On the Job. The Tough Task of Tapering Prescription Drugs

By Mark Pew

The prescription drug overutilization problem in workers' compensation has prompted claims payers to try to reduce the amount of opioids and other drugs. Many companies analyze claims portfolios to identify high-risk cases and intervene in a variety of ways to persuade (or compel) treating physicians to change drug regimens to be more clinically appropriate.

However, the physicians who prescribe the painkillers, tranquilizers, and muscle relaxants often do not want to manage the tapering process. Let's consider why.

They Don't Know Pain

Most physicians lack formal training in pain and pain management, including prescription drug options. According to a Journal of Pain study of 117 U.S. and Canadian medical schools, only three of 104 U.S medical schools (3.8 percent) had a required course in pain. An additional 16.3 percent offered a designated pain elective; less than half of those offered more than one. The study indicated a large number of U.S. medical schools offer no pain management courses, and an equally large number devote less than five hours to the topic. If medical students do not receive much education on pain, how can they be expected to understand the best methods for managing it?

Once in practice, physicians simply do not have time to keep up with the new drugs coming into the market. Specialists tend to understand "their" drugs. For example, cardiologists know blood thinners and arrhythmia medications. General practitioners and internal medicine physicians, however, deal with a wide variety of health issues, making it virtually impossible for them to review every publication or clinical study on every new drug. Because many injured workers with chronic pain do not see pain specialists, their prescribers often are undereducated about pain medications and other treatment options.

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Limited Information

Drug treatment guidelines provide limited information about how to taper prescription drugs. The Official Disability Guidelines (ODG), which have been adopted by many workers' compensation jurisdictions, discuss steps to take before beginning opioid therapy, including how to initiate therapy, when to discontinue/continue opioids, and methods for monitoring aberrant behaviors. In addition, ODG also offers information on tapering for individual drug classifications, as well as options for managing withdrawal symptoms.

While the ODG information is helpful, it tends to view tapering on an individual drug classification-basis. Patients do not use opioids in a vacuum. Instead, they typically take multiple or redundant drugs, a condition called polypharmacy. PRIUM's 2013 analysis of more than 5,500 workers' compensation claims with a date of injury of at least one year found an average of 6.38 drugs per person.

Polypharmacy often arises from using one drug to counter the side effects of another. For example, opioids can cause constipation, requiring stool softeners. In addition, patients'

symptoms can prompt physicians to add other analgesics, tranquilizers, sleep aids, and muscle relaxants.

Despite the prevalence of polypharmacy, few guidelines provide protocols for multidrug tapering. Synthesizing available information into actionable steps can be tedious and time consuming. For example, the manufacturer of Lyrica has published tapering guidelines when used for seizure therapy but has offered no guidelines when Lyrica is used for chronic pain.

Complex and Potentially Risky

Tapering several drugs in multiple drug classifications is complicated because they each might require different tapering protocols. Decisions need to be made about what medication should be reduced first, how it should be reduced, and how reducing one drug affects the body and the remainder of the drugs. If not done properly, the patient can suffer significant symptoms, including tachycardia, fever, and dehydration.

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Comorbidities (hypertension, diabetes, smoking, obesity, depression) that frequently coexist with chronic pain increase the tapering complexity. In addition, physical and/or psychological dependence and addiction or abuse behaviors add to the challenges. No wonder that many physicians do not feel qualified to manage the tapering process.

Psychosocial Elements

Psychosocial issues also can impact chronic pain patients. Catastrophic thinking, fear avoidance, perceived injustice, and childhood abuse can affect a patient's ability to cope with chronic pain, as can the patient's social environment, such as family and socioeconomic circumstances. Physicians often feel poorly equipped to address the psychosocial aspect of pain, but if these issues are not addressed, patients may return to familiar coping mechanisms, including drugs.

Many injured workers suffer from real pain, even if it is medically unexplained. Through cognitive behavioral therapy, they can learn to accept the presence of pain and apply nonpharmaceutical pain management techniques. Physical therapy can help build endurance, improve mobility, and reduce musculoskeletal pain. Innovative clinics feature yoga and biofeedback for pain management, as well as vocational rehabilitation to help them return to work in some fashion.

Clearly, more research and consensus on tapering needs to occur—but who will pay for it? The pharmaceutical companies aren't volunteering. It will take industrywide cooperation to better define and document weaning processes for various drugs alone and in conjunction with other drugs. CM

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