Intermountain® Healthcare

CLINICAL GUIDELINE AUGUST 2015

Tapering Opioid Pain Medication

For Patients With Chronic Pain

The Functional Restoration/Chronic Pain Development Team developed these guidelines to assist providers with tapering patients' opioid pain medications. The Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain,[UTAH] Washington state's Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain,[WASH] and other peer-reviewed clinical guidelines[VA,CAN] were used to develop the guidelines.

WHY FOCUS ON OPIOID TAPERING?

Opioids play an important role in managing chronic pain; however, regular monitoring is essential to minimize these inherent risks:

- **Serious consequences** of long-term opioid use include death, accidents, and increasing disability. The Centers for Disease Control and Prevention described prescription pain medication overdose as a growing and deadly epidemic.
- **Adverse effects** associated with opioid use include functional limitations, apnea, anxiety, and depression.
- **Pain perception** can be altered by opioids, resulting in hyperalgesia. The long-term effectiveness of opioid pain medication is not clear.[KREB] Many patients report less pain when they discontinue opioids.
- **Abuse, addiction, and diversion** are all significant risks of opioids.

KEY POINTS

- This guideline does not apply to patients with cancer pain or those receiving end-of-life care.
- No single approach to tapering is appropriate for all patients.
- If overdose or aberrant behavior is detected or suspected, consider consulting with or referring patient to an addiction specialist.
- If pain is uncontrolled and patient requires a high dose of opioids (e.g., morphine equivalent > 120 mg/day), consider referral to a pain specialist.
- Tapering can be a slow process and requires preparation, planning, monitoring, and follow-up.
- Although potentially unpleasant, withdrawal symptoms associated with tapering generally are not dangerous.

KEY RECOMMENDATIONS

Assess these factors:

- Patient's desire to discontinue opioids
- Pain and function
- Adverse effects
- Reasons for continuing use
- Abuse, addiction, or diversion

Consider these guidelines:

- Most patients tolerate a 10% dose reduction per week. Faster or slower tapering may be indicated.
- Abstinence syndrome may be treated with medications such as oral or transdermal clonidine.
- Patients should be regularly monitored and referred to specialists as needed.

MEASUREMENT & GOALS

- **Improve the quality of life for patients with chronic pain** in terms of overall function, work status, sleep, and activity levels.
- **Reduce admissions for opioid overdose.**
- **Reduce the number of patients taking 2 or more long-acting opioids.**
- **Reduce the number of patients taking a morphine equivalent dose of more than 120 mg/day.**

Indicates an Intermountain measure

These guidelines apply to common clinical circumstances, and may not be appropriate for certain patients and situations. The treating clinician must use judgment in applying guidelines to the care of individual patients.

 Functional Restoration and Chronic Pain Clinical Program approval **08/2015.**
(Patient and Provider Publications 801-442-2963)

ALGORITHM NOTES

(a) The Current Opioid Misuse Measure (COMM) has been shown to be effective in identifying whether a patient may be exhibiting aberrant behaviors associated with opioid medication misuse.

(b) Positive screening results should be confirmed with testing that uses gas or liquid chromatography/mass spectrometry (GC/MS) to ensure accuracy. All results should be interpreted in the context of the clinical setting and discussed with patients to improve patient care.

(c) For guidance on handling suspected diversion, refer to pages *25–26* of the Management of Chronic Non-cancer Pain Care Process Model.

(d) Possible contraindications to continuing opioid therapy include COPD, congestive heart failure, obstructive/central sleep apnea, abnormal breathing/snoring, substance abuse or history of substance abuse, mental health disorders, advanced age, and renal or hepatic dysfunction.

