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DEMYSTIFYING OPIOIDS

OPIOID TAPERING FAQS

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April 3, 2019

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MN Health Collaborative members are **changing the community of practice**, designing practical, evidence-based and innovative approaches to shared problems.

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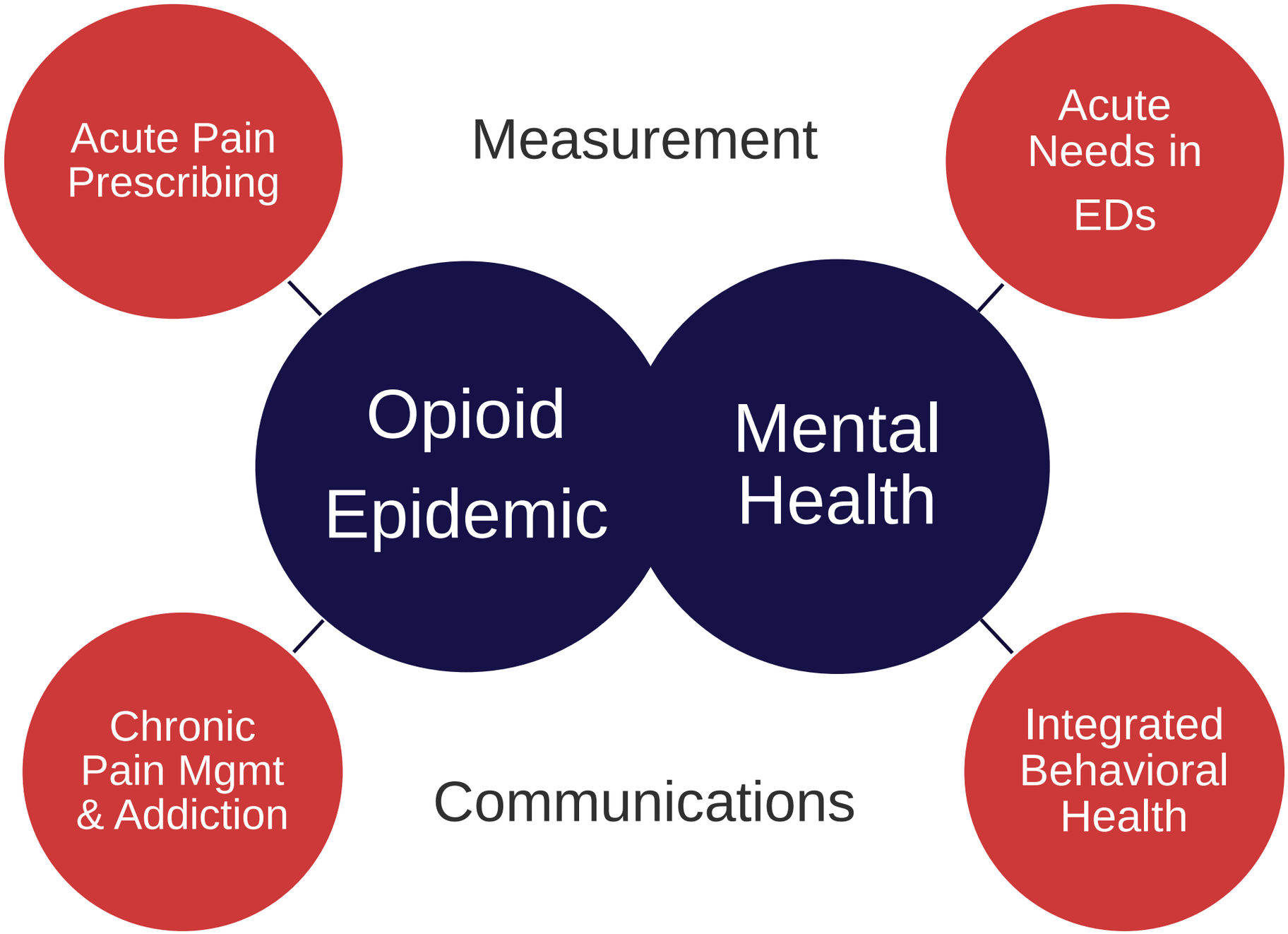

Today’s Topic: Tapering opioids

This is the product of consensus-driven expert panel

Minimal evidence to direct us

Tapering FAQs

Which patients should get a taper?

- For patients on chronic opioids, prescribers should offer a taper every 3-6 months, regardless of duration of therapy, associated diagnosis, and total daily dose.

- Patients at high risk should be more emphatically and frequently advised to taper.

Tapering FAQs

Should the goal of my tapers be to completely discontinue opioids?

- Complete opioid discontinuation is desirable, but may not be appropriate or achievable for every patient.

- Tapering opioids to the lowest possible dose may be the goal for some patients.

- The risk of mortality is linearly proportional to the opioid dose, thus every achievable decrease has significant benefit.

- For patients unable to taper completely, try to taper to at least <50 morphine milligram equivalents (MME) per day, with lower being better. Avoid doses >90 MME per day.

Tapering FAQs

Who is the best prescriber to oversee an opioid taper with the patient?

- Tapers should start with the clinician who is prescribing the ongoing opioids.

- All prescribers of opioids should be able to comfortably discuss the risks and benefits of lowering opioid doses, and know how to initiate a taper.

- Assistance tapering may be needed from a trained pharmacist, nurse, or a pain or addiction specialist.

Tapering FAQs

What do I tell patients who ask how their pain will be controlled if opioids are tapered?

Discuss non-opioid medication options, psychiatry support, physical/occupation therapy, and pain medicine.

Reassure that the underlying condition will still be addressed, with a focus on improving functionality and quality of life rather than just pain.

