# SCOPE of PAIN: Safer/Effective Opioid Prescribing Education

Podcast - October 1, 2023

## Episode 7

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**Ilana Hardesty:** Thanks for listening to Boston University Chobanian & Avedisian School of Medicine's Safer and Competent Opioid Prescribing Education: *SCOPE of Pain* Podcast Series. I'm Ilana Hardesty.

This series has eight episodes. If at any point you want more information on receiving credit, please visit our website, scopeofpain.org. There are also resources that accompany this series. All of it can be found at scopeofpain.org.

In this episode, we'll find out what happens when an opioid rotation for our case study, Michelle, does not help her pain. And in a separate scenario, we'll follow Michelle when she demands to be tapered due to the stigma she's experiencing at her PCP's office and at the pharmacy.

We'll be speaking with Dr. Daniel Alford and Dr. Erica Bial, and we'll bring back our patient, Don, who has chronic pain managed with long term opioid therapy.

First, let's look at what happens when the clinician has switched opioids but with no effect. Remember from the last episode that Michelle had been switched from oxycodone to morphine. Despite one trial dose increase of the morphine, she demanded that she be changed back to oxycodone. After being converted back to oxycodone, her pain did not improve. She is now on medical leave from her job and, according to her husband, spends most of the day in bed. She's been adherent with urine drug testing and pill counts, but clinic staff reported on multiple occasions that she was rude and confrontational when she tried to be seen without an appointment. She states that she's now smoking marijuana to help with her pain.

Dr. Alford, what do we know about marijuana and pain?

**Dr. Daniel Alford:** I'm getting this question a lot from patients these days, mainly because cannabis is being legalized in many states. And it's important to remember that when we talk about cannabis, we're really talking about over 60 pharmacologically-active cannabinoids, and this includes both the psychoactive THC and cannabidiol or CBD. There are meta-analyzes that have found moderate quality evidence that cannabinoids can be effective for treating chronic pain, particularly neuropathic pain. So let's compare their efficacy compared to the things that we normally prescribe. So for example, for a 30% pain reduction, the number needed to treat to get that 30% pain reduction is about 24 for cannabinoids. And that's in comparison to 4 to 10 for tricyclic antidepressants, opioids, gabapentinoids, and SNRIs. So while they may be effective for treating pain for some

individuals, fewer patients will benefit from them compared to the things that we have available to us to prescribe.

I'd say the other piece that's a little confusing from a prescriber perspective is, what is my patient actually getting? We're sending them to a dispensary. Which pharmacologically-active cannabinoid are they actually getting? And so it's a little tricky to say, okay, go to the dispensary and get a cannabinoid when you don't know exactly what they're getting and whether or not they're going to get benefit. But the bottom line is some patients may benefit, but it's not nearly as effective as the medications that we have available to prescribe.

**Ilana Hardesty:** So it seems like we're at an important decision point for our patient's care. Do we continue to escalate her opioid dose like she wants? How do we talk with her about it? I can imagine that if you decide not to increase her dose, it's going to be a very uncomfortable conversation.

**Dr. Erica Bial:** You know, sometimes it is, but I don't think it has to be. I think that we need to continue to use that usual medical model and talk openly about the patient's continued lack of benefit. You know, not all chronic pain is opioid-responsive, as much as I think oftentimes we wish it would be. It's just a really imperfect treatment. And more opioid is not necessarily better, which can be counterintuitive for many patients as well as providers. More opioid might increase the risk of adverse effects, and it's important to remember, and I have actually seen it clinically many times, that some chronic pain paradoxically improves after opioid tapers for many reasons.

