
“BRAVO”

**How to Taper Patients
off of Chronic Opioid Therapy**

Anna Lembke, MD
Associate Professor
Stanford University School of Medicine
alembke@stanford.edu

Disclosures

I have no conflicts of interest.



Overview

- Recognize how to safely and compassionately taper patients down and off of chronic opioid therapy using the BRAVO protocol
- Identify the difference between ‘opioid dependence’ and ‘opioid use disorder’/addiction
- List several strategies to intervene for both opioid dependence and opioid use disorder in a patient with chronic pain

Laura' story

- At age 18, developed a mysterious pain in her abdomen that spread to her whole body
 - All medical work-up negative
- Saw many doctors over time, and was diagnosed with fibromyalgia and rx'd opioids
- By age 30 was taking >120 MED's, prescribed by "the most compassionate doctor I ever saw."
 - Despite meds, pain no better, function worse

Laura' story

- On high dose opioids, Laura spent more and more time in bed.
- Her husband remarked she was “detached from family life.” Laura was not aware of being more detached.
 - Her pain increased over time.

Laura' story

- Laura never met criteria for opioid use disorder/addiction
 - Laura did meet DSM-IV criteria for opioid dependence

Laura' story

- Laura moved with her husband and young son to the Bay Area, and was told by her new doctor that he could not continue her opioids at those high doses.
- Even before starting a taper, Laura landed in the psychiatric inpatient ward overwhelmed by anxiety at the prospect of an opioid taper.



Stanford
MEDICINE

Stanford Center for
Continuing Medical Education
Transforming health care through innovative education



Find a Course

Learning Opportunities



My CME Account



Planning Services



About Us



HOW TO TAPER PATIENTS OFF OF CHRONIC OPIOID THERAPY

ONLINE CME COURSE

Internet Enduring Material Sponsored by the Stanford University School of Medicine. Presented by the Department of Psychiatry and Behavioral Sciences at Stanford University School of Medicine



COURSE DETAILS

Original Release Date:

08/02/18

Expiration Date: 08/02/21

Figure 14-4: Discussing Prescription Opioid Dependence with Patients in the Primary Care Setting

B

• **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 the patient may have

R

• **Risk-Benefit Calculator**

- When assessing benefits, weigh the 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 and opioid-induced hyperalgesia
- Include all of these factors when discussing reasons for tapering off opioids

A

□ **Addiction Happens**

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

V

□ **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 and at what time
- It is OK to take breaks in lowering the dosage
- Never go backwards; your patient's tolerance will increase and progress will be lost

O

□ **Other Strategies for Coping with Pain** – teach patients these 3 Dialectical Behavioral Therapy (DBT) practices:

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

B = Broaching the subject

Recognize patients are *terrified* to come off opioids



Take more time, and get support



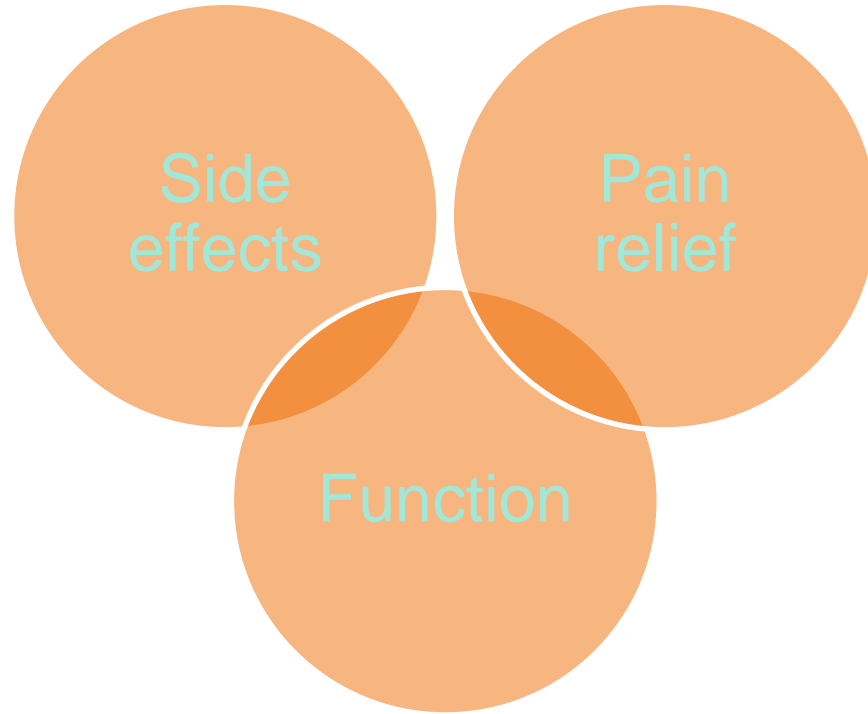
Donald Winnicott's “holding environment”



“I’ve been thinking a lot about
your chronic pain ...”

