BRAVO! ENCORE!: Strategies for Tapering Opioids and Treating Pain

Christina Lasich, MD

Chief Medical Officer, Western Sierra Medical Clinic

North Coast Clinics Network: 2020 Opioid Summit

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BRAVO can help you safely decrease the opioid dosage

Broaching the Subject of the Taper

Risk Benefit Calculator

Addiction Happens

Velocity and Validation

Other Treatments

ENCORE: The Treatment of Pain and Opioid Use Disorder

Evaluate the Pain

Neutralize the Nervous System

Core Strengthening

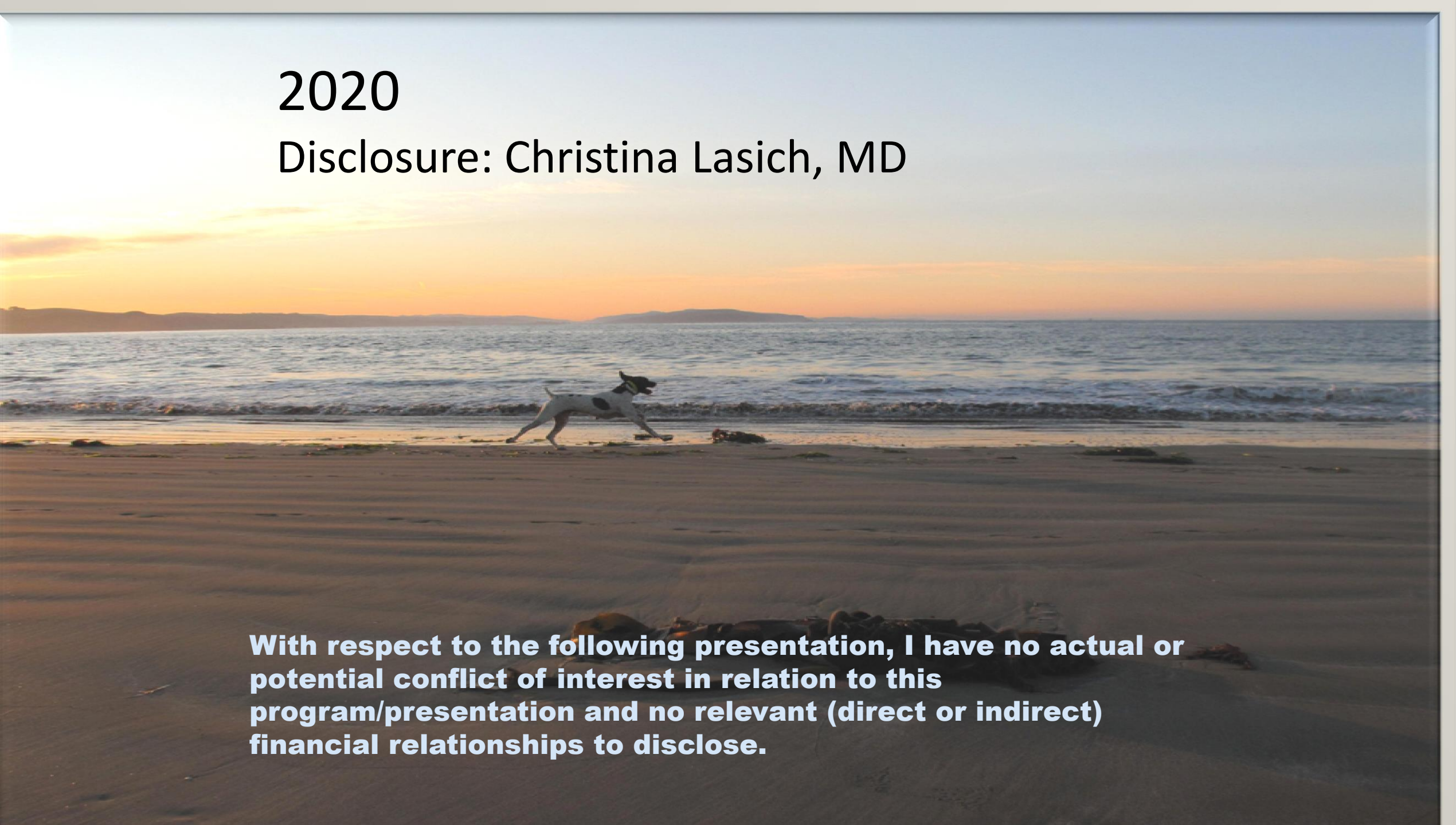
Open a Conversation

Restore Health

Ease Suffering

Learning Objectives

- Improve ability to evaluate and categorize pain in order to provide non-opioid solutions and reduce reliance on opioids
- Learn how to have a conversation about functional goals and expectations during the treatment of chronic pain
- Discover ways to use health and suffering as treatment doorways for both pain and addiction