So how do we talk about continued lack of benefit? I think it is central to the conversation, and to having that conversation not be so uncomfortable, to stress how much you believe in and empathize with the patient's pain severity and the impact of that pain on the patient's daily life. Expressed frustration: "I wish that I had a good pill or an easy treatment that would fix this, and I don't. And this is complicated." So focusing on the patient's strengths, recognizing the things that the patient can do and the skills that the patient does have, that we can capitalize on to improve their global wellness. And encourage therapies for coping with pain. I think there's really a level of acceptance that has to come with this. I have this conversation probably on a daily basis where the patient says, you know, "Okay, Doc, but I just don't want any of this pain." And I try to set realistic expectations. I say, "you know, there's nothing that I have in my toolbox that will make your pain zero. But I want to make the impact of the pain less in your life," and really come up with therapies that help the patient to cope with their pain. We want to show commitment to caring about the patient and their pain, even without the opioid, that we're not firing the patient, that we are firing the treatment that has failed. And then we want to schedule very close follow up during and after a taper. And this is a very critical importance when we decide to lower the dose or discontinue an opioid.

**Dr. Daniel Alford:** So discontinuing opioids can be challenging for sure. But let's just emphasize that you don't need to prove with 100% certainty that the person has developed an addiction or that they're diverting. You only need to assess and reassess the risk-benefit ratio. That is, if the patient's unable to take the opioids safely or they're not adherent with

monitoring, then discontinuing opioids is completely appropriate, even in the setting of benefits. You then need to determine how urgent you should discontinue the opioids, and it's based on the severity of the risks and harms. Make sure you document the rationale for discontinuing your opioids, and sometimes you don't even need to taper the opioids if the person doesn't have physical dependence.

I just want to emphasize what Erica had said, and that is you are not abandoning the patient. You are abandoning the opioid, either because it's not helping or it's hurting or both. Now, when you discontinue opioids, you need to keep in mind that there are some risks to doing so. Well, there've been some recent observational studies that have identified harms, like increased rates of suicide and overdose, that are associated with opioid tapering or discontinuation. There was a recent comparative effectiveness study of well over 200,000 individuals who were on stable, long term opioid therapy, stable being defined as there was no evidence of opioid use disorder or opioid misuse. They found that opioid tapering was actually associated with a small but absolute increase in opioid overdose and suicide compared to maintaining somebody on a stable opioid dose. And in that article, I think they importantly summarized the following: and that is that tapering or discontinuation of opioids should **not** be considered a harm reduction strategy for patients who are receiving stable, long term opioid therapy without any evidence of misuse. And when you do decide to taper someone because of lack of benefit or misuse, you need to do it carefully. And keep in mind that there is an increased risk of suicide and overdose.

**Dr. Erica Bial:** So it really brings us back to this idea of the risk-benefit framework. And I know that you and I have talked so much about this in many aspects of the treatment of patients with opioids. But here again, we want to use that risk benefit framework and how we talk with our patients, weighing the benefits of the opioid – so pain, function, and quality of life – against the risks and harms – misuse, addiction, overdose, or other adverse effects.

So when I make the decision where I think that the risks are outweighing the benefits, I find that many patients might be very fearful of that process. And it's really useful to be ready to avoid a number of pitfalls. So patient might say, "But I need the opioid," or make it about the provider patient relationship: "Don't you trust me?" You know, "I thought we had a good relationship; I thought you cared about me." "If you don't give them to me" – and I hate this one, the scary ultimatum – "I will drink, use drugs, harm myself," or, you know, they want to terminate the relationship with you. "Can't you just give me enough and I'll find a new doctor?"

And your response needs to come back to that risk-benefit framework and a useful mantra. "I cannot continue to prescribe a medication that is not helping you or is hurting you or both."