R=Risk benefit calculator

R = Risk benefit calculator



The Effectiveness and Risks of Long-Term Opioid Therapy for Chronic Pain: A Systematic Review for a National Institutes of Health Pathways to Prevention Workshop

Roger Chou, MD; Judith A. Turner, PhD; Emily B. Devine, PharmD, PhD, MBA; Ryan N. Hansen, PharmD, PhD; Sean D. Sullivan, PhD; Ian Blazina, MPH; Tracy Dana, MLS; Christina Bougatsos, MPH; and Richard A. Deyo, MD, MPH

Background: Increases in prescriptions of opioid medications for chronic pain have been accompanied by increases in opioid overdoses, abuse, and other harms and uncertainty about long-term effectiveness.

Purpose: To evaluate evidence on the effectiveness and harms of long-term (>3 months) opioid therapy for chronic pain in adults.

Data Sources: MEDLINE, the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, PsycINFO, and CINAHL (January 2008 through August 2014); relevant studies from a prior review; reference lists; and ClinicalTrials.gov.

Study Selection: Randomized trials and observational studies that involved adults with chronic pain who were prescribed long-term opioid therapy and that evaluated opioid therapy versus placebo, no opioid, or nonopioid therapy; different opioid dosing strategies; or risk mitigation strategies.

Data Extraction: Dual extraction and quality assessment.

Data Synthesis: No study of opioid therapy versus no opioid therapy evaluated long-term (>1 year) outcomes related to pain, function, quality of life, opioid abuse, or addiction. Good- and

fair-quality observational studies suggest that opioid therapy for chronic pain is associated with increased risk for overdose, opioid abuse, fractures, myocardial infarction, and markers of sexual dysfunction, although there are few studies for each of these outcomes; for some harms, higher doses are associated with increased risk. Evidence on the effectiveness and harms of different opioid dosing and risk mitigation strategies is limited.

Limitations: Non-English-language articles were excluded, meta-analysis could not be done, and publication bias could not be assessed. No placebo-controlled trials met inclusion criteria, evidence was lacking for many comparisons and outcomes, and observational studies were limited in their ability to address potential confounding.

Conclusion: Evidence is insufficient to determine the effectiveness of long-term opioid therapy for improving chronic pain and function. Evidence supports a dose-dependent risk for serious harms.

Primary Funding Source: Agency for Healthcare Research and Quality.

Ann Intern Med. 2015;162:276-286. doi:10.7326/M14-2559 www.annals.org

For author affiliations, see end of text.

This article was published online first at www.annals.org on 13 January 2015.

Risks

- Depression
- Pseudo-dementia
- Constipation
- Hormonal imbalance
- Addiction
- Death
- Tolerance
- Dependence
- Withdrawal
- Hyperalgesia



Weighing the Risks and Benefits of Chronic Opioid Therapy
American Family Physician, Lembke, A., 2016 ♦ Volume 93

Benefits? SPACE Randomized Clinical Trial

Research

JAMA | [Original Investigation](#)

Effect of Opioid vs Nonopioid Medications on Pain-Related Function in Patients With Chronic Back Pain or Hip or Knee Osteoarthritis Pain The SPACE Randomized Clinical Trial

Erin E. Krebs, MD, MPH; Amy Gravely, MA; Sean Nugent, BA; Agnes C. Jensen, MPH; Beth DeRonne, PharmD; Elizabeth S. Goldsmith, MD, MS; Kurt Kroenke, MD; Matthew J. Bair; Siamak Noorbaloochi, PhD

 [Supplemental content](#)

IMPORTANCE Limited evidence is available regarding long-term outcomes of opioids compared with nonopioid medications for chronic pain.

OBJECTIVE To compare opioid vs nonopioid medications over 12 months on pain-related function, pain intensity, and adverse effects.

