Opioid Cases

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Victoria Division of Family Practice. meeting
April 22, 2017,

Case – Mr. B

48 yr old HIV+ HCV+ male with peripheral neuropathy, sleep disturbance, cocaine & alcohol use disorders now both in sustained abstinence (6 years), pain 8/10

Meds:

- Oxycodone/acetaminophen (5/325) 6 q6h– no evidence of current OUD, no pain relief
- Thus oxy 120 mg = 180 mg MEDD
- Temazepam 60mg hs 2-3x/wk (from his wife)
- Intolerable experience in the past with duloxetine, venlafaxine, and amitriptyline

Mr. B, cont'd

Treatment:

1. Taper off oxycodone/acetaminophen 5/325:

- Lower by 1 tablet q4 days until at 1 q6h
- Then lower by ½ tab q4 days until off

2. Titrate onto gabapentin

- Begin with HS dose - 100 mg, incr. q4d until at 300mg hs
- Titrate up daytime doses by 100 mg until 300 tid - qid, then by 300mg weekly until 600 tid (2400 mg/d)
- If no pain relief in 6 weeks at 2400 mg/d then taper off
- If 2400 mg/d helpful can push the dose further to 3600
- Neuromodulators can help ameliorate opioid withdrawal symptoms too which can help Mr. C.

Mr. B, cont'd

Treatment, cont'd:

3. Taper temazepam
   - Stabilize nightly benzo to half current episodic dose
   - Slowly taper, or can use diazepam, remembering that neuromodulators can also help benzo withdrawal
   - Ashton protocol for benzo tapering may be needed

4. Nortiptyline may be better tolerated for sleep but he declined, can try quetiapine 25 mg hs and titrate up

5. Sleep hygiene/relaxation/anger mgt

Mr. B, cont'd

- Result: Pain better controlled, sleep still a challenge but improving with time … Good result!

Mr. B, cont'd

- Q: What if he was binging on alcohol and benzos?

Mr. B, cont'd

Offer residential detox. Not eligible for opioids – stop (or fast taper 10% per day).

Mr. B, cont'd

- Q: What if he had requested more opioids instead of less?

Mr. B, cont'd

Explain that other medications are first line and need to be tried in sufficient doses. Explain that opioids have risks associated with use – outline them. Explain why this is considered a failed treatment attempt = opioids are no longer indicated

Mr. B, cont'd

Q: What if he had some pain relief and increased function with oxy/acetaminophen and was unresponsive to all other med categories?

Mr. B, cont'd

- Once daily oral morphine formulation – which could go to a daily witnessed ingestion (DWI) if needed during initial monitoring, and be reverted back to DWI if there is cocaine or other drugs in the UDS
- NOT eligible for carry doses of opioids if using cocaine or other illicit drugs

Case – Mr. Z

- 61 year old IDU, HIV+, HCV+, polysubstance dependence, previous drug dealer currently on disability and working under the table doing home renovations, with insomnia and bilateral shoulder pain from multiple fracture-dislocations, and back pain from marked thoracic kyphosis and degenerative disc disease

- Asking for increases in morphine and diazepam, threatens to use heroin if denied

Mr. Z, cont'd

Current Medications beyond ARVs for HIV

- Methadone 100 mg/d twice weekly dispensed, first dose witnessed – "doesn't help my pain"
- Morphine extended release (once daily formulation) 50 mg bid, twice weekly dispensed (no witnessed doses) – chewing, runs out early every dispensing cycle by 1-2 doses. "Only thing that gives me temporary relief". Feels "nothing" if he swallows the pill whole. Wants 3 doses/d to chew
- Diazepam 10 mg hs now, wants 40mg/d like last yr
- Zopiclone 7.5 mg i-ii hs
- When out of benzos, gets tryptophan from others, takes 1 pill (unknown strength) and can sleep
- Never tried and not interested in TCAs, SNRIs, gabapentinoids which he referred to as "bug pills"

Mr. Z, cont'd

Substance use hx – verbal report

-Caffeine: ½ jar of instant coffee/d, cigs: none

-Alcohol: "alcoholic " "trying to stop" - night before assessment "2 drinks", "none for 3 weeks prior"

-Cannabis: 3.5 gm/d = 7 joints/d

-Heroin: "not now". Started IV age 19 – most of his life off and on heroin dependence, or other opioid – reported drinking methadone up to 1000 mg at once on several occasions and still be able to walk around Vancouver. Has shot his methadone before

-Cocaine: not currently, 35 years of past IV use

Urine drug screen (point of care)

