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Finding a Soft Landing for Patients on Long Term Opioids

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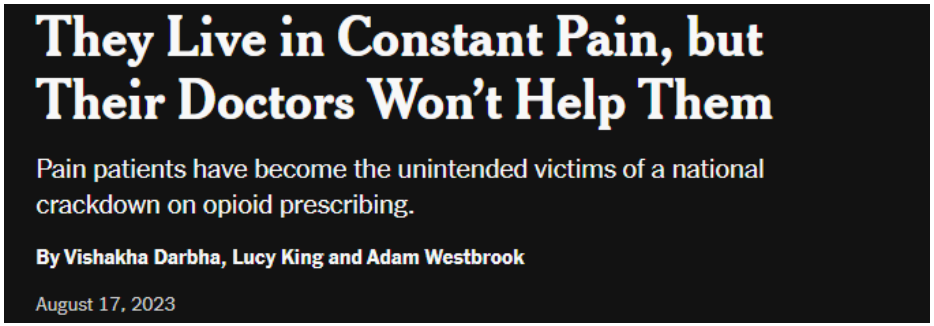
Pooja L et al. PAIN 2021;162:1379-1386

Pain Patients Who Take Opioids Can't Get in the Door at Half of Primary Care Clinics

"Secret shopper" study finds stigma is highest against those who say their last doctor stopped prescribing opioids to them.

New York Times



They Live in Constant Pain, but Their Doctors Won't Help Them

Pain patients have become the unintended victims of a national crackdown on opioid prescribing.

By Vishakha Darbha, Lucy King and Adam Westbrook

August 17, 2023

J Pain 2022;23:1006-1024

The Relationship Between Experienced Discrimination and Pronociceptive Processes in Native Americans: Results From the Oklahoma Study of Native American Pain Risk

Highlights

- Native Americans experience higher rates of chronic pain than other U.S. groups
- Native Americans reported greater experienced discrimination
- Discrimination mediated an inequity in impaired inhibition of spinal nociception
- Thus, experienced discrimination may contribute to Native American pain inequities

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Interrupting a Safe Supply

Known risks of opioid exposure
+
Limited efficacy in chronic pain

Discontinue?

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Interrupting a Safe Supply

Known risks of opioid exposure
+
Limited efficacy in chronic pain

"At the outset, clinicians must delineate decisions about opioid continuation from decisions about opioid initiation"

Fenton JJ. Exp Rev Clin Pharm 2024;17:305-307

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Outcomes of Opioid Tapering

Outcome	Tapered (adjusted IR/100 person years)	Not Tapered (adjusted IR/100 person years)	Adjusted IRR
Overdose	6.3	4.9	1.28
Mental Health Crisis	7.4	4.3	1.74
Depression	5.4	2.9	1.86
Anxiety	1.4	1	1.39
Suicide Attempt	0.3	0.1	2.38

Optum Lab data set
N=113,618

Agnoli A et al. JAMA 2021;326;(5):411-419

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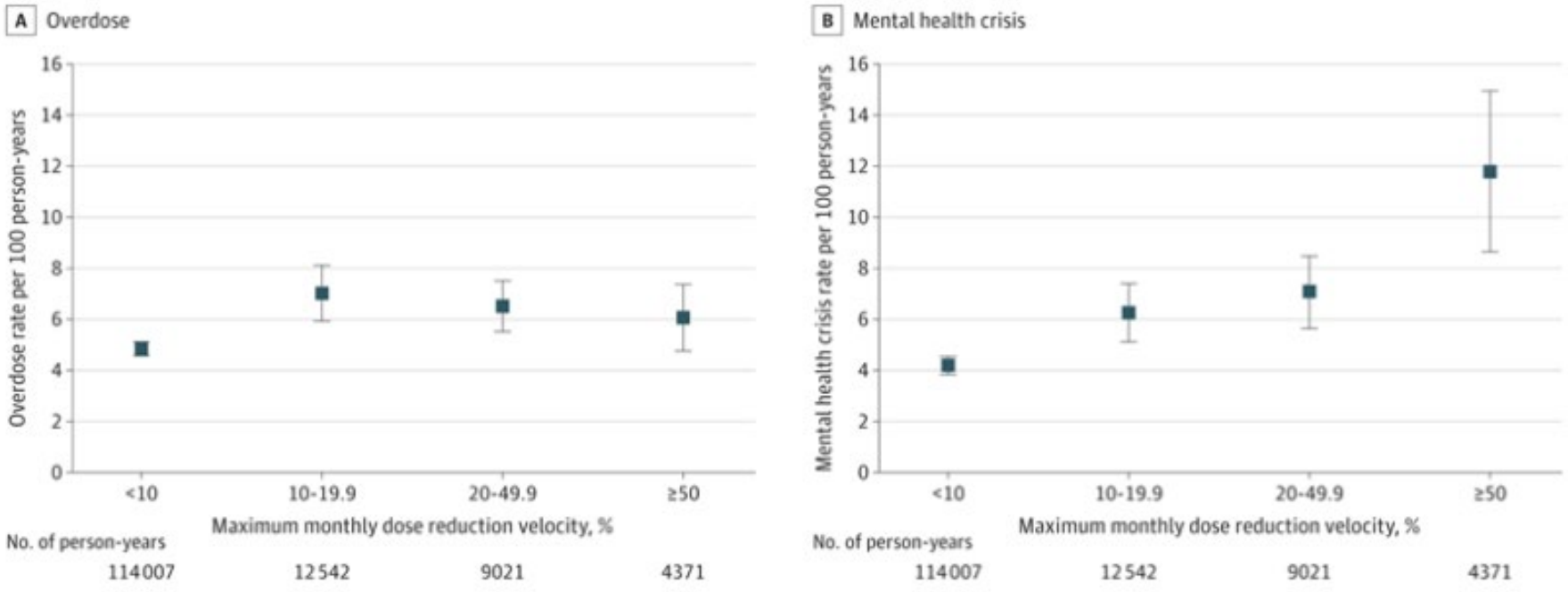
Outcomes of Opioid Tapering



