

*Opioid Agonist Therapy 101:  
An Introduction to Clinical Practice Workshop*

**Polypharmacy and OTC medication use  
in the context of opioid agonist therapy**

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# Disclosure of Commercial Support

- ▶ This program has received financial support from *The College of Physicians and Surgeons of Manitoba* in the form of *funding for payment of presenters and organizers*.
- ▶ This program has received in-kind support from *The College of Physicians and Surgeons of Manitoba* in the form of *logistical support*.
- ▶ Potential for conflict(s) of interest:
  - ▶ None identified

# Faculty/Presenter Disclosure

- ▶ **Faculty:** Marina Reinecke
- ▶ **Relationships with commercial interests:** None

# Learning Objectives

- **At the conclusion of this activity, participants will be able to:**
- Propose how lessons learned from Manitoba's provincial death data should transform local OAT prescribing and dispensing practices.
- Investigate the role that polypharmacy plays in morbidity and mortality in the context of poor prescribing practices.
- Recognize that certain combinations of prescription medications significantly increases overdose risk in OAT patients.
- Propose an approach to managing polypharmacy and concurrent over-the-counter medication use in OAT patients who are at risk for multidrug toxicity.

# Glen

- ▶ Glen; 42 years old
- ▶ Working full time as a project manager for a construction company.
- ▶ History of hypertension, GERD, cigarette smoker and prescription drug abuse since his 20's. Non Drinker.
- ▶ Diagnosed with OUD and started on methadone 8 days ago.
- ▶ Known to have had an argument with his common law partner the night before..
- ▶ Found unresponsive face up on his bed the following morning.
- ▶ No threats of suicide or suicide note

# Case discussion - Glen

- DPIN:
- Methadone 20mgs per day for 5 days, then 30mgs per day for 3 days; no missed doses; last dose taken day he died; all witnessed
- Alprazolam 0.5mg 90 tabs q 30 days; last filled on day 2 of methadone induction
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- Enalapril, HCTz, and omeprazole

