WELCOME
Addiction Medicine ECHO Clinic

The session will begin promptly at **12 pm**.

Please **mute** the audio on your device.

Sessions take place **Thursday on the 2cd and 4th week of the month**.

Please connect your **camera**.

Need technical assistance? Call 907.729.2622 or text your phone number into the chat.

Project ECHO®

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Foundation *for* Opioid Response Efforts

Recording

We will record the **didactic portion** of every session. After the session, the didactic portion of this clinic will be available on the ANTHC Addiction Medicine ECHO page.

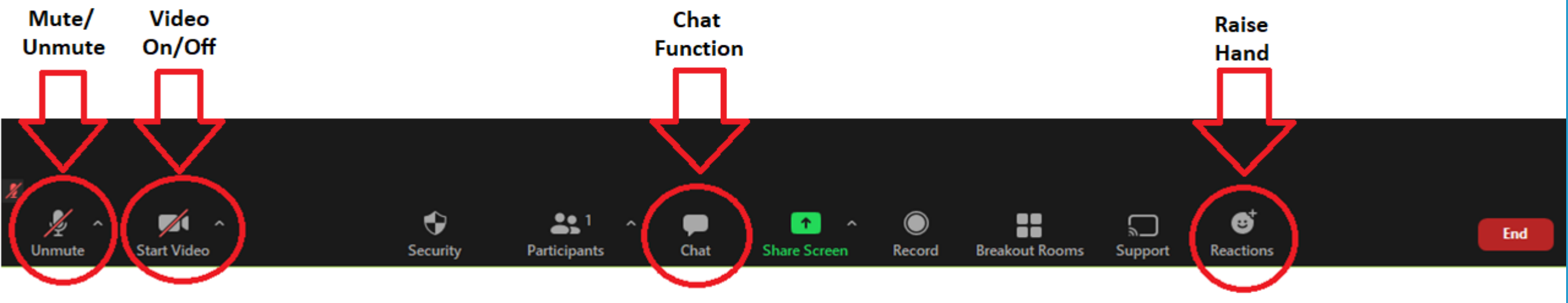
By participating in this clinic you are consenting to be recorded.

If you do not wish to be recorded, please email behavioralhealth@anthc.org at least one week prior to the ECHO Clinic you plan to attend.

Some Helpful Tips

- Please mute microphone when not speaking
- Use chat function
- Position webcam effectively
- Test both audio & video

Need technical assistance? Use the chat function or call 729-2622



ANTHC Clinical ECHO Series

Approved Provider Statements:

ANTHC is accredited by the Washington State Medical Association to provide continuing medical education for physicians.

ANTHC is approved as a provider of nursing continuing professional development by the Montana Nurses Association, an accredited approver with distinction by the American Nurses Credentialing Center's Commission on Accreditation.

AKPhA is accredited by the Accreditation Council for Pharmacy Education as a provider of Continuing Pharmacy Education.

Contact Hours:

ANTHC designates this Live/Virtual Activity for a maximum of 12 AMA PRA Category 1 Credit(s) ™ for the entire series, provided in 1 credit/session certificates. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ANTHC designates this activity as meeting the criteria for one nursing contact hour credit for each hour of participation up to a maximum of 12 hour(s) for the entire series, provided in 1 contact hour certificates/session attended.

The Alaska Pharmacists Association (AKPhA) is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. Through a Joint Providership, ANTHC and AKPhA designates this pharmacist activity for a maximum of 1 hours(s) per session. To receive CE credit, participants must be included in attendance record of facilitator/virtual format moderator with the NABP e-profile number including MM/DD birthdate, and complete the evaluation or post session survey. CPE credit will be posted to the online CPE Monitor System within 60 days of activity completion. CPE credit is offered at no charge to ANTHC/SCF employees and AKPhA members. Fees may apply to participants not affiliated with either organization.

Approved for 1 CHAP CE

Conflict of Interest Disclosures:

None of the presenters and planners for this educational activity have any relevant relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

Requirements for Successful Completion:

To receive CE credit be sure you are included in attendance record as directed by the facilitator/session moderator, and complete the course evaluation or post session survey via this link: https://forms.gle/QhwCeGTf4zLNwpBX7

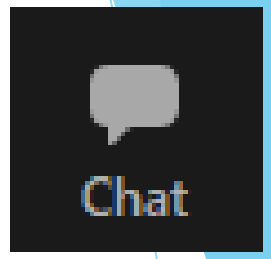
For more information contact Jennifer Fielder at jlfielder@anthc.org or (907) 729-1387

