OPIOID TAPERING – *when reducing or discontinuing an opioid in chronic non-cancer pain (CNCP).*

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A) General Considerations

1) Determine if the goal of dose reduction is reasonable (e.g. opioids have demonstrated some benefit) or if complete discontinuation is more suitable (e.g. trial has been highly problematic/ineffective or opioid induced hyperalgesia is a concern).

2) If goal is to reduce dose, option to taper further & more gradually may be considered at a later point. Tapering plan may be held/reassessed at any point if pain/function deteriorates or withdrawal symptoms persist. However, the "hold off on further taper & plan to restart taper" conversation should have a designated endpoint and be one conversation, not two!

3) Gradual tapers can often be completed in the range of 2 weeks to 6 months. However, some may benefit from a longer time frame of 18 to 24 months.

4) **Initial daily dose reductions in the range of 10% every 1-2+ weeks are reasonable.[1] Once 1/3 of the original dose is reached, smaller dose reductions (e.g. 5% every 2-4+ weeks) may be more optimal for a successful taper.[1] (May require formulation change).**

5) Formulations that offer smaller dose increments are useful for more gradual tapers once in the lower end of the dosage range. {Examples: morphine long-acting: M-Eslon 10mg cap $_{q12h}$, KADIAN 10mg cap $_{q24h}$}

6) More rapid tapers are possible & sometimes desired. In such cases, use of an opioid withdrawal scale (OWS) & corresponding protocols may be recommended, allowing for successful withdrawal within 1-2 weeks. (See links)[2,3]

7) Given the complexities in some cases, discussion with experienced colleagues and an interdisciplinary approach will help optimize management. Continue to use "best practice" tools (e.g. *Opioid Manager* form from Canadian guidelines, urine drug screens, etc).

PATIENT MANAGEMENT

1) Anticipate withdrawal effects & have a plan to manage.

2) Optimize other pain management (e.g. addition of co-analgesics for neuropathic pain such as nortriptyline, duloxetine, gabapentin or pregabalin).

3) Encourage functional goal setting and efforts to enhance non-drug approaches in management plan.

4) Strongly caution patients that a) they have lost their tolerance to opioids after as little as a week or two of abstinence, and b) they are at risk for overdose if they relapse/resume their original dose.

B) Timeline & Tips for Stopping or Reaching a Taper "Target Dose"

- Allow for gradual q3 day, weekly, bi-weekly or monthly dose reductions. Reassess as necessary. In general, the longer the duration of previous opioid therapy, the more time should be allotted for tapering.
- May switch to 50-60% equivalent morphine dose if not already on. Reduced dose accounts for incomplete cross tolerance. See Opioid Manager Switching Tool.
- Last 20-60 mg (morphine equivalent) may require more time.

C) Opioid Withdrawal Symptoms (See table to the right.)

- **Many of these symptoms may <u>not</u> be seen with a gradual taper!**
- Physical withdrawal symptoms generally resolve by 5-10 days following opioid dose reduction/cessation.
- Psychological withdrawal symptoms (dysphoria, insomnia) may take longer.

EARLY symptoms may include:	LATE symptoms may include:	PROLONGED symptoms may include:
- anxiety / restlessness - sweating - rapid short respirations - runny nose, tearing eyes (minor) - dilated reactive pupils	- runny nose, tearing eyes - rapid breathing, yawning - tremor, diffuse muscle spasms/aches - pilo-erection - nausea and vomiting; diarrhea - abdominal pain - fever, chills - ↑ white blood cells (if sudden withdrawal)	- irritability, fatigue, psychological - bradycardia - decreased body temperature
Early = hours to days **Late** = days to weeks **Prolonged** = weeks to months		◆ Some people with chronic pain will find that symptoms such as fatigue and general well-being improve over time with tapering of the opioid. In such cases, <u>gradual gains in function</u> will be possible & should be explored.

D) Management of Other Withdrawal Related Side Effects

<u>Aches/Pains/Myalgia</u>:

⇨ **NSAID** (e.g. naproxen 375-500mg twice daily or ibuprofen 400-600mg four times daily)**:** useful for pain & withdrawal.

