

RECOMMENDATIONS TO PHYSICIANS CARING FOR KATRINA/RITA DISASTER VICTIMS ON CHRONIC OPIOIDS

[from a work group of the American Academy of Pain Medicine, National Pain Foundation, American Pain Foundation, and National Hospice and Palliative Care Organization]

These general recommendations are intended as an overview for relief physicians encountering patients taking prescription opioids for relief of chronic pain. Ultimately the decision on how to care for a patient on opioids must be made by a treating physician in light of the patient's condition in the exercise of the physician's best medical judgment.

1. General Considerations

- No recommendations can anticipate all patient responses to medications
- Believe the patient when they complain of pain
- Provide care while minimizing risk of abuse and diversion as much as possible
 - Do not withhold care solely due to unproven suspicions
 - it may be reasonable to reduce the amount of opioid that is dispensed and to shorten time between clinical visits and increase follow-up frequency
- In emergency or disaster situations, care may focus on
 - Maintaining analgesia when necessary
 - Meeting needs for short term continuation of opioids or offering humane tapering to avoid withdrawal syndrome
 - Taking initial steps toward re-establishing long term care
 - Avoiding or treating withdrawal (see withdrawal advice document)

2. Evaluating a person who claims to be using opioids for chronic pain but has only partial or no documentation:

- Attempt to see old medication prescription bottles/boxes etc (check dates closely)
- Call dispensing pharmacies if possible (some may not be re-opened)
- Document that efforts were made to determine adequate documentation even if unsuccessful
- In the setting of a national disaster – err on the side of believing the patient.
 - Providing opioids for a few days while seeking documentation will not cause addiction and is far less likely to harm the patient than withholding opioids.
 - Withholding opioids in persons with chronic pain will precipitate withdrawal, worsen pain and pain-related distress and increase unnecessary burden on the health care system.

3. Tapering a patient off chronic or high doses of opioids:

- Unless familiar with converting patients on established opioid doses to methadone, avoid methadone as it may pose difficulties in dosing and increase the risk of toxicity
- The use of short acting opioids (hydrocodone, oxycodone, immediate release morphine etc) may be acceptable
 - If possible use short acting opioids without acetaminophen
- The use of tapering doses of long-acting opioids (sustained release morphine, oxycodone or transdermal fentanyl) may be effective but may pose increased risk from increased duration of blood concentrations or accumulation
- Safe tapering may follow several general paths (2 to 3 week tapering regimen should be adequate in most cases)
 - Reduce the each daily dose by 10%
 - Reduce the dose by 20% every 3-5 days
 - Reduce the dose by 25% per week
 - Avoid reducing the daily dose by > 50% at any given interval

4. Continuing opioid prescribing:

- With initiation, titration, and rotation of all opioids, the individual patient's clinical response must guide therapy
- When the drug reported to be used by the patient is acceptable and available:
 - If the patient seems reliable, replace the previous drug with reduced dosage
 - With same drug (such as any of the long-acting opioids)
 - Usually reduce previous dose by 25-50% (give 50-75% of the previous dose)
 - Dispensing small volumes with frequent follow-up may be appropriate
 - If the reported drug and dose is correct, expect the need for an increase in dose
 - If the reported dose is greater than the actual dose, side effects may present (sedation, respiratory depression etc)
 - This represents possible opioid overdose and the patient needs to be observed
- When the drug reported to be used by the patient is not acceptable or available
 - If the patient seems reliable, replace previous drug with reduced dosage
 - With alternative drug (such as a short-acting opioid) use equi-analgesic tables to guide starting doses
 - Usually reduce previous dose by 25-50% (give 50-75% of the previous dose)
 - Dispensing small volumes with frequent follow-up may be appropriate
 - If the reported drug and dose is correct, expect the need for an increase in dose
 - If the reported drug and dose is NOT correct, side effects may present (sedation, respiratory depression etc)
 - This represents possible opioid overdose and patient needs to be observed
 - Equianalgesic prescribing
 - Use guides to equianalgesic dosing such as the Philadelphia VA guidelines
 - Methadone may present special concerns and avoiding its use may be warranted if not familiar with using methadone in chronic pain
 - The VA has a special protocol for methadone prescribing because of safety concerns
- When the physician is only comfortable prescribing a short acting opioid:
 - A short-acting opioid may be used to continue chronic therapeutic dosing or for tapering
 - Some cases may be best handled by dispensing small amounts to cover 1-2 days with frequent f/u and increase dispensing volume and decreasing follow-up frequency as time and trust increase
 - Many short-acting opioids contain acetaminophen or NSAIDs
 - These pose significant risk of toxicity from non-opioid components
 - Do not exceed recommended daily dosages for acetaminophen or NSAIDs
 - May change to pure oxycodone or hydrocodone compounds with reduced acetaminophen levels (i.e. Norco)
 - Alcohol and acetaminophen greater than 4 grams/day can result in significant liver toxicity

5. Patients with a spinal pump delivering opioids or other drugs directly into the spinal fluid

- These patients may be at significant risk of withdrawal, including life threatening consequences (particularly with medications such as baclofen or clonidine)
- These patients need attention from a specialist familiar with filling and running these pumps (usually a pain specialist)
- Pumps on the verge of running out or that have run out may make a beeping sound (not all pumps have audible alarms)
- If a specialist is not available, patients may be temporized with oral medications delivered in a similar fashion to those described above. Medications may be given until the spinal pump can be refilled or may be used for humane tapering and avoidance of withdrawal syndrome. Examples include:
 - Spinal opioid (morphine, dilaudid, fentanyl) – prescribe systemic opioid
 - Spinal baclofen – prescribe oral baclofen
 - Spinal clonidine – prescribe oral clonidine or clonidine patch