Announcement: Free Training

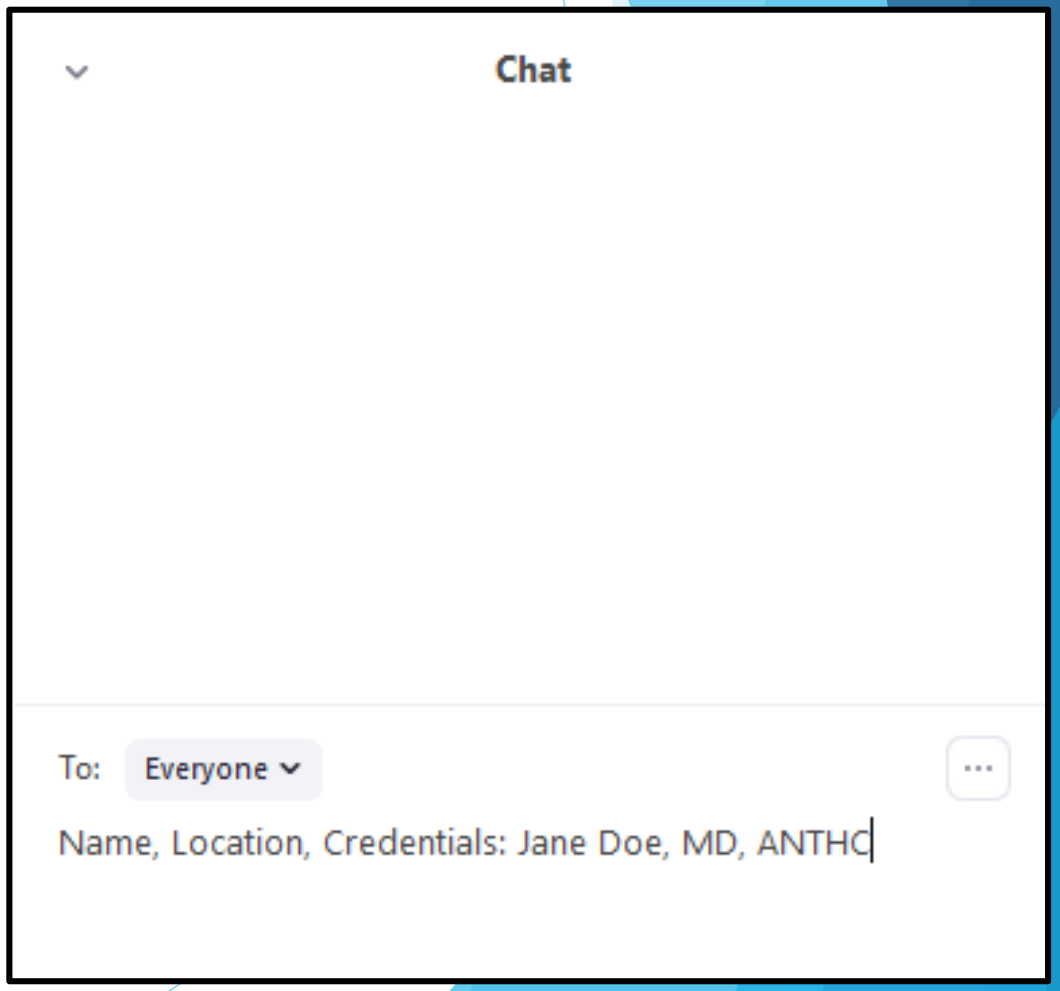
- SCOPE of Pain Live Webinar
- October 26, 2021, 11 a.m. – 2 p.m. AK Time
- Register at scopeofpain.org
- CME's available

Introductions

Addiction Medicine ECHO



- Please introduce yourself in the chat :
  - Name
  - Location
  - Profession/Credentials
  - *Note*: The chat will be saved as our attendance record for continuing education credits.



Benzodiazepines and Opioids

Ryan Wallace, MD, MPH

ANTHC Addiction Medicine ECHO

August 26, 2021

Conflict of Interest Disclosure

- No conflict of interest to disclose

Objectives

- Participants will understand potential interactions between benzodiazepines and opioids.
- Participants will be able to identify treatment considerations for co-occurring benzodiazepines and opioid use.