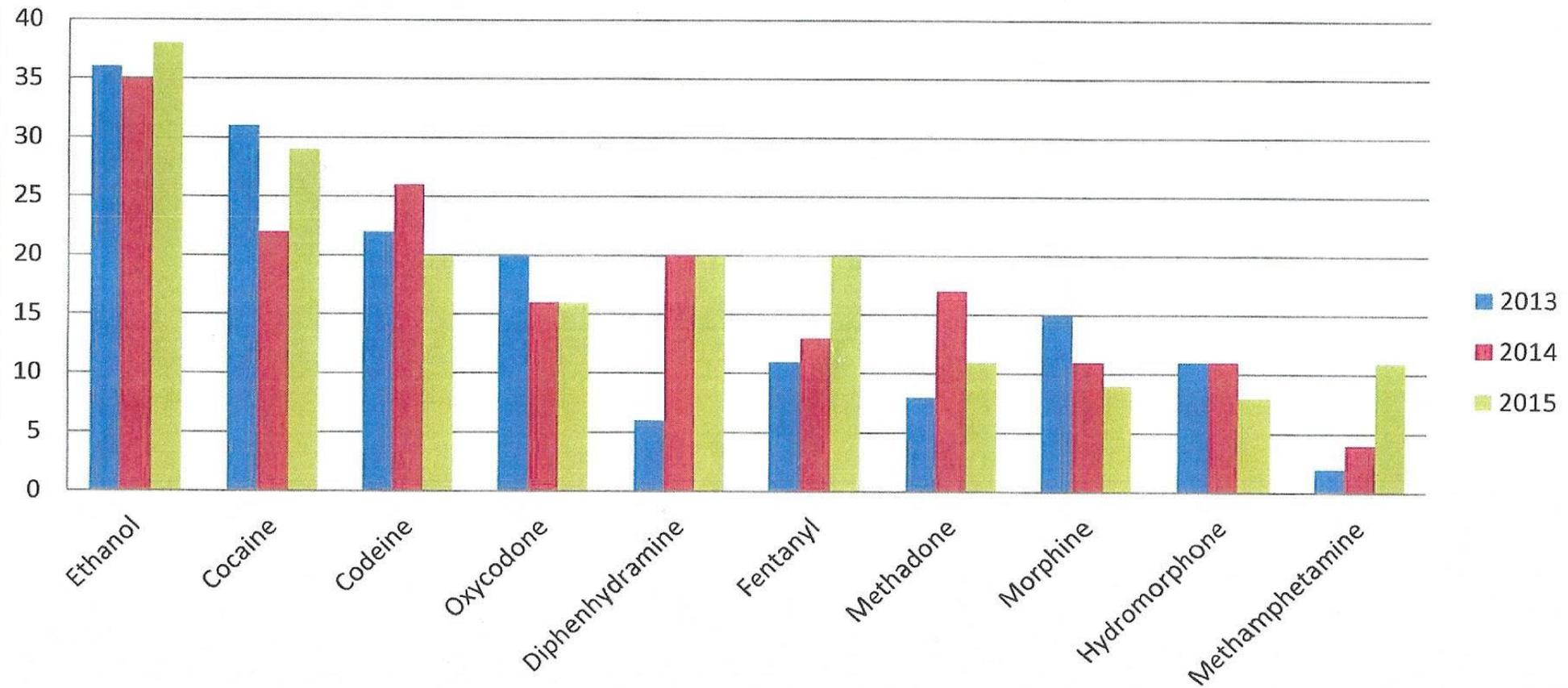
# Chief Medical Examiners' Death Review

A component of the CPSM Prescribing Practices Program



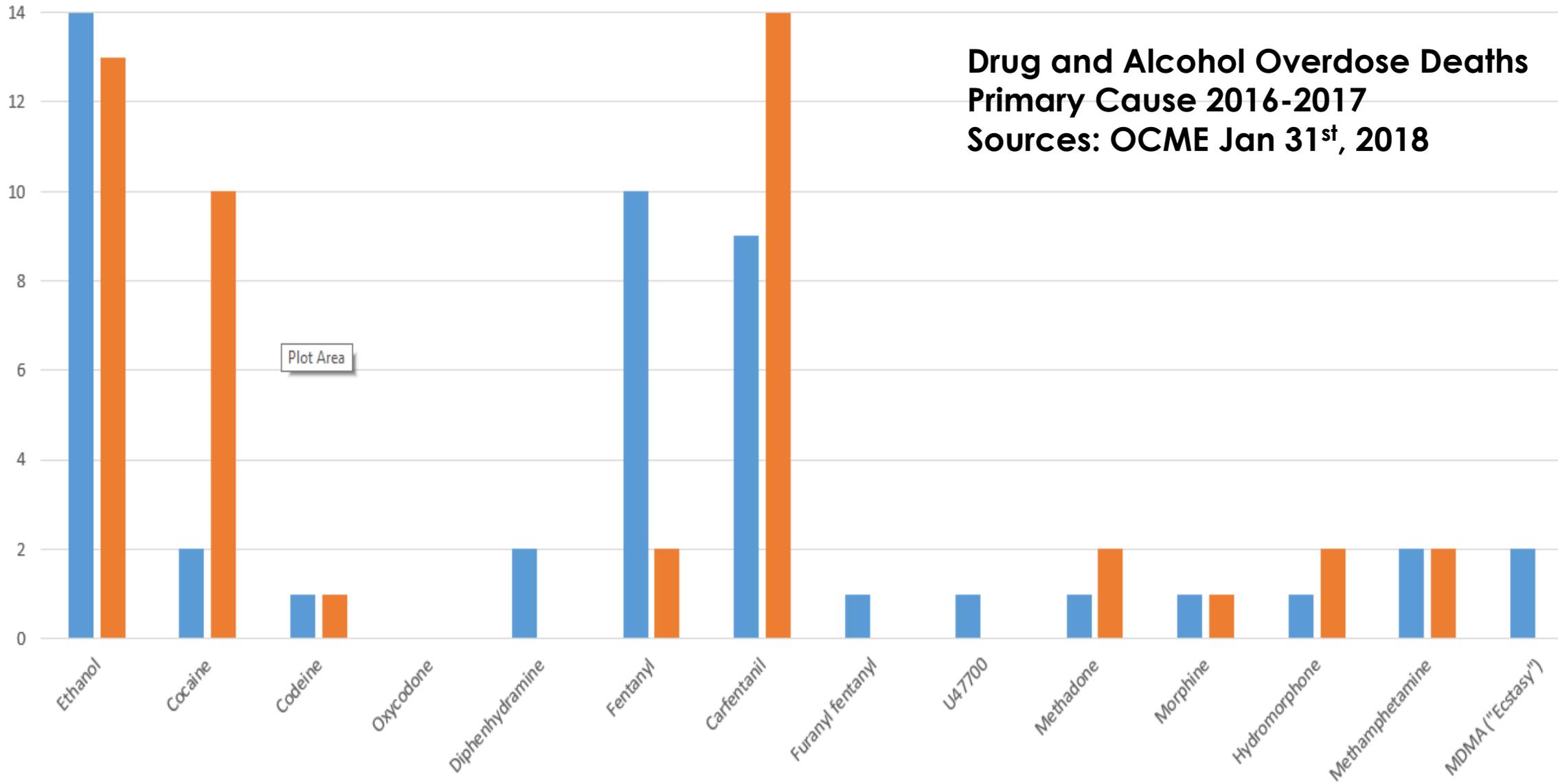
## Drug and Alcohol Overdose Deaths (primary or contributing cause) 2013-2015

source: OCME Nov 3, 2016



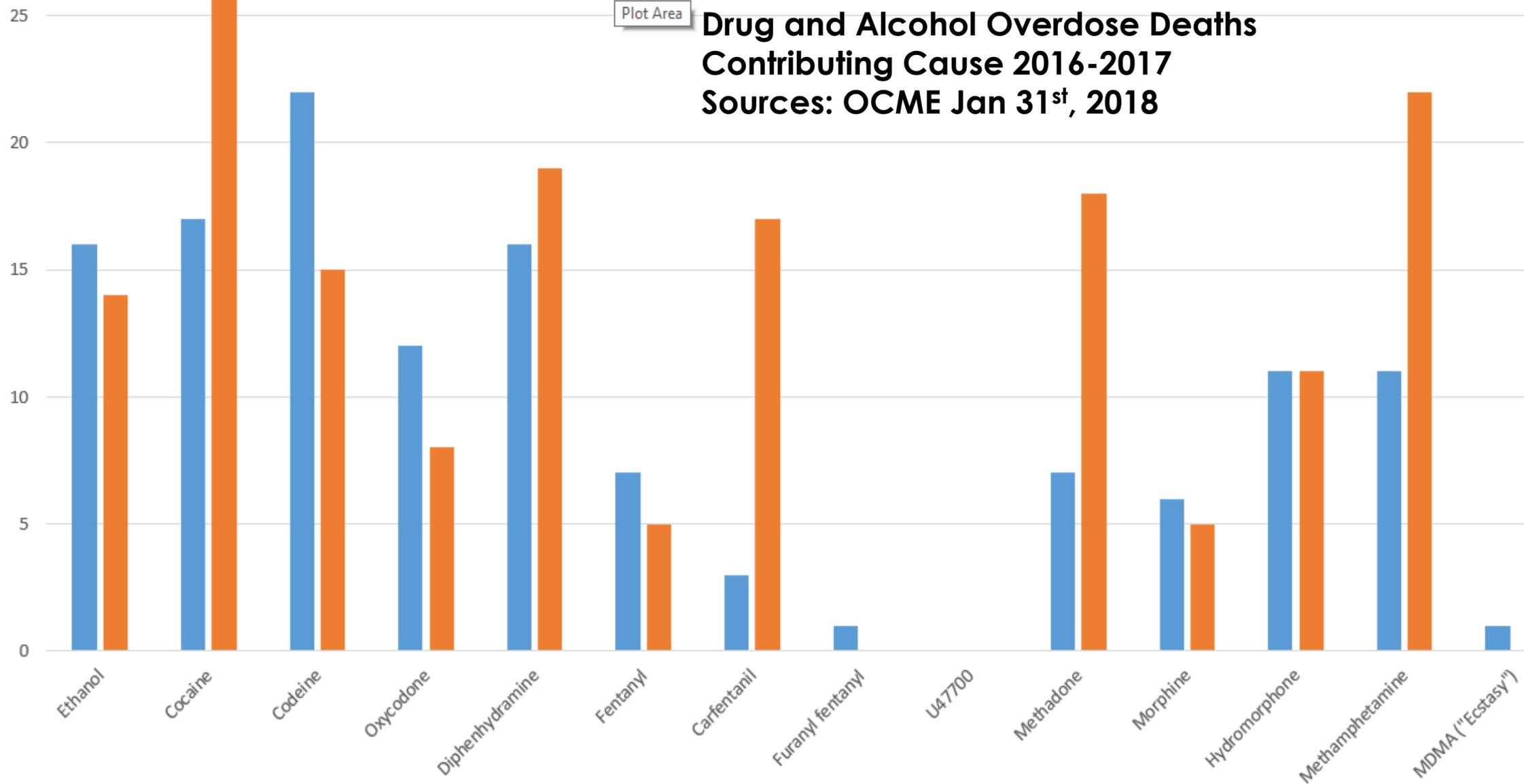
# Drug and Alcohol Overdose Deaths Primary Cause 2016-2017