⇨ **Acetaminophen** (650-1000mg every 6 hours as needed) may be used for *aches, pains, flu-like symptoms.*

<u>Bowel Function (Constipation / Diarrhea)</u>:

⇨ **Laxative** - continue initially to prevent constipation; with time, reduce, hold & eventually stop laxative (See Opioid Induced Constipation Q&A online) [4]

⇨ **Loperamide** - used if necessary for *diarrhea*; may not need with gradual taper.

<u>Nausea/Vomiting</u>:

⇨ **Dimenhydrinate** 50-100mg every 6 hours as needed [Alternatives: prochlorperazine 5-10mg po q6-8h; haloperidol 0.5-1mg po q8-12h]

<u>Anxiety, Irrritability, Lacrimation, Cramps, Rhinorrhea, Diaphoresis, Insomnia</u>:

⇨ **hydroxyzine** 25-50mg po TID PRN (or sometimes just needed at HS)

<u>Insomnia</u>:

⇨ **Non-drug & "sleep hygiene"** measures should be employed (e.g. regular bedtime/wake-time; sleep restriction).[5,6,7] If pharmacologic treatment necessary, short-term **trazodone** would be an option (25mg po HS up to 100mg).

<u>Physical Withdrawal Symptoms (general)</u>:

⇨ **Clonidine 0.1mg twice daily may be prescribed for general relief/prevention**. Initial test dose 0.1mg x1; check BP & HR 1 hr later (if BP <90/60, postural hypotension, or HR <60, do not prescribe further). May titrate up to 4 times daily. Reassess in 3-7 days; taper to stop. [Cochrane review documented typical clonidine use for 7-14 days; longest duration was for 30 days.[8]]
Clonidine not routinely needed if gradual taper.

See also the RxFiles Opioid Tapering Template - version of this document, online.
http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf

RxFiles Academic Detailing
Saskatoon City Hospital
701 Queen Street, Saskatoon, SK Canada S7K 0M7
www.RxFiles.ca

Opioid Tapering Template

For use when a decision is made to reduce or discontinue an opioid in chronic non-cancer pain (CNCP).

General approach considerations:

1. Gradual tapers can often be completed anywhere in the range of 2 weeks to 6 months. However, some may benefit from a longer time frame of 18-24 months. Initial daily dose reductions in the range of 10% every 1-2+ weeks are reasonable.[1] Once a dose of approximately 1/3 of the original dose is reached, smaller dose reductions (e.g. 5% every 2-4+ weeks) may be more suitable for some & more likely to result in a successful taper.[1] More rapid tapers are possible and sometimes desired. In such cases, use of an opioid withdrawal scale (OWS) & corresponding withdrawal protocols may be recommended, allowing for successful withdrawal within 1-2 weeks. (See links [2,3])
2. Formulations that offer smaller dose increments are useful for more gradual tapers once in the lower end of the dosage range. {Examples: morphine long-acting: M-Eslon 10mg cap $_{q12h}$, Kadian 10mg cap $_{q24h}$.}
3. Determine if the goal of dose reduction reasonable (e.g. opioids have offered some benefit) or if complete discontinuation is more suitable (e.g. opioid trial has been highly problematic/non-helpful or there is a concern regarding opioid induced hyperalgesia).
4. If goal is to reduce dose, option to taper further & more gradually may be entertained at a later point. Tapering plan may be held/reassessed at any point if pain/function deteriorate or withdrawal symptoms persist. However, the "hold off on further taper & plan to reassess/restart taper" conversation should have a designated endpoint & be one conversation, not two!
5. Encourage functional goal setting & efforts to enhance non-drug approaches in management plan.
6. Optimize other pain management (e.g. Is something needed for neuropathic pain such as nortriptyline, gabapentin or pregabalin).
7. Anticipate likely and possible withdrawal effects and have a management plan in place. (See pg 2.)
8. Given the complexities in some cases, discussion with experienced colleagues and an interdisciplinary approach will help optimize management. Continue to use "best practice" tools (e.g. Opioid Manager, UDS).
9. Strongly caution patients that a) they have lost their tolerance to opioids after as little as a week or two of abstinence, & b) they are at risk for overdose if they relapse/resume their original dose.