An incremental increase in maximum monthly dose reduction velocity of 10% was associated with an increased aIRR for overdose (1.05 [95% CI, 1.03-1.08]) and mental health crisis (1.14 [95% CI, 1.11-1.17])

Agnoli A et al. JAMA 2021;326;(5):411-419

So What Do We Do?

1. Focus on the patient experience
   - Develop the relationship
   - Hear the story
   - Understand the struggle
2. Find the pharmacological pillow
   - Continuation
   - Simplification
   - Switch to buprenorphine
   - MOUD

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Joanne

<u>Referral</u>

Seen for refill appointment after prescriber retired.

Note per MA “Need PA for oxycodone”

Prescription:

Oxycodone 30mg

Take 4 Tablets five times per day

#600

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Finding the Pharmacological Pillow

Continuation

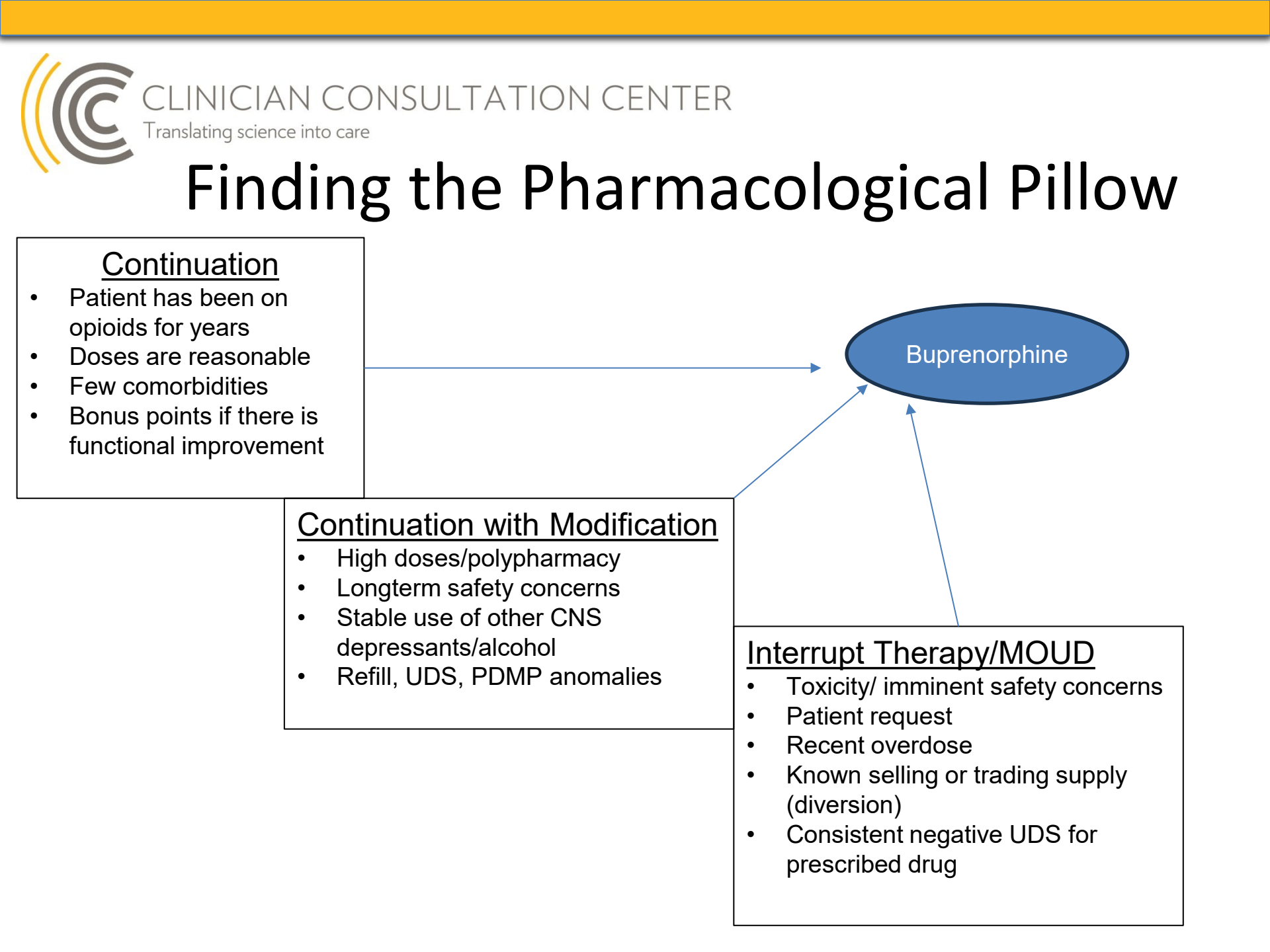
- Patient has been on opioids for years
- Doses are reasonable
- Few comorbidities
- Bonus points if there is functional improvement