Didactic presentation

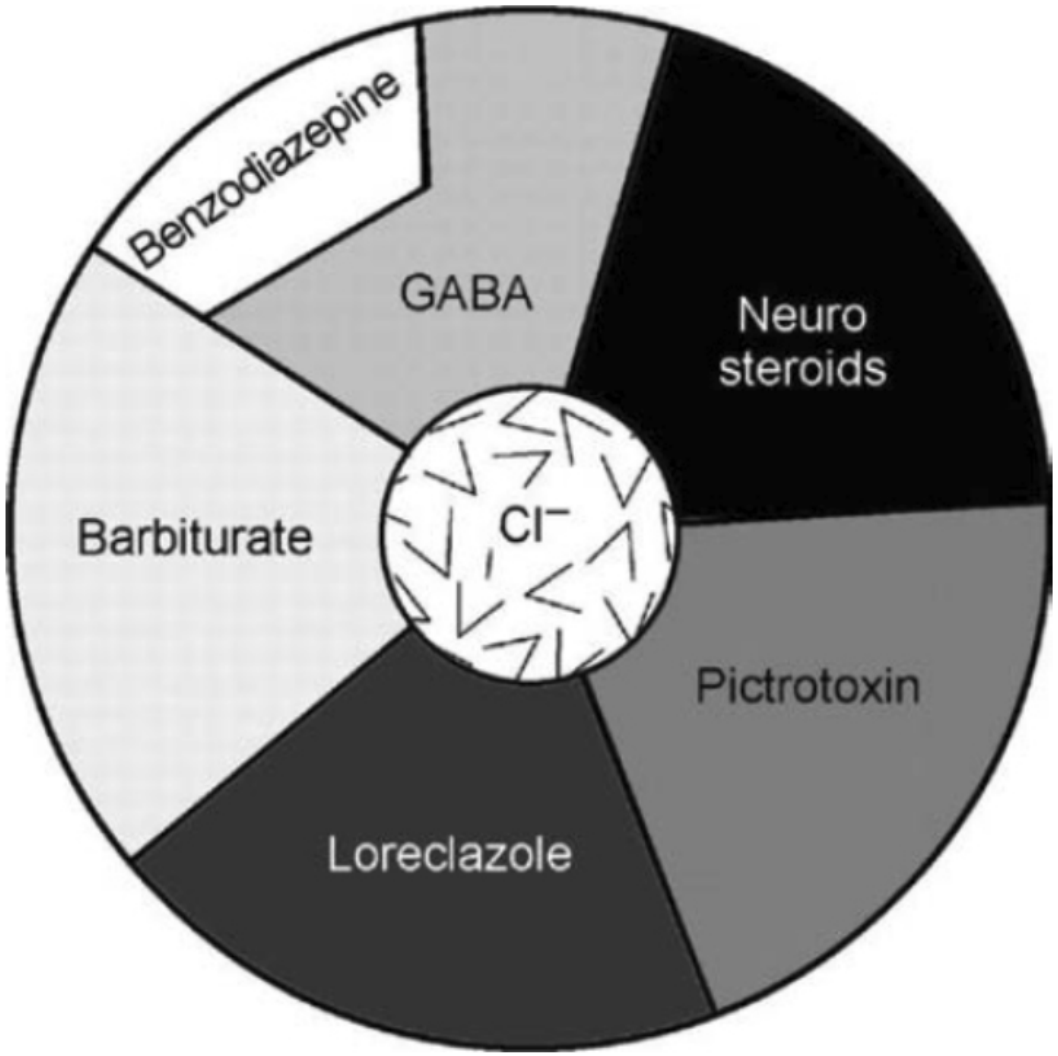
Benzodiazepines and Opioids

Ryan Wallace MD, MPH

8/26/21

Outline

- Introduction to Benzodiazepines
- Interaction of benzodiazepines and Opioids
- Clinical Practice



Benzodiazepines

- Commonly prescribed medications
- CNS depressants that act on Gaba-a receptors
- No known lethal dose when taken alone, but often present in fatal OD

Psychopharmacology revolution

- 1950s-1980s there was a rapid growth in advertisements for pharmaceutical products
- No regulation until the 1970s DHSS
- Barbiturates led the way
- Focused on women
- Reinforced the idea that one needs a pill to cope with everyday emotional stressors

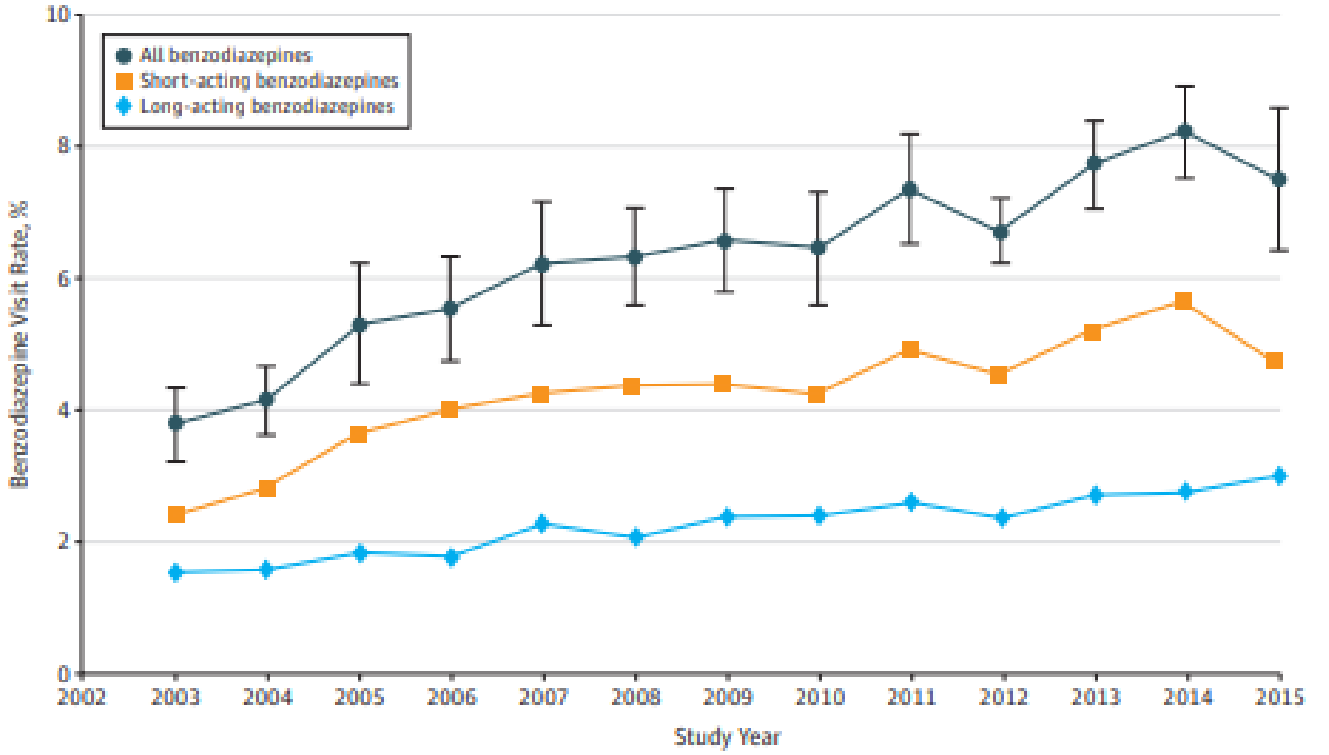
Green and Haddad, 2018

Benzodiazepines

- Originated as “safe” alternative to barbiturates for anxiety
  - No dependence syndrome
  - No withdrawal syndrome
- As with barbiturates, pharma advertisements selectively targeted women
- Further Pathologizing of normal emotional experience

