Complex persistent dependence, withdrawal and opioid use disorder

Jane C Ballantyne
University of Washington, Seattle, US

Disclosures

Speaker: Jane C Ballantyne, MD, has nothing to disclose

Planning Committee: The members of the planning committee (Jonathan Robbins, Catriona Buist, Jess Gregg, Amy Maher, Michelle Marikos, Elizabeth Tiffany) have nothing to disclose.

Dependence is inevitable with continuous use

- Physical – regions of control of somatic function - locus ceruleus (noradrenergic nucleus)

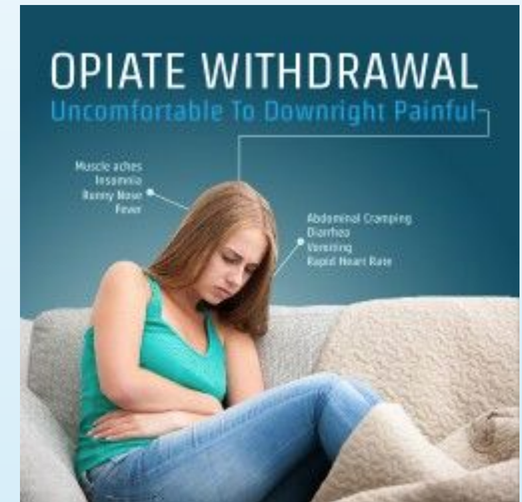
  upregulation of cAMP ⟷ arousal, agitation, nausea, diarrhea, rhinorrhea, piloerection

