Tapering and Discontinuing Opioids

This information accompanies the 2017 VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain and is designed to provide Department of Defense (DoD) and Department of Veterans Affairs (VA) health care providers information and strategies to successfully taper and/or discontinue long-term opioid therapy (LOT). The VA/DoD provider is responsible for evaluating the appropriateness of applying the guidelines and for considering all applicable regulations and policies throughout the course of care.

Prior to any changes in treatment, conduct a patient-centered interview to explore the patient's values, goals, questions and expectations. Collaboration between the patient and his/her care team is essential to the development and implementation of a successful care plan. A signed informed consent is strongly recommended.

Reasons to Taper or Discontinue LOT

The largest risk factor for developing opioid use disorder (OUD) is long-term opioid analgesics use. Additional reasons to consider tapering to reduce dose or to discontinue LOT include:

- Patient requests to discontinue therapy
- Pregnancy or nursing
- Lack of clinically meaningful improvement in function
- Signs or symptoms that risks of LOT outweigh benefits
- Evidence of untreated substance use disorder (SUD) (including alcohol use disorder)
- Concomitant use of medications that increase risk of overdose (e.g., benzodiazepines)
- Patient's age < 30 currently on LOT when risks exceed benefits
- Opioid dosage exceeds 90 mg morphine equivalent daily dose
- Patient non-adherence to a comprehensive pain care plan or unsafe behaviors
- Unmanageable side effects
- Medical comorbidities that increase risk (e.g., lung disease, sleep apnea, liver disease, advanced age)
- Mental health comorbidities that may worsen with opioid therapy (e.g., posttraumatic stress disorder [PTSD], depression, anxiety)
- Prescribed dose is higher than the maximum recommended dose (which increases risk of adverse events)
- Strong concern for diversion

STOP Abrupt discontinuation should be avoided unless required for immediate safety concerns (e.g., overdose event, suicidal thoughts and/or behaviors, dangerous or threatening behaviors) or evidence of diversion while providing urgent or emergent psychiatric referral and medical care for the management of opioid withdrawal. Document dangerous or illegal behavior in the medical record to guide future care planning.

CAUTION Multiple risk factors increase cumulative risk.

Tapering Protocol and Treatment Planning

- ✓ When possible, use an interdisciplinary, team-based approach (primary care, mental health, pain specialty, pharmacy and SUD services)
- ✓ Complete a biopsychosocial assessment, including evaluation of co-occurring medical, psychiatric and substance use conditions and patient's social support system

CAUTION

Caution patients that it takes as little as a week to lose tolerance to their prior opioid dose and that they are at risk of an overdose if they resume their prior dose.

- ✓ Provide patient education on risks of continued use, along with possible benefits of continued use and discuss other available non-opioid pharmacological therapies
- ✓ Determine the treatment goal – is the goal to reduce dosage or to discontinue opioid therapy
- ✓ Develop an individualized tapering plan based on the current treatment plan, risk assessment, and patient needs and characteristics; include pace of taper, care setting and frequency of follow-up
- ✓ Determine appropriate care setting based on safety, patient preference and availability of services
- ✓ If patients are receiving both long-acting and short-acting opioids, determine which formulation is to be tapered first based on patient safety, medical history, mental health conditions and patient preference (tapering both formulations simultaneously may be appropriate)
- ✓ Provide written and verbal instructions to the patient and family members about the taper protocol, possible withdrawal symptoms and the best way to dispose of opioids

Speed of Taper

Determine speed of taper based on opioid dose, duration of therapy, type of opioid formulation, and risk factors such as co-occurring psychiatric, medical and substance use conditions.

Gradual taper considerations	More rapid taper considerations
Higher opioid dose	Non-adherence to treatment plan
Longer opioid therapy duration – the longer the duration of previous opioid therapy, the longer the taper may take	Escalating high-risk medication-related behaviors
When safety permits, gradual taper is more often tolerated	Drug diversion or illegal activities
Can be completed over several months to years	Risks too high to consider gradual taper
Suggested taper	**Suggested taper**
5 – 20% every 4 weeks	5 – 20% per week

*For patients on LOT, consider changing patient's prescription to an equivalent dose of a long-acting opioid (i.e. methadone) then taper methadone accordingly.

CAUTION

The rate of taper may need to be adjusted during the course of lowering the opioid dose – the pace of taper should be re-evaluated after each dose change. Document the rationale for the taper and taper schedule in the medical record.

NOTE: There is insufficient evidence to recommend for or against specific tapering strategies and schedules.

