August 17th 2017
11:00 a.m. – 12:00 p.m. (EDT)

Opioids Across the Lifespan

Part 3 of a 3 part series:

Older Adults

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Welcome! The webinar will begin shortly! To hear audio for this event, please turn up your computer speakers. Please note this event will be recorded.

OPIOIDS & BUPRENORPHINE IN OLDER ADULTS

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OBJECTIVES

- Address the implications of opioid use and dependence in older adults
- Identify and manage Opioid Use Disorder in older adults
- Detail buprenorphine indications and initiation

OPIOIDS & OLDER ADULTS

OPIOIDS

- Indications
- Caution
- Follow-up
- Dose

INDICATIONS

- Acute/Sub-acute pain
- Palliative management
- Historical use for chronic pain
- Misuse (independent or related above)

CAUTION

- Alcohol/Benzodiazepenes
- Impairment
- Falls

CAUTION- MANAGING RISK

- Opioids are contraindicated in cognitively impaired patients living alone unless close ongoing supervision
- Assess for falls (Morse Fall Scale, FRIDS, BEERS)
- Benzodiazepines should be tapered before or during opioid initiation
- Education about alcohol and overdose prevention

OPIOID RISK MANAGEMENT

- Risk for abuse should first be screened (Opioid Risk Tool–Fig 1)
- Falls assessment through Morse Fall Scale
  - High Risk 45 and higher
  - Moderate Risk 25-44
  - Low Risk 0-24

ITEM	MARK EACH BOX THAT APPLIES	ITEM SCORE IF FEMALE	ITEM SCORE IF MALE
Family History of Substance Abuse			
Alcohol	[ ]	1	3
Illegal Drugs	[ ]	2	3
Prescription Drugs	[ ]	4	4
Personal History of Substance			
Alcohol	[ ]	3	3
Illegal Drugs	[ ]	4	4
Prescription Drugs	[ ]	5	5
Age (mark box if 16–45)	[ ]	1	1
History of Preadolescent Sexual Abuse	[ ]	3	0
Psychological Disease Attention Deficit Disorder, Obsessive-Compulsive Disorder, or Bipolar, Schizophrenia	[ ]	2	2
Depression	[ ]	1	1
TOTAL			
Total Score Risk Category **Low Risk:** 0 to 3 **Moderate Risk:** 4 to 7 **High Risk:** 8 and above			

DOSE

Guidelines Transition

- Previous "Watchful dose" = 200 mg MED (Morphine Equivalents per Day); doses above 120 mg strongly associated with increased risk of overdose.
- CMAJ 2017 guidelines list "Watchful Dose" at 90 mg with recommendation for 50 mg MED
- COPA Pocket Guide 2014- "Watchful dose" = 60-120 mg MED for elderly based on old Guidelines
  - = 40 mg oxycodone, 240 mg codeine, 12 mg hydromorphone).

* **Consider BU-TRANS IN THOSE WHO ARE OPIOID NAIVE**

INDICATIONS FOR TAPERING

- Persistent severe pain and pain related disability despite no recent injuries after a reasonable was already achieved (eg 60 MED)
  - Represents possible opioid hyperalgesia
  - Tapering has been shown to improve **mood, pain, function**
- **Patient has a complication of opioid therapy:**
  - Sleep apnea, sedation, fatigue, dysphoria
  - **Addiction- OPIOID USE DISORDER?**

ADDICTION/DEPENDENCE (OPIOIDS)

CASE: ARTHUR

- Arthur is a 60-year old part-time bookkeeper living alone in a 3rd floor apartment
- His use of prescription opiates first started after experiencing pain secondary to gallstones 10 years ago. A cholecystectomy has been recommended but Arthur has feared taking time off work without pay.
- The intermittent episodes led to the use of hydromorphone as prescribed by his gastroenterologist at the outset. His use gradually escalated.
- His family MD retired a few years ago and he sees different walk-in doctors.

