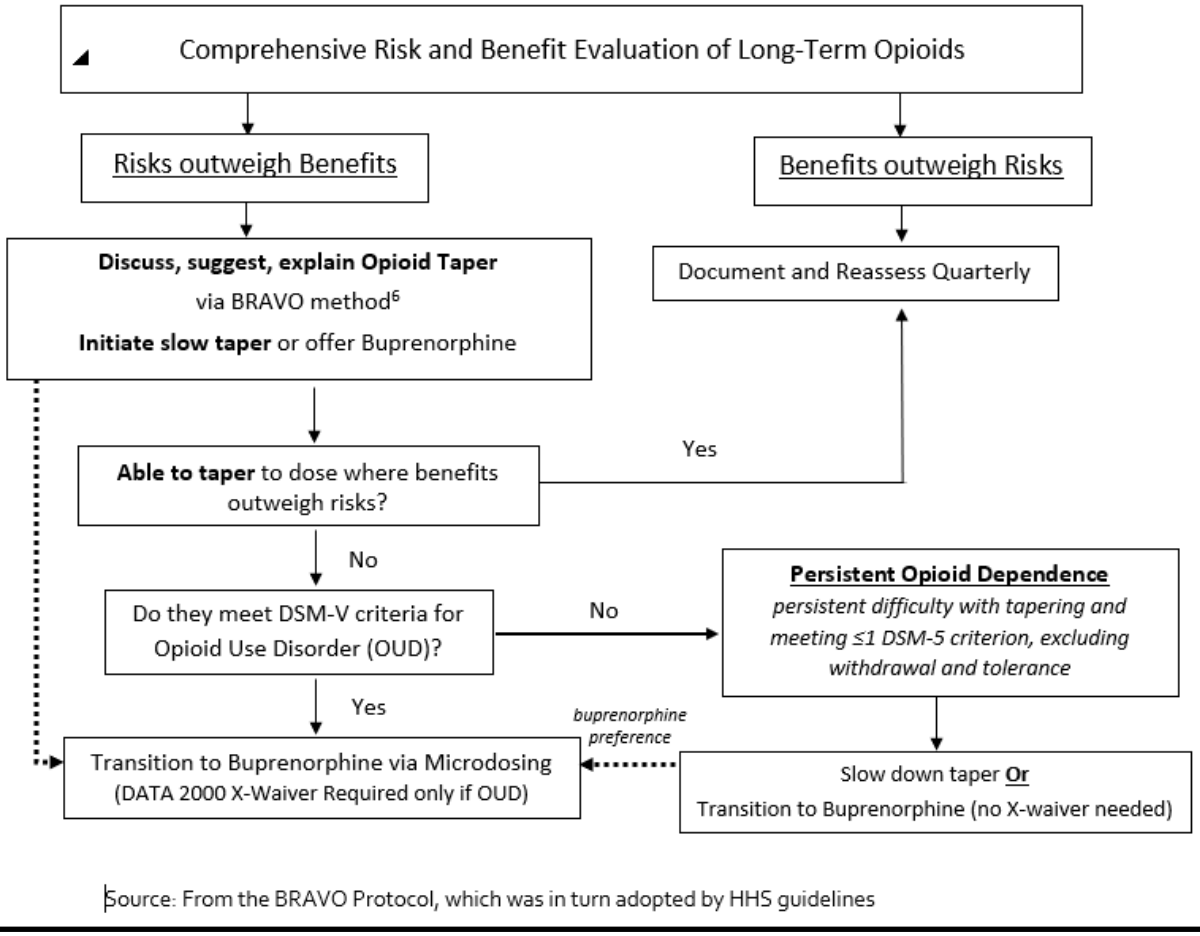
3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

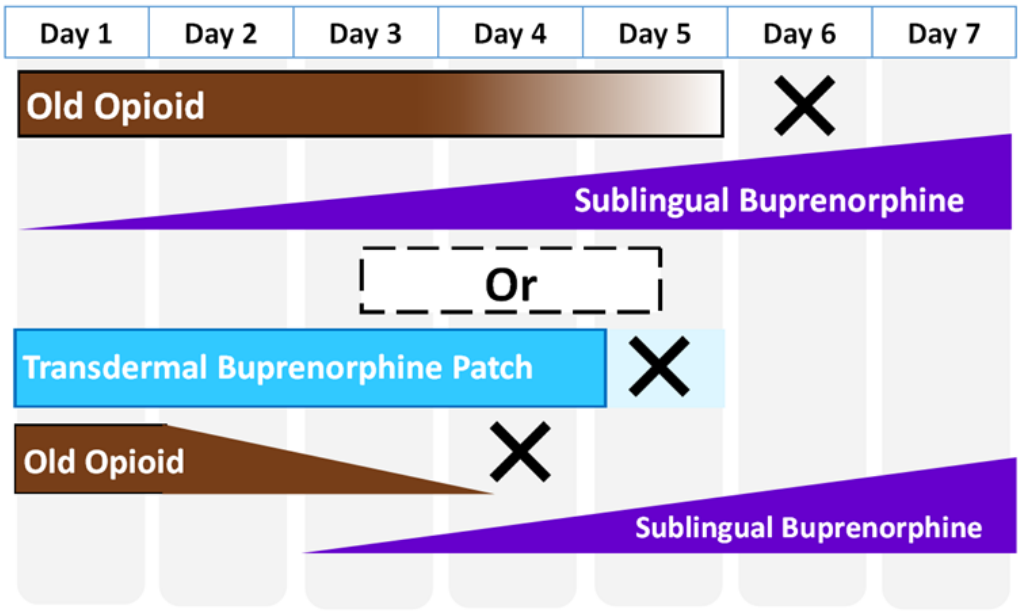
Krebs, E. E., Lorenz, K. A., Bair, M. J., Damush, T. M., Wu, J., Sutherland, J. M., Asch S, Kroenke, K. (2009). Development and Initial Validation of the PEG, a Three-item Scale Assessing Pain Intensity and Interference. Journal of General Internal Medicine, 24(6), 733–738. http://doi.org/10.1007/s11606-009-0981-1

Figure 3.
Clinical Algorithm for long-term opioid therapy in Chronic Non-Cancer Pain.



Source: From the BRAVO Protocol, which was in turn adopted by HHS guidelines

Figure 4. Buprenorphine Microdosing Overview using Sublingual or Patch Method



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