(e) ORAL DOSE EQUIVALENTS of 120 mg/day morphine

Codeine	800 mg/day
Fentanyl (transdermal)	25–50 mcg/hr
Hydrocodone	120 mg/day
Hydromorphone	30 mg/day
Oxycodone	80 mg/day
Oxymorphone	40 mg/day

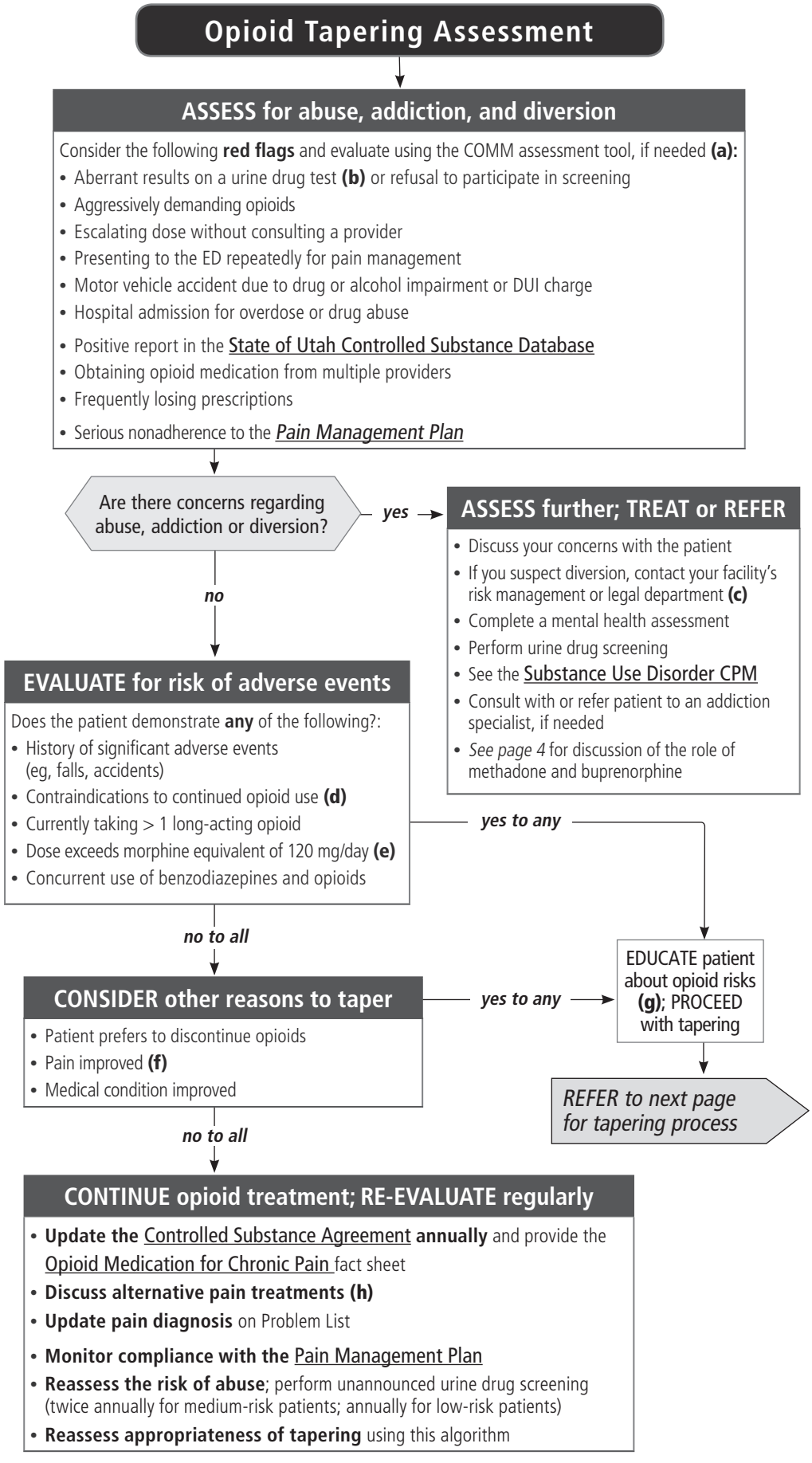
Source: agencymeddirectors.wa.gov/mobile.html

Published equianalgesic ratios are considered estimates and depend on age (use caution with elderly patients) and coexisting conditions, especially liver, renal, or pulmonary disease. When converting to a new opioid, start with a 25–50% lower equianalgesic dose because of incomplete cross-tolerance. When converting from a fentanyl patch, allow 12–24 hours for absorption of residual drug before starting a new opioid. Conversion tables may overestimate the morphine equivalent potency; therefore, reduce the dose of the new drug at least 50%.

