

Opioid Tapering Guidelines

Many patients with chronic pain are currently being treated with opioids. However, evidence supporting the effectiveness of opioids for chronic, non-cancer related pain is weak, and chronic opioid use poses major, life-threatening risks, including addiction and overdose.¹

The best approach to treatment of chronic pain is multi-modal, using a combination of non-opioid medications (e.g., NSAIDs, acetaminophen, antidepressants, topical medications) and non-pharmacologic treatments (e.g., physical therapy, cognitive behavioral therapy, acupuncture, TENS units). The risks that patients with chronic pain bear can be greatly reduced by substituting these safer forms of pain treatment for opioids. Discontinuing opioids in chronic pain patients rarely leads to increased and sustained pain, but health care providers should take steps to avoid unnecessary withdrawal symptoms or exacerbating psychiatric conditions.^{2,3} Use of gabapentin in patients taking opioids is not advised due to the increased risk of overdose seen among patients taking these medications concurrently.⁶

Consider the following recommendations for safely tapering and discontinuing opioids that have been used chronically.

References

1. Dowell D, Haegerich TM, Chou R. CDC Guidelines for Prescribing Opioids for Chronic Pain – United States, 2016. *MMWR Recomm Rep.* 2016 Mar 18;65(1):1-49.
2. Baron MJ, McDonald PW. Significant pain reduction in chronic pain patients after detoxification from high dose opioids. *J Opioid Manag.* 2006 Sep-Oct;2(5):277-282.
3. Krumova EK, Bennemann P, Kindler D, Schwarzer A, Zenz M, Maier C. Low pain intensity after opioid withdrawal as a first step of a comprehensive pain rehabilitation program predicts long-term nonuse of opioids in chronic noncancer pain. *Clin J Pain.* 2013 Sep;29(9):760-9.
4. Washington State Agency Medical Directors' Group. Interagency Guideline on Prescribing Opioids for Pain, 3e. June 2015.
5. Berna C, Kulich RJ, Rathmell JP. Tapering Long-Term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice. *Mayo Clin Proc.* 2015 Jun;90(6):828-842.
6. Gomes T et al. Gabapentin, opioids, and the risk of opioid-related death: A population-based nested case-control study. *PLoS Med.* 14(10):e1002396.

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1 Establish the rate of taper:

- Slow taper if there are no acute medical or psychiatric concerns. Start with a 10% taper of the original dose per week and assess the patient's pain and functional status.⁴ For patients who have been on opioids for more than 2 years, tapering every two weeks or even monthly can be considered.⁵
- Rapid taper (over 2-3 weeks) if the patient has had a severe adverse outcome (i.e., overdose or substance use disorder).
- Immediate discontinuation if there is evidence of diversion.
- Seek specialty care for pregnant patients, as opioid withdrawal during pregnancy has been associated with spontaneous abortion and premature labor.¹

2 Adjust the rate, intensity and duration of taper based on the patient's response and development of withdrawal symptoms.

- Patients using short-acting opioids (e.g., oxycodone) can experience withdrawal symptoms within 6-12 hours of their last dose; the onset of symptoms may be later for patients using long-acting opioids (e.g., OxyContin).⁵ Withdrawal symptoms result from increased sympathetic activity, and commonly include anxiety, palpitations, restlessness, tremor, sweating, nausea, abdominal pain, diarrhea, shivering and rhinorrhea.
- Reducing the taper to less than 10% per week can minimize withdrawal symptoms. Patients should be informed that general malaise and other symptoms of mild withdrawal may persist up to 6 months following opioid cessation.

3 Use medications to treat opioid withdrawal symptoms if needed. These include clonidine (for restlessness, sweating or tremors), an anti-emetic (nausea), loperamide (diarrhea) and NSAIDs (pain), provided there are no contraindications. Do not use benzodiazepines to treat anxiety or restlessness.

4 Monitor for psychiatric disorders during the taper and consult with a behavioral health specialist as needed. If a patient expresses suicidal ideation, refer to a crisis response center, emergency department or urgent evaluation by a behavioral health specialist.

5 Do not reverse the taper. The rate may be slowed or paused while monitoring for and treating withdrawal symptoms, as well as addressing psychiatric disorders.

6 In patients taking both opioids and benzodiazepines, taper opioids before tapering benzodiazepines. When tapering benzodiazepines, start with a 20% reduction over 2 weeks and monitor for signs and symptoms of withdrawal.

7 Consider inpatient withdrawal management or maintenance with Suboxone (buprenorphine/naloxone) if the patient has persistent opioid cravings.

8 Do not resume opioids or benzodiazepines once they have been stopped, as they may trigger drug cravings and a return to use.