MASTERING PAIN MANAGEMENT SKILLS:

Safe Opioid Use Amid Opioid Phobia

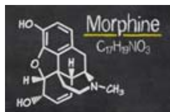
September 22, 2016

Pathways to Success Webinar Series

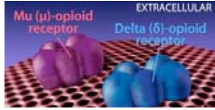
Learning Objectives:

- Describe a proper opioid titration
- Find an opioid equivalency dose using an opioid equivalency chart
- Calculate an appropriate breakthrough dose (BTD) for a patient on a long-acting opioid (LA)
- List 3 situations when an opioid rotation may be indicated.
- Use the Pasero Opioid Sedation Scale (POSS)
- Name 2 safety strategies for seniors on opioids.

Morphine: THE GOLD STANDARD of OPIOIDS



Opioids



Opioids bind to opioid receptors

- μ Mu
- δ Delta
- κ Kappa

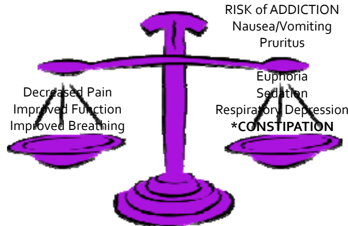
* Multiple subtypes

Indications for Opioids in Hospice

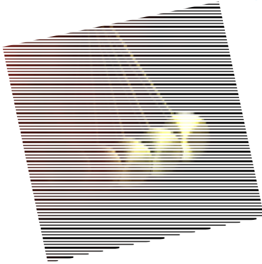
ANALGESIA

TREATMENT OF DYPSNEA

Balancing Benefits & Burdens of Using Opioids



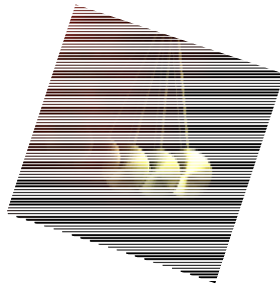
A Swinging Pendulum



- 1990's Pain Epidemic secondary under treatment of Pain
- Increase in opioid RXs
- Increase in opioid related deaths (illegal use of substances & patient overdoses)

2016

- Decrease access to opioids for some pain patients
- Some states are placing limits on daily amounts of MS that physicians can prescribe for a patient mg/day
- Get a "pass card" for cancer patients, palliative care and hospice patients.



Opioid Phobia ?

Opioid Phobia ?

Patients/Families

- "Don't want momma to get addicted."
- Opioids will cause me to stop breathing
- "They went to hospice. Got morphine and then died!"

Opioid Phobia ?

Medical Community

- "I don't want to be the Candy Doctor."
- Fear of scrutiny
- Fear of loosing medical license
- Fear of having a patient die from an overdose a Rx written by them
- Lawsuit

Opioid **Phobia ?** OR Opioid **Fear?**

Fear

- Response to a real or perceived threat.
- Reaction to objects or events
- Experience mild to moderate anxiety

Phobia

- Similar to fear BUT anxiety is severe

Opioid Phobia ? **OR** Opioid Fear?

Fear

REAL PROBLEMS:

- Misuse of Opioids
- Abuse
- Addiction Rates higher than once taught.

How do we ensure safe use of opioids?

KNOW OUR STUFF / SKILLS to MASTER in Pain Management

- Find appropriate starting dose
- Recognize the potency of the opioid compared to morphine
- Calculate breakthrough dose when using a ER/LA (extended release/long-acting) opioid or when giving fixed IR/SA (immediate release/short-acting) opioid ATC (around the clock)
- Titrate an opioid (when & how)
- Recognize 3 situations where opioid rotation is needed
- Assess levels of sedation secondary to opioid use
- Practice safety protocols with seniors.

