

Opioid Tapering for Chronic Pain Patients Information for Family Physicians

Reasons for tapering

- Inadequate analgesia and severe pain levels despite a high dose of opioid (above 200 mg of morphine equivalent daily dose)
- Adverse events (e.g. sedation, constipation, falls in elderly)
- Long-term opioid complications including hyperalgesia, sleep apnea, hypogonadism and resultant osteoporosis
- Patient wishes to discontinue opioids due to negative social stigma or financial issues
- Treatment goals are not met; pain AND function have not improved by at least 30%

Setting for opioid tapering

- Opioid tapering can be done within a recovery/rehabilitation treatment setting, specialty clinic or primary care practice
- Various protocols exist depending on how acutely the taper is needed:
 - Inpatient – rapid tapering along with behavioral therapy for those who are medically unstable, non-compliant, fail outpatient programs, have comorbid psychiatric conditions or require polysubstance detoxification
 - Outpatient – slower tapering protocol; provider needs to be involved in the process and to provide support to the patient and their family

Precautions for outpatient opioid tapering

- Pregnant patients
 - Premature labour and spontaneous abortion have been associated with severe, acute opioid withdrawal
- Significant comorbidities
 - Withdrawal can cause significant anxiety and insomnia, which can worsen unstable medical and psychiatric conditions
 - Withdrawal can be quite uncomfortable but is unlikely to be life threatening in patients without significant comorbidities; otherwise, inpatient programs are recommended
- For patients who regularly access opioids from multiple doctors or “street” sources, tapering is unlikely to be successful
 - An opioid dependency program is recommended
- Sedative-hypnotic medications (especially benzodiazepines) should be avoided

Psychosocial interventions

- We recommend strong social support for the patient during an opioid taper such as access to a psychiatrist, psychologist, dietician, pharmacist, social worker and others
- We recommend discussing a plan for sleep, mood, bowels, nutrition, stress management, physical activity, self-monitoring, positive self-talk, relaxation, pacing, work/social commitments, wellness, etc. to ensure the patient has skills and strategies in place to help manage chronic pain
- Provide supportive counseling to the patient and their family
- Emphasize that the goal of tapering is to make the patient feel better (i.e. to reduce pain intensity, and to improve mood and function)

Rate of taper

- Taper according to patient's physiologic and psychological status
- If conducting an outpatient taper, use a slower taper for patients with:
 - Multiple comorbidities, polysubstance abuse, females, elderly
 - High levels of anxiety, psychological dependence, comorbid cardiorespiratory conditions
 - Extended history of chronic opioid treatment or any centrally acting medications involving receptor pharmacology (e.g. dopamine agonists, SSRIs) due to higher likelihood of withdrawal if the taper is too rapid
- Varies from 10% of the total daily dose every day to 10% of the total daily dose every 1-2 weeks
 - The latter is better tolerated and preferred for outpatient tapering
- Taper at one-half or less of previous rate when one-third of the total dose is reached. The last stage of tapering is the most difficult, as the body cannot adapt as quickly to the changes in concentration and receptor activity at this stage.
- Hold or plateau the dose if the patient is experiencing severe withdrawal, reduced function, or significant worsening of pain or mood
 - We recommend **not** to return to a previous higher dose
 - Consider extending the taper rate from every 1-2 weeks to every 3-4 weeks temporarily until symptoms settle, and then continue with the taper

Type of opioid, dosing and dispensing interval

- Sustained-release formulation preferred
- Use scheduled doses (not PRN)
- Let the patient choose which dose of the day is decreased first (AM, PM or HS)
- Keep dosing interval the same for as long as possible (BID or TID)
- Prescribe at frequent dispensing intervals (daily, alternate days, or weekly)
- We suggest blister packing for better control

Monitoring and completing the taper

- Frequent visits (e.g. weekly)
- Assess pain status, withdrawal symptoms and possible benefits (reduced pain, improved mood, energy, and alertness)
- Use urine drug screening to assess compliance
- Taper can take between 2 weeks and 6 months or longer depending on the situation
- Patients unable to complete the taper may be maintained on a lower dose if mood and function improve and they follow the treatment agreement

Clinical pearls

- The longer the patient has been on opioids, the longer the taper should be
- Do not treat withdrawal symptoms with opioids or benzodiazepines
- When deciding to taper, consider patient-specific factors (risk of withdrawal, level of anxiety, duration of opioid therapy, medical and psychological comorbidities, etc.)
- Consider adjuvant agents only if necessary. In general, we recommend **not** using adjuvants in order to avoid sending the message that medications are the only solution.

References:

Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. 2010 McMaster University National Pain Centre. When and how to taper opioids. The College of Physicians and Surgeons of Ontario. 2012.
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Opioid Tapering: Safely Discontinuing Opioid Analgesics. Pain Treatment Topics. March 2006
Interagency Guideline on Prescribing Opioids for Pain. Washington State Agency Medical Directors' Group. June 2015.