Sources: OCME Jan 31<sup>st</sup>, 2018

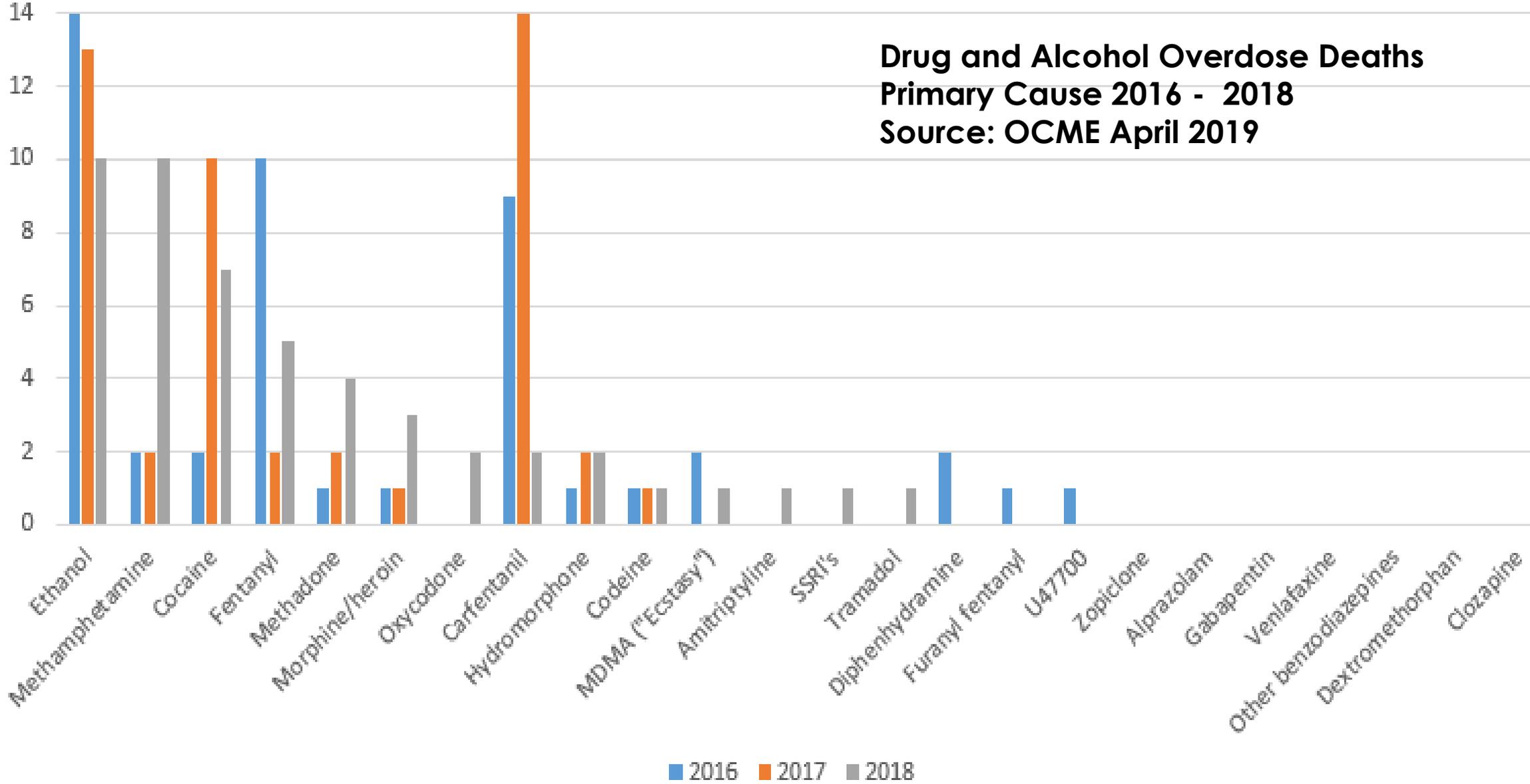


Plot Area

## Drug and Alcohol Overdose Deaths Contributing Cause 2016-2017 Sources: OCME Jan 31<sup>st</sup>, 2018

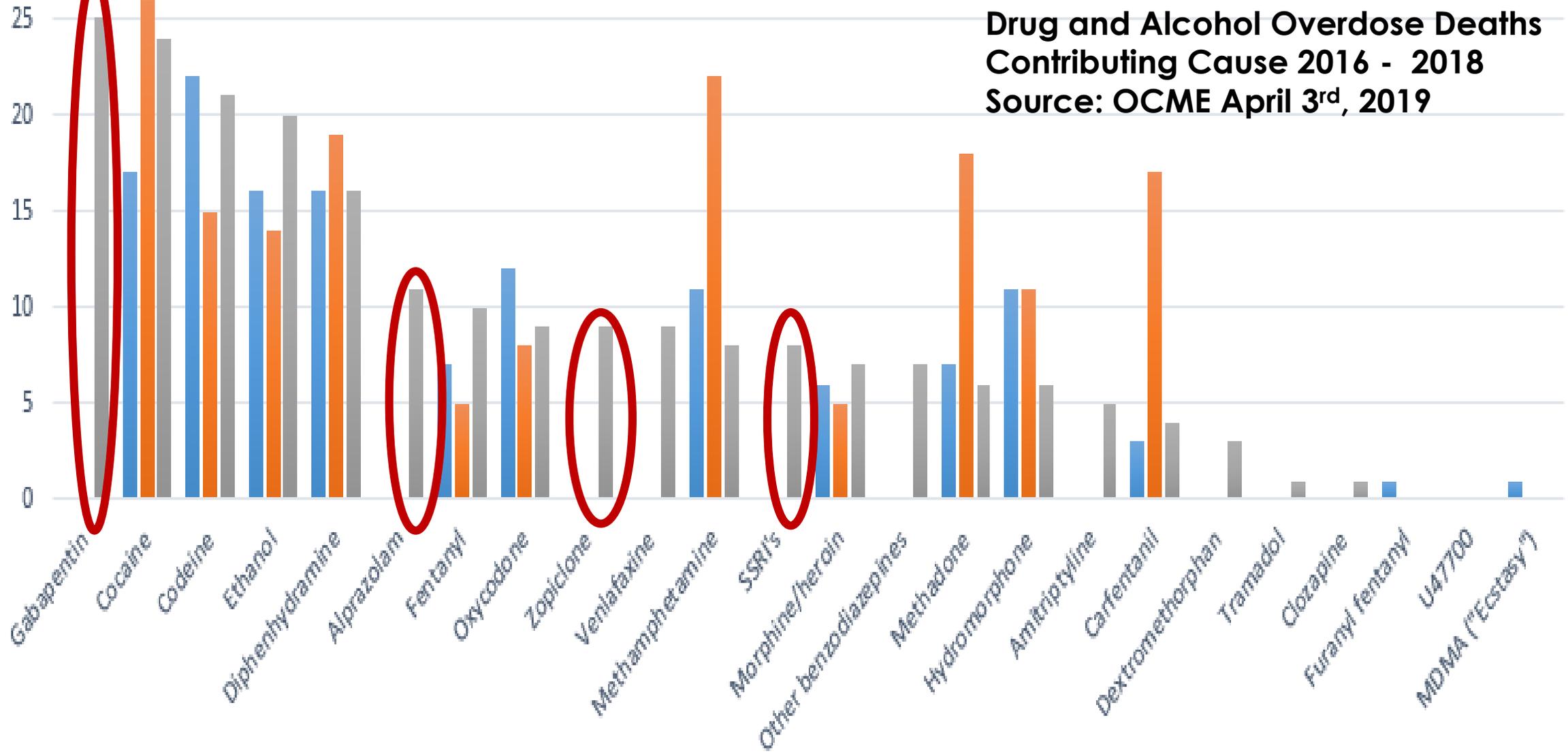


**Drug and Alcohol Overdose Deaths  
Primary Cause 2016 - 2018**  
Source: OCME April 2019



# Drug and Alcohol Overdose Deaths Contributing Cause 2016 - 2018

Source: OCME April 3<sup>rd</sup>, 2019

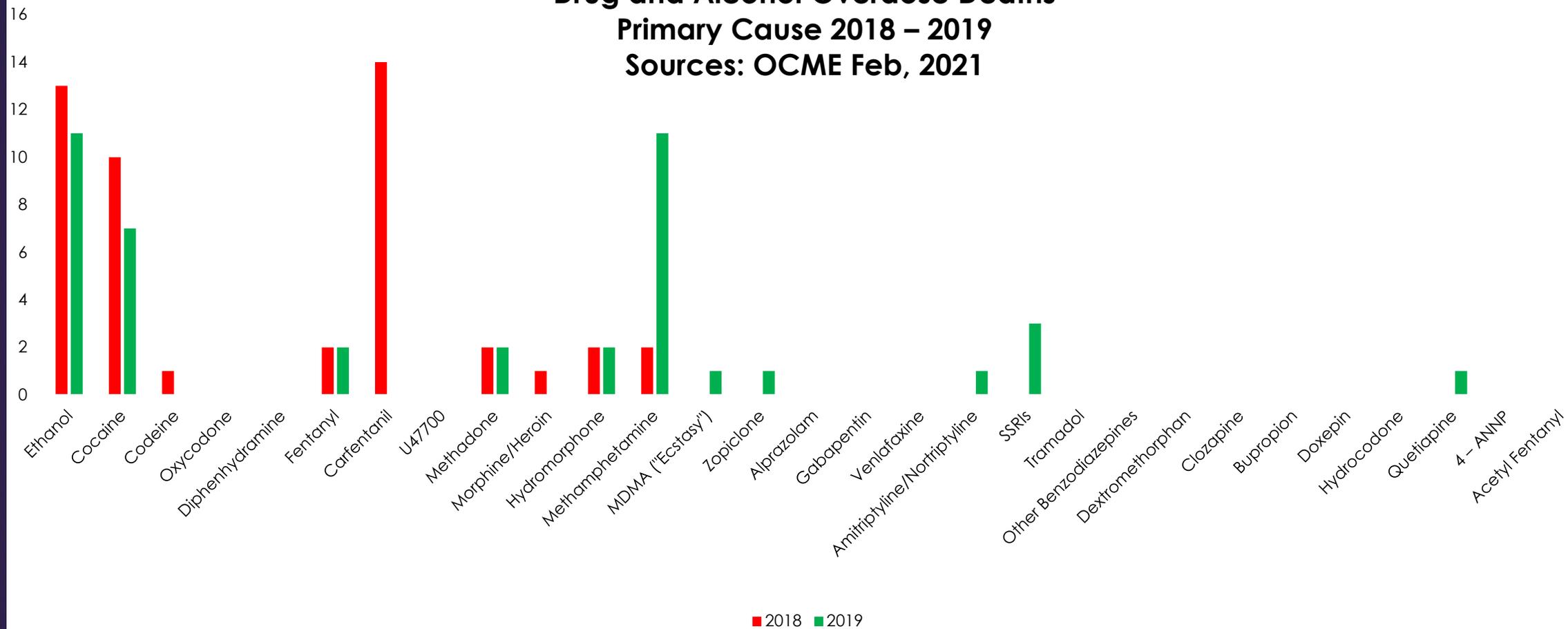


# Important changes in 2018

- ▶ Opioid deaths have leveled off.
