Recommendations for deprescribing or tapering opioids

Information for health professionals

Risks of high-dose opioid use include tolerance and increased pain sensitivity,[1-6] as well as a significant risk of overdose and death.[7-13] See the fact sheet 'Risks of prescribing high-dose opioids' for more information.

Research shows that patients in severe pain despite use of high-dose opioids may experience significant improvement in pain severity, functioning, and mood when their opioid is tapered to a lower, safer dose,[6, 14-18] in addition to reduced sedation[14] and improved cognitive function.[19] Interdisciplinary rehabilitation programs that incorporated opioid withdrawal showed long-term improvements in pain, functioning, health attributes, negative pain-related emotions and depressive symptoms. Non-drug interventions in these programs included cognitive behavioural therapy, physiotherapy and occupational therapy.[6, 20, 21]

When to deprescribe

> If a patient is reaching the recommended threshold of 80–100 mg morphine equivalent dose (MED) per day, and has no improvement in pain or function, consider deprescribing their opioid to a safer dose. If they are not being managed with adjuvant non-opioid analgesics or non-drug treatments such as cognitive behaviour therapy and physiotherapy, review and optimise these.[14, 22]

Also consider deprescribing if the patient is experiencing opioid-related complications, has deterioration in physical, emotional or social functioning, fails to adhere to the treatment agreement, exhibits drug-seeking behaviours, or has a resolution of the pain condition.[14, 15, 22]

Precautions for deprescribing include pregnancy, unstable medical and psychiatric problems, opioid addiction and using concurrent medications during the taper.[15] Seek expert advice in the management of such patients before initiating or increasing opioid medication.

An online opioid tapering calculator is available.

Having the conversation

As soon as your prescriptions are nearing, or go above, the recommended daily MED, start a conversation with the patient about deprescribing. Explain the benefits of lower doses and the risks of chronic opioid therapy, and note that they may have developed an increased sensitivity to pain due to a change in their brain from ongoing opioid use (opioid-induced hyperalgesia) and tolerance.

Emphasise that the goal of deprescribing is to reduce their pain intensity and to improve their function and mood, and reinforce that there are alternative, safer ways to manage their pain.[15, 23] The patient may be relying on the opioid for conditions other than pain, such as stress or insomnia, and a discussion of alternative management for these would be beneficial.[15] Explain that pain management requires a multidimensional assessment and a multidisciplinary approach.

Reassure the patient that you will continue to work closely with them to manage their pain and any withdrawal symptoms. Provide a copy of the patient fact sheet 'Risks of high-dose opioid medicines', and allow them time to make a decision before commencing the taper.

RACGP recommendations for tapering opioids

In Victoria a permit is required when prescribing a Schedule 8 poison for more than 8 weeks, or before prescribing for a drug-dependent person. Relevant documents are available from the health.vic website at www.health.vic.gov.au/dpcs. The Department of Health and Human Services may request confirmation that a pain management plan has been formulated with the patient.[24]

Before tapering, all opioid therapy should be consolidated into a single long-acting medication, if practical, unless there is a clear basis for combining opioids. Dose reduction should proceed at a rate that avoids withdrawal symptoms and pain escalation, and should continue until function or symptoms are improved.[15, 25]

The RACGP clinical governance framework recommends the following:[15]

- Use controlled release morphine if feasible. Prescribe scheduled doses, not as needed, and at frequent dispensing intervals (daily, alternate days, or weekly, depending on the patient's control). If the patient runs out of opioid medications before the scheduled time, consider more frequent (daily or several-daily) dispensing to avoid opiate withdrawal.
- The rate of taper can vary from 10% of the total daily dose every day to 5% every 1–4 weeks. A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological effects.
- Slower tapers are recommended for patients who are anxious about tapering, who might be psychologically dependent on opioids or who have cardiorespiratory conditions.
- Faster tapers may be used for patients experiencing serious adverse effects. If a patient is identified as drug-seeking or exhibiting aberrant behaviour, they may warrant a more rapid withdrawal schedule.
- When one-third of the original dose is reached, slow the taper to half the previous rate.
- Hold or increase the dose if the patient experiences severe withdrawal symptoms or worsening pain or mood.
- Patients who are unable to complete the taper may be maintained at a lower opioid dose if they are compliant with the treatment plan.

Persistent pain can result in people avoiding activities, which may lead to deconditioning, causing loss of muscle condition necessary for good posture and stability of the body.[26-28] Physical rehabilitation should be integrated into the tapering plan.[15]

Problematic use of oxycodone or hydromorphone

If there is evidence of aberrant behaviour in patients on oxycodone or hydromorphone, consider consolidating their opioids into single dosing with frequent collection, eg daily, commencing a tapering program, or referral to an addiction specialist.

If switching to morphine:[15]

- calculate the equivalent dose of morphine
- start the patient on half this dose
- adjust the dose as necessary to relieve withdrawal symptoms without inducing sedation.

Ongoing management

Review the patient regularly and ask about improved pain, mood and alertness. If the patient is not successfully reducing, involve other practitioners, and consider a urine drug screen to document opioid metabolites.[15]

Referring the patient for counselling or other psychological support is recommended for significant behavioural issues. If necessary, arrange for doses to be dispensed daily.[15]

Opioid withdrawal syndrome

Opioid withdrawal syndrome is rarely medically serious, although symptoms may be unpleasant. Nausea, diarrhoea, muscle pain and myoclonus can be managed with clonidine, under close supervision and with monitoring for significant hypotension and anticholinergic side effects. Consider using adjuvant agents such as antidepressants to manage irritability and sleep disturbance, or antiepileptics for neuropathic pain, and to limit hyperalgesia, including opioid-induced hyperalgesia. Refer to the RACGP recommendations for managing withdrawal symptoms.[15, 22, 25]

Refer the patient to a pain specialist or public health dependency centre if they appear to need moderate to high-dose opioids or experience complicated withdrawal symptoms.[15]

Resources

Australian Pain Society – Facility Directory: www.apsoc.org.au/facility-directory

Faculty of Pain Medicine ANZCA

- ***Recommendations Regarding the Use of Opioid Analgesics in Patients with Chronic Non-Cancer Pain***
  http://fpm.anzca.edu.au/Documents/PM1-2010.pdf
- ***Quick Reference Recommendations for Conduct of an Opioid Trial in Chronic Non-Cancer Pain***
  http://fpm.anzca.edu.au/Documents/4462_001.pdf

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