- Emotional/psychological – reward centers

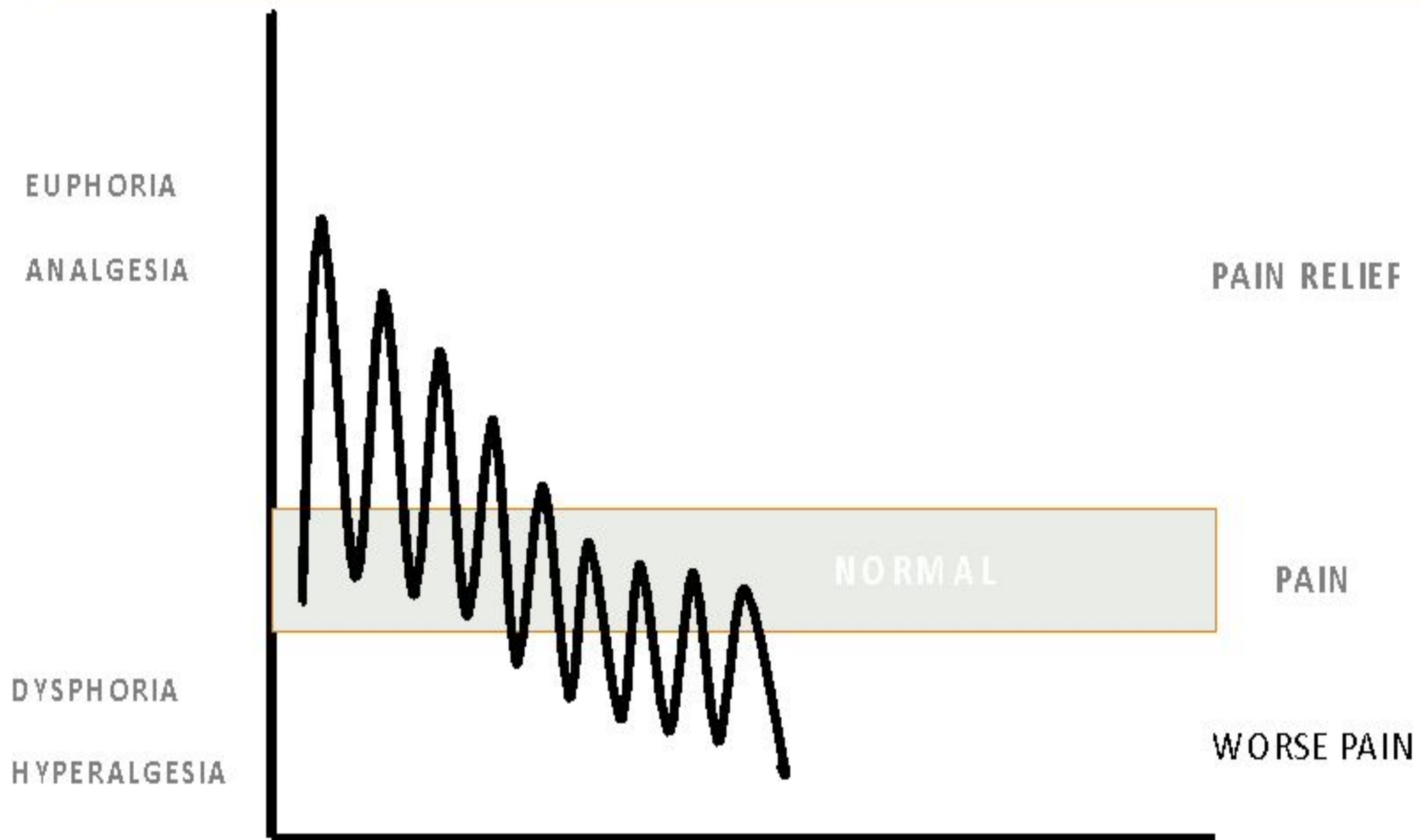
  hedonia ⟷ anhedonia

- Pain pathways

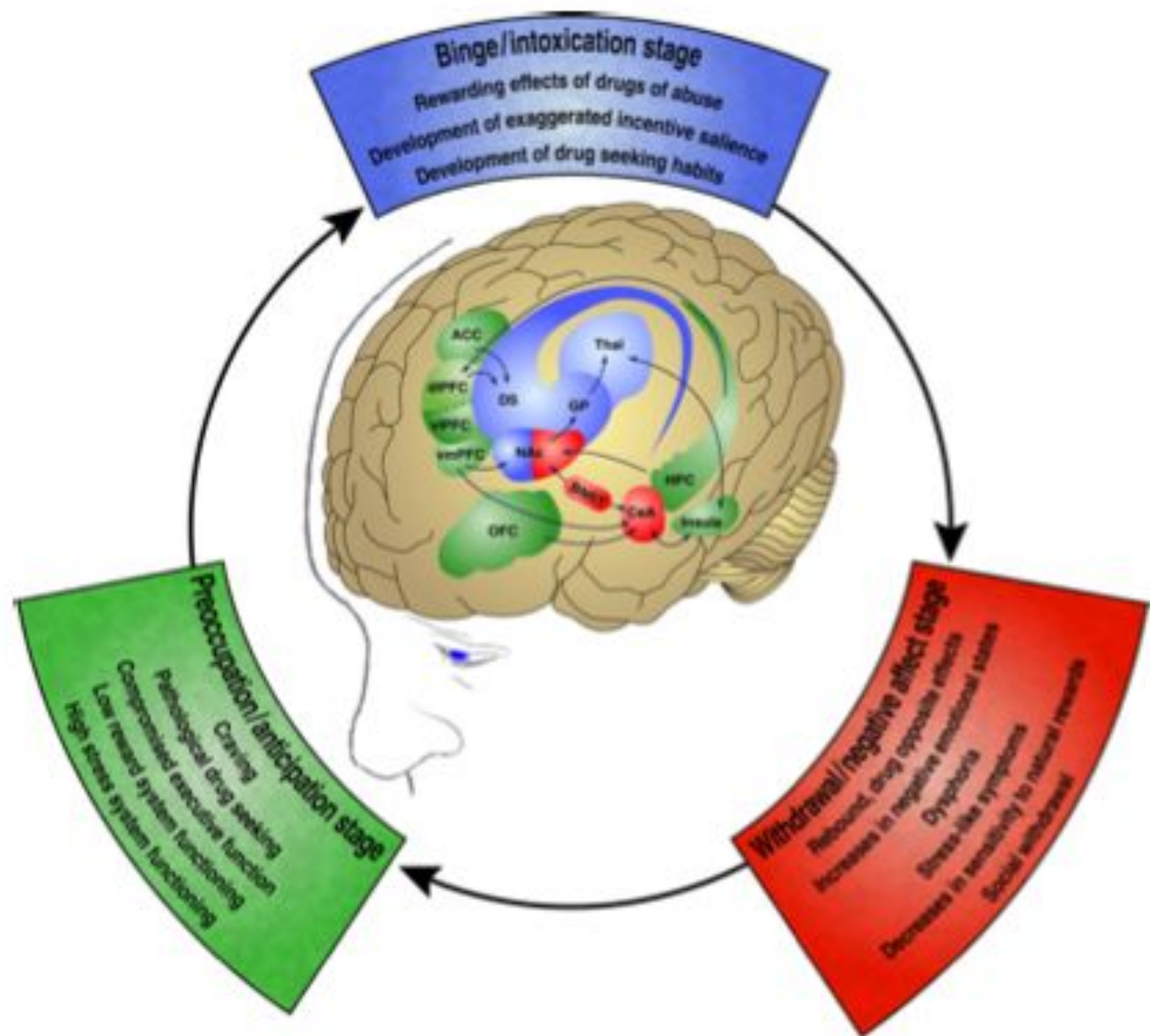
  analgesia ⟷ hyperalgesia



Ballantyne & LaForge, Pain 2007;129:235
Ballantyne et al, Arch Int Med 2012;172:1342



Ballantyne & Sullivan Arch Int Med 2012;172:1342


Binge/intoxication stage
Rewarding effects of drugs of abuse
Development of exaggerated incentive salience
Development of drug seeking habits
ACC
DS
Thal
GP
vmPFC
NAc
HPC
CeA
Insula
OFC
Withdrawal/negative affect stage
Rebound, drug opposite effects
Increases in negative emotional states
Dysphoria
Stress-like symptoms
Decreases in sensitivity to natural rewards
Social withdrawal
Preoccupation/anticipation stage
Craving
Pathological drug seeking
Compromised executive function
Low reward system functioning
High stress system functioning