DESIGN, SETTING, AND PARTICIPANTS Pragmatic, 12-month, randomized trial with masked outcome assessment. Patients were recruited from Veterans Affairs primary care clinics from June 2013 through December 2015; follow-up was completed December 2016. Eligible patients had moderate to severe chronic back pain or hip or knee osteoarthritis pain despite analgesic use. Of 265 patients enrolled, 25 withdrew prior to randomization and 240 were randomized.

Why the SPACE trial is the gold standard

- Key finding: **No benefit of opioids** above non-opioids; fewer side effects with non-opioids
- 12 months in duration
- Studied opioid-naïve patients in a primary care setting, including patients with severe depression and post-traumatic stress disorder
- Participants were regularly assessed for medication misuse, including checking the prescription drug monitoring database and urine drug testing
- Not sponsored by an opioid manufacturer

Tapering off of opioids may improve pain



RESEARCH
EDUCATION
TREATMENT
ADVOCACY



The Journal of Pain, Vol ■, No ■ (■), 2016; pp 1-11
Available online at www.jpain.org and www.sciencedirect.com

Prescription Opioid Taper Support for Outpatients With Chronic Pain: A Randomized Controlled Trial

Mark D. Sullivan, Judith A. Turner, Cory DiLodovico, Angela D'Appolonia, Kari Stephens, and Ya-Fen Chan

Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, Washington.

Abstract: Patients receiving long-term opioid therapy for chronic pain and interested in tapering their opioid dose were randomly assigned to a 22-week taper support intervention (psychiatric consultation, opioid dose tapering, and 18 weekly meetings with a physician assistant to explore motivation for tapering and learn pain self-management skills) or usual care (N = 35). Assessments were conducted at baseline and 22 and 34 weeks after randomization. Using an intention to treat approach, we constructed linear regression models to compare groups at each follow-up. At 22 weeks, adjusted mean daily morphine-equivalent opioid dose in the past week (primary outcome) was lower in the taper support group, but this difference was not statistically significant (adjusted mean difference = -42.9 mg; 95% confidence interval, -92.42 to 6.62; P = .09). Pain severity ratings (0-10 numeric rating scale) decreased in both groups at 22 weeks, with no significant difference between groups (adjusted mean difference = -.68; 95% confidence interval, -2.01 to .64; P = .30). The taper support group improved significantly more than the usual care group in self-reported pain interference, pain self-efficacy, and prescription opioid problems at 22 weeks (all P-values < .05). This taper support intervention is feasible and shows promise in reducing opioid dose while not increasing pain severity or interference.

Perspective: In a pilot randomized trial comparing a prescription opioid taper support intervention to usual care, lower opioid doses and pain severity ratings were observed at 22 weeks in both groups. The groups did not differ significantly at 22 weeks in opioid dose or pain severity, but the taper support group improved significantly more in pain interference, pain self-efficacy, and perceived opioid problems. These results support the feasibility and promise of this opioid taper support intervention.

© 2016 by the American Pain Society

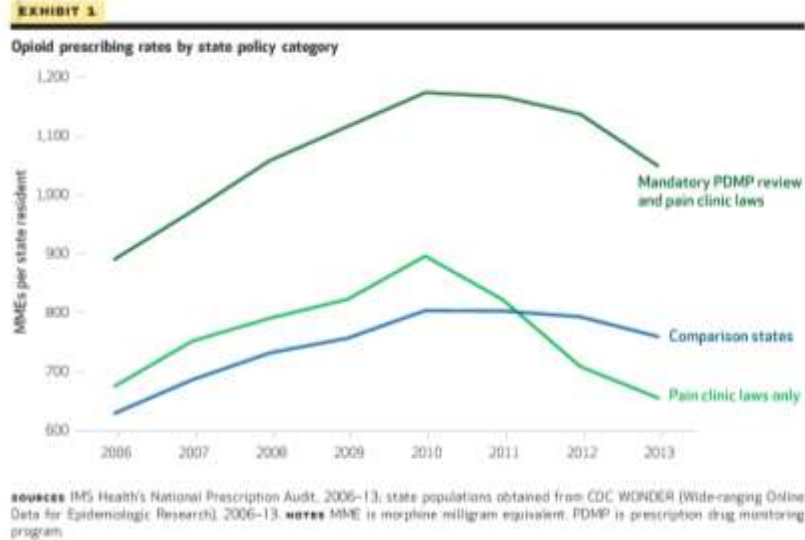
Key words: Chronic opioid therapy, opioid dose taper, pain intensity, pain interference, pain self-management.