(f) Use the Brief Pain Inventory to determine severity of pain and interference with function.

(g) Provide the fact sheet on Cutting Back on Opioid Pain Medication.

(h) Refer to the Management of Chronic Non-cancer Pain CPM.



Opioid Tapering Process

EDUCATE patient

- **Discuss the goals of tapering** (ie, reduced pain, improved function and mood, reduced risk of adverse events)
- **Explain the treatment plan and possible withdrawal symptoms**
- **Emphasize the need for regular follow-up**
- **Arrange counseling and support,** especially if there are behavioral issues
- **Take a shared decision-making approach.** Encourage the patient to communicate his or her preferences about when to start, how quickly to taper, and when to schedule follow-up.
- **Anticipate and respond to resistance from the patient (i)**

PLAN and INITIATE

- **Consider the patient's comorbidities and psychological conditions** that might affect the tapering plan
- **Taper short-acting opioids first,** then taper long-acting medications
- **For most patients, a 10% weekly decrease in dose is well tolerated.** Prescribe at frequent dispensing intervals and do not refill the prescription if the patient runs out. Write the taper on the prescription (e.g., 1 po every 6 hours for 3 days, 1 po every 8-12 hr for 3 days, 1 po every 24 hr for 3 days, stop).
- **Some patients can be successfully tapered more quickly.** A weekly dose reduction of 20% to 50% may be feasible **(j)**
- **Slower tapering is preferable for other patients.** Consider a 5% reduction in dose every 1 to 4 weeks. **(k)**

FOLLOW UP frequently

- **Ask about pain, mood, and alertness** at every follow-up visit or phone call
- **Treat symptoms of abstinence syndrome.** The recommended treatment is clonidine (0.1 mg every 8 hours for 1 to 3 days, depending on the severity of the withdrawal symptoms). Alternatively, a clonidine transdermal patch can be used (0.1 mg/24 hours) weekly throughout tapering. Do not treat symptoms of abstinence syndrome with benzodiazepines or opioids.[CAN, WASH] **(l)**
- **Prescribe nonopioid medications as needed:**
  - Anti-inflammatories, if approrpriate
  - Antidepressants for irritability or sleep problems
  - Antiepileptics for neuropathic pain
- **Evaluate mental health status.** Refer patient to a counselor or other support program if behavioral problems develop during tapering.

Is pain or functioning significantly worse? — *yes* → STOP taper; REASSESS treatment

No

COMPLETE tapering and DISCONTINUE opioids (m)

- Patients who cannot complete tapering may continue on a reduced dose as long as they comply with their treatment plan.

ALGORITHM NOTES *continued*

(i) Providers should be careful to maintain the therapeutic relationship during tapering. Some patients may resort to risky behaviors such as doctor-shopping or illicit drug use. Patients may also challenge providers or exaggerate their pain to avoid tapering. See page 4 for tips on talking with patients.

(j) Fast tapering may be considered for patients who have been on lower doses of opioids and/or taking opioids for a shorter time (e.g., <1 month). Generally, these patients can be tapered more rapidly during the first 50% of dose reduction. The final 25% may be more challenging and require slower tapering.

(k) Slower tapering is suggested for patients who:

- Are psychologically dependent on opioids or anxious about tapering
- Have been on high doses and/or taking opioids for a longer time
- Have unstable cardiac disease

(l) Withdrawal symptoms can persist for up to 6 months after opioids are discontinued and may include the following:

- abdominal cramping
- nausea
- vomiting
- diarrhea
- muscle and joint pain
- myoclonus
- tachycardia
- fever
- elevated blood pressure
- anorexia
- insomnia
- rhinorrhea
- anxiety
- irritability
- dysphoria

Pregnant patients: Acute withdrawal symptoms can trigger premature labor and spontaneous abortion in pregnant patients and can exacerbate some medical and psychiatric conditions.

(m) Re-initiaing opioid therapy: Be extremely cautious about restarting opioid therapy after discontinuance. Patients may redevelop tolerance quickly.

REFERENCES AND RESOURCES

UTAH Rolfs RT, Johnson E, Williams NJ, Sundwall DN, Utah Department of Health. Utah clinical guidelines on prescribing opioids for treatment of pain. Journal of Pain & Palliative Care Pharmacotherapy. 2010;24(3):219-35.