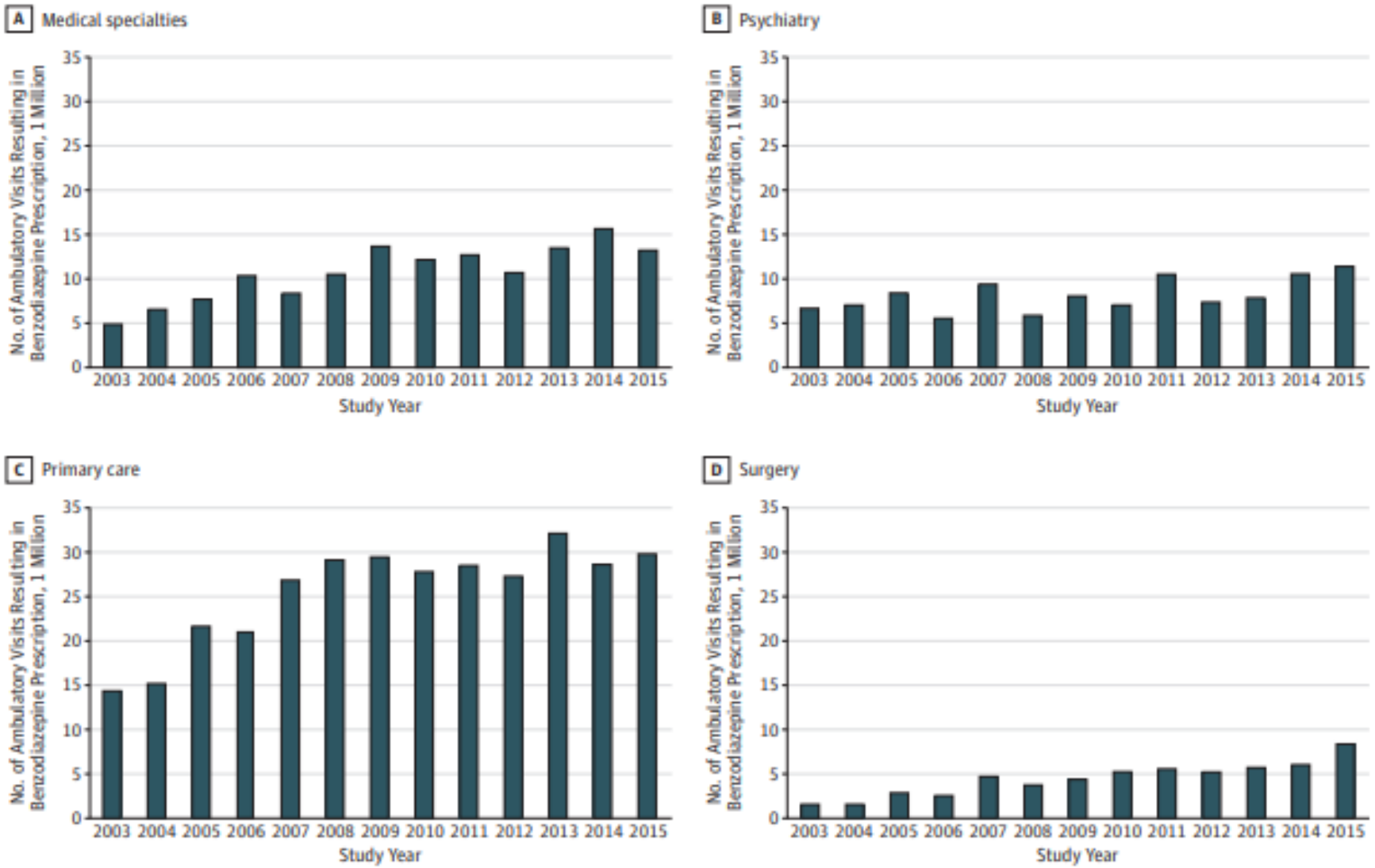
Green and Haddad, 2018
Pieters and Snelders, 2007