Involve family in risk assessment



- 2016 Washington Post Kaiser Family Foundation Survey of patients on chronic opioid therapy
 - 33% of patients worried about addiction
 - >50% of family members worried about addiction

Check your PDMP!



Deborah Dowell, Kun Zhang, Rita K. Noonan and Jason M. Hockenberry; Mandatory Provider Review And Pain Clinic Laws Reduce The Amounts Of Opioids Prescribed And Overdose Death Rates; Health Affairs 35, no.10 (2016):1876-1883
10.1377/hlthaff.2016.0448

Urine toxicology



Naloxone

Family Practice

123 Main Street | Anytown, USA

Rx

Naloxone HCl 1mg/mL

2 x 2mL as pre-filled
Luer-Lock needleless syringe

2 x Intranasal Mucosal
Atomizing Device (MAD 300)

For suspected opioid overdose.
Spray 1mL in each nostril.
Repeat after 3 minutes if no or
minimal response.

MD _____

Signature _____

A = Addiction happens

What is addiction?

- The 3 “C’s”
 - Consequences
 - Control
 - Compulsion



Dependence vs addiction



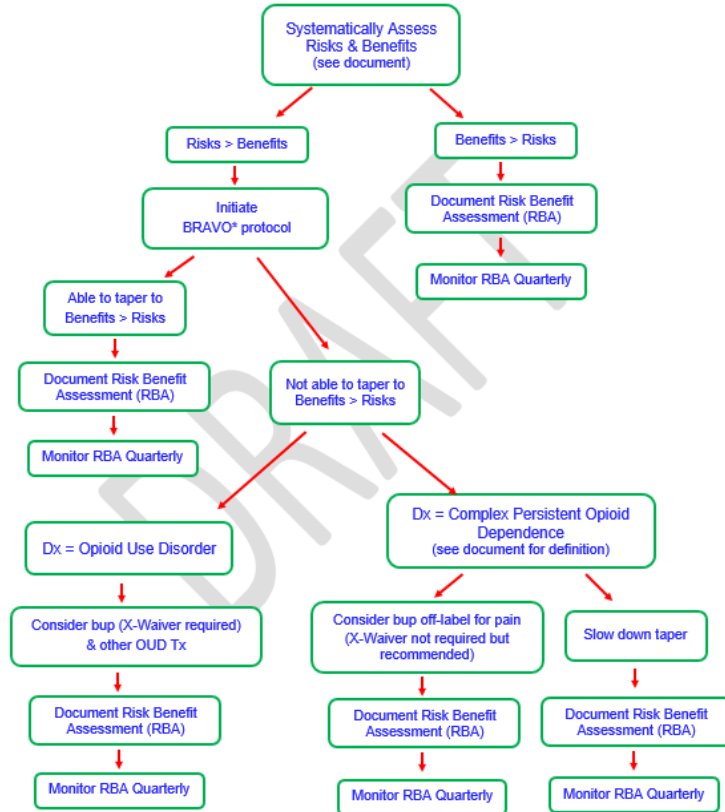
Tapering (*sometimes*) a litmus test for who is addicted



Diagnosing opioid use disorder in the context of a medically managed opioid taper

- Opioids are often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
- A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
- Continued use despite consequences
- **Tolerance: This criterion is not considered to be met for those taking opioids solely under appropriate medical supervision.**

Opioid Tapering Flowchart (Final Draft 10-25-18)



* BRAVO Protocol (reference to OPG Tapering page when posted)

Tell patients about treatment for opioid addiction before the taper



Buprenorphine induction in our outpatient clinic

- 12-48 hours no opioids, then ...
- See patient in clinic and assess for opioid withdrawal
- Send patient home with prescription for home induction, typically 2 mg TID prn daily for the first week (for patients on 150 MED or less)
- Follow up by phone during the week prn
- RTC day seven for seven day refill, urine tox screen, PDMP check
- Respond to aberrant behavior with Tit for Tat

Buprenorphine rotation

Morphine	Methadone	Buprenorphine
250mg	30	8mg
500mg	40	8-16mg
750mg	60	8-24mg
1000mg	80	8-32mg

The Bernese Method

Use of microdoses for induction of buprenorphine treatment with overlapping full opioid agonist use: the Bernese method

This article was published in the following Dove Press journal:
Substance Abuse and Rehabilitation
20 July 2016
[Number of times this article has been viewed](#)