Continuation with Modification

- High doses/polypharmacy
- Longterm safety concerns
- Stable use of other CNS depressants/alcohol
- Refill, UDS, PDMP anomalies

Interrupt Therapy/MOUD

- Toxicity/ imminent safety concerns
- Patient request
- Recent overdose
- Known selling or trading supply (diversion)
- Consistent negative UDS for prescribed drug



More background on Joanne

- Chronic LBP developed after loss of husband with no clear origin
- On schedule for refills and follow-up appointments
- Pill burden is a concern, ER oxycodone previously not covered by Part D plan
- Comorbidities: COPD, hypothyroidism, tobacco 3PPD

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The Approach

- Start off with reassurance
- Quick review of imminent risks and collateral information from the chart and staff
- Prescribe a supply that can be covered while the PA is submitted
- Schedule a follow-up in a week or two to work on the relationship

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Continuation Options

Current:

Oxycodone 30mg 4 tabs five times per day

Simplification options:

- Oxycodone ER 30mg 10 tabs BID
- Oxycodone ER 60mg 5 tabs BID
- Conversion to another opioid
- Begin the conversation about buprenorphine

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Conversion to Buprenorphine

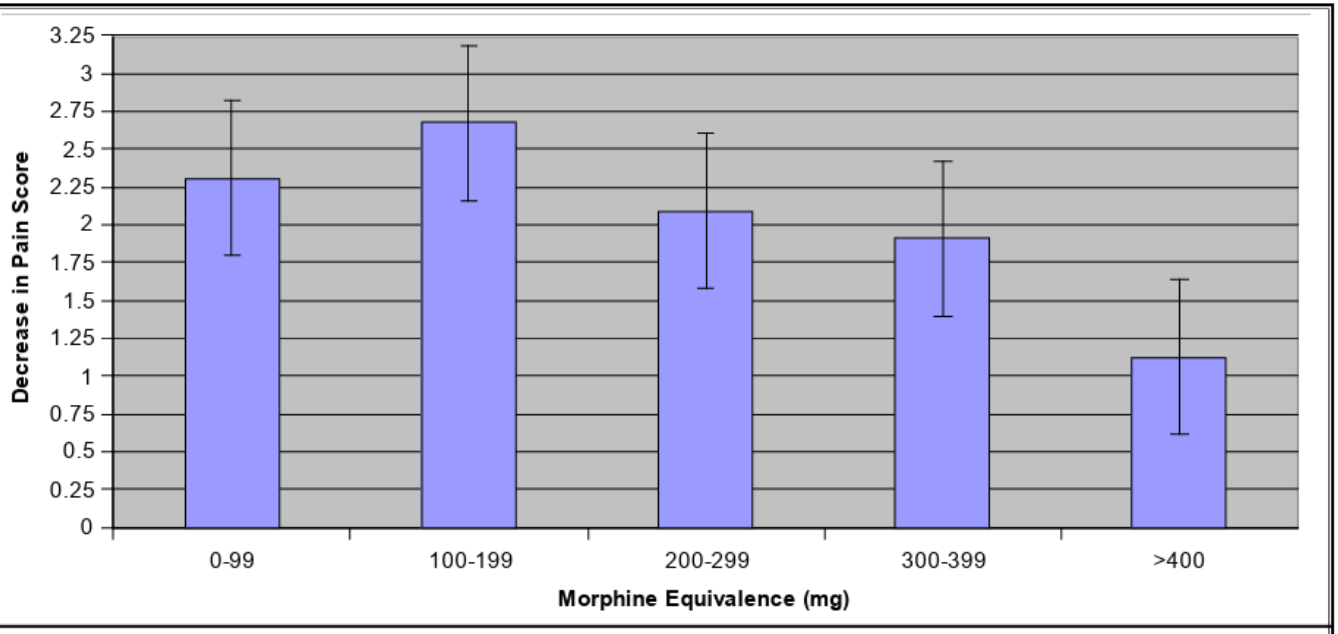

Fig. 3. *Preinduction morphine equivalents versus average decrease in pain.*

Retrospective
N=104
Average MME 180

For those that continued buprenorphine for at least 60 days the average decrease in pain score was 2.3