2020

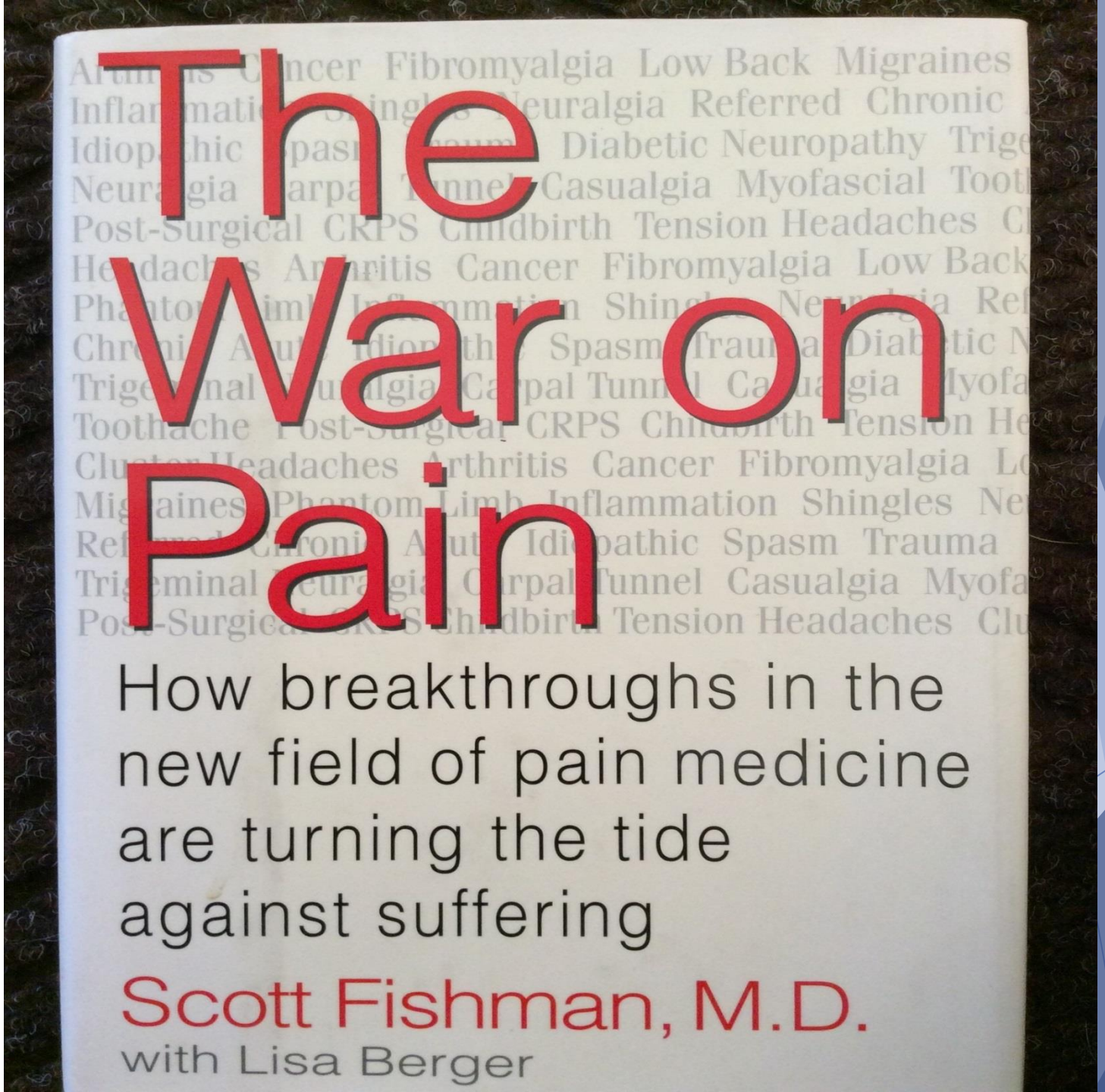
Disclosure: Christina Lasich, MD

With respect to the following presentation, I have no actual or potential conflict of interest in relation to this program/presentation and no relevant (direct or indirect) financial relationships to disclose.

A Tale of Two Epidemics

- **Chronic Pain**
- **Opioid-Overdose Deaths**

- First came…


The War on Pain
How breakthroughs in the new field of pain medicine are turning the tide against suffering
Scott Fishman, M.D.
with Lisa Berger

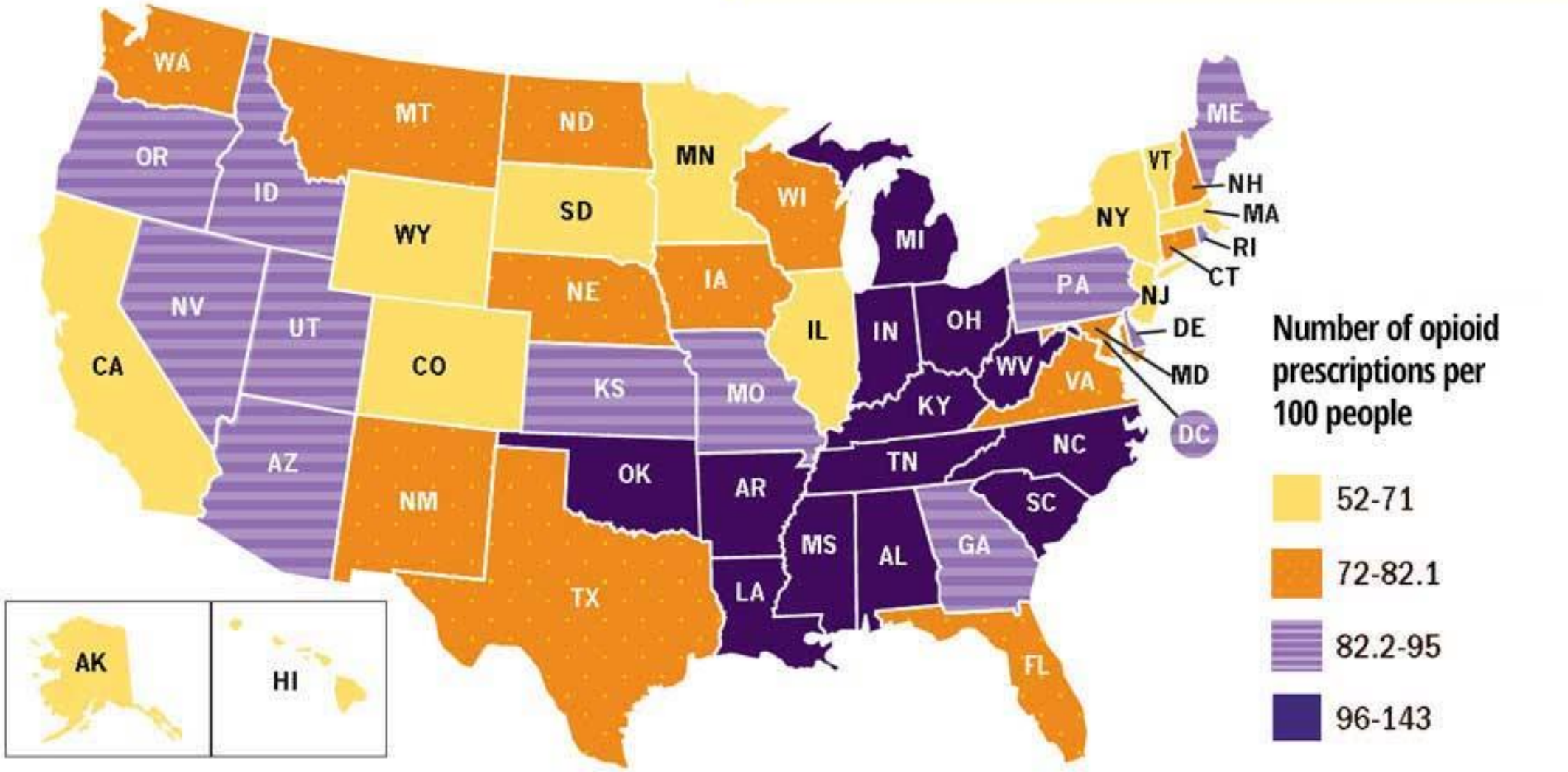
Then Doctors were Sued or Disciplined for Poor Pain Control