- Dependence is distinct from addiction in that there is no craving or compulsive use
- Reward deficiency (inability to experience natural rewards), negative affect and social isolation accompany established dependence
- Dependence is hard to reverse
- Dependence can rapidly progress to addiction during withdrawal

Opioid seeking behaviors

Dependence/addiction develops through pain treatment

- *Pestering reluctant doctors*
- Using opioid to treat pain
- Predominant symptom of withdrawal - pain

Dependence/addiction develops through recreational drug use

- *Need to procure opioid*
- Often use paraphernalia
- Predominant symptom of withdrawal - anhedonia

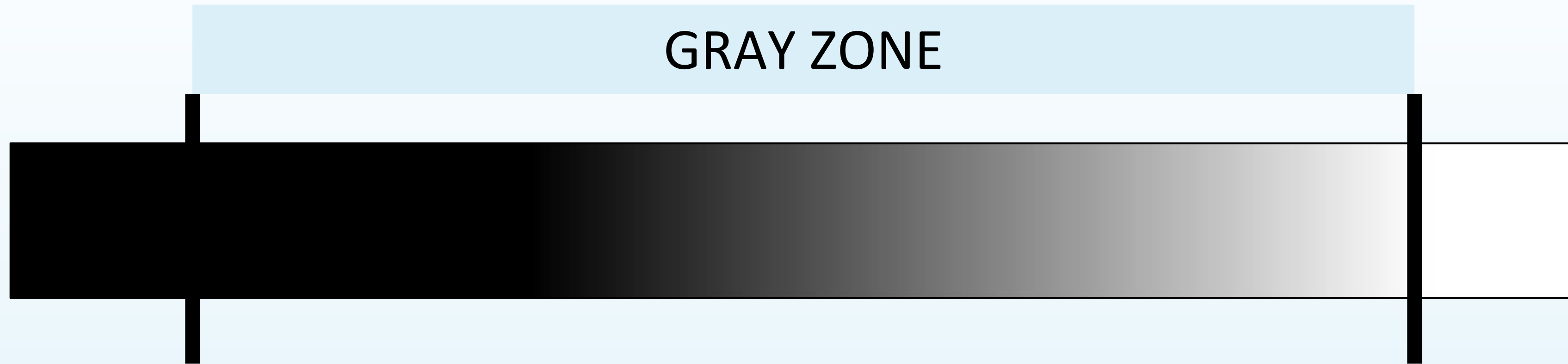
DSM Criteria

- Social Disruption
- Loss of control over use
- Continued use despite knowledge of harm
- (Craving)
  (may not be manifest until off)