Robert Hämig¹
Antje Kemter²
Johannes Strasser²
Ulrich von Bardeleben¹
Barbara Gugger¹
Marc Walter²
Kenneth M Dürsteler²
Marc Vogel²

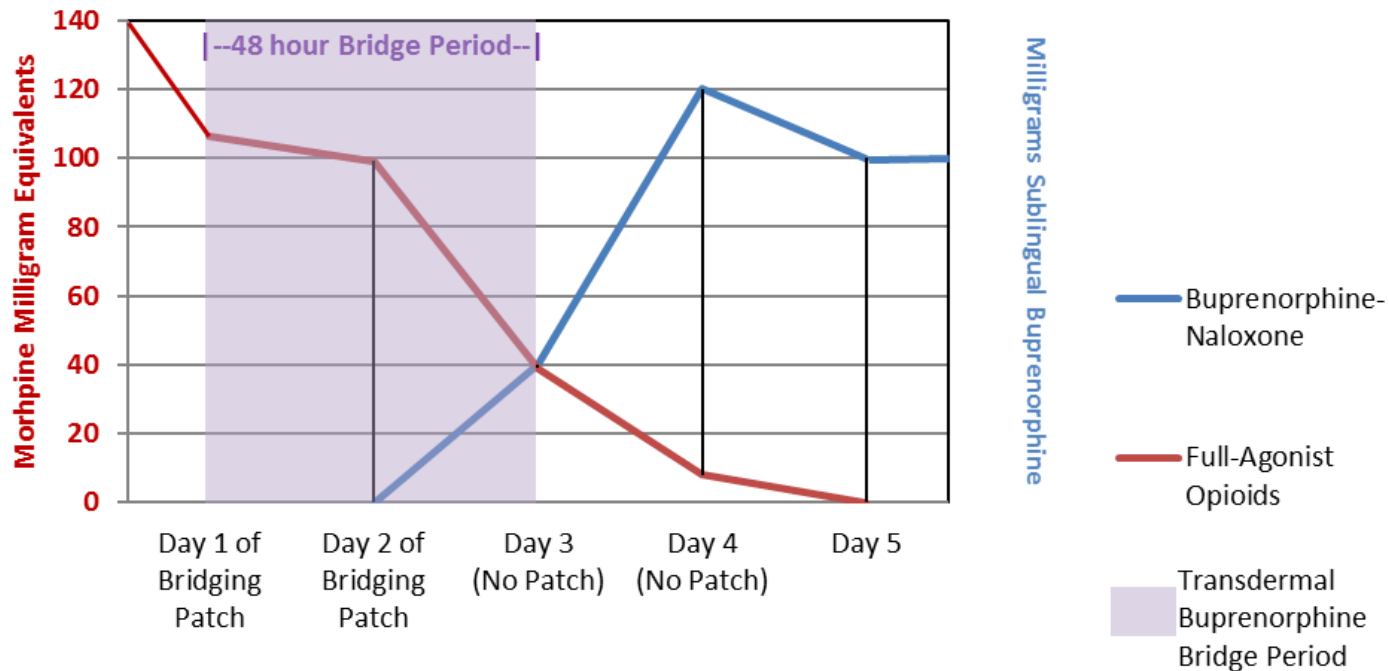
¹Division of Addiction, University Psychiatric Services Bern, Bern, Switzerland; ²Division of Substance Use and Addictive Disorders, University of Basel Psychiatric Hospital, Basel, Switzerland

Background: Buprenorphine is a partial μ -opioid receptor agonist used for maintenance treatment of opioid dependence. Because of the partial agonism and high receptor affinity, it may precipitate withdrawal symptoms during induction in persons on full μ -opioid receptor agonists. Therefore, current guidelines and drug labels recommend leaving a sufficient time period since the last full agonist use, waiting for clear and objective withdrawal symptoms, and reducing pre-existing full agonist therapies before administering buprenorphine. However, even with these precautions, for many patients the induction of buprenorphine is a difficult experience, due to withdrawal symptoms. Furthermore, tapering of the full agonist bears the risk of relapse to illicit opioid use.