Daitch J et al. Pain Physician 2012;15:ES59-66

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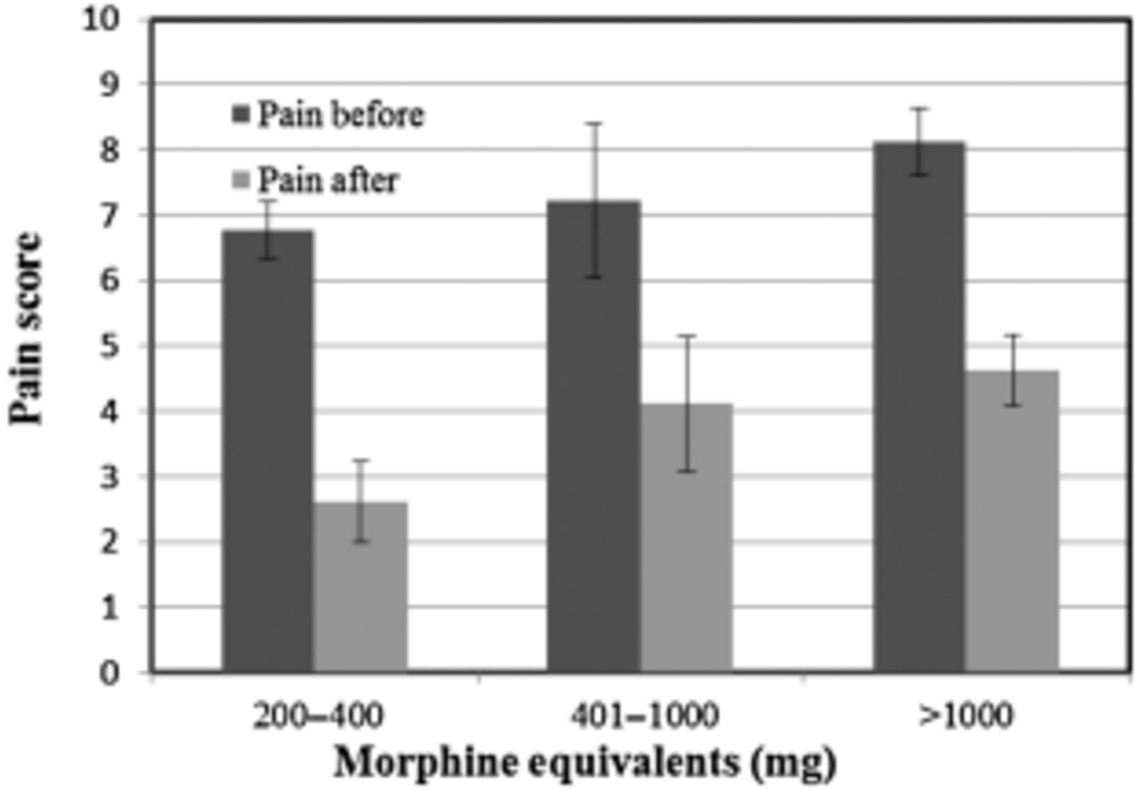
Pre- and postconversion pain scores by preconversion morphine equivalents dosage



35 Chronic pain patients

Mean MME 550mg (200-1370)

Converted to buprenorphine 8-32mg

Pain scores decreased from 7.2 to 3.5

Daitch D et al Pain Medicine 2014;15:2087-2094

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Conversion to Buprenorphine

- 207 chronic pain patients on ≥70MME recruited from 2017-2021
- Subset of VOICE study comparing IPT to PCM
- Secondary intervention randomized to "buprenorphine option" or "no buprenorphine option"
- Initially used standard induction then added on option of low dose transition

Becker WC et al. JAMA InternMed.2025;185(4):372-381

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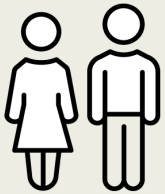
Conversion to Buprenorphine

JAMA Internal Medicine

RCT: Buprenorphine, Pain, and Opioid Use in Patients Taking High-Dose Long-Term Opioids

POPULATION

185 Men, 22 Women



Adults with chronic pain prescribed long-term opioid therapy

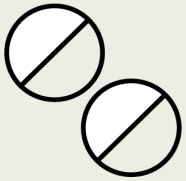
Mean age, 61 y

SETTINGS / LOCATIONS

10 Veterans Affairs health care sites

INTERVENTION

207 Participants randomized and analyzed



104 Buprenorphine option
Participants given the option to trial buprenorphine for management of chronic pain

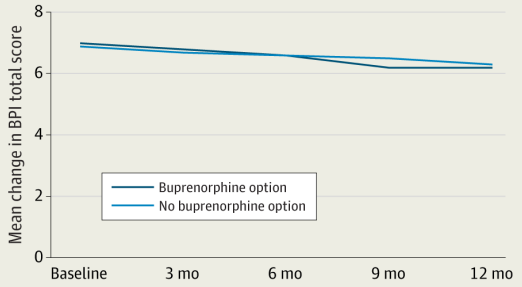
103 No buprenorphine option
Participants not given the option to trial buprenorphine for management of chronic pain

PRIMARY OUTCOME

The primary outcome was Brief Pain Inventory (BPI) total score (range, 0-10, with higher indicating worse pain) at 12 mo

FINDINGS

Mean change in BPI total score from baseline to 12 mo did not differ between groups; the intervention offered no improvement compared with the control condition ($P = .67$)



Adjusted mean difference in BPI score from baseline to 12 mo:
Buprenorphine: −0.59; 95% CI, −0.89 to −0.29
No buprenorphine: −0.50; 95% CI, −0.81 to 0.20

Becker WC, Seal KH, Nelson D, et al; VOICE Study Group. Buprenorphine, pain, and opioid use in patients taking high-dose long-term opioids: a randomized clinical trial. *JAMA Intern Med*. Published online February 17, 2025. doi:10.1001/jamainternmed.2024.8361

Becker WC et al. JAMA InternMed.2025;185(4):372-381

Conversion to Buprenorphine

- "Buprenorphine option"
  - Out of 104 total 27 switched to buprenorphine
  - 9 of the 27 switched back to full agonists
  - Only 17% made the switch and stayed
- Opioid dosages decreased from 157 MME to 94 MME vs 165 to 107 in no buprenorphine option