Find Starting Dose

- **LOOK IT UP!**
- <u>**Start with a conservative dose**</u> (You can always go up if needed.)
- ALWAYS, ALWAYS start with an immediate release/short-acting (IR/SA) opioids

Find Starting Dose

- REDUCE recommended adult starting dose 25-50% elderly & titrate based on patient response
- Titrate according to patient response
- May consider ER/LA opioid formulation after steady-state is reached (24 hours for most oral opioids)

Read Opioid Equivalency Chart

Drug	Parenteral Dose (mg)	Oral Dose (mg)	Duration (hours)
Morphine IR	10	30	3-4
Morphine Controlled Release (MSContin, Oramorph SR)	–	30	8-12
Hydromorphone (Dilaudid)	1.5	7.5	3-4
Codeine (Very limited use)	130	200	3-4
Oxycodone (controlled release = OxyContin)	–	20-30	12
Oxycodone immediate release (Percocet, Tylox, Oxy IR, Roxicodone)	–	20-30	3-4
Hydrocodone (Lortab, Vicodin, Norco)	–	30	3-4
Meperidine (Demerol) (Not for long term use)	100	300+	2-3
Levorphanol (Levo-dromoran)	2	4	6-8
Methadone (Use with great caution)	10 acute 2-4 chronic	20 acute 2-4 chronic	6-8
Fentanyl*	0.1	Transdermal patch	48-72

Miss Mary: Recognizing opioid potency

- Admissions Nurse: "Miss Mary. How much opioid pain medicine are you taking?"
- Miss Mary: "I'm just taking a little bit… 2mg."
- Admissions Nurse: "What's the name of the pain medication? May I see the bottle please?"
- Miss Mary hands the nurse a bottle of hydromorphone (dilaudid) 2mg tablets

Miss Mary: Recognizing opioid potency

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- Admission Nurse: "Miss Mary, did you know that 2 mg of your hydromorphone is equal to ___mg of MS?"
- $\frac{7.5 \text{ mg hydromorphone}}{30 \text{ mg MS}} = \frac{2 \text{ mg hydromorphone}}{x}$
- $x = \frac{2 \text{ mg hydromorphone} \times 30 \text{ mg MS}}{7.5 \text{ mg hydromorphone}}$
- x = 8 mg MS

Miss Mary: Recognizing opioid potency

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- Admission Nurse: "Miss Mary, did you know that 2 mg of your hydromorphone is equal to 8 mg of MS?"
- Miss Mary: "Whoa… well I'll be. I didn't know that."

Equivalency of Transdermal Fentanyl (TDF) patch to morphine

- TDF patch dosed in mcg/hr. NOT mg
- TDF patch is approximately 50% of total daily dose of morphine.

  E.g. 25mcg/hr. patch × 2 ≈ 50 mg of morphine over 24 hours

- Rotation to TDF patch: divide total daily dose (TDD) of oral morphine by two

  E.g. Patient taking TDD 100 mg morphine ÷ 2 = 50 mcg/hr. TDF patch.

Equivalency of Transdermal Fentanyl (TDF) patch to morphine

Titrating TDF upward

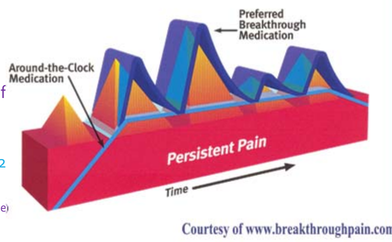
- *After initiation of TDF therapy, evaluate use of rescue opioid on days 2 and 3. If patient using more than three doses of rescue opioid, calculate TDD of rescue opioid, and increase TDF patch strength in an equivalent amount.*
- *Increase by 25-50 mcg/h, but not to exceed a 100% increase Also, no dosage increase should exceed 50 mcg/h*
- *Increase from 25 mcg/h to 50 mcg/h*
- *For patients on 50 mcg/h or higher, increase by 50 mcg/h*

McPherson, M.L. (2010). *Demystifying Opioid Conversion Calculations a Guide for Effective Dosing.* p. 102.Bethesda, MD: American Society of Health-System Pharmacists. Used with permission from publisher for educational purposes.

Calculate BTD (breakthrough dose)

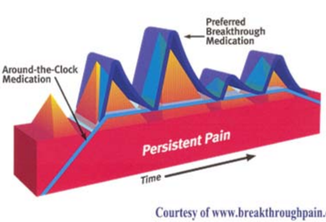
- BTD should be available for BTP (breakthrough pain) when persistent pain is controlled
- BTD needs to be **10 – 15 %** of the total daily dose of opioid controlling baseline pain*
- BTD should be ordered q1 or q2 hours.

