NHS
Derby and Derbyshire
Integrated Care Board

Joined Up Care
Derbyshire

Resource to support Opioid Tapering in Chronic Non-Cancer Pain in Adults

Adapted from Sheffield CCG, Nottinghamshire APC: Opioid tapering

Remember: Opioids can be harmful, dangerous, and not very effective in chronic pain

Step 1 Indications for opioid tapering

- **Assess risk, including emotional influence on pain. Consider** PADT **or** opioid risk tool.
- **Review physical and mental health co-morbidities, including significant emotional trauma.**
- **Decide if specialist input required.** Physio/mental health/specialist addiction/pain management services
- **Patient may need specialist support if taking > 90mg/day oral morphine equivalent.**
- Information on diagnosing opioid dependence, indicators, assessment and risk populations.
- **Precautions with opioid tapering – seek specialist input**: pregnancy, addiction and unstable psychiatric medical condition that can be worsened by anxiety. While opioid withdrawal rarely has serious medical consequences, it can cause significant anxiety and insomnia.

Step 2 Face to face appointment with patient (and carer) – consider double appointment to discuss:

- **Chronic pain** (central sensitisation).
- **Lack of evidence with opioids** and **risk of harm.** e.g. fractures, falls, endocrine abnormalities, immunomodulation, opioid induced hyperalgesia, and dependence.
- **The risk of harm increases** substantially at doses above an oral morphine equivalent of 120mg/day, but there is no increased benefit.
- **Non-drug strategies to help manage pain** e.g. exercise, relaxation, distraction & pacing. Services and support group information
- **Risks and benefit of opioid tapering** – Aim of reducing /stopping opioids is to make you feel better, reduce pain intensity, improve mood and function as well as reduce harm.
- **Provide patient information:** Taking Opioids for Pain Leaflet
- **Discuss symptoms and signs of opioid withdrawal.**
- **Agree and document opioid tapering goals/ plan.**
- **Stress that opioids should not be stopped suddenly,** and that the reduction will take time (months not weeks).

Step 3 Rate of taper - Discuss with patient

- Reduce gradually if prescribed opioid > 2 weeks.
- A decrease by 10% of the original dose every 1-2 weeks is usually well tolerated. **Individualise, can be slower (every 2-4 weeks may be better tolerated) or with smaller reductions.**
- Tapering rate may vary according to response, clinicians to consider:

  - **Patients mental/physical state**: if anxious, feel psychologically dependent on opioids or have cardiorespiratory condition, if experiencing significant adverse effects
  - **Patients behaviour**: displaying aberrant drug taking or drug seeking behaviour.
  - **Patients progress:** Once dose reduction is well established, consider slowing the taper down to half of the previous rate if clinically indicated e.g. when down to 1/3 of the original dose, slow to 5-10% every 2-4 weeks.

- Completion of tapering may take weeks/months.
- Once smallest available dose preparation is reached the interval between doses can be extended.
- Avoid renewing prescriptions sooner than expected. Inform patient's Pharmacy of the plan. Send prescription electronically. Preferably same clinician to follow up and issue prescriptions.

If uncertain ask for advice from experienced practitioner

Ensure a practice approach – involve all clinicians and consider having a Practice Opioid Policy

Tapering Considerations:

- Optimise non-opioid management of pain (consider paracetamol).
- **It is usually preferable to stay on current opioid for tapering**. **As conversion factors are only an approximate guide and patient is familiar with the opioid.**
- Switching from one opioid to another should only be recommended or supervised by an experienced & competent healthcare practitioner. Further information on dose equivalents and changing opioids see: Opioids Aware. If prescribed more than one opioid, try to consolidate all opioid medication into one single MR (modified release) preparation if possible OR prioritise tapering IR preparation.
- Calculate total oral morphine equivalence of all current opioids by any route (approximate Equi-Analgesic)
- Check with the patient what they are actually taking, don't assume the prescribed dose is being taken.
- Prescribe regular doses & not PRN doses.
- Keep daily dosing interval the same for as long as possible e.g. BD.
- Do not prescribe opioid liquid.

Fentanyl and buprenorphine patches:

It is not recommended to convert from an opioid patch (either fentanyl or buprenorphine) to another opioid as conversions are unreliable and may result in overdose. Other factors to consider include: serum drug concentrations will fall gradually after a patch is removed and buprenorphine is a partial agonist opioid with antagonistic activity.

For information see: Transdermal opioid patches local advice and Fentanyl Patches Patient Leaflet.

Fentanyl patches

- Reduce patch strength by 12 mcg every 2 – 4 weeks until a 12mcg/hour patch is prescribed; then change to codeine as required.

Buprenorphine patches

- If prescribed a higher strength 3 or 4 day patch, reduce patch every 2 - 4 weeks
- e.g. 70mcg/hour 52.5mcg/hour 35mcg/hour, then change to 7 day buprenorphine patch which **enables a more gradual dose reduction** or consider changing to 7 day patches, available as 5mcg/hr, 10mcg/hr, 15mcg/hr and 20mcg/hr strengths. A combination of the 7 day patches can be applied in different places to achieve the desired dose (doses above 40 microgram/hour are off-label). It is recommended that no more than two patches are applied at the same time.

Struggling with opioid tapering

Escalation of pain or worsening mood - discuss with patient:

- Reassure you will work closely with patient to manage their pain & mood.
- Importance of non-drug related strategies for pain management (non-pharmacological support)
- Hold tapering dose. Avoid increasing or adding in PRN opioids or other dependence forming medicines e.g. Z drug, benzo.

Withdrawal symptoms - discuss with patient:

- Although withdrawal symptoms may occur and are unpleasant, they are rarely medically serious. Reassure usually settle within a few weeks.
- Hold tapering dose and consider whether tapering rate needs to be slowed down.
- Consider: Loperamide for diarrhoea, Mebeverine for abdominal cramps, Prochlorperazine or metoclopramide for nausea and vomiting,paracetamol & NSAID for pain (muscular/headache).
- Ensure prescribing is in line with the local self-care policy.

Step 4: Clinical reviews and follow up

- Agree follow up interval at each appointment (ideally prior to decreasing each dose).
- Frequency of review depends on rate of taper and degree of support required (face to face / telephone).
- Initial early follow up (1-2 weeks later) to offer support / check for withdrawal symptoms.
- Ask about reduction in side effects, improvement in alertness, daily living, mobility, emotional well-being as well as withdrawal symptoms and pain.
- May need to hold tapering dose. Tapering is successful provided patient is making progress.

If specialist medical support required e.g. evidence of escalation of opioids beyond prescription or signs of dependence:

- Consider referral to pain clinic where appropriate, and for Pain Management Programme.
- A patient unable to complete taper may be maintained (if clinically appropriate) on a reduced dose if treatment plan is being followed and improvement is seen in pain and function. Re-attempt in 3-6 months as dictated by patient and clinical factors.

Further Resources:

- Live Well with pain – www.livewellwithpain.co.uk
- DVLA drugs and driving: the law – www.gov.uk/drug-driving-law
- Opioids Aware: https://fpm.ac.uk/opioids-aware: (patient information leaflets available)
- http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b12.html
- PrescQIPP Reducing opioid prescribing in chronic pain. Bulletin 218i. February 2019. https://www.prescqipp.info/ourresources/bulletins/bulletin-218-reducing-opioid-prescribing-in-chronic-pain
- https://joinedupcarederbyshire.co.uk/stay-well/pain-management/
- https://www.derbyshiremedicinesmanagement.nhs.uk/assets/Clinical_Guidelines/opioid/JAPC%20opioid%20resource%20pack.pdf
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