When it’s time to come down
weaning with compassion

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Disclosures

- Speaker bureau for Salix Pharmaceuticals
- Speaker bureau for Nevro Corp

The content of this activity may include discussion of off label or investigative drug uses. The faculty is aware that is their responsibility to disclose this information.
The overarching goal of PCSS is to train healthcare professionals in evidence-based practices for the prevention and treatment of opioid use disorders, particularly in prescribing medications, as well for the prevention and treatment of substance use disorders.
Educational Objectives

At the conclusion of this activity participants should be able to:

- Explain why it may be appropriate to wean a patient from long term opioid therapy
- Differentiate between tapering and Medication Assisted Detox for Opioid Use disorder
- Identify appropriate pharmacologic treatment of withdrawal symptoms
- Describe 3 strategies used to support patient success/support during weaning
The problem we inadvertently created

- Pain as the 5th vital sign
- Titrate to efficacy
- High dose opioids

Pain as the 5th vital sign

Titrated to efficacy

High dose opioids

PCSS Providers Clinical Support System
From efficacy to epidemic

- Patients are in a very difficult position.
- Lack of evidence to support long-term use of opioids.
- CDC guidelines have led to insurance restrictions.
- Adverse effects of long-term opioid use.
When to wean

- No pain reduction
- No improvement in function
- Patient request/adverse effects
- Changes in medical status
- Age
- Addition or cessation of other medications
- Non-adherence to the prescribed regimen
- Medical comorbidities: renal, sleep apnea, liver disease, lung disease
- Addition of medications that increase risk, ie: benzo for anxiety
- Worsening mental health comorbidities
- Prior to elective surgery
Medication-Assisted Treatment for Opioid Use Disorder

MAT for OUD

- Assess for OUD and refer out
- MAT for OUD vs. weaning
- 3 medications include, methadone, naltrexone, buprenorphine
- Know the legal considerations for OUD treatment
- MAT may be short-term or long-term
MAT medication options

**Methadone (Dolophine)**
- Only opioid treatment programs can dispense for OUD: not the case if written for pain

**Naltrexone (ReVia, Vivitrol)**
- Can be written without federal waiver
- 50mg orally not shown to be superior to placebo
- XR-NTX: IM injection approved q 1 month for alcohol dependence or for prevention of return of opioid dependence (Need to be opioid free for 7-10 days prior)

**Buprenorphine (Suboxone, Subutex, Probuphine, Sublocade)**
- Multiple available forms for OUD: sublingual, subdermal implant, SQ extended-release injection
- To write for OUD you must have a federal waiver
- No waiver needed for buprenorphine pain products (Butrans, Belbuca)
Key components for tapering with success

- Psychological support
- Shared decision making
- Pharmacologic support
- Clear outline of treatment plan
- May require pauses
Meet Pam

- Pain Hx: previous lumbar fusion in 2007 with initial improvement of symptoms but increasing pain in 2010

- Over the next 6 years was titrated up on opioids “to efficacy” for her chronic low back and right lower extremity radicular symptoms.
  - Oxycodone 10mg TID
  - Oxycodone 20mg BID
  - Oxycodone ER (Oxycontin) 20mg TID
  - Duloxetine (Cymbalta) 60mg qd
  - Pregabalin (Lyrica) 100mg BID

- Had a successful spinal cord stimulator trial and implant in 2016
Talking points for patient discussion

- Shared decision-making
- Frequent follow up
- Address the anxiety of tapering
- Pauses in Taper

Give patient prior warning and set expectations
Speed of taper

**Rapid**
- Reduce by 20-50% of first dose: then reduce by 10-20% every day
- Aggressive wean: not the focus of this talk
- Consider referral for MAT if appropriate

**Fast**
- Over weeks
- 10-20% every week
- May need to medicate for withdrawal symptoms

**Slow**
- Months-years
- 5-20% every 4 weeks
- Include prn pauses
- Most common

**Slowest**
- May take years
- 2-10% every 4-8 weeks
- Include prn pause in reductions

(U.S. Dept. of Veteran Affairs. Opioid Taper Decision Tool. 2016)
2 Major Patient Fears

Let’s address both

FEAR OF INCREASED PAIN

FEAR OF WITHDRAWAL
Fear of increased pain and how to mitigate it

Overall, patients report improvements in function without worsening pain

Consider option for continued maintenance at lower dose: decreased likelihood of quitting

Give alternative pain regimens early on: don’t underestimate the power of brainstorming

Reassure that this is not abandonment by you or your team

Plan for pauses in taper

(Veterans, 2016; Berna, Kulick, Rathmell, 2015)
WITHDRAWAL

what to expect, what to plan for
s/s of sympathetic stimulation due to decreased sympathetic antagonism by opioids.

