Opioid Tapering

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Disclosures & CME Credit

Neither the case presenter not the didactic presenter have conflicts of interest

Off label use of medications may be discussed

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OPIOIDS & BENZODIAZEPINES JUST DON'T MIX

https://msp.scdhhs.gov/tipsc/

PICK UP QUICK TIPS ON…tapering opioids and/or benzodiazepines to reduce risk of overdose

Avoid combining opioids and benzodiazepines whenever possible to reduce the risk of respiratory depression and overdose; work to taper one or both to a reduced dose or discontinuation in patients already on both medications.

QUICK tip SC

Co-prescribing naloxone and opioids may save a life

QUICK FACTS TO CONSIDER

- Almost **1 in 3 opioid overdose cases involves a benzodiazepine**; the combination may quadruple risk of fatality versus opioids alone.
- **Tapering opioids before tapering benzodiazepines** may lessen anxiety that can be associated with opioid withdrawal.
- Opioid withdrawal symptoms can be highly distressful but rarely medically serious; **benzodiazepine withdrawal symptoms can be life-threatening.**
- **Slow** opioid **tapers** decrease and often eliminate withdrawal symptoms; slow benzodiazepine tapers help **minimize withdrawal symptoms.**

CLINICAL PEARLS

Risks for respiratory depression with opioids, in addition to concurrent benzodiazepines, include:

- **Use with any CNS depressant** (e.g., Rx cough suppressants, OTC sleep aids, alcohol, illicit drugs)
- **Co-existing conditions** such as older age, obesity, COPD and sleep apnea
- **Opioid doses ≥ 50 Morphine Milligram Equivalents (MME)/day** (Opioids by the Numbers [Sept 2017 Issue No. 1])

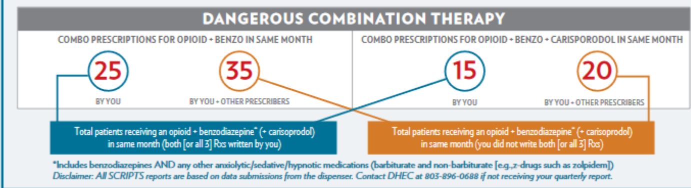
In the office, monitor closely for **sedation** that **could be an important early warning sign of respiratory depression.** The Epworth Sleepiness Scale can be used to identify or track excess sleepiness. Educate the patient, family and caregivers to report excess sleepiness, nodding off during conversations, and frequent dozing or napping during the day.

Conversations about an opioid or benzodiazepine **taper can be difficult.** Consider:

- **Expressing safety concerns** *"I care about your safety…" "I am worried…"*
- **Using Motivational Interviewing techniques** to help make decisions as equals as much as is clinically appropriate
- **Listening to and acknowledging patient's fears** (e.g., fear of pain, fear of withdrawal) *"So you feel…"*
- **Sharing that many patients** improve and **do better** at reduced dose or discontinuation, **even if briefly worse at first**
- **Reassuring patients you will not abandon them** *"I'll stick by you…"*

FIND FREQUENCY OF OPIOID + BENZODIAZEPINE* COMBINATIONS IN SCRIPTS

SCRIPTS (DHEC) PRESCRIBER REPORTS, updated and emailed quarterly, include a barometer on the prevalence of selected high risk medication combinations for each individual prescriber's patients. To view these reports in SCRIPTS, click MENU then PRESCRIBER REPORT [under Rx Search].



*Includes benzodiazepines AND any other anxiolytic/sedative/hypnotic medications (barbiturate and non-barbiturate [e.g.,z-drugs such as zolpidem])

Disclaimer: All SCRIPTS reports are based on data submissions from the dispenser. Contact DHEC at 803-896-0688 if not receiving your quarterly report.

https://msp.scdhhs.gov/tipsc/site-page/cme-opioids-benzodiazepines-dont-mix

Talking about Tapering

- Express safety concerns
  - “I care about your safety…”
  - “I am worried”
- Use Motivational Interviewing techniques to help make decisions as equals as much as is clinically appropriate
- Listen to and acknowledge patient’s fears (e.g., fear of pain, fear of withdrawal)
  - “So you feel…”
- Share that many patients improve and do better at reduced dose or discontinuation, even if briefly worse at first
- Reassure patients you won’t abandon them
  - “I’ll stick by you”

Opioid Tapering Considerations

- Many people who taper opioids to reduced dose or discontinuation have improved function without increase in pain and may have less pain
- Speed of taper, ranging from days to weeks to weeks to months (and even years), depends on level of concern duration of use and current dose
- In general, the longer the duration of the opioid therapy, the slower the taper
  - A more rapid taper may be appropriate for patients on low dose opioids for less than one month or patients with apparent harm/risk
- Non-opioid pain medications (e.g., NSAIDS, APAP) and non-meds (e.g., PT, CBT, meditation) can be used to manage withdrawal pain
  - It is good to have a plan in place to manage other potential withdrawal symptoms