- 1999 Oregon doctor disciplined by Oregon Board of Medical Examiners for failing to proved adequate pain management

- 2002 Bergman v. Chin: Dr. Chin ordered to pay $1.5 million for undertreating pain

- **Next came..**
  The Exponential increase of Prescriptions for opioids from Late ‘90’s to Present

Some states have more opioid prescriptions per person than others.



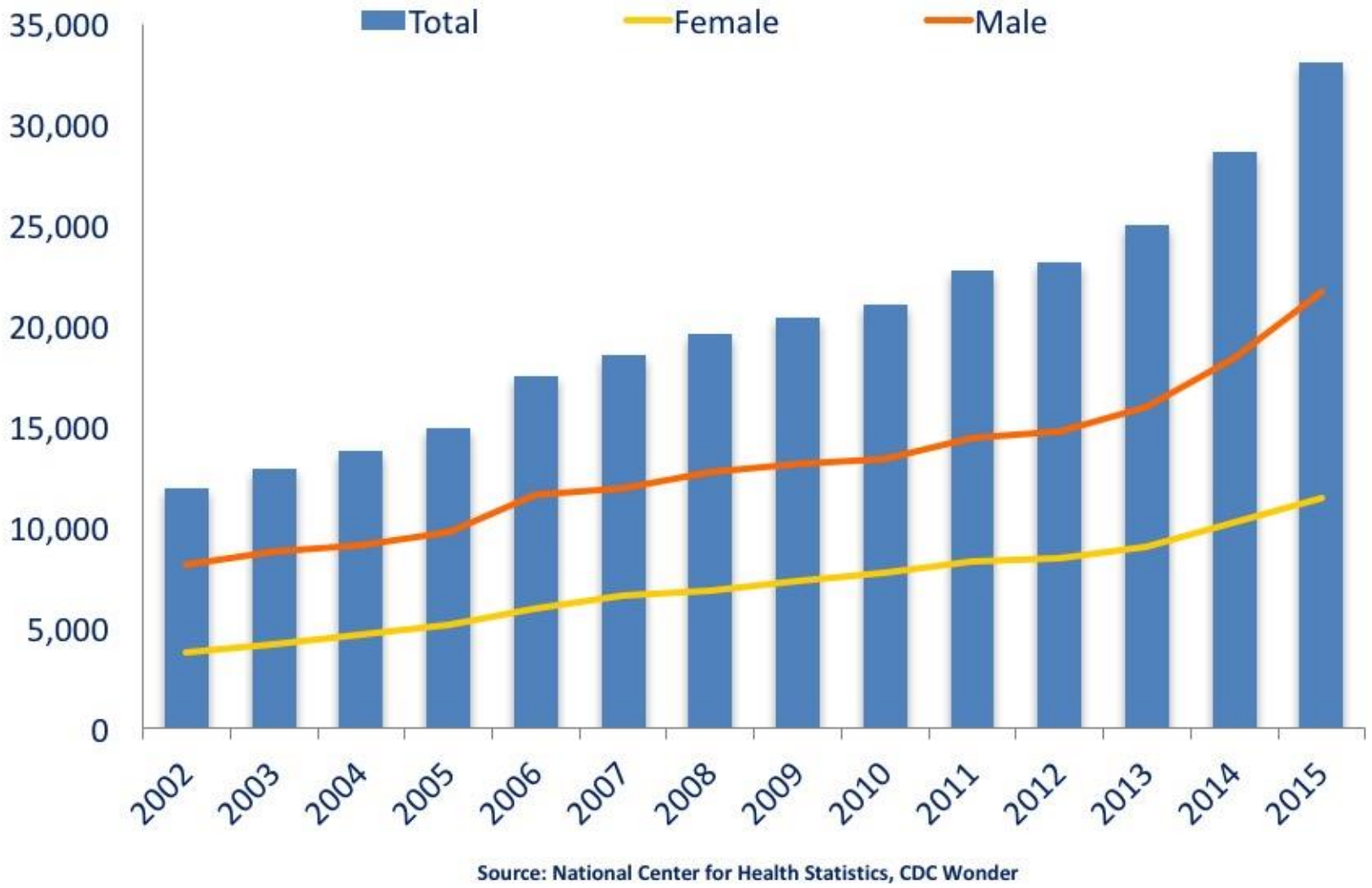
SOURCE: IMS, National Prescription Audit (NPA™), 2012.