Timeline for discontinuation or reaching a taper "target dose"

Current dose _____

Proposed target dose _____

Timeline (in weeks or months) _____ ☐weeks ☐months

⇨ Allow for gradual q3 day, weekly, bi-weekly or monthly dose reductions. Reassess as necessary.

⇨ In general, the longer the duration of previous opioid therapy, the more time should be allotted for tapering. Rate of tapering should often be even more gradual as total daily dose reaches lower end of range (e.g. ≤120 mg Morphine/day)

See page 2 for customizable tapering template.

Name: _____ **Date:** _____

Address: _____

(May switch to 50-60% equivalent morphine dose if not already on.)
Reduced dose accounts for incomplete cross tolerance. See Opioid Manager Switching Tool.

A) Tapering Schedule*: Drug _____

	Dates	(# wks)	Single Dose	Frequency	Total Dose/Day	*Quantities Needed*
0.	Current		mg		mg	
1.		x wk	mg		mg	
2.		x wk	mg		mg	
3.		x wk	mg		mg	
4.		x wk	mg		mg	
5.		x wk	mg		mg	
6.		x wk	mg		mg	
7.		x wk	mg		mg	
8.		x wk	mg		mg	
9.		x wk	mg		mg	
10.		x wk	mg		mg	
11.		x wk	mg		mg	
12.		x wk	mg		mg	

*template may be adjusted based on patient's progress; decisions on further tapering, etc. Last 20-30 mg may require more time

B) Opioid withdrawal symptoms:

- **Many of these symptoms may <u>not</u> be seen with a gradual taper!**
- Physical withdrawal symptoms generally resolve by 5-10 days following opioid dose reduction/cessation.
- Psychological withdrawal symptoms (dysphoria, insomnia), if seen, may take longer (months) to resolve.

Early symptoms may include:	**Late symptoms may include:**	**Prolonged symptoms may include:**
- anxiety and restlessness - sweating - rapid short respirations - runny nose, tearing eyes (minor) - dilated reactive pupils	- runny nose, tearing eyes - rapid breathing, yawning - tremor, diffuse muscle spasms/aches - pilo-erection (goose bumps) - nausea and vomiting; diarrhea - abdominal pain - fever, chills - ↑ white blood cells (if sudden withdrawal)	- irritability, fatigue; hormonal related△ - bradycardia (slower heart rate) - decreased body temperature
Early = hours to days **Late** = days to weeks **Prolonged** = weeks to months		◆ Some people with chronic pain will find that symptoms such as fatigue & general well-being are improved over time with tapering of the opioid. In such cases, <u>gradual gains in function</u> will be possible & should be explored.

☐ **C) NSAID** (e.g. naproxen 250-375mg twice daily or ibuprofen 400-600mg four times daily)**:** useful for pain & withdrawal aches/pains.

☐ **D) Laxative:** continue initially; with time, or if diarrhea emerges, reduce, hold & eventually stop laxative (See Q&A)[4]

☐ **E) Management of other side effects:**

1. **Clonidine** 0.1mg twice daily may be prescribed for *general relief/prevention of physical withdrawal symptoms*. Initial test dose 0.1mg x1; check BP & HR 1 hr later (if BP <90/60, postural hypotension, or HR <60, do not prescribe further). May titrate up to 4 times daily. Reassess in 3-7 days; taper to stop. [Cochrane review documented typical clonidine use for 7-14 days; longest duration was for 30 days.[5]] Clonidine <u>not</u> routinely needed if gradual taper.

☐ 2. **Acetaminophen** (650-1000mg every 6 hours as needed) may be used for *aches, pains, flu-like symptoms.*

☐ 3. **Loperamide** may be used as necessary for *diarrhea*; however, may not need with gradual taper.