*Oral BTD (IV BTD is 50% - 100% of hourly rate)



Courtesy of www.breakthroughpain.com

Calculate BTD (breakthrough dose)



Courtesy of www.breakthroughpain.com

Types of BTP

1. Spontaneous
2. Incident pain -volitional pain
3. Incident pain- non-volitional
4. End-of-dose pain

*Debate: ER/LA formulations more effective for chronic pain

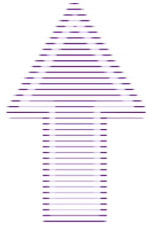
ER/LA Opioids

- ER/LA opioids avoid the peaks and troughs in pain control
- Avoid watching the clock
- QOL advantage: improved quality of sleep

IR/SA

- NO difference in outcome measures (pain intensity and stability) when given on fixed schedule
- NO difference in QOL and depression
- Concerns about misuse. Safer?

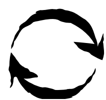
Titrate opioids to patient response



- More than three BTDs are used in 24 hrs.

OR

- Total dose of SA opioid (immediate-release) is more than 50% of the LA dose

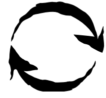


Rotate opioids

Switching to an equianalgesic dose of another opioid

Consider a rotation when patient experiences:

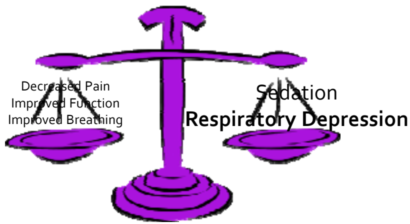
- Inadequate pain relief
- Unacceptable side effects from specific opioid that limits dose escalation (e.g. myoclonus from morphine metabolite build up of M3G)
- Drug shortage



Rotate opioids

- Take into consideration *incomplete cross-tolerance*.
- Find opioid equivalent dose for new opioid
- Reduce the new opioid dose 25 – 50 % and titration dose according to patient response.
- IF you switched opioid because pain was poorly controlled on the original opioid, you may consider using the calculated dose of the new opioid without a reduction.

Assess sedation levels



Sedation precedes respiratory sedation

Assess Sedation levels/ Pasero Opioid Sedation Scale **(POSS)**

S = Sleep, easy to arouse
Acceptable; no action necessary; may increase opioid if necessary.
1 = Awake and alert
Acceptable; no action necessary; may increase opioid if necessary.
2 = Slightly drowsy, easily aroused
Acceptable; no action necessary; may increase opioid if necessary.
3 = Frequently drowsy, arousable, drifts off to sleep during conversation
Unacceptable; monitor resp. status & sedation level. Decrease opioid dose 25-50% or notify provider for orders. Ask pt. to take deep breathes every 15 to 30 minutes
4 = Somnolent, minimal or no response to verbal and physical stimulation
Unacceptable; STOP opioid; consider administering naloxone; call a code if indicated by pt. status; support respirations; notify provider; monitor respiratory status & sedation level.

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POSS

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STOP opioid; consider admin. Naloxone. Call Code if indicated by pt. status; notify provider. Monitor resp. status & sedation level.

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Safety protocols with seniors

- Lower the starting opioid dose for seniors (>70 years) by 25 – 50 % recommended adult dose
- "Start low, Go slow."
- Consider a longer interval between opioid doses (kidney function decreases with age slowing the elimination of opioids)

Mastering Pain Management Skills: Safe opioid use amid opioid phobia

- Maybe NOT *phobia* after all. Maybe *fear* is better term.
- Pain Management Skills Needed
  - **Find** starting dose
  - **Read** an opioid equivalency chart
  - **Calculate** BTD when patient taking ATC fixed dosages of opioids ER/LA or IR/SA
  - **Titrate** an opioid
  - **Rotate** opioids
  - **Assess** opioid-induced sedation
- Safe practices for seniors

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