Opioid Tapering Guide

Non-malignant, Non-palliative Chronic Pain

NHS Southampton City Clinical Commissioning Group

Key Message: If a medication is not providing useful pain relief, it should be tapered or stopped, even if no other treatment is available.

Other indications for opioid tapering/discontinuation:

- Patient request
- >120mg oral morphine equivalent per day
- Opioid trial goal not met
- Opioids not indicated
- Indicators for dependence:
  i.e. refusal to explore other treatments, failure to attend appointments for review, early/repeated requests for prescriptions, lost medication, seeking opioids from other prescribers and services, resisting referrals to specialist services, deteriorating social function, alcohol abuse or use of illicit/OTC/internet drugs.
- Underlying condition resolves
- s/e intolerable or impairing function
- Patient receives definite pain relieving intervention
- Strong evidence patient is diverting medication

Precautions:
Pregnancy: Acute opioid withdrawal has been associated with premature labour and spontaneous abortion.
Unstable psychiatric or medical conditions: Although withdrawal does not have serious medical consequences, it can cause significant anxiety and insomnia.
Opioid addiction: Withdrawal is unlikely to be successful if patient accesses opioids from other sources, i.e. multiple doctors, 'street'. Referral to drug addiction services will be required.

Step 1: Discuss with patient

Explain the reasons for tapering or decreasing opioids:

Side effects of opioids include constipation, itchy skin, breathing problems, unable to think clearly, low mood, tiredness, low libido, risk of falls and fractures

The amount of pain relief from opioids can become less at higher doses because of tolerance

Gradually tapering doses may result in less pain and better mood, function and overall QOL

Sometimes opioids can cause your pain to get worse. This is called 'opioid induced hyperalgesia'

Written information is available to give to patients – ***'Why does my GP want to reduce my pain killers'***

Enlist support and understanding from friends and family.

Learn and practice non-drug-management strategies.

What to expect:

- Increased pain - Taking a dose of opioid may reduce the pain but only temporarily. Pain associated with withdrawal generally subsides within 1-2 weeks and is lessened by tapering doses slowly.
- Withdrawal symptoms – Flu-like symptoms i.e. sweats, chills, headache, joint and muscle pains, diarrhoea, fatigue, anxiety, insomnia, can occur with stopping opioids suddenly. Therefore it is best to decrease slowly over weeks or months.

What if the patient isn't keen? GMC guidance is that doctors have to act in the patients best interests – this may involve reducing an opioid against a patient's wishes. Ensure your reasons are documented.

Step 2: Start the tapering process

Give the patient as much choice as possible over how the opioid reduction is achieved. This gives more ownership and improves engagement and is therefore more likely to succeed.

- The long term goal is to improve pain control and quality of life whilst reducing harms.
- Make it clear that once the opioid dose is reduced, it will NOT be increased.
- There is a risk of overdose if a higher dose of opioid is taken following tapering as tolerance is reduced.

Mixed opioids:	Reduce one at a time
Immediate release or prn doses:	Either keep frequency the same (e.g. 4 times a day) and reduce the dose each week or maintain the dose and decrease the frequency each week.
MR doses:	A decrease of 10% of the original dose every 1-2 weeks is usually well tolerated.
Slower tapering	May be more effective for people who are anxious or psychologically dependent. Use smaller of reductions (5%) or increase the interval of dose reductions.
Faster tapering	May be indicated for patients experiencing significant adverse effects or displaying aberrant drug taking or drug seeking behaviours.
Patches:	Reductions in doses of patches are dictated by available strengths and are therefore larger than the other opioids.

Once a third of the original dose is reached, the tapers may need to be slowed as the reductions become a higher proportion.

Anxiety and depression often worsen during an opioid reduction. Be prepared to manage this if necessary.

Do not treat withdrawal with more opioids or benzodiazepines.

Step 4: Follow-up and review

Review regularly: Ideally before each dose reduction (telephone or face to face). Ask about reduction in side effects, improvement in alertness, mobility, functional goals and emotional wellbeing as well as withdrawal symptoms and pain.

Worsening pain or mood:	Hold the tapering dose. Do not add prn opioids, sedatives or hypnotics.
Withdrawal symptoms:	Hold the tapering dose and consider if the rate need to be slowed.

It may be clinically appropriate to maintain a patient on a reduced dose rather than a complete taper if pain and functional goals are met in line with treatment plan. Review after 3-6 months.

Depression and Anxiety:
Steps to Wellbeing
https://www.steps2wellbeing.co.uk/

Pain Medicines Management Advice:
Vicki Rowell – Southampton CCG
vicki.rowell@nhs.net

Drug Abuse and Addiction:
Southampton Drug and Alcohol Recovery Service
https://www.changegrowlive.org/content/southampton-drug-and-alcohol-recovery-service-dars

Other:
Pain Toolkit - https://www.paintoolkit.org/
Live Well With Pain - https://livewellwithpain.co.uk/
Opioids Aware - https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware

References: Opioids Aware https://www.rcoa.ac.uk/faculty-of-pain-medicine/opioids-aware
Adapted from Anglia Medicines Optimisation Team: Tapering Opioids For Non-Malignant, Chronic Pain