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**Ilana Hardesty:** Despite her PCP's best efforts to explain to Michelle why the treatment plan will include tapering off opioids due to a lack of adequate benefit, and focusing on increasing non-opioid pain treatments, including cognitive behavioral therapy, Michelle keeps on insisting that she needs a higher dose of oxycodone. Though she's offered

alternative pain treatments, she becomes increasingly angry, stating that she's going to find a new doctor. Michelle storms out of the office and says she'll be calling patient advocacy. Let's think about other ways that Michelle's case study can end. Let's go back to when she was on her original dose of oxycodone. She was doing well on her pain treatment plan, including oxycodone, for her painful diabetic neuropathy and chronic hip pain for 11 months. But then she started to struggle and become frustrated with the rules and stigma of taking opioids. Michelle calls her PCP after being unable to refill her oxycodone prescription because of new insurance requirements. She's angry and crying with frustration and notes the stigma that she feels in her treatment by her family, by the staff at the PCP office and at the pharmacy. She says she's tired of being treated with suspicion, and like a drug addict and criminal, and just wants to get off the pills. This is a great time to hear again from Don, our patient.

This is a great time to hear again from Don, our patient. Don, what have been your challenges in continuing on a therapy that works for you, even with its risks?

**Don (Patient):** One way to describe it would be that you would go to the doctor's office, pick up the prescription, you would bring it to the pharmacy. And it was sort of like a trail of stigma, you know, sort of they get used to seeing you like once a month. And, you know, they're here to give you the prescription and just the people at the desk. Right. Just the sort of administrative people that you're walking past. And then sometimes they're put in a position of having to say, I can't give this to you until you go downstairs and pee in the bottle. And then you're sort of walking past the lab people. And it's hard to imagine that anybody would see being drug-tested as neutral, certainly not positive. I mean, it's an index of some kind of suspicion. And then, you know, of course, you get the same thing from practitioners that don't know you.

At one point, I was given a contract that was, I don't know, written by an angry physician. And it said things like, "under no circumstances will a lost supply of pills be replaced before the next month. We don't care whether the dog ate it; t fell down the drain. We've heard all the stories." That seemed like a bizarre way for a caregiver to be addressing patients. But clearly, I mean, a lot of a lot of prescribers, I think, have felt burned and basically gotten angry. And some of that anger, I think, gets pointed at people who need medication. I think that's in some ways the ultimate stigma because it's being reduced from an individual human being to just sort of an irritating category of patient.

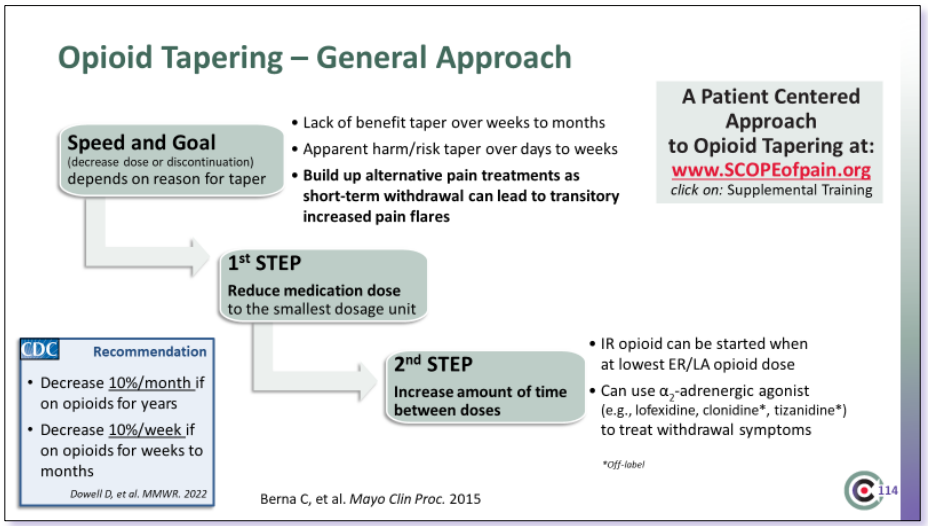
**Ilana Hardesty:** Dr. Bial, how do you taper someone like Michelle, who's requesting to come off opioids and do it safely?