- ▶ **Stimulant-related deaths are climbing rapidly. Alprazolam and gabapentin,** as well as **diphenhydramine**, have become significant drugs of abuse.
- ▶ Note that more than one drug is often involved in a given death where a drug is given as a “contributing” cause.
- ▶ Overall, **138 drug-related deaths have been tabulated for 2018** so far. This does not include deaths where drug intoxication led to death by other means (MVAs, suicides, homicides, etc.), or where death occurred due to the effects of chronic drug use (cirrhosis, etc.).

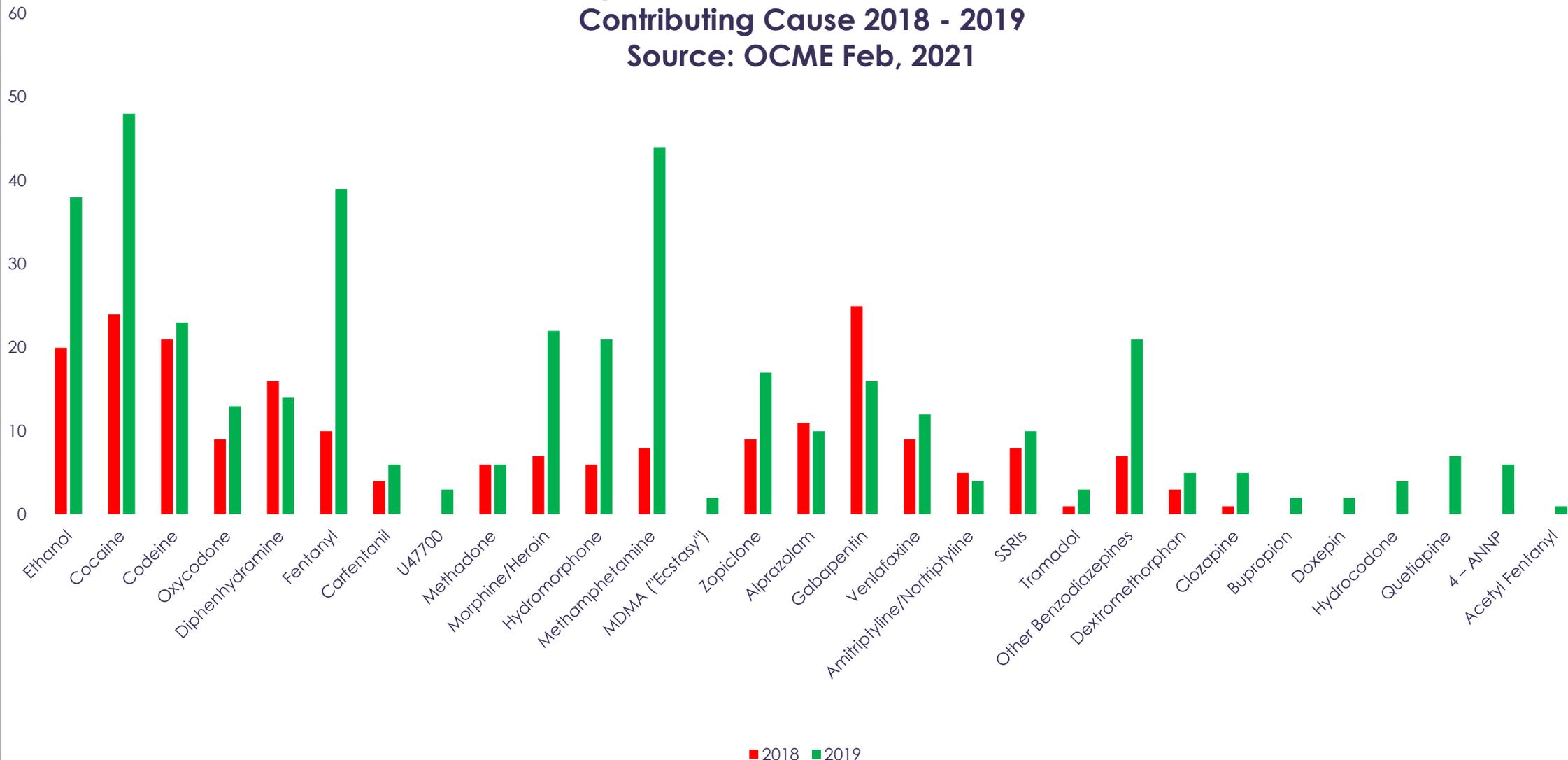
## Drug and Alcohol Overdose Deaths Primary Cause 2018 – 2019

