Why Taper?

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Why Taper?

![High Opioid Dose and Overdose Risk](chart)

*Overdose defined as death, hospitalization, unconsciousness, or respiratory failure.*
Reducing the Risks of Relief — The CDC Opioid-Prescribing Guideline


- NNK = 550 for all doses
- NNK = 32 for doses > 200 MME
- Median time to opioid related death is 2.6 years
Our Challenge in Maine

From PMP data we estimate:

- 16,000 Mainers on > 100 MME daily
- 1200 Mainers on > 300 MME daily
- 60 opioid pills per person per year prescribed
- Nation’s highest rate of prescribing of long acting opioids
- Accelerating opioid deaths (both prescription and illicit)
Noah’s Unofficial and Likely Derivative Chronic Pain and Suffering Principle

Role of Emotion in the Intensity of Chronic Pain

Emotional/Psychosocial Factors

Suffering

Insight

Time
Adverse Selection

“Intensity of Chronic Pain – The Wrong Metric”

Ballantine and Sullivan, NEJM, Nov. 26, 2015

• 30 years of escalating opioid prescribing, no decrease in burden of chronic pain in the US
• Mis-applied the acute and end-of-life approach to chronic pain
• Intensity of chronic pain does not correlate with tissue damage
• Change in brain processing from pain matrix to emotion/reward
Adverse Selection

• Suffering reported as intensity of pain

• Treatment with opioids
  o Chemical coping
  o Blocking/distracting from insight
  o No work on meaning
  o Despair
Adverse Selection

• Co-morbidities with MH issues, chronic disease
  o Increased anxiety
  o Overwhelmed
  o Less insight
  o Higher intensity of pain
  o Increased risk of abuse of or addiction to controlled substances
Sustained Compassionate Engagement

• Prevalence of OUD for population using opioids for chronic pain is 35%
  
• \(0.35 \times 16,000 = 5600\)

• May be higher due to adverse selection

• Almost certain to be a very high percentage of people taking it for psychological reasons

• Very high prevalence of trauma/PTSD
Compassionate Medication Tapering

Eva Quirion, NP
St. Joseph Internal Medicine
Fundamental Concepts

• Your patient did not prescribe opioids to themselves
• Someone told them that they NEED this medication
• Maybe YOU told them that they need this medication
• Pain = Fear
• The threat of MORE pain = MORE fear
How to break the news...

• The decision to taper opioids has been made, what next?
• Before you speak with the patient know your rationale for the taper and be confident
• Meet your patient face to face to discuss their medications
• Have your plan figured out to the best of your ability, but be flexible
The Conversation

• Frame the entire conversation around the patient and their safety

• DO NOT frame the conversation around things like, “I am not comfortable…” or “the law says…”

• Be reassuring, “I will walk beside you.” “I will work with you to treat your pain in other ways.”

• Acknowledge that tapering can be difficult
The conversation

• Reframe the purpose of their opioid medication during the taper
  – “you no longer take oxycodone for pain, you are taking it to avoid being sick while we taper”

• Normalize and anticipate the sensations and difficulties that the patient may have
  – “Many people feel anxious, have trouble sleeping, feel achy. These things are normal and will regulate in time.”
Developing a Taper plan

• There are tapering calculators, meh...
• Develop a plan that you think your patient can handle, but something that will not stagnate
• Think of it in percentages
• A 10% cut is reasonable
• Weekly decreases are reasonable
• My style is usually no faster than every TWO weeks and less than 10%
Developing a taper Plan

• Look back to why you are tapering
• If it’s related to contract issues or a safety emergency...choose a more rapid taper
• If it’s related to the long-term health of a patient who is not having difficulty, you may wish to take more time
• It can be like ripping off a band-aid and the patient may want to just get things over with
Developing a taper plan

• It’s great if you have a taper plan all written out with dates and doses at the time of the visit
• However, it’s ok to tell a patient that you need to write it all down “I want to get it right and take time to concentrate” and mail it to them
• Before the patient leaves you, be sure that they know what the dose will be for their NEXT prescription, no surprises
The Characters – The Negotiator
The Characters – the Negotiator

- You will encounter patients who will think of every reason why they need to stay on opioids
- Some will tell you they don’t care if they die
- Some will tell you that they will start buying opioids on the street
- Some will tell you that they will start drinking again
- Some will offer veiled or overt threat of suicide
- “I care about you and do not want to see you harmed.” “We do not treat suicidal thoughts with opioids.”
The Characters – The Sad Face
The characters – The Sad Face

• This can feel like a breech of trust to the patient
• Some patients feel that they are being punished
• It’s a betrayal of sorts
• There could be tears
• Disbelief
The Characters – The Angry Bird
The Characters – The Angry Bird

• Again, some feel betrayed and may get angry at you for this clinical decision
• Agree that it’s ok for a provider and patient to disagree on a health issue, but that the decision is made
• Remind the patient that the decision is made to improve medication safety
• Do NOT take the anger personally
The Characters – The Eager Beavers
The Characters – The eager Beavers

- Surprisingly, some patients are happy to think about being free from opioids
- I have a patient who refers to controlled substances as “chemical cuffs”
- They are excited
- Caution them to not get too far ahead of the taper or they may unintentionally sabotage their own efforts
The unexpected – Running out Early

• NO early refills
• If a patient is going to go without opioids for a few days and will withdraw...
• DO NOT REFILL
• Provide comfort medications
Comfort Medications