**Dr. Erica Bial:** So this is actually quite challenging question because there are no validated protocols in patients on opioids for chronic pain in terms of how we should necessarily assume is the right way to taper. There is some very low-quality evidence that suggests that several types of opioid tapers might be effective and that pain, function, quality of life, they all might improve for some patients with decreased opioid use, as we've talked about before. There was a study that found that 62% of patients in a pain clinic who completed a voluntary, patient-centered opioid taper over four months with a greater than 50% dose reduction, found that neither their pain intensity nor the pain's interference with their lives

increased with opioid reduction. And surprisingly, maybe, success was not predicted by the patient starting dose, baseline pain intensity, or how long the patient had been prescribed the opioids, or any other identified or measured psychosocial variable.

There was an additional study of over 100,000 patients also on long term opioids and found that annual tapering increased and was more likely in women and those on higher dose opioids at the starting point. 19% of those patients had a maximum dose reduction rate that exceeded the usual 10% per week that is commonly recommended. But it's important to recognize that in the situation of both of these studies, these are quite specialized, maybe non-typical, non-generalizable patient populations: they volunteered.

So maybe a general approach to opioid tapering is again that risk to benefit kind of delicate balance. We want to think hard about what's our speed and what is our goal. How quickly do we need to decrease the patient's opioid will really depend a lot on the reasons for that taper. So if the patient's just suffering a general lack of benefit but there isn't acute harm, you might take weeks or months or maybe even, in a patient on a very high dose, a year to gradually, gently bring them down off their opioid. But if there is apparent harm or risk, if the patient has suffered a recent overdose event, for example, that might be much more rapid – days, two weeks. And while we are in the process of tapering their medication, I think it's really important to remember to build up alternative pain treatments as short-term withdrawal can absolutely lead to transitory increases in pain flares, as Dan mentioned earlier.




So how do you do it in practicum? First step is look at the patient's overall daily dose and reduce their medication dosage. So if a patient is on a long acting opioid, they're taking it twice daily. We want to gently start to lower that to the smallest dosage unit. And then you might find you run out of what's available in that smallest dosage unit. And so a next step might be to try to increase the amount of time between doses. And we could transition the patient from a long acting formulation to a short acting formulation once we have run out of that lowest available dose. Also, consider that you can use Alpha-2 adrenergic agents like – granted it's off-label use – but like clonidine or tizanidine, or on-label use with medications like lofexadine, to help to blunt withdrawal symptoms. So the CDC has some recommendations here, and these are very general: that we could decrease opioids as slowly as 10% per month if the patient has been on opioids for many years, and it's really just for lack of benefit. We could decrease their patient's opioid as quickly as 10% per week, if the patient has been on opioids for weeks to months or if we have more urgent reasons for discontinuation.

**Dr. Daniel Alford:** Erica, I just want to give a lesson learned that I've learned over the years, and that is what you don't want to do is give the patient a 30 day taper because more often than not they will come back and say, "I finished my opioids and I'm only two weeks into the taper," because they didn't follow the exact tapering instructions. So I really give short duration of opioids, and I'm very clear in saying I'm not going to refill your opioid early. And I think that really sells the importance of following the taper as prescribed.

**Dr. Erica Bial:** I agree. And also, that's a time when we want to increase our monitoring. And so I might see the patient week-to-week or every time that I'm making an adjustments that there's no opportunity, or certainly a decreased opportunity, for those overuse or potential overdose events.

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**Ilana Hardesty:** Thank you, Dr. Bial and Dr. Alford, and thanks again to Don, our patient.

Over six months, Michelle successfully tapered off oxycodone. Her neuropathic pain was moderately controlled on a combination of acetaminophen, nortriptyline, gabapentin, and capsaicin cream. Michelle joined a monthly chronic pain support group. Her individual PEG scores remained between four and five on the ten-point scale. She remained employed and remained adherent with treatment and monitoring. She continued with her regularly scheduled follow up visits.

Join us for our final episode, when we discuss another possible scenario where Michelle was doing well on her oxycodone but then had an unexpected urine drug test result: it was negative for her prescribed oxycodone. Is she diverting her oxycodone? How would you respond to this worrisome development?

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I'm Ilana Hardesty. Thanks for listening.