PHARMACIST'S LETTER

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PRESCRIBER'S LETTER

Opioid Discontinuation: FAQs

With careful patient selection, education, and monitoring, opioids can be safe and effective tools to improve function and pain intensity in chronic noncancer pain. However, discontinuation may become necessary, either because of inefficacy, adverse effects, or misuse. The table below provides information to help clinicians deal with this challenging patient care situation. See our *PL Chart*, *Management of Opioid Dependence*, for help identifying opioid use disorder and information on pharmacotherapy options.

Clinical Question	**Suggested Approach/Pertinent Information**	
	Situation	**Alternatives to Discontinuation (if Benefit Outweighs Risk), and Other Considerations**
What are some situations in which opioid tapering and/or discontinuation might be considered?	Misuse	• Re-evaluate treatment.[1] • Educate patient.[1] • Increase frequency/intensity of monitoring.[1] • Involve addiction or mental health providers.[1] Prescribe limited quantities.[1] • Egregious misuse (e.g., injecting tablets) will likely require discontinuation.[1]
	Use of illicit drugs or nonprescribed opioids	• Refer, ideally to a specialized program that can provide directly-observed therapy.[1]
	Diversion	• Usually requires immediate discontinuation.[1,2] • Alternative is to refer to a specialized program that can provide directly-observed therapy.[1]
	Nonadherence to opioid agreement	• Restructure therapy (e.g., more intense monitoring, opioid tapering, addition of nonopioid or psychiatric treatment).[1]
	Overdose[2]	
	Adverse effects (e.g., sleep apnea, low libido, nausea, constipation)[1,4]	• Consider opioid rotation (i.e., switching patient from one opioid to another).[1] • Consider tapering to a safe dose and continuing.[2] • True allergic reactions require immediate discontinuation.[10]

Continued…

More. . .

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Clinical Question	**Suggested Approach/Pertinent Information**	
Situations in which to consider opioid tapering and/or discontinuation, continued	**Situation**	**Alternatives to Discontinuation (if Benefit Outweighs Risk), and Other Considerations**

	No progress toward therapeutic goals	• If there is no sustained, clinically meaningful improvement (≥30%) in pain AND function, compared to baseline or dosage increase, using validated tools, then:[2]
		  • discontinue,[2] or
		  • go back to previous dose if it provided some benefit.[5]
		• Tools recommended to assess progress in this context include the Three Item PEG Assessment Scale and the Two Item Graded Chronic Pain Scale, available at http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf.

	Reduced analgesia	• Restructure therapy (e.g., more intense monitoring, opioid tapering, addition of nonopioid or psychiatric treatment).[1]
	Hyperalgesia	• Discontinuation probably necessary.[5]

	Repeated dose escalation or need for high doses[1]	• Assess risk/benefit:[1]
		  • Assess underlying diagnosis and concomitant conditions.[1]
		  • Assess psychological issues and social situation.[1]
		  • Assess pain control, function, quality of life, and progress toward therapeutic goals.[1]
		  • Assess adverse effects.[1]
		  • Assess adherence.[1]
		• Rule out misuse and diversion.[1]
		• Restructure therapy (e.g., more intense monitoring, opioid tapering, addition of nonopioid or psychiatric treatment).[1]
		• Consider opioid rotation.[1]
		• Consider dose reduction rather than complete discontinuation if opioid is providing some benefit.[5]
		• Consider prescribing naloxone for patients on high doses to keep patients and families safe. See our *PL Detail-Document*, *Naloxone for Opioid Overdose: FAQs*, for information about preparing and prescribing naloxone rescue kits (U.S.).

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Clinical Question	Suggested Approach/Pertinent Information
How do I prepare patients for opioid discontinuation?	• When starting chronic opioid therapy, set clear expectations. This may help prevent opposition to discontinuation if it is indicated later.[2] • Use motivational interviewing techniques to identify reasons for patient opposition to discontinuation.[2] • Identify and treat depression to improve pain control and improve taper success.[2,9] Patient education points: • Chronic pain is complex; opioids are not a "cure-all," and may not provide adequate pain relief long-term.[2,4] • Side effects of chronic opioid therapy include low hormone levels leading to fracture risk, low libido, and low energy and mood; worsening sleep apnea, leading to fatigue; and constipation.[1,4] • When opioids are no longer providing good pain relief, most people feel better without them.[4] • Most patients do not experience increased pain.[1,3] • You are not abandoning the patient, and will still help them with their pain.[9] Pain will be addressed with non-opioid alternatives.[2,5,9] • Withdrawal symptoms are uncommon if the dose is tapered slowly.[9]
What can be expected if the opioid is tapered or discontinued?	• Patients being tapered due to lack of efficacy may or may not experience a worsening of pain.[1] • In a VA population (n = 50) being tapered for reasons other than aberrant behavior, 70% of patients had no change or less pain vs baseline despite a 46% average dose reduction.[3] • Patients should expect to have some insomnia and anxiety.[4] • Patients should plan ahead for not feeling well.[4] • Increased pain is an early symptom of withdrawal; pain with opioid dose reduction is not a sign that the opioid is effective for the patient's pain.[4,9] Pain due to withdrawal should resolve after the first week.[4] • Unmasking of psychiatric conditions may occur.[2]