Sources: OCME Feb, 2021



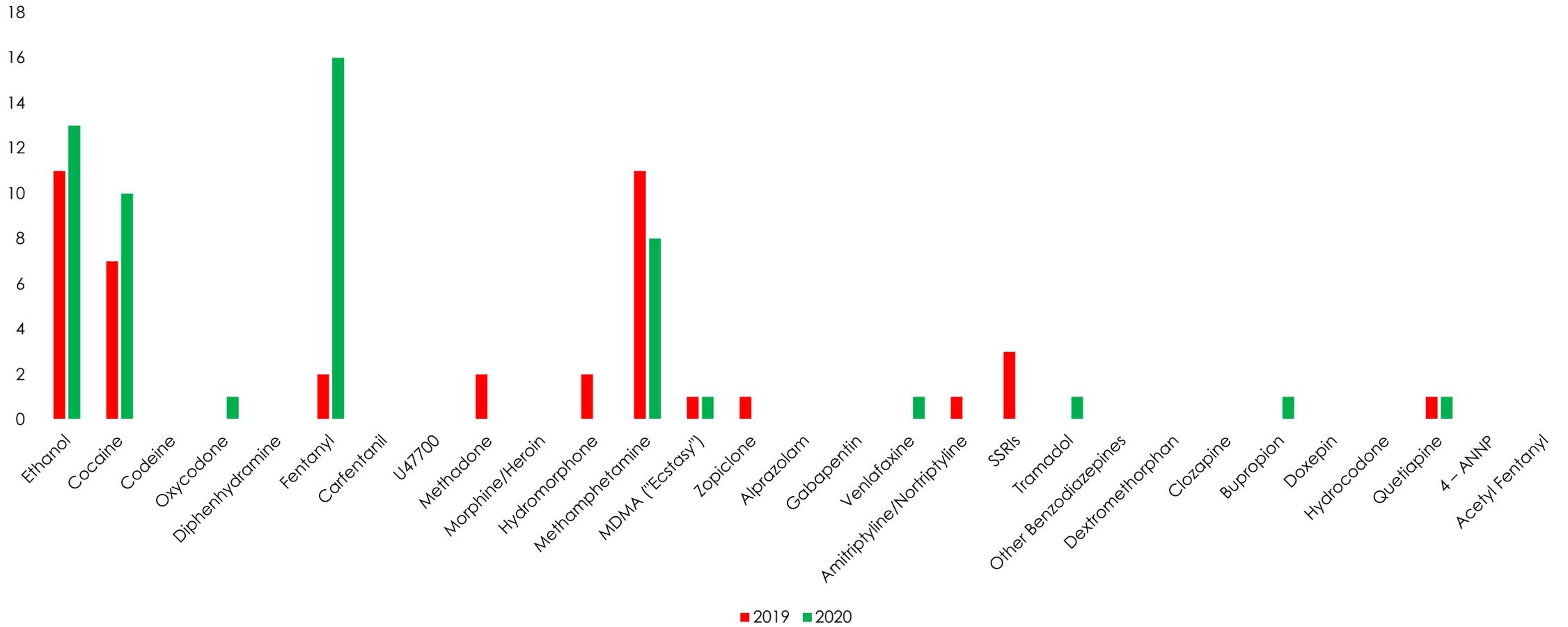
## Drug and Alcohol Overdose Deaths Contributing Cause 2018 - 2019

Source: OCME Feb, 2021



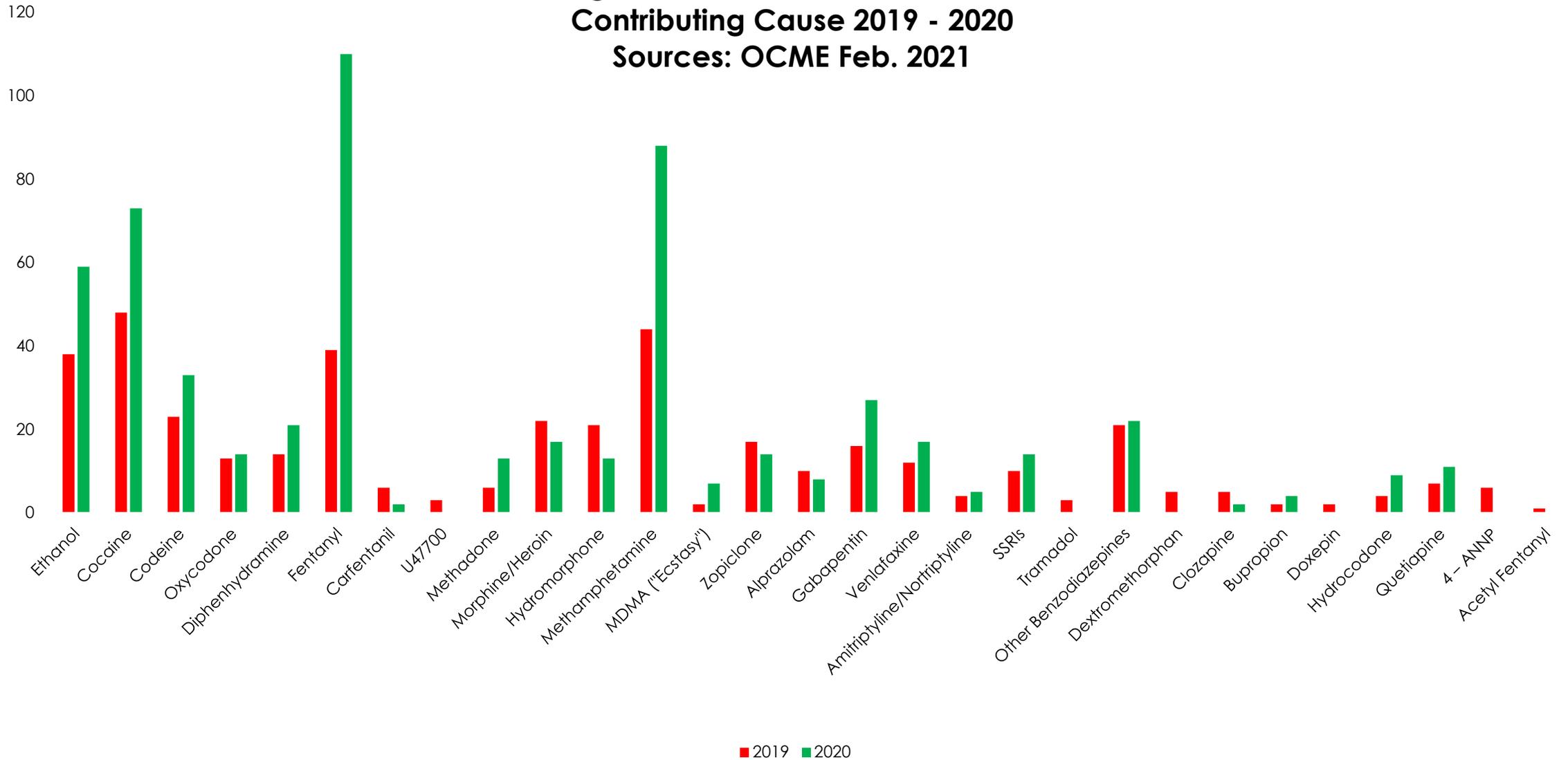
## Drug and Alcohol Overdose Deaths Primary Cause 2019 – 2020

