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ECHO Idaho: Opioid Addiction and Treatment

Tapering Opioids and Benzodiazepines in Primary Care

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The speaker has no relevant financial relationship(s) to disclose.
My Real Disclosure

- Slides are easy
- Tapering opioids and benzos in primary care can be challenging

“Maybe they've oversimplified the cockpit controls.”
Learning Objectives

• Understand why to taper
• Utilize a case to illustrate tapering methods
• Discuss how to support your patients during a taper
Why bother?

• If in past 6 months you filled a prescription for:
  – An **opioid**: risk of (drug related) death goes up **3x**
  – A **benzo**: “” goes up **7x**
  – Both: “” goes up **15x**

*Med Care 2012;50: 494–500*
Case

• 64 year old male veteran on morphine ER 30mg q8hrs and oxycodone 10mg q6hrs for his degenerative disc disease, as well as diazepam 10mg QID for his PTSD. He has stage 3 fibrosis from Hep C “in the war”, as well as a history of mild AUD, though he states he does not drink anymore.

• He is seeing you as new PCP, needs refills
Start with Benzodiazepines

Who needs to taper?
**Taper anyone on continuous Benzos 30-d or longer**

Acute Withdrawal Symptoms occur after 10-21 days of continuous use:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insomnia</td>
<td>71%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>56%</td>
</tr>
<tr>
<td>Mood swings</td>
<td>49%</td>
</tr>
<tr>
<td>Muscle twitching</td>
<td>49%</td>
</tr>
<tr>
<td>Tremor</td>
<td>38%</td>
</tr>
<tr>
<td>Headache</td>
<td>38%</td>
</tr>
<tr>
<td>Nausea, vomiting, anorexia</td>
<td>36%</td>
</tr>
<tr>
<td>Hypersensitivity to smells, sounds, lights, noise, touch</td>
<td>Up to 38%</td>
</tr>
<tr>
<td>Seizure*</td>
<td>4%</td>
</tr>
</tbody>
</table>

Jahnsen, 2015 [https://www-ncbi-nlm-nih-gov.liboff.ohsu.edu/pmc/articles/PMC4318457/pdf/Dtsch_Arztebl_Int-112-0001.pdf](https://www-ncbi-nlm-nih-gov.liboff.ohsu.edu/pmc/articles/PMC4318457/pdf/Dtsch_Arztebl_Int-112-0001.pdf)

*Hx of prior seizure = risk of seizure again*
Tapering Benzos as an Outpatient

• Generally, switch to equivalent dosing of a single, long-acting agent (clonazepam or diazepam)*
  – http://www.globalrph.com/benzodiazepine_calc.htm
• Reduce the dose by no more than 10% per week, and as slowly as is safe
• See your patients frequently
• Treat their symptoms proactively

*With significant liver disease, avoid benzos that are metabolized by the liver through oxidation (diazepam, clonazepam, chlordiazepoxide). Preferentially use those that undergo glucuronide conjugation (lorazepam, oxazepam)
Treating Symptoms of a Benzo Taper

• Anxiety:
  – Buspirone goal of 15mg TID
  – Start an SSRI if you can
  – Mirtazapine 15mg qhs
  – Gabapentin 100-300mg TID
  – Hydroxyzine 50-100mg q6hrs
  – Clonidine 0.1mg-0.2mg BID

• Insomnia:
  – Trazodone 50-200mg qhs
  – Mirtazapine 15mg qhs
  – Melatonin 10mg qhs
  – CBT

• Seizures:
  – Moderate evidence:
    • carbamazepine (200 mg bid-tid)
    • valproic acid (250-500mg bid)
    • Typically continue 2-4 weeks after benzo cessation, taper if using higher doses

N Engl J Med 2017;376:1147-57
Case Example: Benzo Taper

- Diazepam 10mg QID = 40mg daily
- Want to decrease by ~10-25% per month: $0.1 \times 40 = 4mg$, round to 5mg
  - Month 1 = 35mg
  - Month 2 = 30mg
  - Month 3 = 25mg
  - Month 4 = 20mg
  - Month 5 = 15mg
  - Month 6 = 10mg
  - Month 7 = 5mg
  - Month 8 = d/c
Inpatient tapers

Consider when:

– Your patient cannot adhere to taper, and you do not have resources to see/administer medication
– Your patient is medically unstable or has a history of seizures
– Tapers in the setting of polysubstance use
– Your patient is taking very high doses
  • >100mg diazepam equivalents/day – i.e. 10mg alprazolam, 20mg lorazepam
Tapering Opioids
BRAVO: The Cardinal Principles of Tapering Patients Off of Chronic Opioid Therapy

BRAVO is an acronym that outlines Dr Anna Lembke's cardinal principles for tapering patients off of chronic opioid therapy. BRAVO stands for Broaching the Subject, Risk-Benefit Calculator, Addiction Happens, Velocity Matters—and so does Validation and Other Strategies for Coping with Pain.