WASH Washington Agency Medical Directors Group. Interagency guideline on opioid dosing for chronic non-cancer pain. 2010. Available at: http://www.agencymeddirectors.wa.gov/Files/OpioidGdline.pdf

VA United States Veterans Administration/ Department of Defense. VA/ DoD clinical practice guideline for management of opioid therapy for chronic pain. Washington, DC: Veterans Administration; 2010, Available at: http://www.va.gov/painmanagement/docs/cpg_opioidtherapy_fulltext.pdf

CAN Kahan M, Wilson L, Malis-Gagnon A, Srivastava A. Canadian Guideline for safe and effective us of opioids for chronic noncancer pain: clinical summary for family physicians. Canadian Family Physician. 2011;57(11):1269-1276.

CDC Centers for Disease Control, National Center for the Prevention for Injury Prevention and Control. Common Elements in Guidelines for Prescribing Opioids for Chronic Pain. Available at: http://www.cdc.gov/homeandrecreationalsafety/pdf/Common_Elements_in_Guidelines_for_Prescribing_Opioids-a.pdf.

KREB Krebs EE. Difficult conversations in opioid management: limiting, reducing, or stopping opioids. AMA webinar presented June 19, 2014. Available at: http://pcss-o.org/wp-content/uploads/2014/10/Difficult-Conversations-in-Opioid-Management-Limiting-Reducing-or-Stopping-Opioids-Slides.pdf

TOP My Top Care. How to discuss stopping opioid therapy with the patient. Available at: http://mytopcare.org/prescribers/stopping-opioids/how-to-discuss-stopping-opioid-therapy-with-a-patient/.

DISCUSSION WITH PATIENTS

While some patients choose to discontinue opioids, others may be anxious about the process or prefer not to taper. The following approaches[KREB,TOP] can be helpful when patients are resistant, hesitant or anxious about opioid tapering:

- Summarize the risks and benefits of opioids, focusing on the patient's particular situation. Explain that tapering is necessary in his or her case because long-term use could do more harm than good.
- Emphasize the likely benefits of tapering, such as improved day-to-day functioning, greater energy, and clearer thinking. Ask the patient about his or her personal goals and discuss how tapering opioids could help achieve them.
- Remind the patient that people taking opioids are at risk for addiction, even if they have not had problems with drugs or alcohol in the past.
- Discuss nonopioid pain treatments, including alternative therapies that appeal to the patient. Explain that although you are recommending tapering, you are committed to caring for the patient and treating his or her pain.
- Reassure the patient that the tapering protocol will be tailored to his or her needs and can be modified if necessary. Encourage regular follow-up.
- Inform the patient that while discontinuing opioid pain medications might be uncomfortable, it is generally not dangerous.
- Set realistic expectations for tapering. Tell the patient that pain might increase temporarily when the dose is reduced. Discuss common withdrawal symptoms and possible treatments. Encourage patients to call if withdrawal symptoms are bothersome.
- Acknowledge the patient's emotional distress, if appropriate. Discuss coping strategies and offer referral to a behavioral health specialist.
- Respectfully "agree to disagree" with the patient's perspective on the situation, if necessary.

NOTES ON METHADONE & BUPRENORPHINE

Methadone: Patients who are already on a stable dose of methadone can be tapered according to this guideline. Although methadone can be used to taper off other opioids, it should only be used this way by clinicians who are familiar with its risks and use and are prepared to conduct the necessary careful monitoring. Its use in the setting of opioid addiction requires special licensure.

Suboxone (buprenorphine/naloxone): This drug is approved for the treatment of opioid addiction and also requires special licensure. It is a partial agonist at the mu opioid receptor and therefore does have analgesic properties. This makes it particularly useful in treating chronic pain complicated by comorbid opioid abuse, misuse, or addiction. While it may be used as a means of tapering off opioids, addicted patients should consider staying on it longer term due to the high recidivism rates in these patients.

Topical and sublingual buprenorphine: These can be used in chronic pain disorders and can be prescribed by primary care physicians.

Intermountain® Healthcare