Source: OCME Feb, 2021



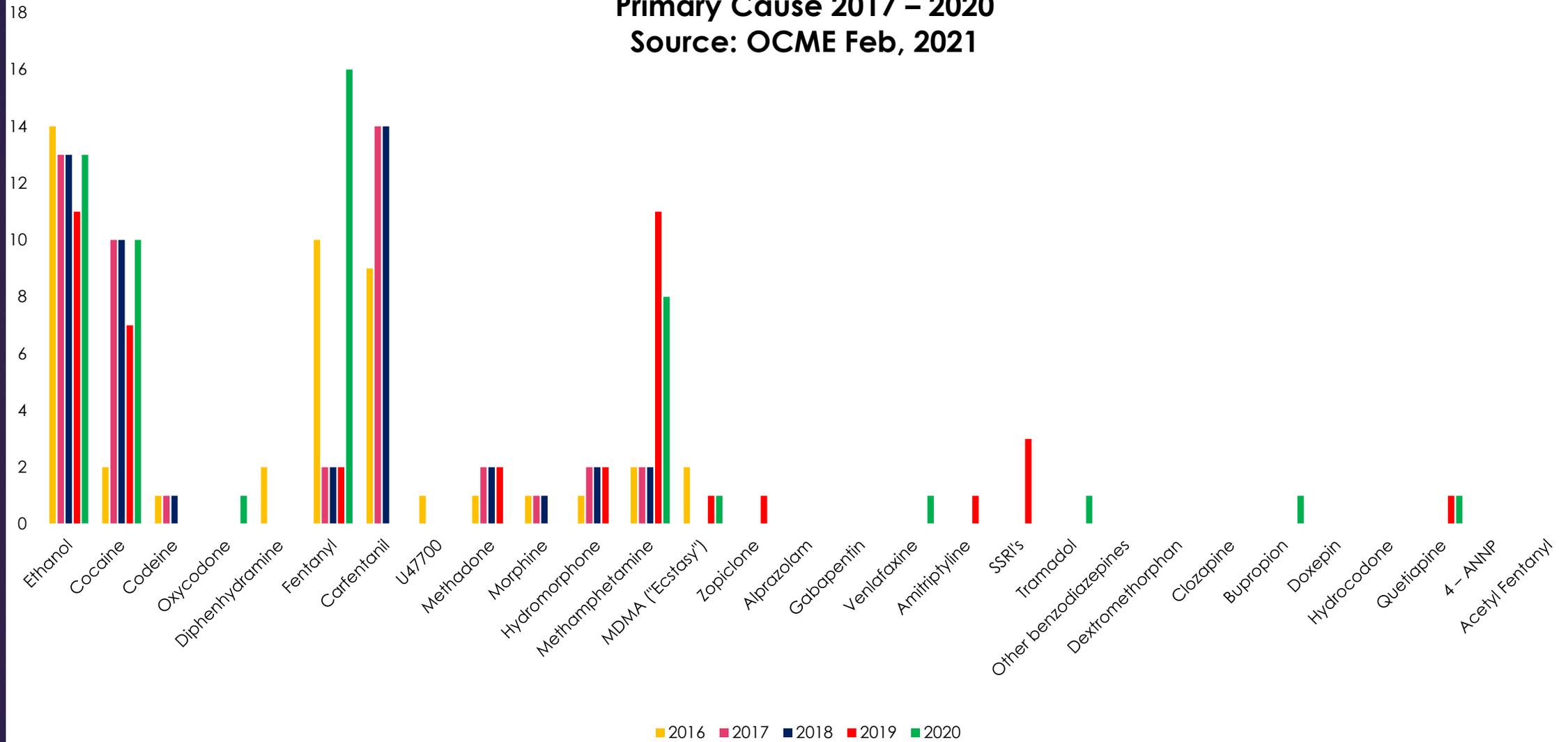
## Drug and Alcohol Overdose Deaths Contributing Cause 2019 - 2020

Sources: OCME Feb. 2021



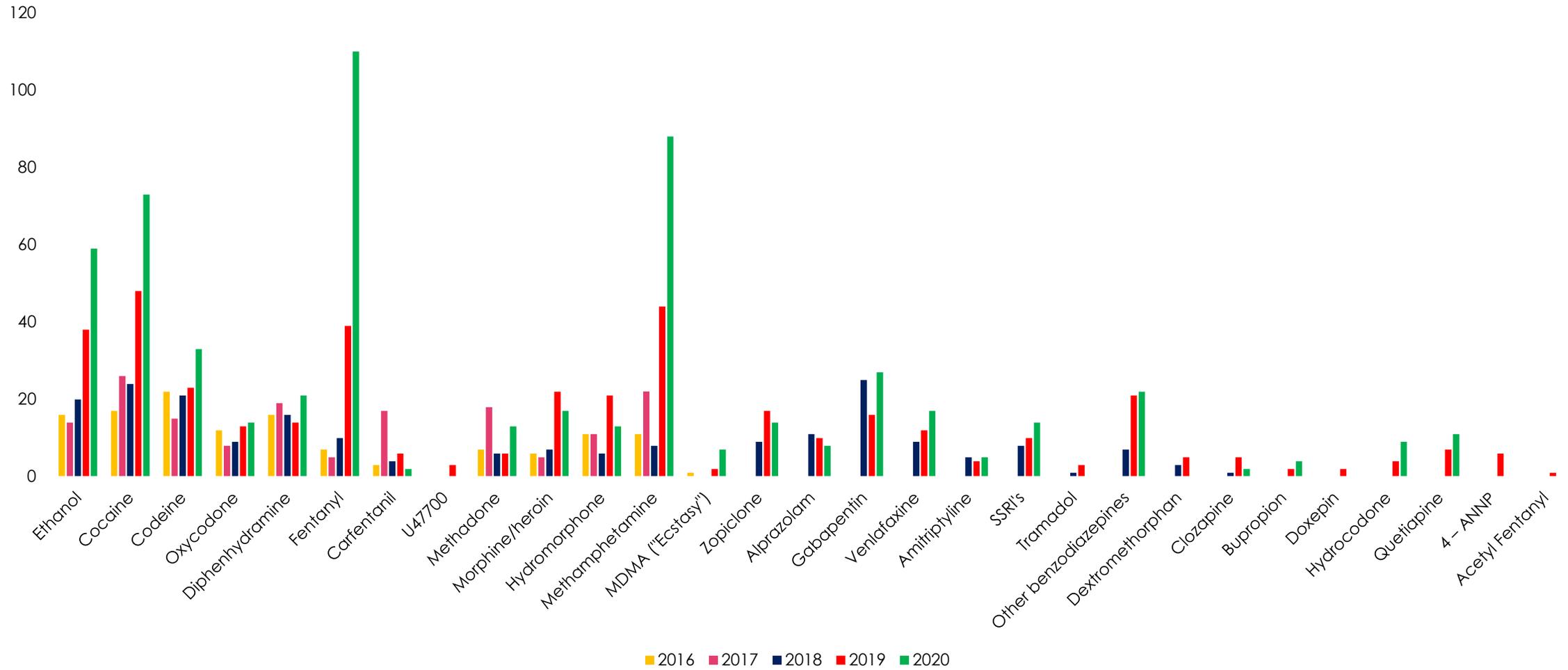
## Drug and Alcohol Overdose Deaths Primary Cause 2017 – 2020

Source: OCME Feb, 2021



## Drug and Alcohol Overdose Deaths Contributing Cause 2017 – 2020

Source: OCME Feb, 2021



# 2019..

- ▶ **TOTAL NUMBER OF DRUG-RELATED DEATHS:** 191
- ▶ Deaths due to single opioid toxicity: 6
- ▶ Deaths with one or more opioids contributing: 87
- ▶ Total opioid-related deaths: 93 (49% of all drug-related deaths)
- ▶ Fentanyl-related deaths: 41 (44% of all opioid-related deaths, 21% of all drug-related deaths)
  