**Broaching the Subject**

- Schedule enough time with your patient to have a discussion on this difficult topic
- Anticipate the patient's strong emotional reaction
- Identify the feelings, normalize those feelings and express empathy with the concerns they may have

**Risk-Benefit Calculator**

- When assessing benefits, weigh a patient's pain relief against their functionality
- Involve family members for more objective views on a patient's opioid use
- Track common risks such as tolerance & opioid-induced hyperalgesia
- Include all of these factors with discussing reasons for tapering off opioids

**Addiction Happens**

- Addiction is defined by The Three C's: Compulsive use, Continued use despite consequences, and use that is out of Control
- Dependence happens when a body relies on a drug to function normally
- Dependence and Addiction are not equivalent

**Velocity Matters—and So Does Validation**

- Go Slowly, take the necessary time to ease your patients down on their doses
- Let the patient be involved when deciding how much to decrease & at what time
- It is O.K. to take breaks in lowering the dosage
- Never go backwards; your patient's tolerance will increase & progress will be lost

**Other Strategies for Coping with Pain**

Teach patients these three Dialectical Behavior Therapy (DBT) practices:

- STOP: Stop, Take a breath, Observe internal & external experiences, & Proceed mindfully
- Opposite Action Skills: acting opposite to a negative emotional urge in the service of pursuing values or goals
- Radical Acceptance: accepting reality as it is and not as we wish it would be

These materials are part of the Stanford Medicine Center for Continuing Medical Education (CME) Online Activity: How to Taper Patients Off of Chronic Opioid Therapy

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Opioid Tapering

- Prescribe Narcan
- Start with either long-acting or short
- Taper by no more than 10% per week, ideally 10% per month if safe to go slow
- Be prepared to plateau
- Never increase the dose
Case Example: Outpatient Opioid Taper

- Gentleman taking morphine ER 30mg q8hrs and oxycodone 10mg q6hrs = 150 MED
- Goal 50-90 MED? Off entirely?
- 10% of 90mg morphine = ~10mg morphine monthly. 10% of 40mg oxycodone = ~5mg oxycodone monthly; total taper will take 17 months.
Supporting pain while tapering

• CBT/DBT and education
• Non-opioid pain management
  – Maximize NSAIDs and tylenol if no contraindications
  – SNRIs, TCAs
  – Gabapentinoids
  – CBD?
Difficult Day Kit

**Relaxation tools**
- Essential oils - lavender
- Teas - chamomile
- Bath bombs
- Heating pad or ice packs

**Distraction tools**
- Magazines, books, comics
- Crafts - simple, one hour projects
- Funny movies
- Games
- Pictures - remember the good days
- Gift cards - to restaurants or movies
- Journal
- Travel planner - looking to the future to get through today
- Small pieces of candy
- Cards written to you or blanks to write
- Fun socks, ugly sweater, funny tee

**Mindfulness or meditation tools**
- Podcasts, phone apps
- Coloring books
- Favorite music
- Movement videos - Gentle yoga, tai chi, or stretching
If taper is not tolerated...

- Diagnose Complex Opioid Dependence or OUD
- Start Buprenorphine
Pain is not going away.
The Goal of Treatment is to Help the Patient Increase Life
Key Points

• When possible, taper slowly
• Pick opioids or benzos to taper first
• Tapering may plateau but never increase dose
• Support tapering with alternatives
• Prescribe Narcan
• This work is hard, but it is important.
• Email me: alyson.smith@boulder.care
References

• Opioid Tapering Guide:  
  https://www.oregonpainguidance.org/guideline/tapering/

• Benzo Converter:  
  http://www.globalrph.com/benzodiazepine_calc.htm

• Benzo Tapering Guide:  
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