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CASE: ARTHUR (CONT'D)

- He admits to use of 5 tabs of 12 mg hydromorph contin daily now and has been using regular hydromorphone for the last 5 years.
- He first started using in response to related abdominal pain but now uses regularly in the morning before going to work in anticipation of pain and to prevent withdrawal.
- A taper has been suggested to him and he refuses as the thought of being without makes him quite anxious
- He has used diazepam through a friend between 3-5 tabs per day (10 mg diazepam) most days per week.

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OPIOID USE DISORDER DSM V CRITERIA- IS ARTHUR ADDICTED?

- Continuing to use opioids despite negative personal consequences
- Repeatedly unable to carry out major obligations due to use
- Recurrent use of opioids in physically hazardous situations
- Continued use despite persistent/recurring social or interpersonal problems Tolerance
- Characteristic Tolerance/Withdrawal or the substance is used to avoid withdrawal (NOT APPLICABLE IN THE CONTEXT OF MEDICALLY SUPERVISED PAIN MANAGEMENT)
- Persistent desire or unsuccessful efforts to control/cut down
- Spending a lot of time obtaining, using, or recovering from using opioids
- Using greater amounts or using over a longer time period than intended
- Stopping or reducing important activities due to opioid use
- Consistent use despite acknowledgment of difficulties from using opioids
- ***Craving or a strong desire to use opioids (New criterion added)***
- ***Tolerance and withdrawal secondary to pain-induced dose dependence is exempted in DSM-V***

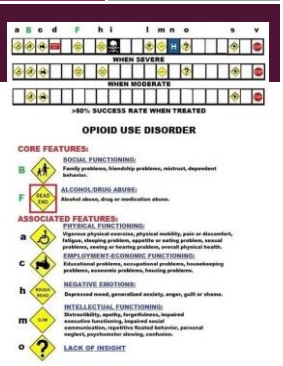
OPIOID USE DISORDER (DSM V)

Very similar to those outlined in DSM-IV for abuse and dependence combined

- meeting 2-3 of the criteria indicates Mild substance use disorder
- meeting 4-5 of the criteria indicates Moderate
- meeting 6-7 of the criteria indicates Severe (Generally regarded as Addiction)

CRITERIA IN PRACTICE

- Patient's opioid dose high for underlying pain condition
- Inconsistent analgesic response (e.g. 'pain is 10/10, opioids only take edge off, but I would die if I don't have my pills')
- Strong resistance to tapering or switching current opioid
- Depressed and anxious when running out
- May acknowledge that opioids improve mood, relieve anxiety, improve mobility by increasing energy



MANAGEMENT OF OPIOID USE DISORDER

- Get an Addictions Assessment
- Call ACCESS-CAMH- 416 535 8501 option 2

MANAGEMENT OF OPIOID USE DISORDER

- Abstinence
- Withdrawal Management
- Buprenorphine

ABSTINENCE

- Taper opioids with sufficient support and pain management alternatives
- … Often doesn't work
- Elderly patients can experience prolonged subacute withdrawal symptoms and de-stabilization of medical comorbidities
  - Anxiety, depression, fatigue
  - Insomnia
  - Cravings

OPIOID WITHDRAWAL

- Begins day 1-2, Peaks day 3-5 and can last for weeks in the form of subacute withdrawal
- **Opioid withdrawal that de-stabilizes other medical conditions can be threatening and inpatient withdrawal management should be a major consideration for older adults**
- Acute Signs and Symptoms
  - Nausea, vomiting, diarrhea, ataxia
  - anxiety, dysphoria, insomnia, cognitive dysfunction

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OPIOID WITHDRAWAL (CONT'D)

Buprenorphine Taper

- Partial Agonist
- Very slow release from brain
- Superior to other medications in treating withdrawal
- Less likely to relapse if medication stopped gradually over weeks rather than days
- However relapse rates remain high over longer time periods