- **Now we are seeing an exponential increase in opioid overdose deaths from 2000 to 2015**

National Institute on Drug Abuse

National Overdose Deaths

Number of Deaths from Opioid Drugs



Source: National Center for Health Statistics, CDC Wonder

- **How do we stop both the epidemic of chronic pain and opioid-overdose deaths?**

BRAVO can help you safely decrease the opioid dosage

Broaching the Subject of the Taper

Risk Benefit Calculator

Addiction Happens

Velocity and Validation

Other Treatments

Broaching

- Recognize the anxiety that is created by mentioning an opioid taper
- Acknowledge the anxiety and express empathy
- Make it clear that the taper was carefully considered and is not punitive

Risks

- Discuss risks of long-term opioid use
- Evaluate side effects, MME's, and function

Addiction Happens

- Misuse of opioids is common in long-term opioid use and can predict subsequent addiction
- Physical Dependence is not addiction
- Addiction refers to behaviors: 4 C's (control, compulsion, craving and continued use despite consequences)

Velocity

- Tapering too fast is a common mistake
- It's okay to take breaks but never go backwards
- Validate the withdrawal symptoms and remind patient that they are temporary
- Use other medication to mitigate withdrawal symptoms

Other: How do we support an **BRAVO** opioid taper in someone that has chronic pain?

Without:

- **Losing Function**
- **Losing the Therapeutic Alliance**
- **Losing Hope**

Ask for an ENCORE and bring alternatives to opioids back into the practice of medicine

Evaluate the Pain

Neutralize the Nervous System

Core Strengthening

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Restore Health

Ease Suffering

ENCORE: Evaluate Pain

- What does the pain feel like?
- What makes it worse?
- What makes it better?
- Are there any other abnormal sensations?
- Is there a time of day when the pain is worse?
- Physical exam!!

Mechanical Pain

Positional, Activity or Functional Dependent Pain

- **Examples include: spinal stenosis, neck pain, shoulder tendonitis, knee or hip arthritis**
- **Solutions include: zero gravity chair, assistive devices, improve the wake and sleep posture, and improve the body mechanics**

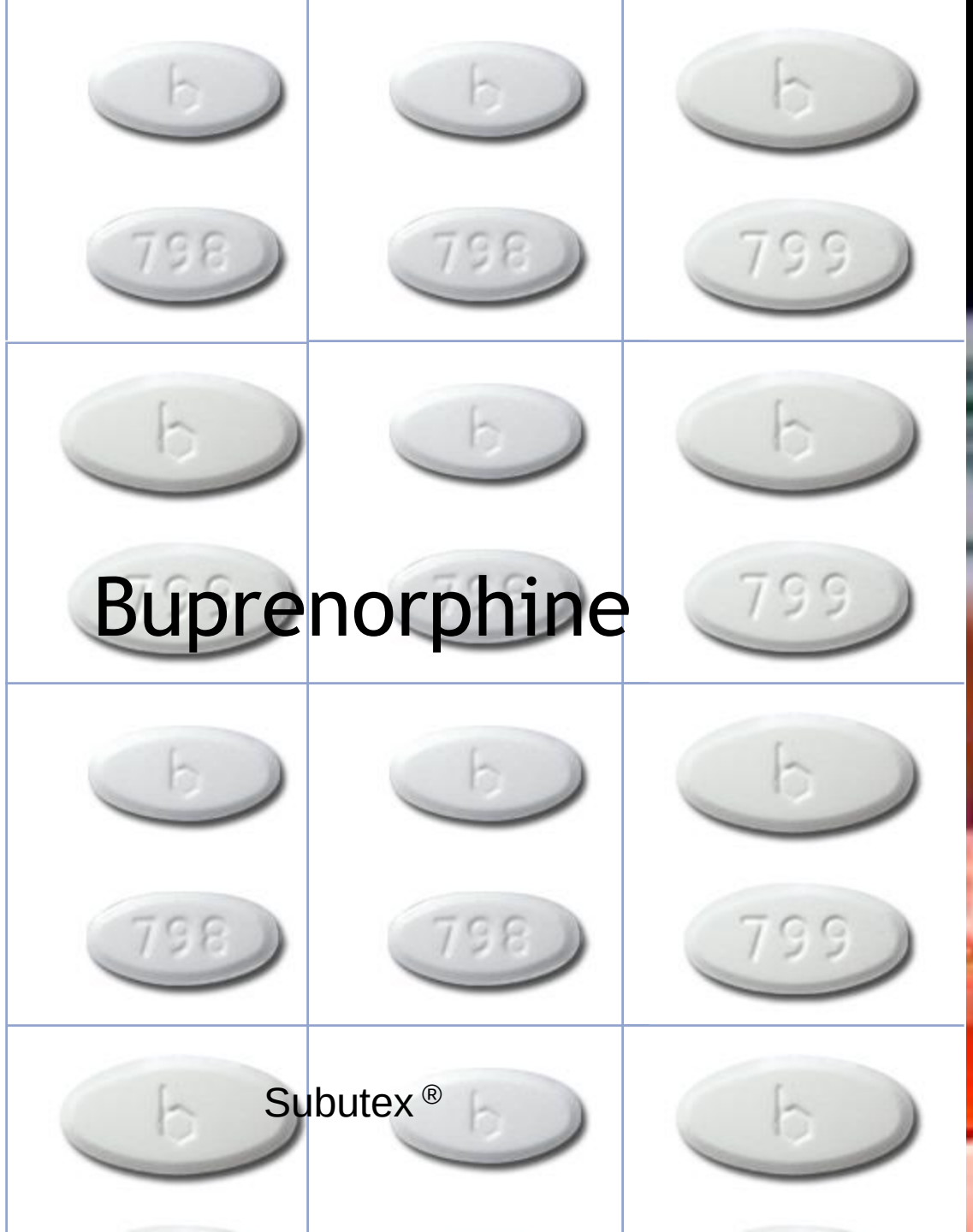
Neuropathic Pain

Pain that is driven by a sensitive "alarm system", the peripheral or central nervous system