Figure 1. Benzodiazepine Visit Rate in the United States



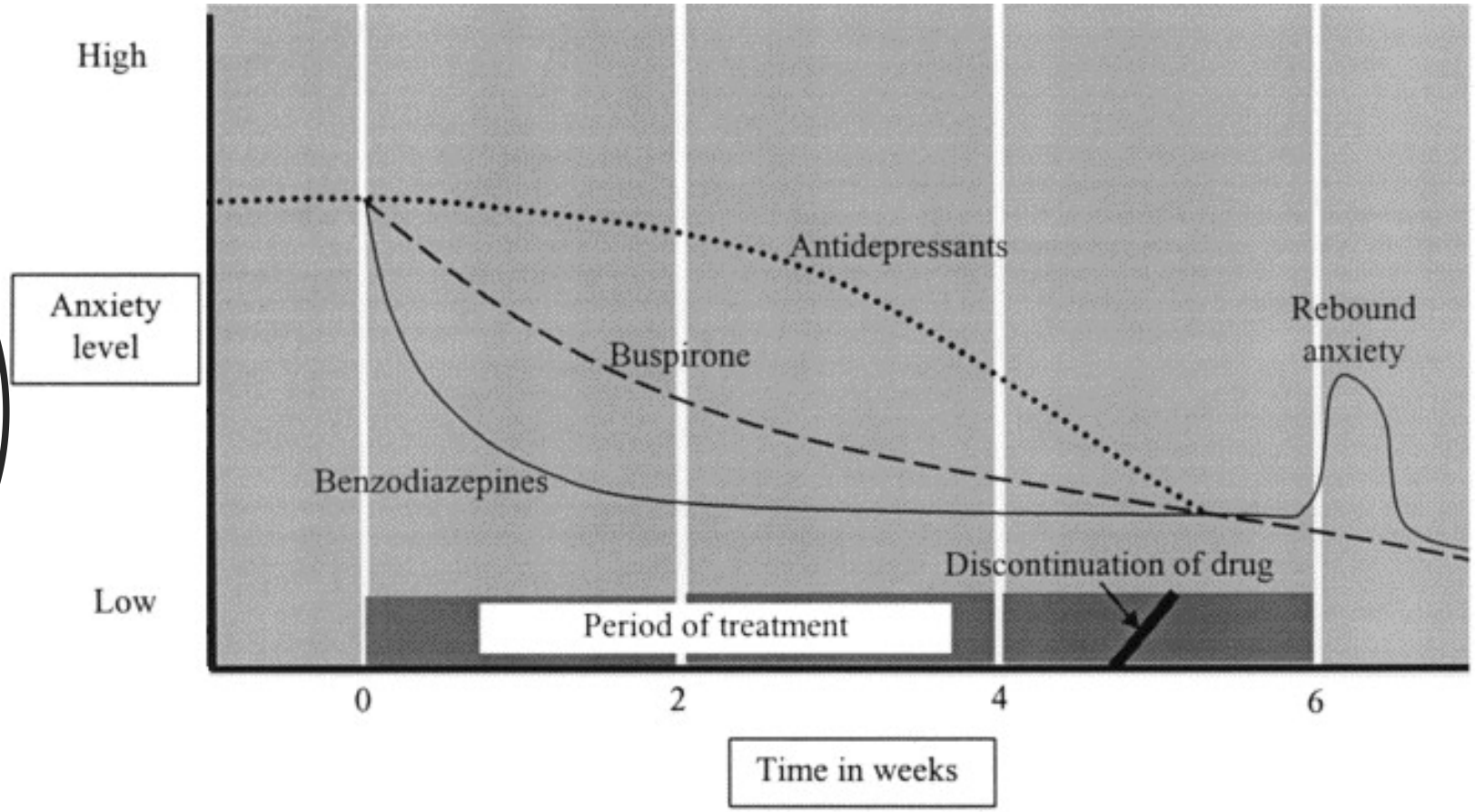
Agarwal, Jama, 2019

Figure 2. Benzodiazepine Visits by Specialty



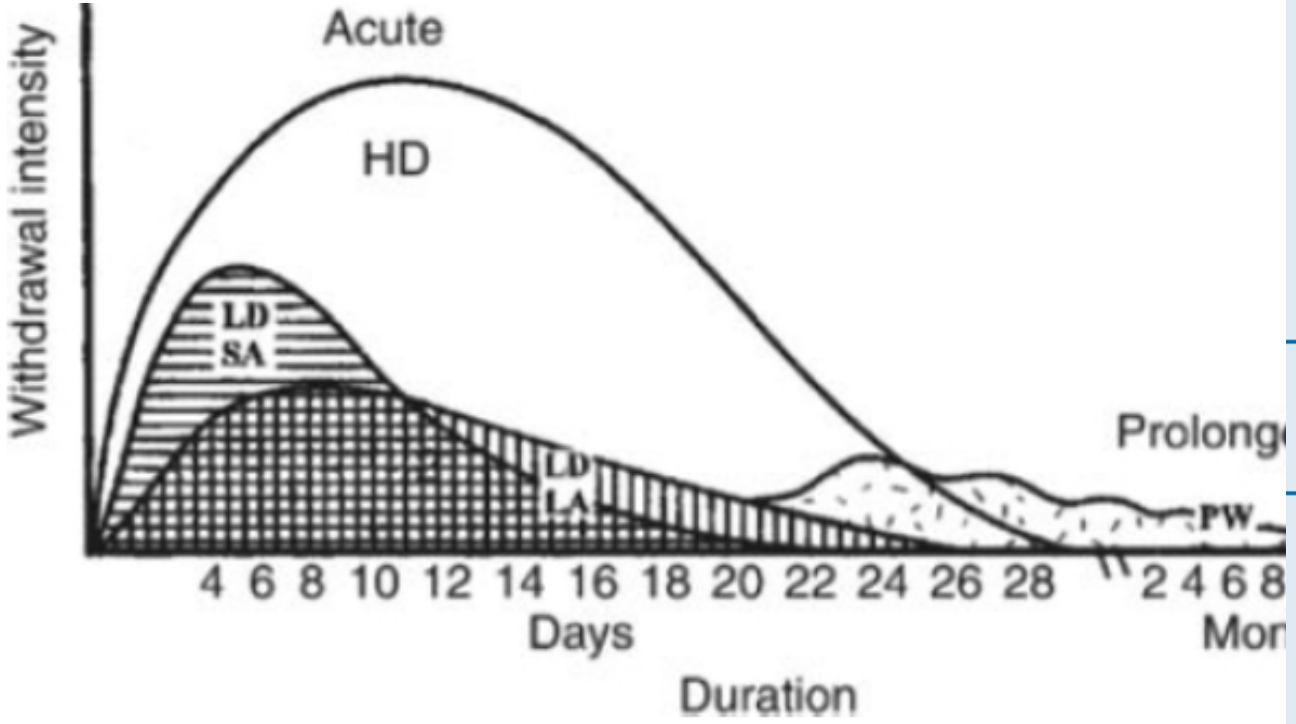
Agarwal, Jama, 2019

And they do work!! Well, sort of



Nutt, European Neuropsych, 1999

Withdrawal



Vital Signs

- Tachycardia
- Hypertension
- Fever

Central Nervous System

- Agitation
- Anxiety
- Delirium
- Hallucinations
- Insomnia
- Irritability
- Nightmares
- Sensory disturbances
- Tremor

