**OPIOID TAPERING**: Choosing an Approach

The best approach to opioid tapering is unstudied; an individualized approach is required. Prior to tapering, determine if the goal is dose reduction, complete discontinuation, or transition to OAT. Consider questions such as: has there been previous opioid benefit? How high are the risk of harms? Is opioid-induced hyperalgesia likely? How high is the risk of overdose? Is diversion a concern? Is opioid use disorder present?

### Method

<table>
<thead>
<tr>
<th>Slow &amp; Gradual Taper</th>
<th>Typically ↓ dose 5-10% every 2-4 weeks.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation</td>
<td>• A slower taper is often completed in 1-6 months. Some (esp. on high opioid dose) may benefit from a longer time frame of 12-24 months. In general, the longer the duration of previous opioid therapy, the more time should be allotted for tapering. Some have suggested allowing at least 1 month of tapering per year of opioid therapy.</td>
</tr>
<tr>
<td>Comments</td>
<td>• Rebound or withdrawal pain is common. Try to give adequate time for withdrawal pain to resolve (often at least 2 weeks) before the next dose decrease (&amp; may wait longer when nearing end of the taper). See &quot;How Dangerous is Opioid Withdrawal?&quot;, below.</td>
</tr>
</tbody>
</table>

### Rapid Taper

<table>
<thead>
<tr>
<th>Typically ↓ dose 10-20% every 1-3 days.</th>
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<tbody>
<tr>
<td>Implementation</td>
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<tr>
<td>Comments</td>
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</tbody>
</table>

### Rotating Opioids

Switch to an alternate opioid at 50-75% of the current MED.

| Step 1: Sum up the total daily dose of the current opioid, including PRN & parenteral use. |
| Step 2: Calculate the MED of the total daily dose (e.g. using Table 1). |
| Step 3: Choose opioid you plan to rotate to. Calculate equivalent MED. |
| Step 4: Reduce to 50-75% of the current MED to get the new opioid’s total daily dose. |
| Step 5: Divide the new opioid total daily dose by the desired interval based on formulation (e.g. q12h) and round to the nearest commercially available strength. |
| Step 6: Discontinue current opioid and instruct the patient when to take the first dose of the new opioid. |

### Cross-Over Rotation

Simultaneously decrease the dose of one opioid while uptitrating a new opioid.

| Follow steps 1-3 of "Rotating Opioids", above. |
| Decrease the current opioid dose by ~25% each week (i.e. complete discontinuation after 4 weeks). |
| Simultaneously increase the new opioid’s dose over 4 weeks (starting at 12.5% of the MED) until it is at 50% of the current MED. |

### Opioid Agonist Therapy (OAT): useful approach to tapering/switching patients with opioid use disorder, concurrent psychiatric conditions e.g. depression, long-term opioid use e.g. >Syx, pregnancy. See page 222 of this book.

### When Should I Pause a Taper?

Tapering plans can be held/reassessed at any point if pain becomes unmanageable or function deteriorates, or if withdrawal symptoms persist for 1 month or more. Remember even a small reduction in opioid dose can be a "win" for some patients. However, the "let this taper until x" conversation should have a designated endpoint & be one conversation, not two!

### How Can a Fentanyl Patch be Discontinued?

**Preferred Option**: Decrease patch dose by 12mcg/hr every 2-4 weeks (facilitated through 12mcg/hr patch dosage form). Once taper reaches 12mcg/hr: discontinue, OR discontinue but with limited supply of an IR oral opioid, OR convert to oral opioid (e.g. morphine SR 15mg BID) and continue taper, OR cover half of 12mcg/hr patch with adhesive to limit skin contact (this option is off-label & may risk inconsistent exposure).

**Alternate Option**: First taper patch to 100mcg/hr or less. Calculate MED using Table 1, and rotate to an oral opioid at 50% calculated MED. Give half of the oral opioid dose 12hrs after patch removal, and the full oral opioid dose 24hrs after patch removal.

### How Dangerous is Opioid Withdrawal?

- **Opioid withdrawal is not life-threatening, but can be extremely uncomfortable. Patients may go to great lengths to avoid withdrawal, including seeking illicit opioids, or even committing suicide.**
- **Tolerance to opioids can be lost very rapidly, but can be extremely uncomfortable. Patients may go to great lengths to avoid withdrawal, including seeking illicit opioids, or even committing suicide.**
- **A naloxone kit is useful for all patients to have on hand in case of accidental overdose.**

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**Caution tapering**: pregnancy (premature labour, abortion with severe withdrawal); acute coronary syndrome (recent); severe/unstable psych; diabetes mellitus (sick day management); Q-cognitive fnx.

=Exceptional Drug Status in Sask ≠prior approval NHIB COWS=clinical opioid withdrawal scale MED=morphine equivalent dose OAT=opioid agonist therapy SOWS=subjective opioid withdrawal scale
**OPIOID TAPERING:** Addressing Patient Barriers to Tapering

There are many reasons why patients may not want to taper their opioid. In general, identifying patient-specific barriers is best done through a Motivational Interviewing approach, which uses listening, asking, and informing in order to explore a patient's individual reasons for change. For more on this, see our Motivational Interviewing chart on page 132, and read our article "Tapering Opioids Using Motivational Interviewing" from Canadian Family Physician [www.cfp.ca/content/64/8/584](http://www.cfp.ca/content/64/8/584).