Positive (+) for methadone, opioid, benzos, THC

Negative (-) for cocaine, amphetamine, PCP

Mr. Z, cont'd

Assessment (beyond orthopedic condition)

-High risk for unintentional OD (mixing ETOH, benzos, and opioids – chewing extended release morphine into quick release)

-Not a good candidate for carry doses of any opioid (misuse of prescribed route of administration, active opioid use disorder, high diversion risk)

-MEDD over 700mg/d = failed opioid tx for pain

-May have opioid induced hyperalgesia

-Active alcohol and cannabinoid use disorders

-Not tried first line pain treatments

-Uses sarcasm and threats to try to get meds

Mr. Z, cont'd

Recommendations

- Explain the way he is taking morphine is unsafe, and is contraindicated for chronic pain on methadone especially with alcohol and benzodiazepines
- Explain tolerance, withdrawal pain, and opioid induced hyperalgesia
- Change all opioids to DWI
- Taper off morphine (decrease by 10 mg every 4-7 days, he may be able to go faster since no effect)
- Taper benzos: Decrease diazepam 2.5 mg q 1-2 wks, then taper zopiclone by 3.5 mg in the same fashion, compounding lower at the end if needed

Mr. Z, cont'd

Recommendations, cont'd

- Offer prescription for tryptophan 500 mg titrating up to 5 gms as needed before bed for sleep only because he reports good sleeps on this
- If tryptophan ineffective for sleep – use nortriptyline 10 mg titrated to up every 4-7 nights as needed to max 100 mg (for sleep and pain)
- If more sedation needed use instead amitryptyline 25 mg hs titrated to 200 mg
- If ineffective try quetiapine 25 mg hs titrated up to 200mg hs, can also use 25 in the day for anxiety

Mr. Z, cont'd

Other considerations:

- Ensure a thorough medical work-up has been done – e.g. physical, imaging, electrophysiologic studies
- Review PharmaNet and Random UDS each visit

Mr. Z, cont'd

Q: What options do you have …If he had had had relief for the first 6 hours of methadone daily dose, **and** he didn't have a history of methadone binging and shooting, **and** if UDSs were clear once off morphine x3 months?

Mr. Z, cont'd

- You could offer a trial of split methadone doses 33mg q8h (witness first dose, carry 2) and dose titration
- Return to DWI if no help or destabilizes

Mr. Z., cont'd

Q: What if he had neuropathic pain?

Mr. Z., cont'd

- A lower dose of cannabis is advised
- Venlafaxine can be offered starting at 37.5 mg/d titrating to 225mg/d to get pain relief from noradrenergic effect
  - Duloxetine (a sister SNRI) gets noradrenergic effect at low dose (30mg/d), not covered by Pharmacare
  - If ineffective or side effects taper over 2-4 weeks

Mr. Z., cont'd

Gabapentin

- Start low 100 mg hs, increasing by 100 mg hs every 3-4 days until 300 mg hs then add daytime doses until 300 mg tid, then can increase by 300mg
- If no effect at 2400 mg after 6 weeks then taper: can back off 300-600 mg every 2-4 days
- If some benefit and no side effects at 2400mg/d can titrate to 3600mg/d only if added benefit.
- Nb Risk of **diversion** due to street value. May help him stop drinking. Increases risk of OD.
- Pregabalin is not covered by Pharmacare but is easier to dose, titrate and taper

Mr. Z., cont'd

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- Q: What non-medication treatment strategies can be employed?

Mr. Z., cont'd

- Physiotherapy, and a pool pass for self help
- Sleep hygiene education
- Cut caffeine to 3c or less/d
- CBT 1:1 or group, peer support group
- Nerve root blocks, epidurals, trigger point release massage, cortisone injections, etc.

Mr. Z., cont'd

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Q: What if Mr. Z lands in hospital with a new painful issue?

Mr. Z., cont'd

- All non-opioid strategies should be considered 1st
- If an opioid is used, continue the methadone as usual and add a short acting opioid temporarily, witnessed by nursing staff and specify days and taper schedule (or PCA with lock out if anesthesia orders).

Mr., Z., cont'd

Q: What if Mr. Z could not stop drinking alcohol (on history or ETG positive UDS)?

Mr., Z., cont'd

- He is no longer a candidate for opioid therapy and can be offered detoxification (residential or out patient) and long term treatment for all of his substance use disorders
- Offer hope: Recovery house, treatment for HCV

Mr., Z., cont'd

Q: What if he was not on methadone and just binging on high dose street oxycodone?

Mr., Z., cont'd

- Convert to bup/nx
- Even if he is on methadone this conversion can be useful, though retention is somewhat lower

Thank you!