- ▶ Deaths with gabapentin as contributing cause: 16
- ▶ Deaths with gabapentin present, not contributing: 21
- ▶ Total deaths with gabapentin present: 37 (19% of all drug-related deaths)

# Important changes in 2019-2020 (1<sup>st</sup> 3 quarters)

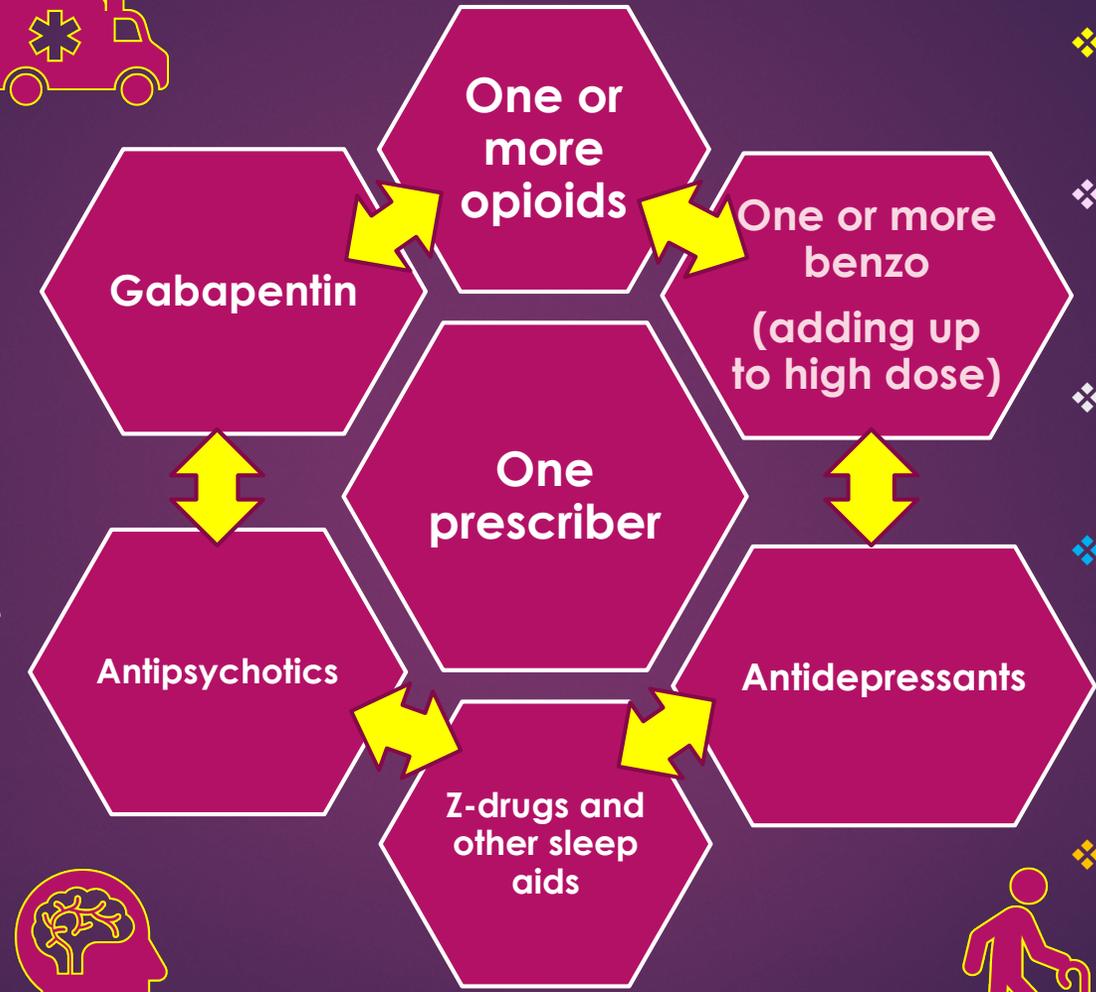
- ▶ “The data for the fourth quarter of 2020 is still coming in, but indications are that drug-related deaths will continue to be shockingly high for those months. This is happening across the country, as well as in the U.S.”
- ▶ Drug supply coming from the U.S. and China, has been disrupted by the pandemic and border closures to non-essential traffic; mailed drug supply has become more expensive and more toxic with not only higher concentrations of fentanyl but additional substances being added in.
- ▶ Concurrent changes in prescribing and regulation may contribute?
- ▶ **Toxic supply and contaminated drugs** are now commonplace in Winnipeg and surrounding areas e.g., “down” which can be a combination of fentanyl, heroin as well as other CNS depressants.

# What can we learn from local CME data?

Three themes:

Largest category: Deaths involving **sedating polypharmacy** where all prescriptions were written by a single physician.

- ❖ Drug interactions
- ❖ Additive ADVERSE EFFECTS
- ❖ Often mimics symptoms of the condition being treated
- ❖ Memory impairment, falls, confusion, sedation and additive respiratory depression
- ❖ Often leads to high doses increases risk of DM, metabolic syndrome, cognitive impairment



- ❖ Incomplete tapers or switches
- ❖ Poor adherence (looks like partial response)
- ❖ No Longer clinically relevant
- ❖ No evidence that combining agents from same class increases efficacy (**benzodiazepines** hypnotics, SSRI's)
- ❖ Simplifying therapy without clinical deterioration is possible with medical supervision



# An APPROACH to polypharmacy

- ▶ You have to actively manage polypharmacy
- ▶ Set the stage at intake appointment
- ▶ Single prescriber/group of prescribers – AND one pharmacy
- ▶ Get a detailed history of every drug
- ▶ Reformulate list of active problems (acute or in remission)
- ▶ Discontinue what is not indicated, not being taken, diverted, or reduce dose if appropriate

# An APPROACH to polypharmacy

- ▶ Taper what can't be discontinued abruptly
- ▶ One at a time (if feasible)
- ▶ More frequent visits; increased supports; frequent safety messaging; enlist loved ones
- ▶ Be patient but persistent
- ▶ Actively collaborate with community/hospital OAT pharmacist and primary care prescriber.

# The evidence: Opioids and benzodiazepines

**Benzodiazepines increase opioid toxicity and risk of overdose.**

- The **serum concentration of opioids is lower in mixed overdoses** than in pure overdoses, suggesting that other drugs significantly lower the lethal opioid dose (Cone 2004).
- Most **opioid overdoses involve multiple drugs in addition to opioids**. Overall, the top two other substances contributing to deaths between 2014 and 2017 were **benzodiazepines** and antidepressants.

Government of Manitoba, Manitoba Health, Seniors and Active Living, Epidemiology and Surveillance. (2018). Surveillance of Opioid Misuse and Overdose in Manitoba: October 1 – December 31, 2017.

# The evidence: Opioids and benzodiazepines

**There is evidence that benzodiazepines can be successfully tapered in a primary-care setting, with improved health outcomes.**

- Several controlled trials have demonstrated that benzodiazepine tapering can be done in a primary-care setting.
- ▶ R06 For patients taking benzodiazepines, particularly for elderly patients, consider a trial of tapering (Grade B). If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses. (Grade C).

