Clinician information sheet on opioid analgesic tapering: summary

Opioids are no longer indicated for Chronic Non Cancer Pain (CNCP) other than in exceptional circumstances. This guide is for cases where the prescriber and patient believe they can collaborate to achieve a reduction in opioid dose.

Goals of intervention

- **Indications for opioid analgesic tapering include** suspected lack of efficacy of opioid in pain management (including increased pain sensitivity), hazardous/harmful use of opioid analgesics, other adverse events (respiratory depression, tiredness, constipation, difficulty in concentrating, difficult to treat depression and/or sexual dysfunction).
- The **oMEDD** (oral morphine equivalent daily dose) is a measure of how potent the opioid analgesic dose is. The Faculty of Pain Medicine have a simple dose calculator www.opioidcalculator.com.au that is free to download, including as an app.
- **In particular, CNCP patients taking more than 60mg oMEDD** should aim to taper to below this dose to improve safety outcomes. Use of 60 mg or higher likely indicates pain that is poorly responsive to opioid analgesics and potential for harm. **Patients with CNCP taking less than 60 mg oMEDD** should have an opioid analgesic tapering plan developed after discussion of possible tapering. **For frail or older patients and those prescribed other sedative medicines** such as benzodiazepines, gabapentinoids or antipsychotics, a better oMEDD threshold is lower, at 30 to 40 mg.

Having the opioid analgesic tapering discussion

Explain to the patient that taking opioid analgesics for long periods may not be safe or beneficial. Outline the potential side effects of long-term opioid analgesic use, relating this to the patient, and the benefits of reducing their dose.

Discussions about future opioid analgesic prescribing with patients who have been on opioids for a significant period are challenging. The discussion should not always start from the view that a lower dose of opioid analgesic is preferable for each patient who is on less than 60 mg oMEDD. Noting a lower threshold oMEDD of 30 mg in older, frail patients and those prescribed other sedating medicines. It is important to reassure the patient that opioid analgesic tapering does not mean that you will abandon them, and that you will continue to support them to take up more efficient strategies they can use in the longer term. Transition from opioid analgesic treatment to supported self-management and other pain management strategies is strongly supported by evidence.

Successful opioid analgesic tapering can take time with multiple facilitators, most importantly the patient. Tapering is supported by policy and regulation, clinician expertise including holding therapeutic boundaries with empathy and patient empowerment, opportunity and motivation. Opioid analgesic tapering is more likely to succeed when there is a shared decision between the prescriber and patient. In particular, be clear when the patient has made an active decision to taper their opioid analgesic, and document and agree on the tapering plan. Recognise there is variability in the level of opioid tapering and discomfort patients can or will accept that will guide the approach.

Opioid analgesic tapering protocols

Whether a faster or gradual opioid analgesic tapering is best will depend on the level of patient engagement, and how the patient progresses during tapering (e.g. withdrawal symptoms). In general, switching between different opioid analgesics during tapering may be unsettling to the patient. However, switching from opioid analgesics, such as oxycodone to buprenorphine (a partial agonist), may be appropriate for those patients who may be at risk of overdose. Pain management services are usually willing to provide telephone advice to prescribers to support replacement of poorly performing treatments such as opioid analgesics with better or safer alternatives for particular patients.

At every consultation, give the patient a written tapering plan. With the patient's agreement, communicate the plans with the patient's nominated pharmacy to reinforce the plan. Prescribe only enough of the opioid analgesic until the agreed review date and emphasise that "bridging" prescriptions will not be provided.

Gradual taper

- Rationalise the patient's regimen to a single modified release opioid analgesic. However, in patients on higher doses of an immediate release opioid, taper on the same product.
- When stabilised, the opioid dose should be reduced slowly by 5 to 20% oMEDD **each month**. Some symptoms of withdrawal and transient rebound pain may last several weeks.
- In the case of persisting or recurrent withdrawal symptoms, consider reverting to the previous lowest tolerated dose. Then slow the process by recommencing weaning after 6 to 12 weeks at lower weaning rate (e.g. by 5 to 10 % oMEDD every 2 to 3 months).

Faster taper

- If tapering after a short (< 3 month) period of opioid analgesic treatment or opioid analgesic trial, reduce dose by 10 to 25% oMEDD **every week**.
- If significant adverse events or significant risk of harm likely if current opioid analgesic dose is maintained, reduce dose by 10 to 25% oMEDD **daily** (may require hospital admission).

End points for opioid analgesic tapering

The timing and rate of opioid analgesic reduction should always be negotiated. In some cases, it may be appropriate to taper to the lowest tolerated opioid analgesic dose rather than de-prescribing, as some patients will report reduced function and increased distress and pain with opioid analgesic de-prescribing. In other patients it is appropriate to cease opioid analgesics altogether. These patients may continue non-pharmacological pain management approaches and use other analgesics, such as NSAIDs, if tolerated, and not contraindicated. It is vital that patients are closely monitored and supported during opioid analgesic tapering to increase the chance of success.

Other practice points

- **Only prescribe enough opioid analgesic** during the tapering period until you can see the patient again. Set up a series of regular appointments with the patient and stage dispensing from the patient's pharmacy.
- The opioid analgesic tapering plan should **take into account the available formulations** for the chosen opioid analgesic, and ensure the patient understands the percentage reduction that is practical at each stage.
- **Setting a treatment agreement with the patient**, including conditions such as the patient using only a single pharmacy, single prescriber (or a nominated second prescriber from the same practice if the patient's main GP is not available), staged supply, regular review, real time prescription monitoring services (where available) and Urine Drug Screen check, and agreement to engage with specialist services. For some patients, if on the advice of an addiction medicine specialist opioid use disorder is the primary problem, conversion to opioid substitution treatment (for example, buprenorphine) may be appropriate. This can be undertaken either in outpatient or inpatient settings.
- **Opioid analgesic tapering requires special care with pregnant patients** on high doses, and should be carried out in conjunction with an obstetrician/neonatologist as it is important to avoid precipitating withdrawal - perinatal risk or risk of miscarriage or premature labour.
- An online directory is available to provide people living with chronic pain—and their health practitioners—with a comprehensive list of available services to help manage their conditions: www.painaustralia.org.au/getting-help/pain-directory.