Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

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

Adapted from West Suffolk CCG: Opioid tapering

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

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

Step 1 **Indications for opioid tapering -** local guidance: Prescribing in Chronic Non-Malignant Pain in Adults.

- **Assess risk, including emotional influence on pain. Consider** PADT **or** opioid risk tool.
- **Decide if specialist input required** (see overleaf).
- **Patient may need specialist support if taking > 300mg/day oral morphine equivalent.**
- Information on diagnosing opioid dependence, indicators, assessment and risk populations.
- Review physical and mental health co-morbidities, including significant emotional trauma.
- **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.**
- **Non-drug strategies to help manage pain** e.g. exercise relaxation, distraction & pacing.
- **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 harm reduction.
- **Provide patient information:** Taking opioids for pain.
- **Discuss symptoms and signs of opioid withdrawal.**
- **Agree and document opioid tapering goals/ plan.** Not to miss or delay doses. Increased risk of overdose if higher opioid dose taken after tapering as tolerance is reduced.

- Optimise non-opioid management of pain (consider paracetamol).
- **It is usually preferable to stay on current opioid for tapering**. **This is because 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 a healthcare practitioner with adequate competence and sufficient experience. If uncertain, ask for advice from a more experienced practitioner. Further information on dose equivalents and changing opioids see: Opioids Aware. **Local advice on fentanyl and buprenorphine TD overleaf**.
- 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.
- Prescribe regular doses & not PRN doses.
- Keep daily dosing interval the same for as long as possible e.g. twice daily.
- Do not prescribe opioid liquid.

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 or with smaller reductions (10% every 2-4 weeks may be better tolerated).**
- Tapering rate may vary according to response.
- 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.

- **Slower tapering**: if anxious, feel psychologically dependent on opioids or have cardiorespiratory condition.
- **Faster tapering**: if experiencing significant adverse effects, displaying aberrant drug taking or drug seeking behaviour.
- **Once 1/3 of the original dose is reached:** consider slowing the taper down to half of the previous rate if clinically indicated e.g. 5-10% every 2-4 weeks.

If uncertain ask for advice from experienced practitioner (for Sheffield Treatment and Recovery Team (START) – see page 2 for contact details).

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 guideline and Opioid patches – patient information 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.

Step 4: Clinical reviews and follow up (Preferably same clinician to follow up and issue prescriptions).

- 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.

Struggling with opioid tapering

Escalation of pain or worsening mood - discuss with patient:

- Reassure you will work closely with them to manage their pain & mood.
- Importance of non-drug related strategies for ↓pain.
- Hold tapering dose. Avoid increasing opioid or adding in PRN opioids or other Dependence Forming Medicines e.g. z drug, benzo.
- If patient hasn't had non-pharmacological education, consider referral to: Pain Clinic for Pain Management Programme or IAPT – Live well with pain course.

Withdrawal symptoms - discuss with patient:

- You will work closely with them to manage withdrawal symptoms. 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).

If support required with opioid tapering refer to: START for PSI (psychological intervention) at Sidney Street- better uptake when GP refers patient, but patient can self-refer (Tel: 0114 3050500). Weekly support for up to 12 weeks.

If medical support required e.g. evidence of escalation of opioids beyond prescription or signs of dependence Contact START Tel: 0114 3050500 (refer to Fitzwilliam):

- 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.

References:

- 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/our-resources/bulletins/bulletin-218-reducing-opioid-prescribing-in-chronic-pain/

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