# Key message

- ❖ **Keep the overall picture in mind: The overall risk may outweigh the benefit from individual medications**

# What can we learn?

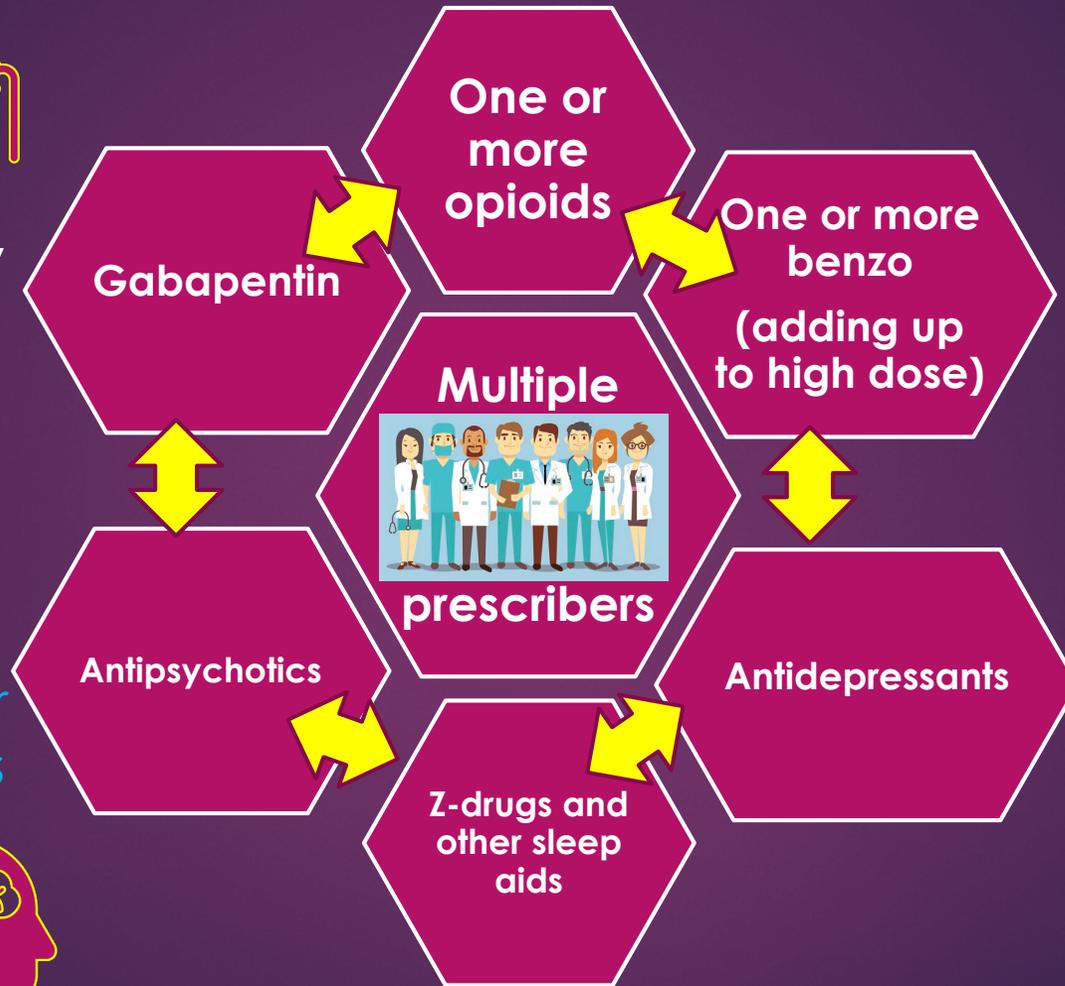
Deaths involving **multiple sedating medications** (often including an opioid and more than one benzodiazepine at a time) prescribed to the same patient by different physicians; filled at multiple different pharmacies.

❖ Frequently prescribers not aware of Rx history or each other?



❖ Increases risk of adverse events even further...

❖ CPSM Standard for prescribing opioids requires DPIN review



❖ Cross-over or consultative collaborative care?

❖ Who takes the lead on different aspects of care?

❖ DPIN not universally available

❖ e-Chart

❖ Collaboration with community pharmacist key!

# Key messages

- ❖ All prescribers should utilize DPIN or e-Chart (ungrouped) to improve patient safety.
- ❖ Clear treatment agreement with the primary prescriber or group of prescribers responsible for monitored drugs.
- ❖ Listen to and actively collaborate with community/hospital pharmacist!

# What can we learn?

- ❖ **OTC medications used in combination with prescribed medications can significantly contribute to overdose risk.**
- ❖ **Pharmacists can provide valuable collateral information – listen to and actively collaborate with community pharmacist!**

# Tracking Deadly OTC's

- ▶ Diphenhydramine (contributed to 16 deaths in 2016, 19 in 2017, 16 in 2018, 14 in 2019 and 21 in 1<sup>st</sup> 3 quarters of 2020)
- ▶ It is a first generation H<sub>1</sub>-antihistamine and an anticholinergic
- ▶ Because of its sedative and anxiolytic properties, diphenhydramine is widely used in non-prescription sleep aids for insomnia.
- ▶ **Diphenhydramine** is the primary constituent of **dimenhydrinate** and dictates the primary effect. The main difference relative to pure diphenhydramine is a lower potency due to being combined with 8-chlorotheophylline



# Others to watch...

- ▶ Dextromethorphan (**contributed to 3 deaths in 2018, 5 in 2019** and 0 in 1<sup>st</sup> 3 quarters of 2020)
- ▶ Dextromethorphan acts as a dissociative anesthetic in doses exceeding recommended ranges.
- ▶ DXM and its major metabolite, dextrorphan, also act as an NMDA receptor antagonist at high doses, which produces effects similar to, yet distinct from, the dissociative states created by other dissociative anesthetics such as ketamine and phencyclidine.



# An approach to managing OTC medication use

- Ask your patient about OTC medication use in a non-judgemental way!!
- Pay attention to collateral - “family” and pharmacists!!
- Urine drug testing (UDS) may be useful if concerning report, appearance, function or collateral information.  
(Comprehensive UDS preferred)
- **Treatment intensification**; ? Residential treatment
- **Reduce carries if on OAT; controlled dispensing for all**
- **Taper other sedating Rx meds** to offset OD risk

# Key messages

- ❖ **OTC medication use is common and increases OD risk!!**
- ❖ **Ask re OTC meds and screen utilizing comprehensive UDS's if concerning appearance, function or collateral reports**
- ❖ **Listen to and actively collaborate with community pharmacist!**

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# References

I wish to recognize the following sources:

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- ▶ Government of Manitoba, Manitoba Health, Seniors and Active Living, Epidemiology and Surveillance. (2018). Surveillance of Opioid Misuse and Overdose in Manitoba: October 1 – December 31, 2017.
- ▶ Chateau D, Enns M, Ekuma O, Koseva I, McDougall C, Kulbaba C, Allegro E. Evaluation of the Manitoba IMPROVE Program Winnipeg, MB. Manitoba Centre for Health Policy, January 2015.
- ▶ Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain, NOUGG, April 3<sup>rd</sup>, 2010
- ▶ Clinical Guideline: Management of anxiety in adults. UK National Institute for Clinical Excellence. 2004;152. [http://www.nice.org.uk/pdf/CG02\\_2niceguideline.pdf](http://www.nice.org.uk/pdf/CG02_2niceguideline.pdf)
- ▶ Barbone F, McMahon AD, et al. Association of road-traffic accidents with benzodiazepine use. Lancet. 1998;352:1331-1336.

THANK YOU