☐ 4. **Non-drug & "sleep hygiene"** measures should be employed (e.g. regular bedtime/wake-time; sleep restriction).[6,7,8] If additional treatment necessary, short-term **trazodone** 25-50 or 100mg at bedtime would be an option.

☐ 5. **Dimenhydrinate** 50-100mg every 6 hours as needed for *nausea/vomiting* [Alternatives: prochlorperazine 5-10mg q6h, haloperidol 0.5-1mg q12h]

☐ **6. Other**

Physician: _____

Extras, Links & References

A) Sample Slow Tapering Schedule*: Drug _____Morphine long acting_(MS Contin)

	Dates	(# wks)	Single Dose	Frequency	Total Dose/Day	*Quantities Needed*
0.	Current	-	245mg	Twice daily	490 mg	
1.		X2 wk	230 mg	Twice daily	460 mg	*(4x100mg) + (2x30mg) x14d*
2.		X2 wk	215 mg	Twice daily	430 mg	
3.		X2 wk	200 mg	Twice daily	400 mg	
4.		X2 wk	190 mg	Twice daily	380 mg	
5.		X4 wk	175 mg	Twice daily	350 mg	
6.		X4 wk	160 mg	Twice daily	320 mg	
7.		X4 wk	145 mg	Twice daily	290 mg	
8.		X4 wk	130 mg	Twice daily	260 mg	
9.		X4 wk	115 mg	Twice daily	230 mg	
10.		X8 wk	100 mg	Twice daily	200 mg	
11.		X8 wk	90 mg	Twice daily	180 mg	
12.		X8 wk	80 mg	Twice daily	160 mg	*Switch to m-Eslon* *smaller titrations*
13.		X8 wk	70 mg	Twice daily	140 mg	
14.		X12 wk	60 mg	Twice daily	120 mg	
15.						*Option of switch to once daily Kadian if taper continues.*

***this template may be adjusted based on patient's progress; decisions on further tapering, etc.**

Additional information:

CAMH: Video discussion of issues around how to taper. http://knowledgex.camh.net/videos/Pages/tapering_presopioids_selby2013.aspx

Opioid Taper Template & related materials at: www.RxFiles.ca

Opioid Manager tool from Canadian CNCP guideline group: http://nationalpaincentre.mcmaster.ca/opioidmanager/

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[1] Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain — Part B: Recommendations for Practice, Version 5.5 April 30, 2010. [NOUGG] Accessed at: http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf

[2] Opioid withdrawal scales, Saskatoon Health Region, Saskatchewan. http://pauliplace.com/02%20Involuntary%20DSS/03%20YIAP&MA%20hyperlinks/YIDSMAIS%2008%20SHR%20Opiate%20Withdrawal%20Scale.pdf

[3] Butt P, McLeod M. Opioid withdrawal protocol, Saskatchewan. http://www.quadrant.net/cpss/pdf/Opioid_Withdrawal_Protocol.pdf

[4] http://www.rxfiles.ca/rxfiles/uploads/documents/members/Opioid-Induced-Constipation-QandA.pdf

[5] Gowing L, Farrell MF, Ali R, White JM. Alpha2-adrenergic agonists for the management of opioid withdrawal. Cochrane Database Syst Rev. 2014 Mar 31;3:CD002024.

[6] Merrigan JM, Buysse DJ, Bird JC, Livingston EH. JAMA patient page. Insomnia.JAMA. 2013 Feb 20;309(7):733. Accessed online 21 Oct, 2013 at http://jama.jamanetwork.com/article.aspx?articleid=1653524.

[7] Sedative Patient Information Sheet (RxFiles) http://www.rxfiles.ca/rxfiles/uploads/documents/PSYC-Sedative-PtHdout.pdf

[8] Chronic Insomnia in Older Adults (RxFiles Q&A) http://www.rxfiles.ca/rxfiles/uploads/documents/Insomnia-Older-Adults-QandA.pdf