SHORT-TERM MEDICATIONS TO ASSIST WITH OPIOID WITHDRAWAL SYMPTOMS*

Symptom	Medications
Autonomic symptoms (sweating, tachycardia)	• Clonidine 0.1 to 0.2 mg orally every 6-8 hours (sometimes may be used twice daily) Hold if blood pressure < 90/60 mmHg o Recommend 0.1 mg test dose with blood pressure check 1 hour post dose. Increasing dose requires increasing blood pressure monitoring o Re-evaluate in 3-7 days (average duration 15 days). Taper to stop • Gabapentin start at 100 to 300mg and titrate to 1800 to 2100 mg divided in 2 to 3 daily doses (dose-adjust in renal impairment)
Anxiety, dysphoria, lacrimation, rhinorrhea	• Diphenhydramine 25 mg every 6 hours as needed (caution in older adults) • Hydroxyzine 25 to 50 mg three times daily as needed
Muscle aches, joint pain, headache	• Ibuprofen 400 mg orally every 4 to 6 hours as needed, not to exceed 2400 mg daily (caution in older adults or those at risk for GI bleed) • Acetaminophen 650 to 1000 mg orally every 4 to 6 hours as needed, not to exceed 4000 daily
Sleep disturbance	• Trazodone 25 to 100 mg orally at bedtime • Doxepin 6 to 50 mg orally at bedtime
Nausea	• Ondansetron 4 to 8 mg orally every 12 hours as needed, not to exceed 16 mg daily • Prochlorperazine 5 to 10 mg orally three times daily before meals or every six hours as needed, not to exceed 40 mg daily
Diarrhea	• Bismuth subsalicylate 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg daily • Loperamide 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily

*Maintain the patient on all appropriate non-drug therapies (e.g., cognitive behavioral therapy, sleep hygiene)

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Reprinted with permission from the Vermont Academic Detailing Program. Advanced Management of Opioids in Primary Care. November 2017.

Opioid Tapering Considerations

- Individualize plan
- Evaluate patient throughout the process (at least before each dose change)
- Engage the patient throughout the process
- Screen for opioid use disorder prior to initiating taper
  - Decline in functioning
  - Loss of control
  - Continued use despite negative consequences
- Be alert to signs of mental health concerns (e.g., anxiety, depression) or OUD that may unmask later during the taper
- Refer to or coordinate care with specialists and MAT providers if needed

“Slower” Tapers from Selected Guidelines

*Percent reductions below are based on the **original dose** before starting the taper, NOT the previous dose (e.g., if the initial decrease is 15 mg, you decrease by 15 mg every time if using same percent reduction)*

GUIDELINE	SLOWER TAPER RECOMMENDATIONS (until discontinue or at dose reduction goal)
VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain – 2017	• 5 - 20% reduction every 4 weeks[1] (see taper example below) • Pauses in taper as needed
Canadian Guideline for Use of Opioids for Chronic Non-Cancer Pain – 2017	• 5 - 10% reduction every 2 – 4 weeks • Frequent follow-up
CDC Guidelines for Prescribing Opioids in Chronic Pain – 2016[2]	• 10% reduction every month[3], especially if long term use • Pauses in taper as needed

[1] 5-20% reduction every week if faster taper is needed. [2] SC State Boards of Dentistry, Medical Examiners, Nursing and Pharmacy – 2017 align with CDC Guidelines. [3] 10% every week is a ‘reasonable’ starting place to minimize withdrawal symptoms.

Opioid Taper Example

OPIOID TAPER EXAMPLE

Morphine ER 90 mg (60 mg + 30 mg) q8h = 270 MME/day

16% monthly reduction of original 270 mg total daily dose

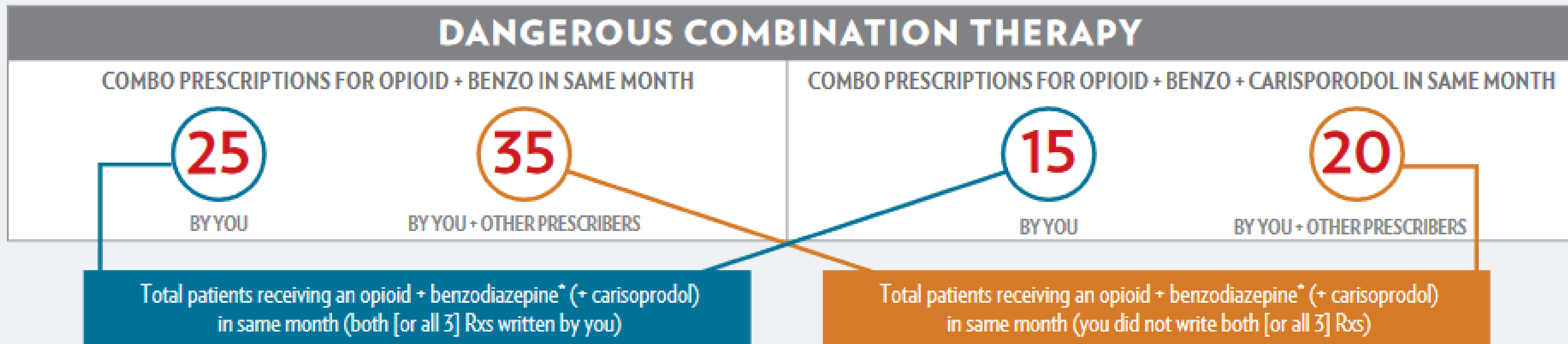
Month 1	75 mg (60 mg + 15 mg) ER q8h
Month 2	60 mg ER q8h
Month 3	45 mg ER q8h
Month 4	30 mg ER q8h
Month 5	30 mg ER q8h
Month 6	15 mg ER q8h
Month 7	15 mg ER q12h
Month 8	15 mg ER qhs, then stop

Example adapted with permission from VA PBM Academic Detailing Service. Opioid Taper Decision Tool. 2016 Oct. IB 10-939; P96820.

There is an **increased risk of overdose if patient resumes a previous dose** (using prescription or illicit drugs); **patient tolerance** (including respiratory depression) to previous opioid dose **is lost after 1 – 2 weeks on a reduced dose or abstinence.**

Tapers may be slowed or paused according to patient's response, but not reversed (Months 4–5)

Once the smallest dose is reached, the interval between doses can be extended (Months 6–8)



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