- **Examples include: neuropathy, radiculitis, complex regional pain syndrome, fibromyalgia, AND Opioid-Induced Hyperalgesia**
- **Solution is to desensitize the nervous system or in other words, "reset the alarm", "calm the nerves down"…**

ENCORE: Neutralize the Nervous System

- The Neutralizing Medications: “calm the nerves”
  - Beyond Gabapentin is Zonisamide, Topiramate, Tiagabine and Pregabalin
  - TCA= Tricyclic Analgesics (amitriptyline, imipramine, desipramine)
  - Baclofen, a muscle relaxant and NMDA antagonist
  - Buprenorphine!!??!!


Buprenorphine
Subutex ®

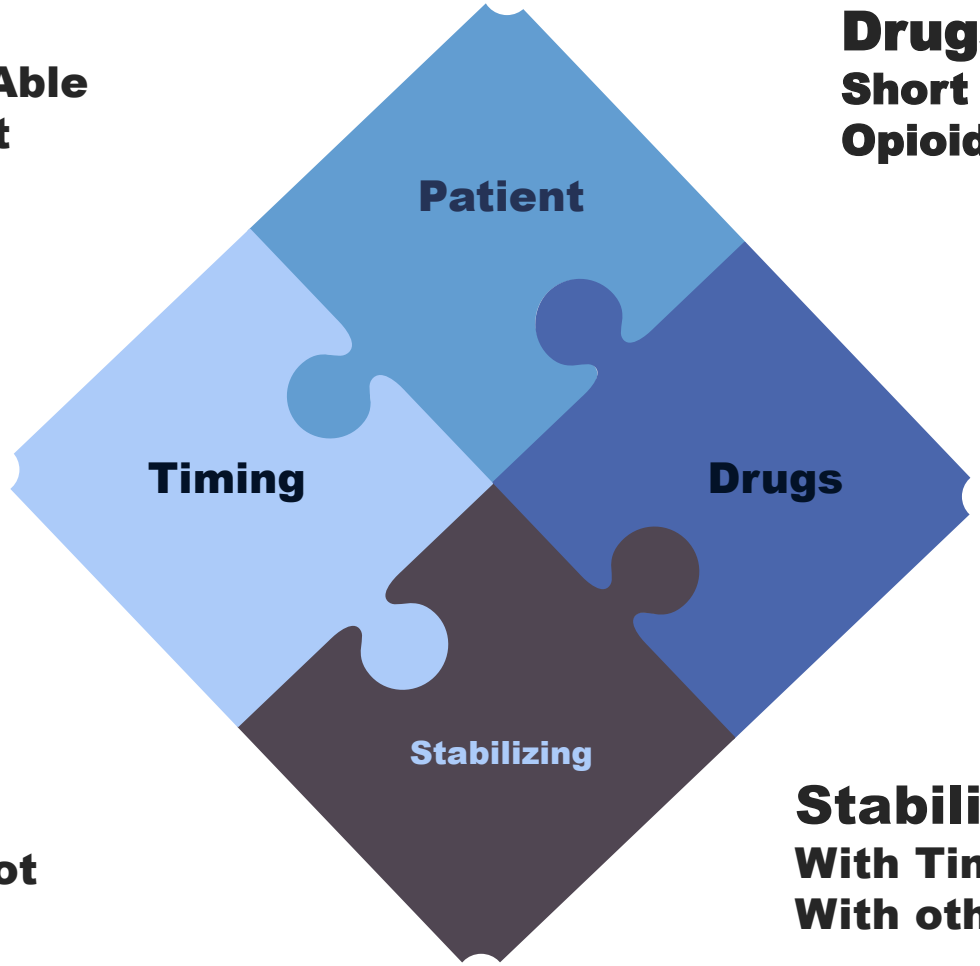

Buprenorphine/
Naloxone
Suboxone ®

The animation automatically begins.

The Induction Puzzle, Starting Buprenorphine Without Causing Precipitated Withdrawals