Becker WC et al. JAMA InternMed.2025;185(4):372-381

Conversion to Buprenorphine

Table 4. Primary and Main Secondary Outcomes Among Patients With Long-Term Opioid Therapy for Chronic Pain Who Did and Did Not Switch to Buprenorphine During the Trial Period

Outcome	Switched to buprenorphine (n = 27)			Did not switch to buprenorphine (n = 175)			Between-group difference, AMD (95% CI)[a]
	Mean (SD)[b]	Mean change (SD)	Participants, No.	AMD (95% CI)	Mean change (SD)	Participants, No.	
Primary outcome							
BPI total score[c]							
Baseline	6.91 (1.48)	NA	27	6.76 (1.56)	NA	175	NA
3 mo	6.91 (1.60)	0.18 (1.14)	23	6.52 (1.69)	0.20 (1.21)	148	0.96 (−0.15 to 1.93)
6 mo	6.45 (1.86)	0.41 (1.61)	26	6.44 (1.77)	0.28 (1.29)	142	−0.25 (−0.83 to 0.33)
9 mo	5.71 (2.24)	1.10 (1.57)	21	6.33 (1.79)	0.39 (1.27)	134	−0.56 (−1.09 to −0.04)
12 mo	5.83 (2.33)	0.96 (1.82)	26	6.25 (1.71)	0.47 (1.45)	147	−0.50 (−1.03 to 0.03)

Becker WC et al. JAMA InternMed.2025;185(4):372-381

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Conversion to Buprenorphine

Standard Induction

Day 1 Dosing Recommendations

Selecting day 1 doses

- Day 1 doses can be estimated based on the most recent chronic opioid daily dosage:
  - 50-100 morphine equivalent (ME) mg/day: Estimated day 1 target is 4-8 mg of buprenorphine, divided into a max of four doses (2mg for dose 1, 2, 3, and 4). Doses 2-4 are optional and based on how the patient is feeling.
  - 100-150 morphine equivalent (ME) mg/day: Estimated day 1 target is 8-10 mg of buprenorphine, divided into a max of four doses (2-4 mg for dose 1, 2 mg for any subsequent doses). Doses 2-4 are optional and based on how the patient is feeling.
  - > 150 ME mg/day: Estimated day 1 target is 10-12 mg of buprenorphine, divided into a max of four doses (4 mg for dose 1 and dose 2, 2 mg for any subsequent doses). Doses 2-4 are optional and based on how the patient is feeling.

Day 1 target standard induction:

50-100 MME → 4-8mg
100-150 MME → 8-10mg
>150 MME → 10-12mg

Low Dose Conversion

- Regardless of baseline dose full-agonist dose, the starting dose of buprenorphine should be 1mg on day 1, usually divided as 0.5mg BID*. As illustrated in the example below, buprenorphine/naloxone doses increase in a step wise fashion over 4-5 days. The target buprenorphine/naloxone dose at which the full agonist will be totally discontinued will vary based on baseline opioid regimen.
  - Baseline opioid regimen < 200mg MEDD: target dose allowing full agonist discontinuation = 2mg TID. (to occur on day 4).
  - Baseline opioid regimen > 200mg MEDD: target dose allowing full agonist discontinuation = 4mg TID (to occur on day 5).

Dose to Discontinue Full Agonist

<200 MME → 6mg
>200 MME → 12mg

Becker et al. JAMA Intern Med 2025;185;(4):372-381

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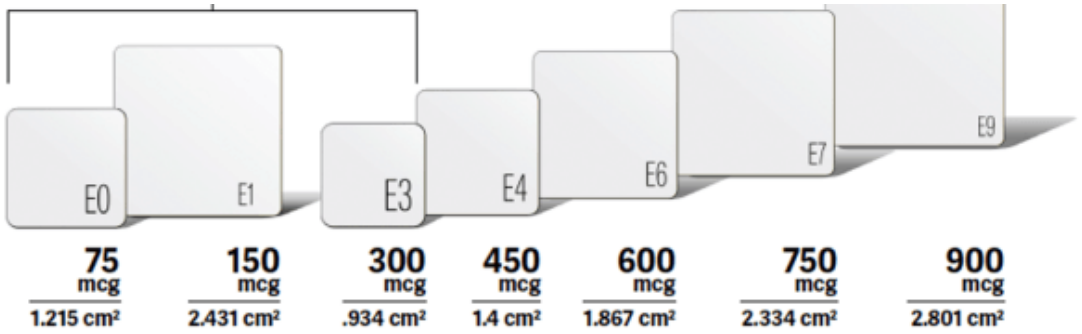
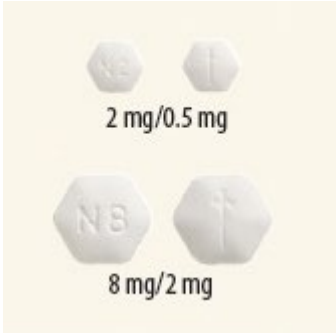
Options for Chronic Pain