Managing Withdrawal

Opioid withdrawal can develop within hours of drug cessation. Symptoms of withdrawal may include[1]:

- Anxiety, restlessness, irritability
- Rapid respiration
- Runny nose, tearing eyes, sweating
- Insomnia
- Tremors, muscle spasms
- Nausea, vomiting, diarrhea
- Abdominal pain
- Fever, chills
- Craving
- Piloerection
- Increased white blood cells if sudden withdrawal

Do NOT treat withdrawal symptoms with an opioid or benzodiazepine

Short-term oral medications can be used to manage withdrawal symptoms. Withdrawal should be medically managed for patients with significant co-morbidities.[2]

Indication	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	**First line** ▪ Clonidine 0.1 – 0.2 mg oral every 6 – 8 hours; hold dose if blood pressure < 90/60 mmHg (0.1 – 0.2 mg 2 – 4 times daily is commonly used in the outpatient setting) — Recommend test dose (0.1 mg oral) with blood pressure check 1 hour post dose; obtain daily blood pressure checks; increasing dose requires additional blood pressure checks — Re-evaluate in 3 – 7 days; taper to stop; average duration 15 days **Alternatives** ▪ Baclofen, gabapentin, tizanidine
Anxiety, dysphoria, lacrimation, rhinorrhea	▪ Hydroxyzine 25 – 50 mg 3 times a day as needed ▪ Diphenhydramine 25 mg every 6 hours as needed*
Myalgias	▪ NSAIDs (e.g., naproxen 375 – 500 mg twice daily or ibuprofen 400 – 600 mg 4 times daily)** ▪ Acetaminophen 650 mg every 6 hours as needed ▪ Topical medications like menthol/methyl salicylate cream, lidocaine cream/ointment
Sleep disturbance	▪ Trazodone 25 – 300 mg orally at bedtime
Nausea	▪ Prochlorperazine 5 – 10 mg every 4 hours as needed ▪ Promethazine 25 mg orally or rectally every 6 hours as needed ▪ Ondansetron 4 mg every 6 hours as needed
Abdominal cramping	▪ Dicyclomine 20 mg every 6 – 8 hours as needed
Diarrhea	▪ Loperamide 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily ▪ Bismuth subsalicylate 524 mg every 0.5 – 1 hour orally, not to exceed 4192 mg/day

*Avoid for persons > 65 years' old

**Caution in patients with risk of GI bleed, renal compromise and cardiac disease

Special Considerations

Benzodiazepines

Abrupt discontinuation of benzodiazepines should be avoided as it can lead to serious adverse effects, including seizures and death. Tapering benzodiazepines should be performed with caution and within a team environment when possible; even gradual benzodiazepine taper may result in exacerbation of severe PTSD symptoms.

Opioid use disorder

For patients with OUD, sudden discontinuation of opioids due to suspected diversion may place them at high risk for illicit opioid use and resulting opioid overdose. Patients on LOT with OUD are at increased risk of overdose when opioids are either continued or discontinued without appropriate treatment for OUD.[3]

Reassessment and Follow-up

- Conduct a periodic re-evaluation of risks and benefits together with a biopsychosocial assessment within one week to one month after any opioid dosage change
- The frequency and type of follow-up is determined by the risk assessment conducted by the health care team

STOP Opioid medications are potentially lethal and suicide risk should be regularly assessed whether the provider is initiating, maintaining or terminating LOT.

- If the initial treatment goal is dose reduction, ongoing assessment of the balance of risks and benefits should be conducted once the original treatment goal is achieved
- Following discontinuation of opioids, consider continuing risk mitigation strategies
- Tapering may unmask underlying mental health and SUD co-morbidities – frequent assessment for these conditions is recommended

Referral for Consultation and Care

- If the provider determines a patient to be at significant risk of adverse outcome and if the patient or clinician is concerned about potential destabilizing effects of opioid tapering, the provider should refer to or consult with specialty services, including mental health, SUD, pain medicine and rehabilitation
- For patients currently on LOT and benzodiazepines, consider tapering one or both when risks exceed benefits and obtain specialty consultation as appropriate
- If the provider determines the patient's risks are high enough to warrant a rapid taper, referral for specialty consultation is recommended
- If there is concern for OUD or SUD, the provider should refer for a SUD assessment and treatment

References

1, 2 U.S. Department of Veterans Affairs, VA Academic Detailing Services. (2017). Opioid Taper Decision Tool. Retrieved from http://www.pbm.va.gov/PBM/academicdetailingservicehome.asp

3 Management of Substance Use Disorder Working Group, Department of Veterans Affairs & Department of Defense. (2015). VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders. Version 3.0. Retrieved from http://www.healthquality.va.gov/guidelines/mh/sud/index.asp

VA/DoD Evidence-Based Practice

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