Patient
Motivated and Able
Pregnant or Not

Drugs
Short or Long Acting
Opioids



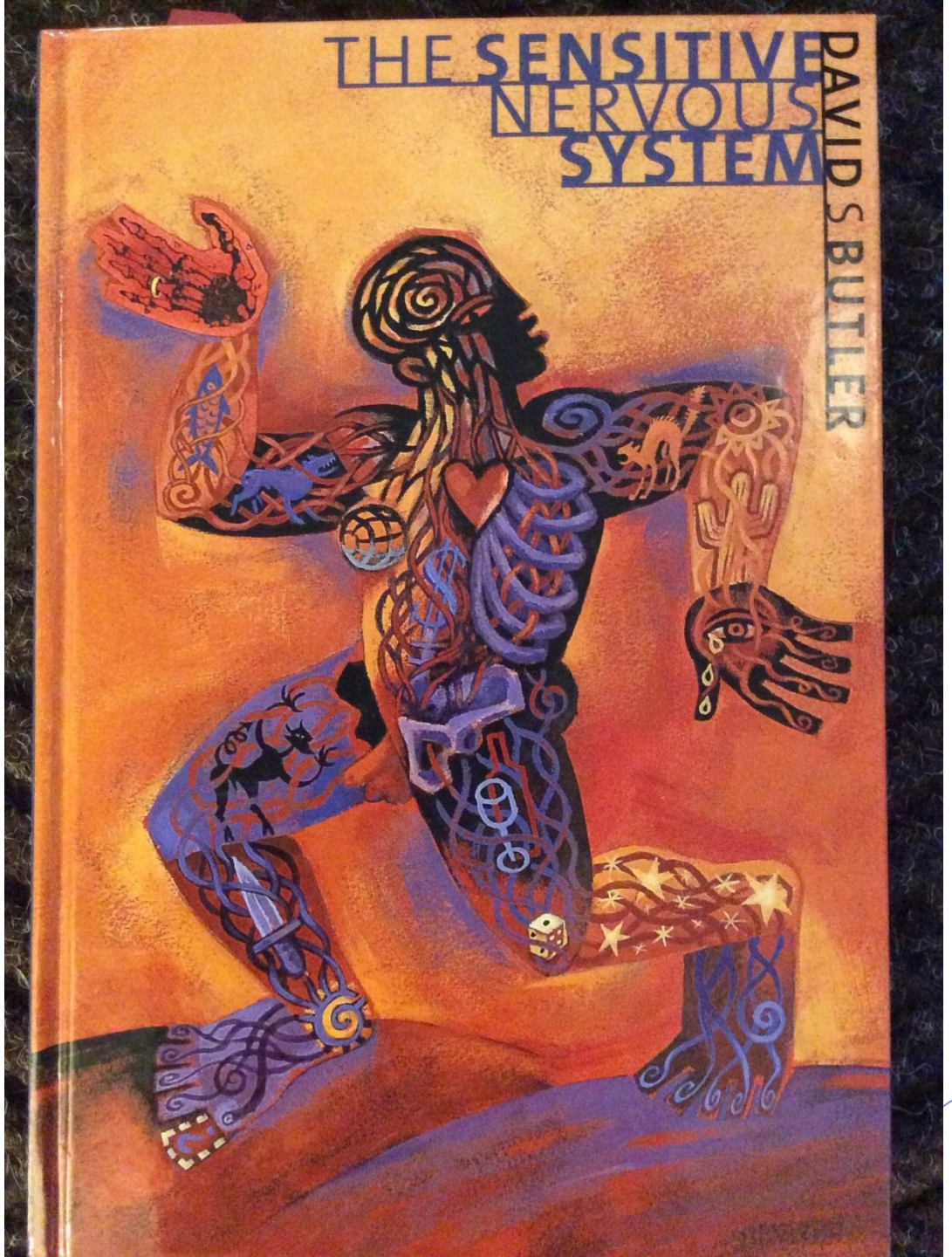
Timing
Opioid-Free or Not
@Home or Not

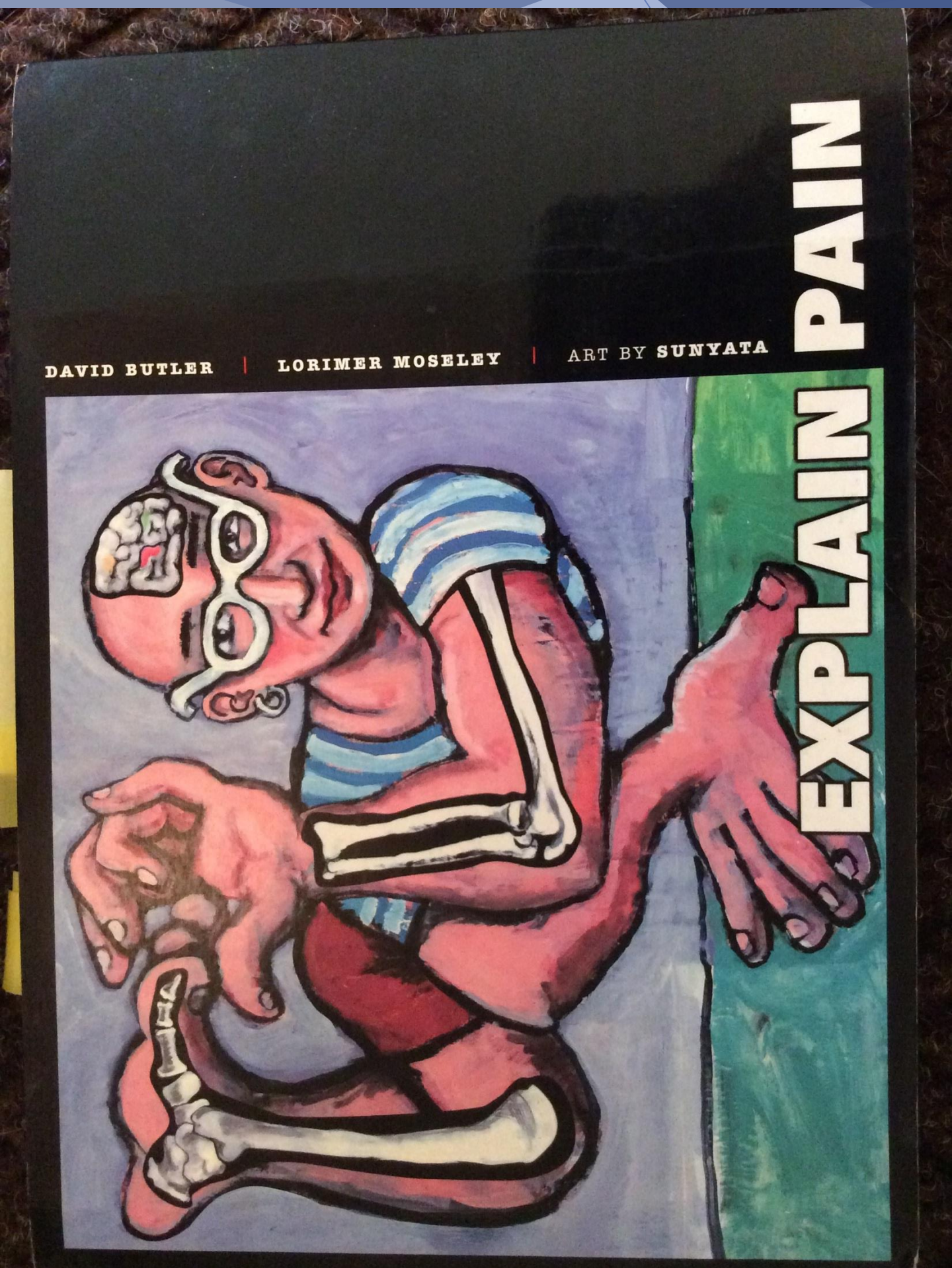
Stabilizing
With Time
With other Drugs

References:
Journal of Substance Abuse Treatment; "Comparison of Buprenorphine Induction Strategies"; 2011; June; 40(4): 349-356
The New England Journal of Medicine; "Neonatal Abstinence Syndrome after Methadone or Buprenorphine Exposure";

Neutralizing Neural Tension

- Stop Stretching or Hanging on the Nerve
  - Use arm rests
  - Stop using recumbent stationary bicycle
  - Stop reaching
- Physical Therapy for “Nervous System Mobilization” by “flossing” the nervous system with “gliders” and “sliders”
  - Book references by David Butler:


THE SENSITIVE NERVOUS SYSTEM
DAVID S. BUTLER


EXPLAIN PAIN
DAVID BUTLER | LORIMER MOSELEY | ART BY SUNYATA

ENCORE: Core Strength

- **Poor Core strength in proximal muscle groups: Rhomboids, Trapezius, Abdominal Wall, and Gluteal Muscles**

- **Poor Core strength causes painful conditions like: “thoracic outlet syndrome”, back and neck pain, trochanteric tendonitis/bursitis, and foot pain (!!?!)**


GymnastikBall
Made in Italy by LEDRAGOMMA

ENCORE: Open a Conversation

- About the expectation to be pain free and to do things the same way
- About the functional goals (it's not about the pain scale)

What are you able to do now with the use of opioids that you were not able to do before?