Share that many people discover, to their surprise, that pain can be managed without opioids.

Tapering FAQs

How do I begin a taper? What are the increments to decrease? How many days?

- Voluntary tapers should be tailored for each specific patient.
- A 10-20% dose reduction from the baseline dose is a reasonable place to start.
- On average, taper durations may be as short as a couple months and may extend six months or longer in some cases.
- You may taper by extending the interval between doses or decrease the dose, or both. This depends on patient preference and medication dosing availability.
- In general, use the original dose to calculate each dose reduction until you reach about ~30% of the original dose. Then recalculate dose reduction using new dose.

Tapering FAQs

- After each decrease, give plenty of time for the patient to adapt to the new dose.
- It is ok to leave a patient on the same dose for a long period of time, if necessary.
- Towards the end of the taper (approximately 30% of original dose), the rate of tapering may need to be decreased.
- Avoid changing the type of opioid.
- Consider stopping the opioid completely when it is taken less frequently than once a day.
- Rapid tapering should be reserved for patients at high risk for opioid related adverse effects or those demonstrating aberrant behaviors.

Tapering FAQs

Which patients should have opioids stopped without a taper?

- For the following patients, there is generally no concern for withdrawal:
  - -If length of therapy is less than 10 days
  - -Patients who are not taking their opioids
  - -Patients past the window of withdrawal (in general, that window is one week for most opioids, two weeks for all opioids)
  - -If total daily opioid dose is <30 MME, taper is optional depending upon length of therapy, patient-specific characteristics, and clinical judgment.

Tapering FAQs

Which patients should have opioids stopped without a taper?

For the following patients, the harms of continuing opioids outweigh the risks of discontinuing (i.e., withdrawal, turning to other illicit drugs). These patients may need an emergency treatment program:

-Patients who are in danger of death if opioids continue

-Active Mental Health Crisis

-Patients for whom there is evidence of diversion

-Patients with positive urine toxicology for illicit substances and clinician concern of high risk addictive behavior

Tapering FAQs

What to taper first: Long-acting opioids or short-acting opioids?

- Generally, try to taper the short-acting first followed by long-acting. This is definitely appropriate for a forced, rapid taper.

- For a collaborative slow taper, it is reasonable to use shared decision making and allow taper of the long-acting first if that is what the patient is more willing to do.

Tapering FAQs

What to taper first: benzodiazepines or opioids?

- There is not a clear right answer to this question.
- In general, taper first what is safest and what the patient will do.
- If the patient is at high risk of benzodiazepine withdrawal, consider tapering opioids first.
- If patient is on low dose benzodiazepines and it is appropriate to stop, consider starting with the benzodiazepine.
- Keep in mind that benzodiazepines cause amnesia and disinhibition, which may complicate the patient's executive ability to carry out a taper.

Tapering FAQs

Do you need to evaluate for opioid use disorder (OUD) or substance use disorder (SUD) before starting a taper?

- If the patient has not previously been evaluated for OUD/SUD, or if not done recently, you should evaluate for these disorders before starting a taper.
- Tapering a patient who has undiagnosed OUD/SUD could lead to severe withdrawal symptoms, and other challenges to tapering

Tapering FAQs

What are withdrawal symptoms? How can they be managed?

- Withdrawal symptoms may include nausea, diarrhea, restlessness, sweating, tremors, insomnia, and/or pain not otherwise explained.

- Slow tapers will prevent or minimize the symptoms of withdrawal.

- Patients should be educated about these symptoms prior to starting and throughout the taper.

- Some patients may benefit from targeted management for withdrawal symptoms.

- Prescribers may simply ask patients about symptoms or use more formal tools such as the Clinical Opiate Withdrawal Scale (COWS).

Tapering FAQs

Does Tramadol need to be tapered?

Tramadol is an opioid and may need to be tapered depending on the calculated MME and prescriber judgment.

For reference, 50mg Tramadol is approximately 5 MME.

Tapering FAQs

Should my patient be given naloxone during the taper?

Yes, consider prescribing naloxone for an opioid taper.

This is in case:

- the patient seeks illicit drugs during the taper
- they return to higher doses of opioids for which they no longer have tolerance.

Tapering FAQs

What should I do if my patient takes illicit drugs during the taper?

- Perform a diagnostic addiction interview
- Consult with an addiction specialist
- Consider accelerating the taper

Tapering FAQs

Why do patients resist or fear tapering opioids?

- Patients may worry about loss of control, pain, and withdrawal.
- For some, opioids have become part of their coping with life and they may fear the pain returning without a viable alternative.
- Prescriber messaging around opioids has changed in recent years and patients may wonder why safety is a concern now when it wasn’t before.

Tapering FAQs

What is the best approach to convincing a patient resistant to tapering to give it a try?

- Reassure them that other pain management modalities are available.

- Demonstrate empathy, validate their pain, and educate on the risk of death and addiction with opioids.

- Go small and slow. It is better to take many small steps, each of which are successful, than it is to take big steps that fail and are not well tolerated.

Tapering FAQs

If my patient struggles to carry out a taper are they likely to have an addiction?

- No.

- There are other reasons why tapers do not succeed, including untreated mental health disorders, flare of the underlying pain condition, discomfort with withdrawal, and lack of social support.

- If symptoms of addiction emerge (evident loss of control over opioid use), a diagnostic evaluation is warranted.

Tapering FAQs

What are the biggest pitfalls to a taper?

- Going too fast
- Inadequate, infrequent follow-up
- Not incorporating patient preferences
- Not educating the patient throughout the process
- Not identifying/treating addiction or underlying mental health disorder

Thank You!

Questions?

https://www.icsi.org/programs/mn-health-collaborative/