Buccal



Transdermal

Sublingual



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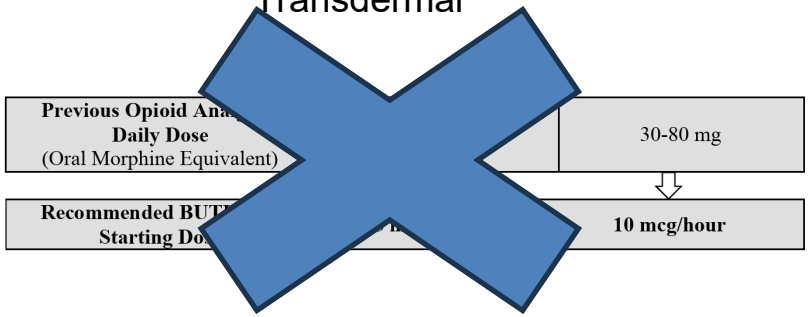
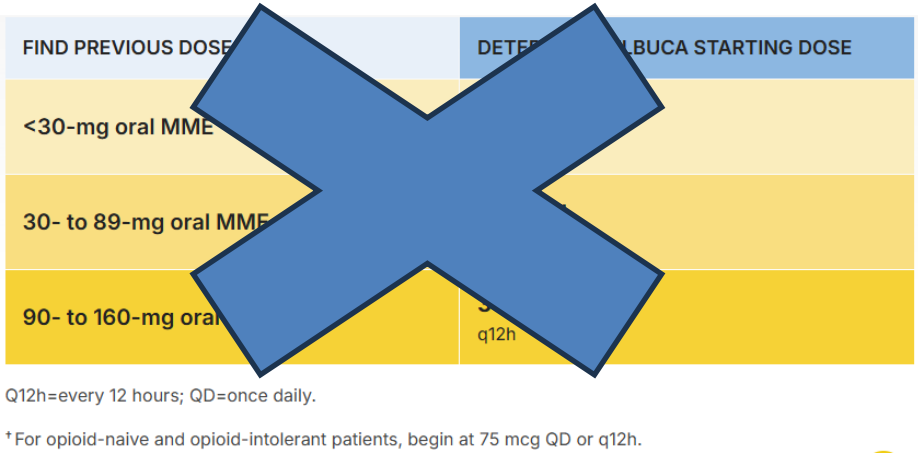
Conversion to Buprenorphine

Transdermal



Buccal



Ok for lower dose opioid conversions, PRN use, opioid naïve new starts

Often underestimate opioid requirement in opioid tolerant patients

Simplified Dosing

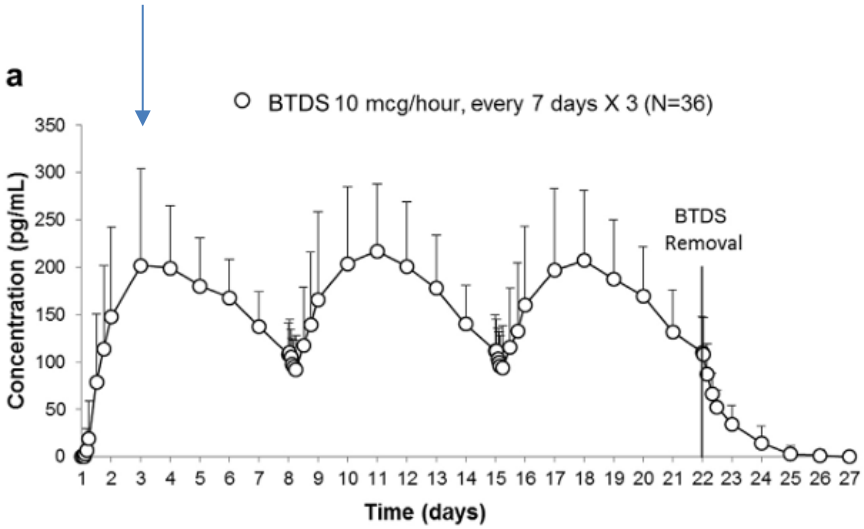
- Initial doses should be ~ 0.5mg SL or equivalent (150-300mcg buccal, 20mcg/hr TDS) with continuation of full agonist
- Target dose ranges by MME
  - ≤ 50MME analgesic products
  - 50-200MME increments of 2mg
  - ≥ 200MME increments of 8mg

Titrate to response/ comfort

* For OUD always target 16mg/day minimum and do not use analgesic products

Pharmacokinetic Product Comparison

T_{max} 72hr



Dose	C_{max} (ng/ml)	T_{max} (hr)
300mcg	0.47	2.5
1200mcg	1.43	3
20 mcg/hr	0.47	72
2mg	0.95	1.72
8mg	3.37	1.53

0.5mg ~ 0.25ng/ml

Kapil RP et al. J of Pain Symptom Management 2013;46:65-72
www.accessdata.fda.gov/drugsatfda_docs/label/2019/207932s012lbl.pdf
www.accessdata.fda.gov/drugsatfda_docs/label/2011/020733s007s008lbl.pdf
www.accessdata.fda.gov/drugsatfda_docs/label/2014/021306s015s019lbl.pdf

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Low Dose Transition in Chronic Pain

Day of Treatment	Dose (mg)	
1	0.5 QD	≤ 50MME
2	0.5 BID	
3	1mg BID	
4	2mg BID	50-200MME
5	4mg BID	
6	8mg +	≥ 200MME or OUD