- Sleep better
- Return to work
- Resume activities of enjoyment
- Play with children
- Exercise

How can we help you increase your activity level while decreasing the reliance on opioids?

Start with addressing the fear-avoidance behavior by helping patients:

- **Learn about the problem**
- **Explore ways to move**
- **Explore and nudge the edges of pain**
- **Stay positive**
- **Make plans**
- **Remember that hurt does not always equal harm**

*Reference: “Explain Pain” by David Butler

ENCORE: Restore Health

- Pain is a doorway to transformation
- Pain is a “signal” from the brain that means something needs to change
- Pain is a motivator

Vitamins and Supplements

- **Vitamin D: Low levels associated with chronic pain and headaches**
  - **Virtanen, J. K. *et al*. Low serum 25-hydroxyvitamin D is associated with higher risk of frequent headache in middle-aged and older men. *Sci. Rep.* 7, 39697; doi: 10.1038/srep39697 (2017).**
- **Acetyl-L-Carnitine for Neuropathy**
  - **Sima, AA *et al*. Acetyl-L-Carnitine improves pain, nerve regeneration, and vibratory perception in patients with chronic diabetic neuropathy: an analysis of two randomized placebo-controlled trials. *Diabetes Care*, Jan. 28 (1) (2005)**

Anti-Inflammatory Diet

ENCORE: Ease Suffering

What is the difference between pain and suffering?

Pain is a physiological experience,
Suffering is a perception

Suffering is created by the way we think about time, threats, meanings, circumstances and stories