Ears

- Tinnitus

Gastrointestinal

- Anorexia
- Diarrhea
- Nausea

High-Dose (Severe) Withdrawal

- Seizures
- Delirium
- Death

Risks with BZD and Z-drugs

- **Cognitive impairment** clearly demonstrated. (Vignola 2000, Sakol 1998, Golombok 1998, McAndrews 2002)
- **Motor Vehicle Accidents** – 2-4x increase risk of fatal and non-fatal MVA (Brandt, 2017)
- **Hangover Effects**- Day following Z-drugs impair driving, memory, psycymotor performance; (Mets, 2011)
- **Mortality Risk** – Hazard ratio = 3.46!; (Weich 2014)
- **Suicide Risk** (Dodds 2017, Sun Yu et al, 2016)
- **Falls** (Wang, 2001)
- **Pneumonia** – 1.25 x more likely (Guo-qing Sun, 2019)

Benzodiazepines activate reward pathway

- Benzodiazepines activate the same parts of the brain that are implicated in addiction. (Tan, Nature, 2010)
- 50% of chronic bzd users (>1 month) meet DSM 4 criteria for BZD dependence. (Guerlais, 2015)
- Physiologic dependence occurs in 50% of patients taking longer than one month. (De la Cuevas, 2003)

Dementia???

- Controversial
  - Association
    - 10+ studies indicate risk, including 350k subject case-control study (Tapainen, 2018)
  - No Association
    - UK Cohort study of 8216; (Grossi, 2019)
    - Registry study of 200k +; (Osler, 2020)

Sleeping pills

- **Z**olpidem (Ambien)
- Es**z**opiclone (Lunesta)
- **Z**aleplon (Sonata)

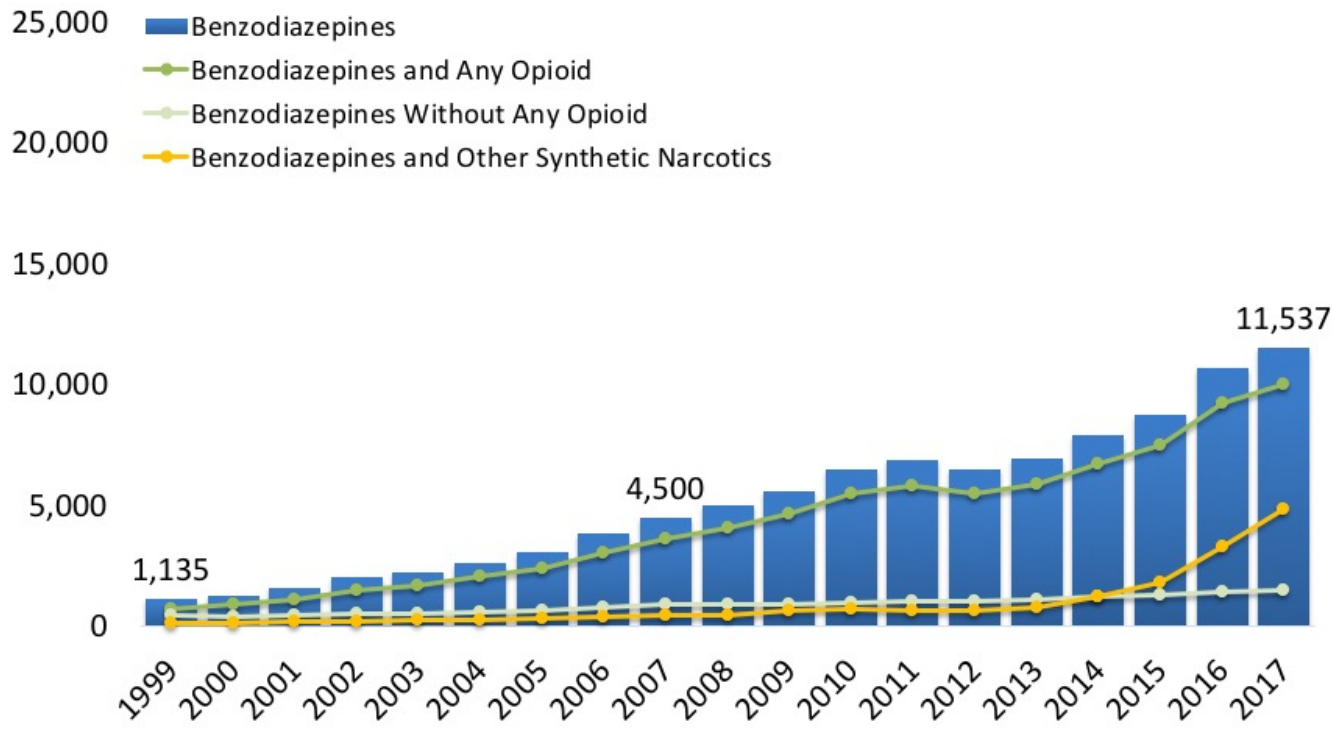
Promoted as safer than BZD.

However, risks and Side effects are similar.