Continue full agonists until exiting the titration

Standard Induction in Chronic Pain

≤ 50 MME

- start analgesic doses and overlap with PRN of short acting for 7 days

50-200 MME

- onset of withdrawal symptoms start at 2-4mg

≥ 200 MME

- onset of withdrawal symptoms start at 8mg

Examples of Initial Dose Ranges

- Tramadol 50mg BID (20 MME)
  - Low to moderate doses of analgesic products
- Hydrocodone/APAP 10/325 QID (40 MME)
  - Higher doses of analgesic products and maybe low doses of sublingual
- Oxycodone 20mg TID (90 MME)
  - Low to moderate doses of sublingual
- Methadone 30mg TID (~400 MME)
  - High doses of sublingual

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Examples of Initial Dose Ranges

Day of Treatment	Dose (mg)
1	0.5 QD
2	0.5 BID
3	1mg BID
4	2mg BID
5	4mg BID
6	8mg +

Tramadol 50mg BID

Hydrocodone/APAP 10/325 QID

Oxycodone 20mg TID

Methadone 30mg TID

≥ 200MME of OUD

Continue full agonists until exiting the titration then may change to PRN of short acting for first week

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Joanne

Current = 600mg oxycodone (900MME)

Standard Induction?

Low dose transition?

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Finding the Pharmacological Pillow

Continuation

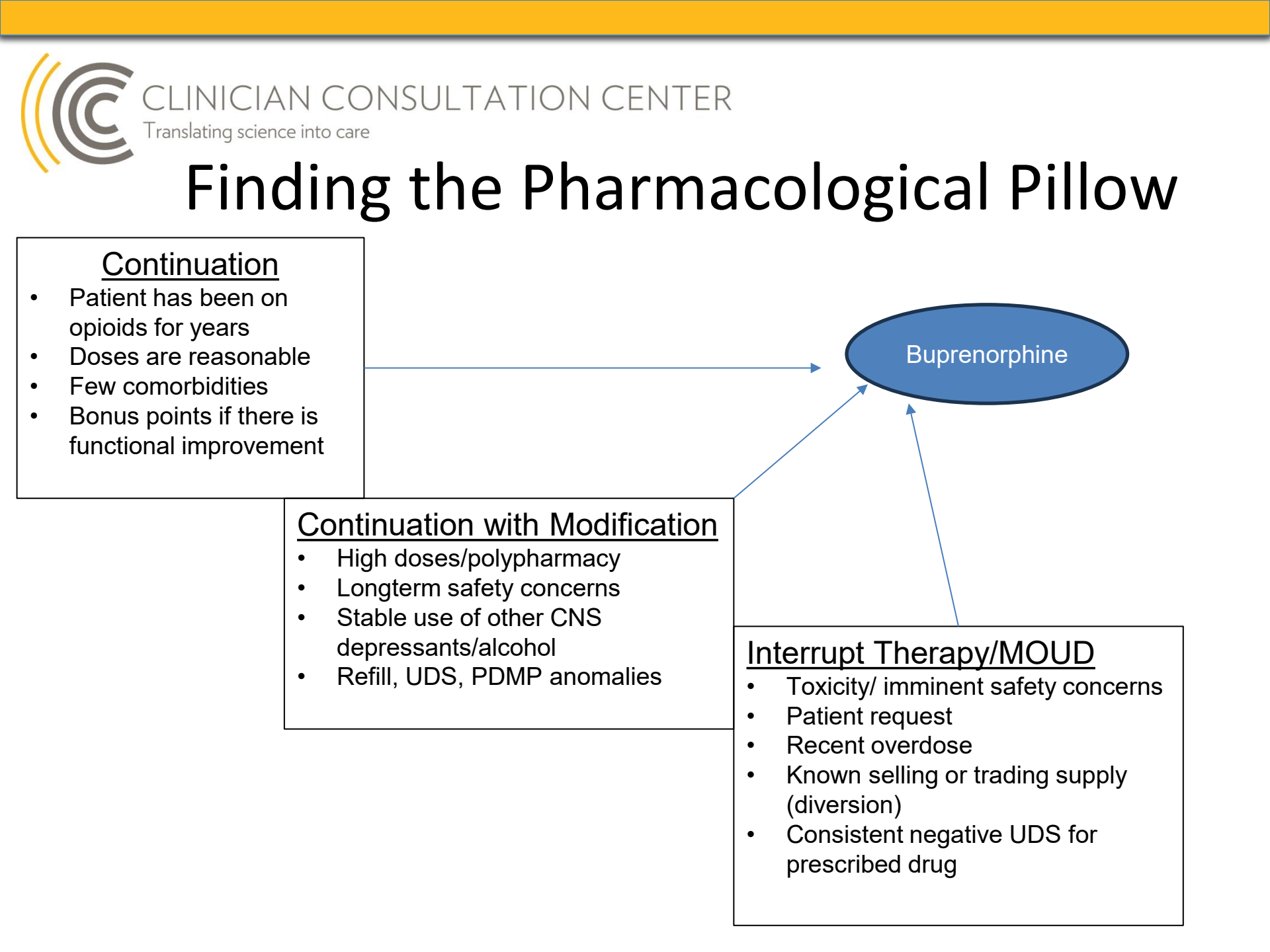
- Patient has been on opioids for years
- Doses are reasonable
- Few comorbidities
- Bonus points if there is functional improvement

Continuation with Modification

- High doses/polypharmacy
- Longterm safety concerns
- Stable use of other CNS depressants/alcohol
- Refill, UDS, PDMP anomalies