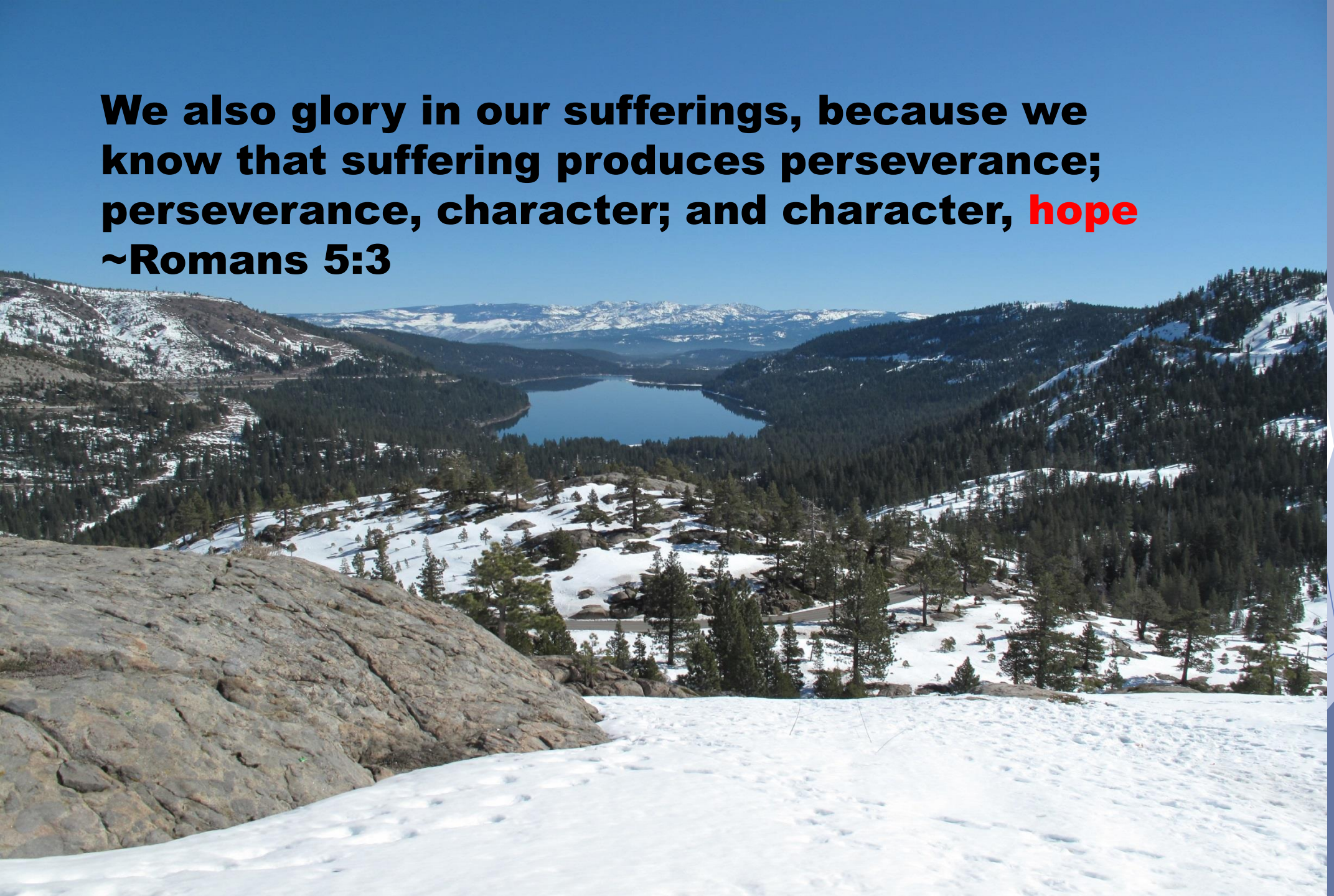
How can You Ease Suffering in Your Patient?

- Encourage patients to anchor into the moment instead of using the past as a source of comparison and the future as a source of worry
- Help patients to develop outlets for frustration like hobbies and exercise
- Reframe the story as a story of survivorship and strength
- Be present for your patient

Cultural Humility

“a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic and to developing mutually beneficial and non-paternalistic partnerships with community on behalf of individuals and defined populations”

(Tervalon and Murray-Garcia, 1998)



We also glory in our sufferings, because we know that suffering produces perseverance; perseverance, character; and character, **hope**
~Romans 5:3

How can we solve the epidemic of both chronic pain and OUD?

BRAVO can help you safely decrease the opioid dosage

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Risk Benefit Calculator

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ENCORE can help you effectively treat pain and OUD

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Restore Health

Ease Suffering

The Goal Is To…

Create a more deeply satisfying life
And restore HOPE

Thank you

christinal@wsmcmed.org

Case Discussion

Case of Opioid and Alcohol Use

- 83 year old man with a right below knee amputation and subsequent phantom pain presents to your treatment facility after being in the ED for alcohol withdrawal associated seizure. He spent one week in the hospital for management of alcohol withdrawals. The hospital referred him to you because he also is using Morphine ER 60mg twice daily plus hydrocodone/APAP 10mg/325mg four per day but the patient reports that the pain is poorly controlled which is why he started using alcohol especially when he runs out of pills. His wife is very concerned because he frequently falls at the house and is not sleeping well due to discomfort. She states that, "He is just not the same since he lost his leg. He used to love to go out but now has no interest in doing anything."
- **How would you "Broach" the topic or "Open" the conversation?**
- **How would you help him maintain sobriety and treat pain?**

Case of Opioid PLUS Benzodiazepine Dependency

- 53 year old woman with lumbar pain following lumbar discectomy with laminectomy presents to you because of worsening pain and to establish care. She is currently taking hydrocodone/APAP 10/325 tablet every 4 hours (6/day) and has been taking it for over 5 years. Two years ago she began taking alprazolam 0.5mg three times per day for anxiety as prescribed by previous primary provider. She is also using zolpidem 10mg at bedtime. Her CURES report shows that hydrocodone is frequently filled a week early. Her urine drug test is consistent accept for positive test result for oxazepam. When questioned, she admits to using a friends diazepam when she ran short of her medications. Her pain has been a 9/10 lately and she is feeling depressed.
- **Why is she experiencing increasing pain, anxiety and insomnia?**
- **What questions would you ask about her health?**
- **How would you address the opioid dependency?**

Case of High MME and concurrent use of benzodiazepine…Yikes!

- 57 y/o woman who just moved to the area, injured left ankle 15 years ago and developed CRPS; She is currently using 70mg/day of methadone, three per day of 10/325mg oxycodone product, 1mg/day of clonazepam. She has spinal cord stimulator in place but poorly functioning. She tried duloxetine which did not help; and trouble getting pregabalin through her insurance. She is using w/c for community distances and walker for household distances. She is feeling anxious and depressed. Left leg is atrophied with skin discoloration. She also has extreme allodynia with light touch.
- What would you do in your first appointment with her?
- How would you broach the topic of an opioid taper?

Case of High MME and concurrent use of benzodiazepine…Yikes!

- Two years later….57 y/o woman is currently using 60 mg/day of methadone, three per day of 10/325mg oxycodone product, and no longer using clonazepam. Prozac 40mg/day has helped improve her mood. Tiagabine was not helpful. Her spinal cord stimulator is still poorly functioning. All monitoring of UDS and PDMP has been consistent. EKG QT interval is acceptable. Vitamin D level is 41. Activities are poorly tolerated and sleep is disrupted due to pain.
- How would you proceed now?

Thank you

christinal@wsmcmed.org