Do not accept that anything is wrong other than pain

Accept that they are addicted

Ballantyne & LaForge
Pain 2007;129:235-55



ADDICTED

Meets DSM criteria for addiction

NOT ADDICTED

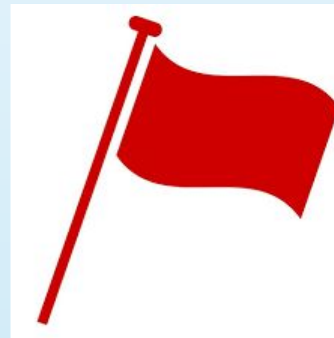
- No lost prescriptions
- No ER visits
- No early prescriptions
- No requests for dose escalation
- No UDT aberrancies
- No doctor shopping (PMP)

Who is addicted and requires more than office based treatment?

A patient that cannot control opioid usage to the extent that it is not safe to use opioids at home should be sent to addiction or methadone maintenance program.

Red flags:

Polysubstance abuse
Prior history of overdose
Stigmata of IV use



Take home message

- There is no bright line between dependence and addiction
- Treat all gray area patients the same
- Single out serious addiction* for formal addiction treatment

*Serious addiction = compulsive use that endangers the patient

A reasonable approach:

- Try to taper
- If taper fails, mandatory suboxone
- Maintain on suboxone as needed

- ALWAYS include counseling

Approaches to managing high dose and opioid dependent patients

- Start with the conversation, involve the family if at all possible
- Provide naloxone
- If not already instituted, start universal precautions (UDTs, signed agreement, PDMP)
- Send to addiction services or methadone maintenance program
- to safe dose or off
- Switch to suboxone

Anna Lembke's BRAVO approach

B Broaching the subject
R Risk-Benefit calculator
A Addiction happens – summary points
V Velocity matters (and so does validation)
O Other strategies for coping with pain

The conversation

- Don't be judgmental or threatening
- Explain that we have discovered that people feel better and usually have better pain control on lower doses, or off opioids altogether
- Understand that however logical you are, some dependent patients cannot see a way to living without their opioids; that is where family can be helpful
- Use motivational interviewing techniques to make the patient part of the effort to improve pain and lifestyle, including tapering

Whether tapering or going to suboxone

- Counselling and support are essential
- Use specialists whenever possible
- Groups are helpful
- The taper or switch to suboxone is less likely to be successful without counselling

Opioid taper

- Reasonable to taper **10% per month**, or per week for a more rapid taper
- If on long-acting and short-acting, first decide whether eventual goal is to be on long-acting or short-acting
- Taper the other first
- If on benzodiazepines, first decide whether to taper opioid or benzodiazepine first
- Be prepared to plateau
- You are tapering as long as the overall trend is down
- Never increase the dose, unless circumstances warrant it (rare)