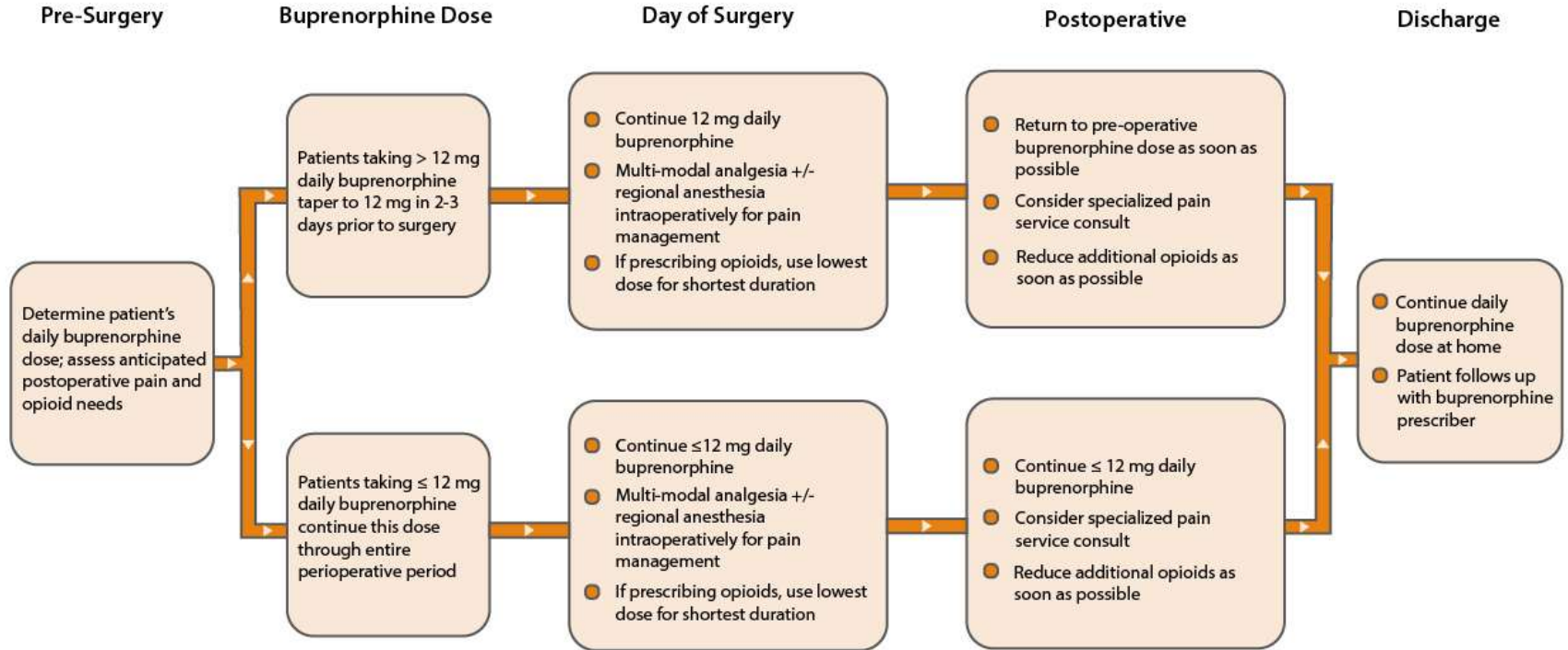
Cases: We present two cases of successful initiation of buprenorphine treatment with the Bernese method, ie, gradual induction overlapping with full agonist use. The first patient began buprenorphine with overlapping street heroin use after repeatedly experiencing relapse, withdrawal, and trauma reactivation symptoms during conventional induction. The second patient was maintained on high doses of diacetylmorphine (ie, pharmaceutical heroin) and methadone during induction. Both patients tolerated the induction procedure well and reported only mild withdrawal symptoms.

Discussion: Overlapping induction of buprenorphine maintenance treatment with full μ -opioid receptor agonist use is feasible and may be associated with better tolerability and acceptability

Transdermal Buprenorphine Bridge



Stanford Perioperative Buprenorphine Protocol



[PREV ARTICLE](#) | [THIS ISSUE](#) | [NEXT ARTICLE](#)

SPECIAL ARTICLE | 6 NOVEMBER 2018

The Next Stage of Buprenorphine Care for Opioid Use Disorder

Stephen A. Martin, MD, EdM; Lisa M. Chiodo, PhD; Jordon D. Bosse, MS, RN; Amanda Wilson, MD

Article, Author, and Disclosure Information

FULL TEXT



MORE ▾

Abstract

Buprenorphine has been used internationally for the treatment of opioid use disorder (OUD) since the 1990s and has been available in the United States for more than a decade. Initial practice recommendations were intentionally conservative, were based on expert opinion, and were influenced by methadone regulations.