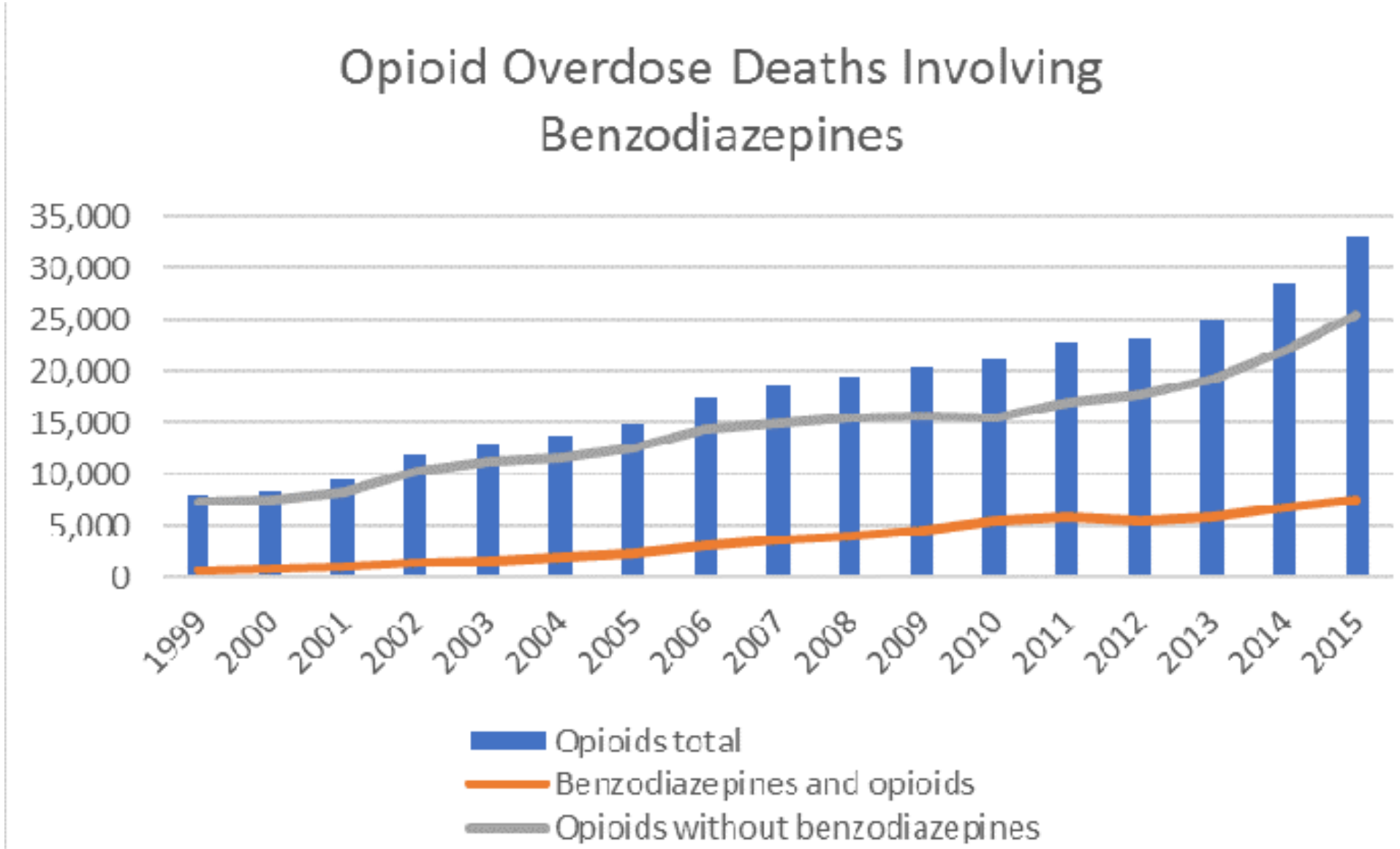
Black Box Warning: We implore health care professionals to heed these new warnings and more carefully and thoroughly evaluate … whether the benefits of using opioids and benzodiazepines … together outweigh these serious risks." -- *FDA Commissioner Robert Califf, MD*

Benzodiazepines and Opioids

Figure 8. **National Drug Overdose Deaths Involving Benzodiazepines, by Opioid Involvement,** Number Among All Ages, 1999-2017

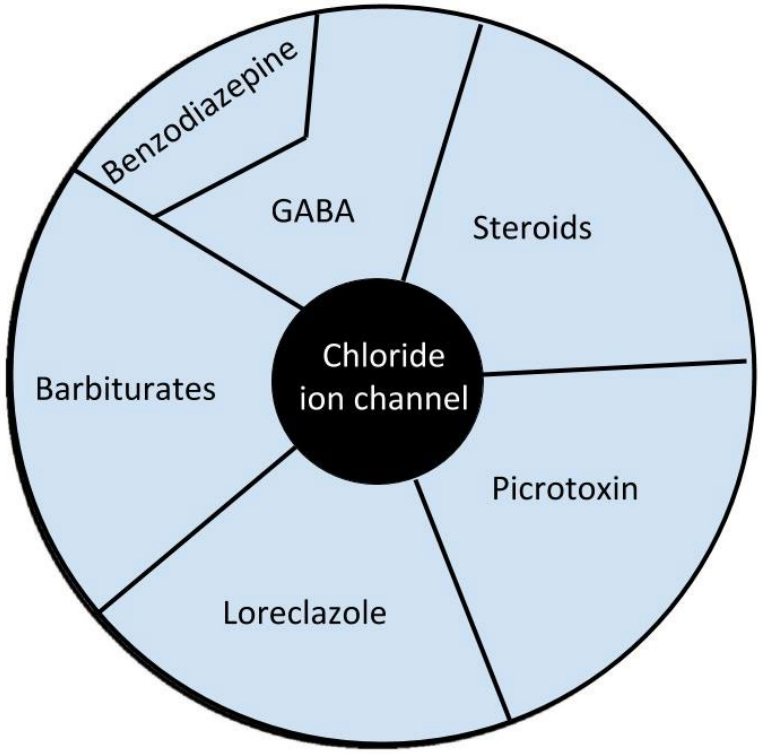


Source: : Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2017 on CDC WONDER Online Database, released December, 2018