<table>
<thead>
<tr>
<th>Barriers</th>
<th>Addressing Barriers (critical for success!)</th>
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</table>
| **1** Availability of a Trusted Health Care Provider &/or Team  
Patients describe a trusted health care provider as one who is "supportive, nonjudgmental, flexible, and accessible."?  
supportive: e.g., patients need to know that their providers will not abandon them throughout the tapering process; see "Addressing Fear of Withdrawal," below.  
nonjudgmental: e.g., able to manage difficult conversations. When patients and providers do not reach a shared understanding, difficulties arise.  
flexible: e.g., patients need to feel they have input, even if simply to the rate of tapering.  
accessible: e.g., available for the patient when a "crisis" arrives. | **2** Noting Benefit of Improved Quality of Life After Tapering  
Evidence is limited, but one systematic review found that of 40 studies identified, the majority noted improved pain (29/36 studies), improved function (13/17 studies), and improved quality of life (7/12 studies) following an opioid taper. Consider informing patients that their pain may be the same or better after the taper, and that they may have less fatigue & better general well-being. Patients often respond to this approach better than being told there are addiction or overdose concerns.? |
| **3** Offering Non-Opioid Options  
See "Principles of Chronic Pain Management" in this book. Non-opioid options may include:  
- **nonpharmacologic:** exercise, behavioral therapy, interdisciplinary rehab, acupuncture, mindfulness, acceptance & commitment therapy, stress reduction, tai chi, yoga, sleep hygiene, psychosocial interventions, hypnosis, music therapy, TENS, low level lasers, heat/cold, positioning therapy, weight loss, massage therapy ...  
- **pharmacologic:** acetaminophen, ASA/NSAIDs (oral/topical), TCAs, SNRIs, anticonvulsants, capsaicin topical, etc. (see Chronic Pain Colour Chart page 123). | **4** Encouraging Social Support  
Social support may include family, friends, or an education/support group. Social support can help patients identify problematic symptoms and side effects of their opioids (e.g., poor self-care or "you don't see yourself"). It can provide empathy and encouragement (e.g., to stick with the plan for tapering). It can provide a check against bad judgment decisions. In particular, hearing true success stories of living better after a taper from fellow patients can help! |
| **5** Addressing Fear of Withdrawal  
*note:* many withdrawal symptoms can be avoided if taper is slow enough! | **Table 2:** Withdrawal Management. Search "withdrawal" at rxfiles.ca for a pre-printed prescriptions set.  

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Management Options</th>
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</table>
| **Physical Symptoms**  
There is large patient variability in onset, duration, and occurrence of physical withdrawal symptoms. In general, symptoms may begin hours after a missed or reduced opioid dose (often rebound diarrhoea & nausea/vomiting are slower onset), and resolve within 5-10 days (note: evidence primarily from trials rapidly stopping, not tapering, opioids).  
Aches/Pains/Myalgia  
Sweating  
Itchiness, Rhinorrhea  
Rebound Diarrhoea  
Nausea/Vomiting | See Step 3 above for alternate pain management therapies.  
Ensure adequate hydration; oxybutynin 2.5-5mg BID prn; clonidine 0.1mg BID prn  
Ensure adequate hydration; reduce or discontinue laxatives as opioid dose decreases; loperamide 2mg qid prn if necessary, but typically only needed for rapid tapers.  
Hydroxyzine 25-50mg TID prn, or sometimes just HS.  
Ensure adequate hydration; dimenhydrinate 50-100mg QID prn; haloperidol 0.5-1mg TID prn; ondansetron 4mg QID prn; nabuloxine 0.5mg HS up to 0.5-1mg TID; clonidine 0.1mg BID.&n |
| **Psychological Symptoms**  
Psychological symptoms may take longer than physical symptoms to resolve (i.e., >10 days).  
Insomnia  
Anxiety, Agitation, Irritability, Dysphoria | Sleep hygiene (e.g., limit stimulation near bedtime: caffeine, alcohol, TV; regular bedtime & wake-time; sleep restriction); trazadone 25-100mg HS; amitriptyline 10mg HS; doxepin 3-6-10mg HS  
clonidine 0.1mg BID prn (caution: if SBP <100, orthostasis, HR <60). Some evidence clonidine may ↑ opioid abstinence by ↓ stress of tapering.  
quetiapine 25mg HS prn (best for anxiety +/- sleep). |
| **Other potential symptoms**  
Hormonal changes, fatigue, bradycardia, decreased body temperature, increased white blood cells, pilo-erection, rapid breathing, yawning, tremor, fever/chills | Medications are usually unhelpful for these symptoms. Some symptoms (e.g., hormonal changes) may take months to fully resolve. |

Patients commonly mistake the pain of withdrawal for their usual pain. This means they may think the opioid is providing great benefit (as it relieves withdrawal pain), even if the effect on usual pain has been lost. Patients can be counselled that increased pain is normal for the first few days on a lower opioid dose, and pain will often return to baseline by the second week.  
See RxFiles Opioid Patient booklet (available at rxfiles.ca) for a patient-friendly explanation of this.

Alternatives to clonidine: **Tizanidine** ZANAFLEX ⇒ 2mg po HS, may titrate to max ~8mg q8h. Taper gradually! **Lofexidine** LUCEMYRA (not available in Canada): 0.18 mg tabs, 0.54 mg po QID; less hypotension vs clonidine but ↑ cost.
References


2. Eccleston et al. Interventions for the reduction of prescribed opioid use in CNCP. Cochrane Database of Systematic Reviews 2017. CD010323


12. Chronic Insomnia in Older Adults (RxFiles Q&A) http://www.rxfiles.ca/rxfiles/uploads/documents/Insomnia-Older-Adults-QandA.pdf