Interrupt Therapy/MOUD

- Toxicity/ imminent safety concerns
- Patient request
- Recent overdose
- Known selling or trading supply (diversion)
- Consistent negative UDS for prescribed drug



Continuation Strategies

- Simplify multiple opioids to one
  - Might require initial dose increases to compensate for discontinued products
- Consolidate dosing frequency into ER/LA
- Modest dose decreases are possible over a long period of time (~ 30% after 1 year)
- Allow for pauses and even dose increases along the way

Continuation with Modification

- Shorter days supply
- Dose reduction
- Tapering or discontinuing other high-risk medications
- Treatment of comorbid conditions
  - Medical, psychiatric, SUD

Interrupt Therapy

- Toxicity/overdose- transition to MOUD or rapid taper
- Diversion (not taking)- discontinue, might need to transition to MOUD, consider coercive type diversion

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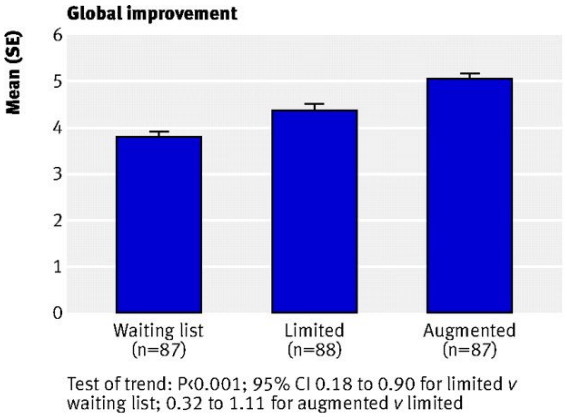
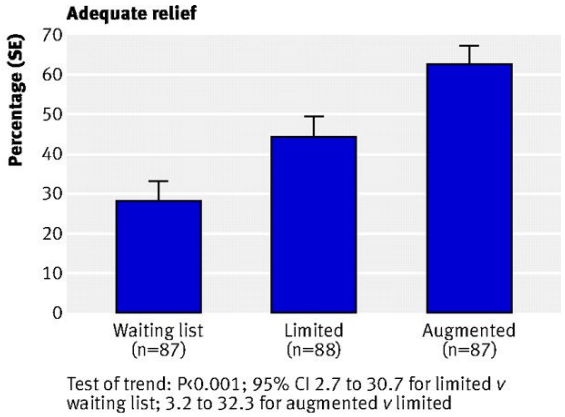
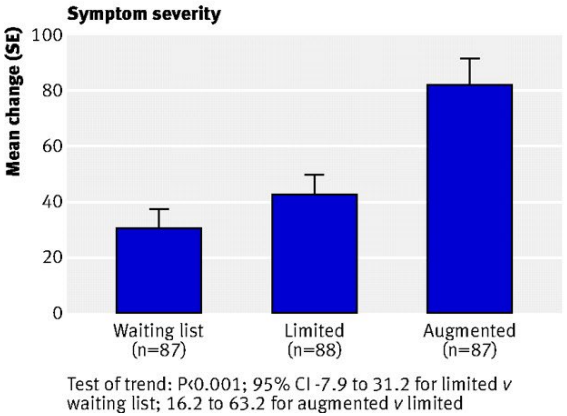
The Patient Experience Matters



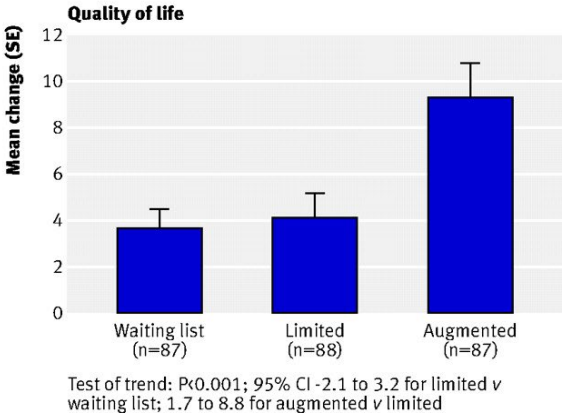
Test of trend: P<0.001; 95% CI 0.18 to 0.90 for limited *v* waiting list; 0.32 to 1.11 for augmented *v* limited



Test of trend: P<0.001; 95% CI 2.7 to 30.7 for limited *v* waiting list; 3.2 to 32.3 for augmented *v* limited



Test of trend: P<0.001; 95% CI -7.9 to 31.2 for limited *v* waiting list; 16.2 to 63.2 for augmented *v* limited



Test of trend: P<0.001; 95% CI -2.1 to 3.2 for limited *v* waiting list; 1.7 to 8.8 for augmented *v* limited

262 Adults with IBS

Waiting list- no intervention

Limited- sham acupuncture

Augmented- sham acupuncture + enhanced patient provider relationship

Kaptchuk TJ et al. BMJ 2008;336:999

The Soft Landing

- Focus on the relationship first
- Maintain access to a safe supply
- Convert to buprenorphine as appropriate
- Treat emergent addiction

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Hepatitis C Warmline	HCV testing, staging, monitoring, treatment
PrEPline	HIV pre-exposure prophylaxis options and monitoring
Perinatal HIV Hotline	Pregnancy, infant feeding and HIV
Substance Use Warmline	Substance use evaluation and management
PEPline	Bloodborne pathogen (HIV, HBV, HCV) exposure management

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