V = Velocity (and validate)

Mechanics



- Go slowly
- Start wherever the patient is willing to start
- Let the patient drive (within reason)
- Keep dosing schedule (BID, TID, etc)
- Take breaks
- Never go backwards

What to expect when you're tapering



- Body fluids
- Psych symptoms (irritability, anxiety, insomnia, dysphoria)
- More PAIN!!!
- The pain of withdrawal “is not the pain you’ll have to live with when this is over.”
- Cancer treatment metaphor

Medications to tx withdrawal

- Clonidine 0.1mg QID x anticipated length of withdrawal. (Check BP & watch for hypotension)
 - Diarrhea: Hyocosamine 0.125mg every 4-6 hours PRN
 - Myalgias: Ibuprofen 400mg po QID or Acetaminophen 325mg po Q6hrs
 - Anxiety: Hydroxyzine 25mg po TID
 - Insomnia: Trazodone 50-300mg po QHS
- Nausea: Ondansetron 8mg po BID x anticipated length of withdrawal. (Check QTc)
 - NO BENZOS!

Laura' story

- In the psych unit, Laura's opioids were decreased from 120 MEDs to 40 MEDs daily (methadone 15 mg daily)
- As an outpatient, it took from Aug. 2014 to March 2016 to get down to methadone 2mg ...18 months!!
- Laura went into the hospital for a week to get off the last 2 mg.

**O = Other ways to talk about
pain**

(hurt does not necessarily equal harm)

Opposite action

- Acting opposite to the emotional urge in the service of pursuing values or goals.
- Encourage patients to do the opposite of dialing into pain, and instead, engage in activities, within reason, in spite of pain being present.



Radical Acceptance

- Radical acceptance is accepting reality as it is, not as we wish it would be.
- For chronic pain patients, this often means that their pain may likely never go away, but life can still be worth living even if it includes pain

Reframing pain

- Pain as a source of creativity, compassion, gratitude, spirituality, meaning

Laura' story

- Three years later, Laura still off of opioids.
 - Still with daily pain, but less.
- Much more active and engaged in her life

BRAND!

The decision to taper opioids

- A. Should occur in every patient taking more than 120 MME's daily
- B. Should take into account adverse effects, pain relief, and functionality
- C. Should only be initiated by the patient
- D. Should occur in every patient who is opioid dependent

Increased pain during opioid withdrawal in chronic pain patients

- A. Is a sign of the underlying pain disorder getting worse
- B. Is an indication that the taper needs to be stopped and the dose raised again
- C. Is likely to cause the patient only minimal discomfort
- D. Requires reassurance that withdrawal-mediated pain is not a symptom of the underlying pain condition

Case #1

- 65 yr old male on 250 MED. Scoliosis surgery as a child, several surgeries since, but none for the past 20 years. Dose has been stable for 20 years and there have been no aberrancies. Works as a university professor and has just published his 3rd book. He and his prescribing physician are convinced he could not function at the level he is currently functioning without present dose of opioid. Tapering has never been tried. Does benefit exceed risk?

Case #2

● 55 yr old female on 80 MED. She has fibromyalgia and a complex psychiatric history. She has been shuttled between physicians and has attempted tapering in the past (unsuccessfully), but has finally found a physician willing to prescribe the 80 MED she believes she needs to function, in a clinic that is making progress with her in counseling. Unfortunately, her physician is retiring and she is terrified that she will lose what she has gained. She has fallen off the wagon a couple of times, but is doing well currently (ie stable dose and no aberrancies for 2 yrs) and does not want to even have the conversation about trying to taper. Does benefit exceed risk?

Case #3

- 35 yr year old male on 30 MED. Spinal cord injury and paraplegia 3 yrs ago. Has a good relationship with his PCP. He fully admits that his pain is minimal, and not helped much by the opioid. He stacks the opioid and takes it for distress on days that he feels he wants to escape. Dose is stable and there have been no aberrancies. Does benefit exceed risk?

Case #4

- 48 yr old male on 110 MED. Work injury to back 1 yr ago. Has not returned to work, but is making very good progress with PT, wants to return to work, but does not feel ready to try a taper. There have been multiple requests for dose increases, but no other aberrancies. Does benefit exceed risk?