Alberta Health Services

Chronic Pain Centre
1820 Richmond Road SW
Calgary, Alberta T2T 5C7

Opioid Tapering for Chronic Pain Patients
Information for Family Physicians

Evidence and Guidelines

- Among 40 studies examining patient outcomes after opioid dose reduction, improvements were reported in pain severity, function, and quality of life *(Frank et al. 2017 Annals of Internal Medicine)*
- The 2017 Canadian Opioid Guidelines recommend tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy
    - Patients on high doses (90 mg of morphine equivalent daily dose or more) should be prioritized for gradual dose reduction
    - The balance of benefits and harms often becomes unfavourable at high doses

Reasons for Tapering

- Inadequate analgesia
- Adverse events (e.g. sedation, constipation, falls in elderly, etc.)
- Long-term opioid complications including hyperalgesia, sleep apnea, and hypogonadism
- Nonadherence to the treatment plan
- Patient request (e.g. due to negative social stigma, financial issues, etc.)
- Treatment goals are not met; pain AND function have not improved by at least 30%

Precautions for Outpatient Opioid Tapering

- Patients with suspected Opioid Use Disorder should be counselled to consider opioid agonist treatment
    - Tapering is unlikely to be successful for patients who regularly access opioids from multiple doctors or “street” sources. The high risk of relapse places them at risk of opioid poisoning.
- Pregnant patients
    - Risk for premature labour and spontaneous abortion with severe, acute withdrawal
- Significant comorbidities
    - Withdrawal can cause significant anxiety and insomnia, which can worsen unstable medical and psychiatric conditions
- Sedative-hypnotic medications (especially benzodiazepines) should be avoided

Psychosocial Support

- 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)
- Explore benefits and barriers of tapering in a non-judgmental manner
- Provide supportive counseling to the patient and their family
- We recommend strong social support for the patient during an opioid taper such as access to a nurse, psychiatrist, psychologist, physiotherapist, dietician, pharmacist, social worker and others
- We recommend discussing a plan for:
    - Sleep, nutrition, movement, productivity, relationships, mindfulness, and mental health
    - The Big 5 Skills of Self-Management for chronic pain:
        - Self-Monitoring, Relaxation, Pacing, Self-Talk, and Communication

Rate of Taper

- There is no single tapering strategy to fit all patients
- Taper according to the patient’s physiologic and psychological status; adjust the taper as needed
- The longer the patient has been on opioids, the longer the taper should be
- The 2017 Canadian Opioid Guidelines recommend 5-10% every 2-4 weeks as a reasonable rate for chronic pain patients

Last Updated: October 2019

- Consider a slower taper for:
    - High levels of anxiety, psychological dependence, comorbid cardiorespiratory conditions, elderly
- Taper at one-half or less of previous rate when one-third of the total dose is remaining
    - 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
    - Do **not** return to a previous higher dose
    - Consider extending the taper rate from every 2-4 weeks to every 4-6 weeks temporarily until symptoms settle, and then continue with the taper

Type of Opioid, Dosing and Dispensing Interval

- Use a controlled-release formulation and a fixed dosing schedule (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)
    - If the patient runs out early, increase the frequency of dispensing
- We suggest blister packing for better control

Withdrawal

- Withdrawal can be quite uncomfortable but is unlikely to be life-threatening in patients without significant comorbidities
- Signs/symptoms: Abdominal cramping, nausea, vomiting, diarrhea, myalgias, arthralgias, muscle spasms, tremors, headaches, yawning, lacrimation, rhinorrhea, piloerection, diaphoresis, chills, hypertension, tachycardia, insomnia, fatigue, anxiety, irritability, restlessness
- Do not treat withdrawal symptoms with opioids or benzodiazepines
- Consider adjuvant agents (use caution to avoid sending the message that medications are the only solution). If no contraindications, clonidine 0.05-0.1 mg BID-TID PRN may alleviate autonomic symptoms such as hypertension, diaphoresis, and tachycardia (monitor blood pressure)

Monitoring

- Schedule frequent visits (e.g. weekly)
- Assess pain status, withdrawal symptoms and possible benefits (reduced pain, improved mood, energy, alertness, etc.)
- Use urine drug screens for safety and to assess compliance
- Allow between 2 weeks and 6 months or longer for the taper, depending on the situation
- Some patients may not eliminate use of opioids, but any reduction in dose may be beneficial

Patient Education

- Patients should be strongly cautioned that they may lose their tolerance after as little as one week after a reduction, and they are at risk for poisoning if they return to a previous opioid dose
- All patients who are on high doses of opioids should be offered a take-home naloxone kit

Specialist Link Advice (See http://www.specialistlink.ca/)

- Need advice from a chronic pain specialist? Call a nurse practitioner via Specialist Link:
    - 403-910-2551 (toll-free 1-844-962-5465)
    - Your call will be returned within one hour; available Mondays-Fridays 8 am - 4 pm.

References:
Frank JW et al. Patient outcomes in dose reduction or discontinuation of long-term opioid therapy: a systematic review. Ann Intern Med 2017;167(3);181-191.
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