- Clonidine 0.1 mg tid
- Promethazine 25 mg 3-4 times a day OR hydroxyzine 50-100 mg 3-4 times a day OR diphenhydramine 25-50 mg 3-4 times a day
- Loperamide 4 mg first dose, then 2 mg after every loose stool (NTE 16 mg/24 hours)
- Cyclobenzaprine 5 mg tid
- Trazodone 50 mg QHS
- Ibuprofen 200 mg + acetaminophen 500 mg 3-4 times a day
The Unexpected – Pause Requests

• Sometimes patients wish to pause their taper for a month
• “I have had a hard time”
• Sometimes it is humane to pause for a month, but be very careful for repeated requests
• Also, remember that we don’t use opioids to treat stress, grief, and bad weather
• There are times the provider must gather some tough love
The Unexpected – Reversal Requests

• Never reverse a taper
• This is like letting your grounded teenager go to a movie
• Pause if appropriate
• If there is an acute injury, treat that independently while pausing the taper
• Once healing has happened, stop the acute medications and resume the taper
Words from Experience

• The majority of your patients will do just as well
• The pain generally regulates to exactly what it was when the patient was on opioids
• Sometimes...the pain is better
• “I thought I had Alzheimer’s, turns out I was just medicated”
• Function generally improves somewhat
Words from experience

• Work to gather a team around the patient
• Be sure that treatments are exhausted
• Work with your patient in the spirit of “lifestyle medicine”
• Anti-inflammatory diet, yoga, exercise, weight loss, stop smoking, stop smoking, stop smoking
• Cognitive behavioral therapy, biofeedback, acupuncture, counseling
Goals

• Maintain or gain function
• Improve health and prognosis
• Restore the spirit, the personality, the relationships if possible
• Teach your patient to find things that bring them joy
Thanks for your kind attention!!

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Morphine milligram equivalents

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Morphine milligram equivalents (MME)

- Aka Morphine Equivalents (MEQ) or Morphine Equivalent Dose (MED)
- Apples-to-apples comparison of opioid potency with morphine as the standard
- Equianalgesia is *approximate*
Morphine milligram equivalents (MME)

Morphine

Oxycodone

Methadone
## Equianalgesic dosing

<table>
<thead>
<tr>
<th>Oral Opioid</th>
<th>Equianalgesic Dose (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20</td>
</tr>
<tr>
<td>Tramadol</td>
<td>120</td>
</tr>
<tr>
<td>Methadone</td>
<td>***</td>
</tr>
</tbody>
</table>
Methadone MME

Methadone
Oxycodone
Morphine

Dose (mg)

MME (mg)
## Opioid dose calculator


<table>
<thead>
<tr>
<th>Opioid (oral or transdermal):</th>
<th>mg per day:</th>
<th>Morphine equivalents:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Fentanyl transdermal (in mcg/hr)</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Methadone</td>
<td>10</td>
<td>40</td>
</tr>
<tr>
<td>Morphine</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Tapentadol</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td>Tramadol</td>
<td>10</td>
<td>2</td>
</tr>
</tbody>
</table>

TOTAL daily morphine equivalent dose (MED) = 77
Opioid calculator caveats

- Sources: studies on single-dose, acute pain, and/or opioid-naïve patients
- Patient-specific variables unaccounted for
- Not always bidirectional
- Does not account for incomplete cross-tolerance
Methadone taper algorithm

Methadone

MME greater than 200 mg/day? Yes

↓ by 20% every 2 weeks until 25 mg/day reached

Switch to long-acting opioid at 50% MME

Maintain for 2 months

↓ by 20% of original dose every 2 weeks until 20% remains

↓ by 10% of original dose for 2 weeks, then stop

No
methadone taper Design

1. Calculate MME the patient is receiving from methadone daily
2. If greater than 200 MME/day, decrease methadone by 20% every 2 weeks until 25 mg/day is reached
3. Discontinue methadone and replace with another long-acting oral opioid (morphine SR or oxycodone ER)
methadone taper Design

4. Start new opioid at total daily dose that delivers **50% of the methadone MME**

5. Two months after switch, decrease opioid by 20% of original dose every 2 weeks until 20% remains

6. Decrease by 10% of original dose for 2 weeks, *if possible*, then stop
Example methadone taper

Original prescription: methadone 20 mg BID

1. Calculate methadone MME
Methadone 40 mg/day
MME = 320 mg/day
Example methadone taper

2. Taper methadone by 20% every 2 weeks until 25 mg/day is reached

20% of 40 mg = 8 mg (~5 mg)

<table>
<thead>
<tr>
<th>AM dose</th>
<th>PM dose</th>
<th>Length</th>
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<tbody>
<tr>
<td>20 mg</td>
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</tr>
<tr>
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<td>10 mg</td>
<td>2 weeks</td>
</tr>
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</table>
Example methadone taper

3. Replace methadone with another long-acting oral opioid

Choice: Morphine SR

4. Start new opioid at 50% of methadone MME

Methadone 25 mg, MME = 200 mg/day
Start morphine SR at 100 mg/day
(50 mg in the AM and 50 mg in the PM)
Example methadone taper

5. After 2 months, decrease by 20% of original dose every 2 weeks until 20% is reached

20% of 100 mg = 20 mg

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<td>30 mg</td>
<td>2 weeks</td>
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Example methadone taper

6. Decrease by 10% of original dose for 2 weeks, then stop

10% of 10 mg = 10 mg

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<td>----</td>
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Stop
Questions? kdowling@pchc.com