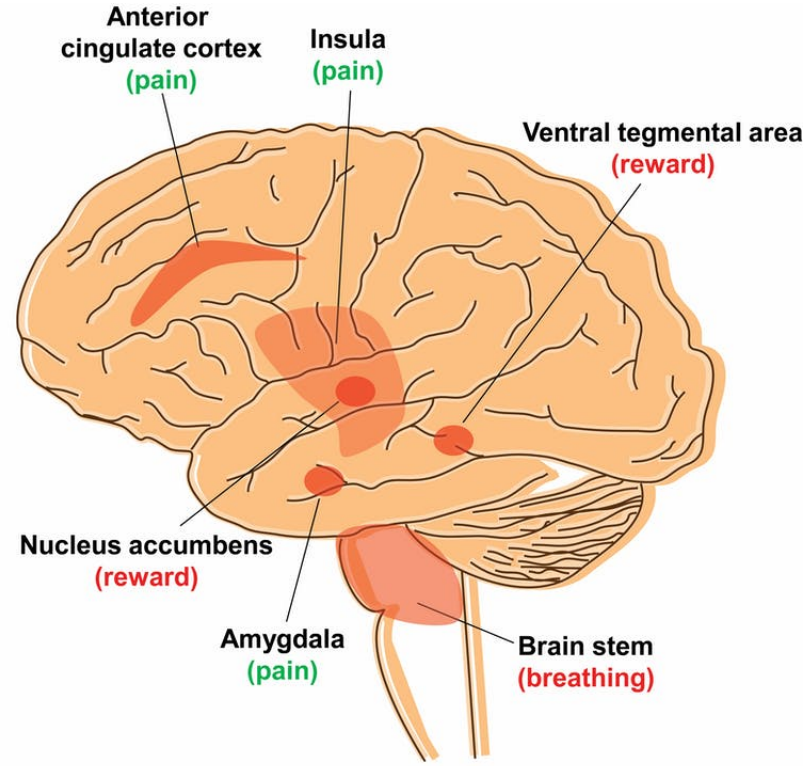

Opioid Overdose Deaths Involving Benzodiazepines
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
Opioids total
Benzodiazepines and opioids
Opioids without benzodiazepines

Respiratory Depression

Benzodiazepines



Opioids



Clinical guidance?

A CARLAT PSYCHIATRY REFERENCE TABLE

Benzos and Opioids: When to Avoid Their Combination	
Benzos raise the risk of an opioid overdose by 2–4 fold. The features below increase that risk further. When available, I've estimated the magnitude of the increase in parentheses.	
Near-absolute contraindication	• Active prescription misuse • Active opioid, alcohol, or benzo/sedative use disorder • History of sedative overdose • Methadone use (7x)
Strong relative contraindication	• History of sedative, alcohol, or opioid use disorder (3x) • Borderline or antisocial personality disorder (2x) • Unstable psychiatric disorder (2x) • Respiratory disease (eg, COPD, sleep apnea), pregnancy, or systemic medical illness such as HIV (5x); organ failure (1.5x); and renal or hepatic impairment • Daily opioid dose ≥50 morphine milligram equivalents (2x) (see www.oregonpainguidance.org/opioidmedcalculator); long-acting opioids carry a higher risk than short-acting ones • Risk of falls or traffic accidents • Age ≥65

Sources: Centers for Disease Control and Prevention, 2012. MMWR *2014;63(26);563–568; Dilokthornsakul P et al,* J Pain *2016;17:436–443; Dowell D et al,* JAMA *2016;315:1624–1645; Webster LR et al,* Postgrad Med *2015;127:27–32.*

Clinical guidance?

- NEVER initiate BZD and opioids concurrently.
  - Starting opioids and bzd concurrently → higher mortality (Hawkins, 2019)
- If someone is taking an opioid (including for MAT) and requests BZD for anxiety, pursue safer treatments for anxiety first
  - BZD higher all-cause mortality vs SSRI, regardless of opioid status. Though 2x increase with cotreatment. (Xu, 2020)
  - CBT has never killed anyone
- If pt is already on both, work with them to minimize risks, be sure to screen for use disorders, give naloxone, offer multimodal management for pain/anxiety

Compassionate Taper

- Target the ambivalence patients have about these medications
- Recognize patients have likely had to “fight” with providers previously about their medication
- If an individual cant tolerate even discussing a taper, broaden differential diagnosis
- Provide advice and psychoeducation; PATIENTS WILL HEAR YOU (on some level)
- Slow or Fast?

Stage of taper	Rate of taper
First half	5 mg equivalent diazepam per week OR 10% per week
Second half	½ the decreased used for first half, half as often (sometimes even slower)

Case Presentation

Project ECHO's goal is to protect patient privacy

- To help Project ECHO accomplish that goal, please only display or say information that doesn't identify a patient or that cannot be linked to a patient.
- **References: For a complete list of protected information under HIPAA, please visit www.hipaa.com**

Thank you for joining us today.
We appreciate your participation and hope to see you at the **NEXT ECHO Session:**
September 9, 2021 from 12pm -1 PM

You will be receiving a follow up survey that we hope you will complete to help us improve. If you are requesting continuing education credits, you will be required to complete the survey to receive your CEs.


quyana • gunalchéesh • háw'aa • way dankoo • igamsiqanaghhalek • baasee' • tsin'aen • 'awa'ahdah • qagaasakung • maasee' • dogidinh