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OPIOID AGONIST THERAPY

- Methadone and Buprenorphine/Naloxone (Suboxone) are both legitimate agonist treatments for opioid dependence
- Indications differ based on age, QT eligibility, length of addictions history (relative) and cost

CASE: INGRID

- Ingrid is a 70-year old woman with Ontario Drug Benefit (ODB) living on ODSP in Rice Lake with a past history of use of alcohol, crack, marijuana, IV heroin.
- She has a PTSD diagnosis from previous assault in her adolescence and 20's and her previous Methadone history coincides with her initial PTSD experience.
- She uses Oxycodone IR for migraines and running out of her oxycodone early, crushing her pills and often appearing intoxicated to her PSW
- Walker for mobility (Bilat Hip OA & Lumbar spondylolithesis) and receives PSW support for 1 hr per day.

CASE: INGRID (CONT'D)

- Ingrid's PTSD has been managed by her psychiatrist with a combination of anti-depressant and anxiolytics. Despite different anti-psychotic trials, her most effective management appears to involve a twice daily clonazepam regimen that she has had for years.
- She was previously on Methadone but finds the initiation arduous because of the burden of daily observed doses in the first 2 months. She lives a distance from the closest methadone pharmacy and fears difficulty with using wheel-trans for this.
  1. What could be encouraging for BMT use as an option?

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BUPRENORPHINE MAINTENANCE TX (BMT) INDICATIONS

- Buprenorphine is a safer maintenance drug than methadone in the elderly. (Kahan et al., Opioid Fact Sheet 2014)
- Indications include high risk for methadone toxicity because of
  - Elderly
  - Benzodiazepine use
- Buprenorphine may be prescribed by primary care practitioners without a methadone exemption, although training is recommended. Most provincial drug plans only cover Suboxone when it is prescribed by a physician with a methadone exemption.
- *CAMH is offering "Buprenorphine-assisted treatment of opioid dependence: An online course for front line clinicians". Clinicians can register to the course online by following:*

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http://www.camh.ca/en/education/about/AZCourses/Pages/BUP.aspx

BMT INDICATIONS

- Higher risk of overdose (especially at initiation)
- Acquires opioids from multiple sources – other doctors, friends and relatives, the street
- Currently misusing alcohol or other sedating drugs
- Injecting or crushing oral tablets

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DOSING

- Minimum 6+ hrs abstinence; recommended 12+ hrs
- No sedatives during that time
- 2-4 mg first day; max 8-12 mg
- Return 1-3 d for further increase

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DOSING/TAKE HOMES

- Median dose = 12-16 mg
- Max dose = 24 mg in Canada
- Can provide take home doses on weekends & holidays within 2 months
- Gradual take home doses recommended; not mandated
- *Urine Drug Screens integral

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BMT FLEXIBILITY- MISSED DOSES

- Opportunity for carries early in the initiation period. Beyond level 2 carries in areas of greater clinical stability
- Can resume similar dosing after missed doses on 5 consecutive days. (See table 2). Safety with overdose

Buprenorphine Dose	Number of Consecutive Days Missed	New Starting Dose
> 8 mg	>7 days	4 mg
> 8 mg	6-7 days	8 mg
6-8 mg	6 or more days	4 mg
2-4 mg	6 or more days	2-4 mg

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CASE 4: INGRID (CONT'D)

- Ingrid reports notable improvement on suboxone after 6 weeks
- It is still quite difficult getting out to the pharmacy even with less days observed than methadone in the early going
- **Home delivery system? Community nursing support? Previous example of CCAC from 2015**

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MANAGEMENT

- Bowmanville Complex Pain & Addiction Service
  - 222 King St, Bowmanville Family Health Organization
  - **Physician or Self referral for Addictions only**
  - **Physician Referral for Pain AND Addictions**
- CAMH Pain and Chemical Dependency Service (iPARC)
- CAMH Addiction Medicine Service (AMS)
- **Access CAMH contact** (416) 535-8501, press 2
- **Fax referrals to Access CAMH:** 416-979-6815.