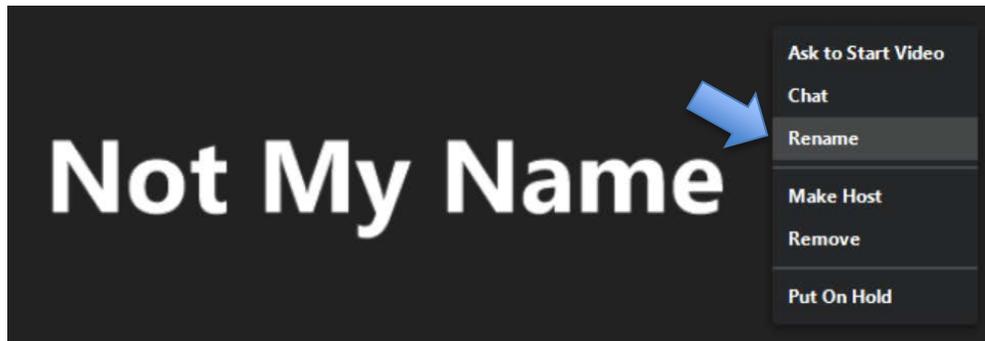




## ECHO Idaho: Opioid Addiction and Treatment Clinic

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# ECHO IDAHO



## ECHO Idaho: Opioid Addiction and Treatment

Tapering Opioids and Benzodiazepines  
in Primary Care

January 23, 2020

Alyson L. Smith, MD

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

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# 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:

Symptom	Frequency
Insomnia	71%
Anxiety	56%
Mood swings	49%
Muscle twitching	49%
Tremor	38%
Headache	38%
Nausea, vomiting, anorexia	36%
Hypersensitivity to smells, sounds, lights, noise, touch	Up to 38%
Seizure*	4%

Jahnsen, 2015 [https://www.ncbi.nlm.nih.gov/liboff.ohsu.edu/pmc/articles/PMC4318457/pdf/Dtsch\\_Arztebl\\_I nt-112-0001.pdf](https://www.ncbi.nlm.nih.gov/liboff.ohsu.edu/pmc/articles/PMC4318457/pdf/Dtsch_Arztebl_I nt-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](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

# Case Example: Benzo Taper

- Diazepam 10mg QID = 40mg daily
- Want to decrease by ~10-25% per month:  $0.1 * 40 = 4\text{mg}$ , 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 patients 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*

# 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 though today  
Small pieces of candy  
Cards written to you or blanks to write  
Fun socks, ugly sweater, funny tee

## Mindfulness or meditation tools

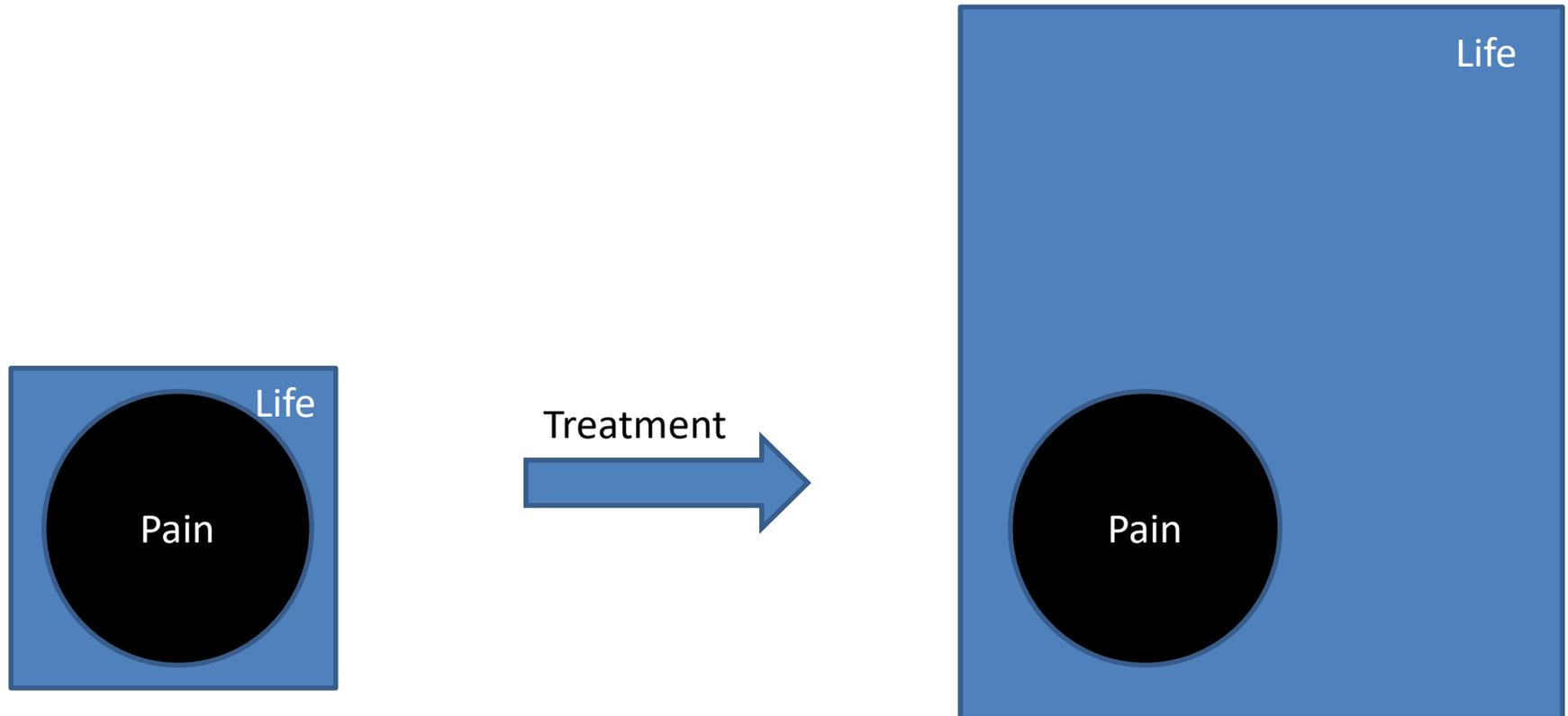
Podcasts, phone apps  
Coloring books  
Favorite music  
Movement videos - Gentle yoga, tai chi, or stretching



# 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](mailto:alyson.smith@boulder.care)

# References

- Opioid Tapering Guide:  
<https://www.oregonpainguidance.org/guideline/tapering/>
- Benzo Converter:  
[http://www.globalrph.com/benzodiazepine\\_calc.htm](http://www.globalrph.com/benzodiazepine_calc.htm)
- Benzo Tapering Guide:  
[https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Benzodiazepine\\_Provider\\_AD\\_%20Risk\\_Discussion\\_Guide.pdf](https://www.pbm.va.gov/PBM/AcademicDetailingService/Documents/Benzodiazepine_Provider_AD_%20Risk_Discussion_Guide.pdf)



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