How should the opioid be tapered/discontinued?	General concepts:
	• High-quality evidence to guide tapering is lacking; individualize.
	• The reason for discontinuation and amount of opioid being used will influence the rate of taper.
	  • At high doses, rapid taper may cause withdrawal or drug seeking.[2]
	  • Discontinue immediately if there is diversion.[2]
	• Adjust taper based on response, such as appearance of withdrawal symptoms.[2]
	• Consider referral for patients who have risk factors for failure: high-dose, substance use disorder, active psychiatric disorder, previous outpatient taper failure, or benzodiazepine use.[2]
	• If benzodiazepine discontinuation is indicated, discontinue opioids before discontinuing benzodiazepines.[2]

Continued…

Clinical Question	Suggested Approach/Pertinent Information
Tapering/discontinuation, continued	• Consider consolidating the patient's opioids into a single long-acting formulation.[4] (See our *PL Chart, Equianalgesic Dosing of Opioids for Pain Management*, for help). Choose a product that offers small dose increments (e.g., morphine 10 mg) to facilitate a slow taper.[5] A short-acting formulation can be used once the lowest dose of the long-acting formulation is reached.[9] • Fentanyl patch can be switched to a long-acting oral formulation, or tapered in decrements of 12 mcg/hr.[9,10] • Before constructing the taper, check for insurance coverage limitations, and availability of specific opioid products/strengths at your local pharmacy. Flexibility may be needed. <u>Tapering protocols</u>: • Taper over two to three weeks in the event of severe adverse effects, overdose, or substance abuse disorder.[2] • Otherwise, taper by 10% or less of the original dose per week.[2] An even slower taper (e.g., 10% every two to four weeks) may be needed for patients who have been taking opioids for years.[9] • High doses may be able to be tapered rapidly (e.g., 25% to 50% every few days) until reaching 60 mg to 80 mg of morphine or its equivalent. Then the rate can be slowed (e.g., 10% of the original dose per week) to prevent withdrawal.[1] • Keep in mind that a more rapid taper may be possible. The minimum dose to prevent withdrawal may be only 25% of the previous day's dose.[9] • A sample "Opioid Tapering Template" is available at http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Taper-Template.pdf.

How should the patient be monitored during dose reduction or discontinuation?	• Check pain control and functional status at each visit.[2]
	  • Manage increased pain with non-opioids.[2]
	• Monitor for psychiatric disorders such as depression or panic disorder.[2]
	• Monitor for withdrawal (e.g., flu-like symptoms, insomnia, anxiety, abdominal cramps and other GI symptoms, goose bumps, fatigue, malaise).[4]
	  • If withdrawal symptoms occur, manage the symptoms (see below) and slow the taper (e.g., to 5% per week) or suspend the taper; do not increase the dose (i.e., don't "backpedal").[2,4]
	• Warn patients that they are at risk of overdose if they try upping the dose on their own. Opioid tolerance is lost after a week or two of abstinence.[5] Consider prescribing naloxone for use in case of an overdose emergency. See our *PL Detail-Document, Naloxone for Opioid Overdose: FAQs*, for information about preparing and prescribing naloxone rescue kits (U.S.).

More. . .

Clinical Question	Suggested Approach/Pertinent Information
What adjunctive medications may help with withdrawal symptoms?	• Acetaminophen or NSAIDs for malaise and myalgias.[5,6] • Ondansetron 8 mg q 12 h for nausea and perhaps other symptoms.[6,8] • Trazodone for insomnia (25 mg to 100 mg at bedtime).[5] • Hydroxyzine 25 to 50 mg three times daily as needed for anxiety, lacrimation, and rhinorrhea.[7] • Loperamide for diarrhea (not usually needed for gradual taper).[5] • Clonidine is not usually needed for gradual tapers.[5] Also see our *PL Chart*, *Treatment of Opioid Withdrawal During Medical Hospitalization*, for clonidine dosing and more.
What are some opioid alternatives for common types of pain?	See our *PL Charts*, *Treatment of Chronic Low Back Pain*, *Analgesics for Osteoarthritis*, and *Pharmacotherapy of Neuropathic Pain*.

More. . .

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