Goal of taper

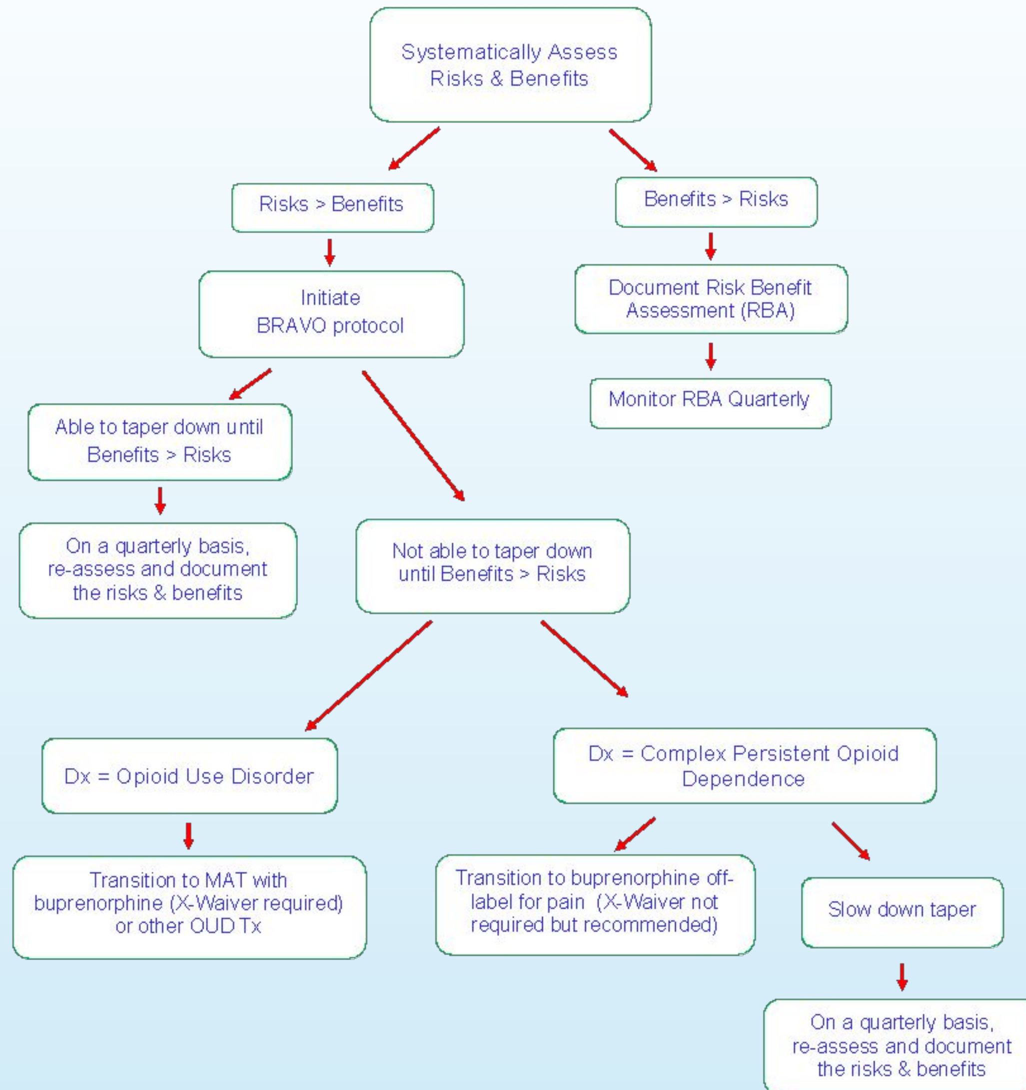
- 50-90 MED
- OFF altogether

Some taper without difficulty, others struggle

Our hardest question concerns what to do about those that struggle

Discussion points:

- If we force them off, will they relapse or seek street opioids
- If we leave them on high doses, are we liable if they die
- If we force them off, will they seek medical care elsewhere or not at all
- Can we threaten them with suboxone or nothing?
- Should we prescribe suboxone without a waiver?
- Who is going to pay for the suboxone?
- Who is going to pay for time consuming care?



This flowchart summarizes the steps in a tapering protocol developed by the Oregon Pain Guidance Clinical Advisory Group https://www.oregonpainguidance.org/guideline/tapering/

Opioid Dependence is distinguished from Opioid Use Disorder to avoid the binary choice between OUD versus no OUD, which is problematic particularly for the many patients who have Opioid Dependence that does not meet criteria for OUD. These patients need treatment akin to OUD treatment BUT, in contrast to OUD:

- It is acceptable to continue the patient's usual opioid (but with supplementary monitoring and support) if attempts to taper result in a deterioration in function and quality of life
- Buprenorphine should be offered specifically to treat Opioid Dependence and pain and may obviate the need to continue patient's usual opioid
- Where OD and not OUD diagnostic criteria are met, avoidance of the OUD diagnosis relieves the patient from the stigma, employment implications and possible child custody implications of OUD.