a2-adrenergic agonists activate presynaptic a2-receptors in the locus coeruleus, reducing sympathetic activity and therefore reducing symptoms of withdrawal

lofexidine, (Lucemyra), clonidine (Catapres), guanfacine (Intuniv, Tenex), and tizanidine (Zanaflex)
Withdrawal Symptoms

**Early symptoms:**
hours to days

- anxiety
- restlessness
- rapid short respirations
- runny nose
- tearing eyes
- sweating
- insomnia
- dilated reactive pupils
- fever chills increased white blood cells if sudden withdrawal
- hyperalgesia

**Late symptoms:**
days to weeks

- runny nose
- tearing eyes
- rapid breathing
- yawning
- tremor
- diffuse muscle spasms
- piloerection
- nausea
- vomiting
- diarrhea
- abdominal pain
- insomnia
- aches
Watching the clock?
Management of withdrawal symptoms
Lofexidine (Lucemyra)

Dosage: Three 0.18 mg tablets po QID at 5- to 6-hour intervals for up to 14 days (guided by symptoms)

Discontinue lofexidine (LUCEMYRA) with a gradual dose reduction over 2 to 4 days. (2.1)

Dose adjust for Hepatic or Renal Impairment

Risks: bradycardia, hypotension, QT prolongation, CNS depressant

Metabolized by CYP2D6, with CYP1A2 and CYP2C19
More Pharmacologic Options

Clonidine (first line)
- Dose: 0.1 to 0.2 mg po q6-8h
- check BP first
- 0.1 to 0.2 mg 2 to 4 times daily common dose outpatient
- Re-eval 3-7d avg duration 15 days

Baclofen
- Dose 5 mg po TID up to 40 mg total daily dose
- Re-eval 3-7d avg duration 15 days
- May help to decrease cravings after acute withdrawal
- Discontinue via taper

Gabapentin
- Dose 100 to 300 mg and titrate to 1800 to 2100 mg divided in 2 to 3 daily doses*
- Can help reduce withdrawal symptoms and help with pain, anxiety, and sleep

Tizanidine
- 4 mg po TID up to 8 mg three times daily

**Anxiety, dysphoria, lacrimation, rhinorrhea**
Hydroxyzine 25 to 50 mg TID prn
Diphenhydramine 25 mg q 6h prn

**Myalgias**
NSAIDs (ie: naproxen 375-500 mg BID; ibuprofen 400-600 mg QID)
Acetaminophen 650 mg q 6h prn
Topical medications:
menthol/methylsalicylate cream, lidocaine cream/ointment

**Nausea**
Prochlorperazine 5 to 10 mg q4 hours prn
Promethazine 25 mg orally or rectally every 6h prn
Ondansetron 4 mg every 6h prn

**Sleep disturbance**
Trazodone 25 to 300 mg qhs

**Abdominal Cramping**
Dicyclomine 20 mg q6 to 8h prn diarrhea
Loperamide 4 mg orally initially, then 2 mg with each loose stool, max 16 mg daily
Bismuth subsalicylate 524 mg q 0.5 to 1 hour orally, max 4192 mg/day

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More Symptoms?
Safety

tolerance can lessen as early as one week

return to previous does can result in overdose.

All patient should have a rx of naloxone
Strategies for success

- Shared Decision Making
- Frequent Follow up
- Brainstorming other modalities
- Taking a pause
- Manage withdrawal
- Manage expectations
- Address cognitive dissonance and REPEAT
So what about Pam?

Verbalized a desire to decrease her meds about 4 months after her stimulator trial

**Before:** Total daily dose of Oxycodone =130mg
- Oxycodone 10mg TID
- Oxycodone 20mg BID
- Oxycodone ER (Oxycontin) 20mg TID

**What worked:**
- Letting her pick what to go down on first.
- Medicating for withdrawal
- Taking Pauses
- Learning Mindfulness
- Frequent reprogramming of SCS

**AFTER???
Weaning does not have to mean suffering. It does not have to equate abandonment.

Weaning can be the next step to health if we treat the whole patient.
Questions?

I would love to hear from you!

Reach out at 
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References


PCSS Mentoring Program

- PCSS Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid use disorder.

- PCSS Mentors are a national network of providers with expertise in addictions, pain, evidence-based treatment including medications for opioid use disorder (MOUD).
  
  • 3-tiered approach allows every mentor/mentee relationship to be unique and catered to the specific needs of the mentee.
  
  • No cost.

For more information visit: https://pcssNOW.org/mentoring/
Have a clinical question?

Ask a Colleague

A simple and direct way to receive an answer related to medications for opioid use disorder. Designed to provide a prompt response to simple practice-related questions.

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