Opioid Therapy to Treat Chronic Pain – When to Taper/Discontinue

Throughout the course of opioid therapy, the physician and patient should regularly balance the benefits and risks of continued treatment and determine whether such treatment remains appropriate. If it is determined that opioid therapy is to be continued, the patient's treatment plan may need to be adjusted to reflect the patient's changing needs, as well as to support safe and appropriate medication use. At some point, discontinuance or tapering of a patient's opioid therapy may be appropriate. Ideally, a patient's treatment plan should, at the outset of treatment, include an "exit strategy" for discontinuance and termination of opioid therapy. Consideration should also be given to alternative modalities in an effort to reduce the potential for abuse or the development of physical or psychological dependence.

Not all patients benefit from opioids, and a prescriber frequently faces the challenge of reducing the opioid dose or discontinuing opioids altogether. Discontinuing or tapering of opioid therapy may be required for many reasons. Possible reasons for discontinuing opioid therapy may include:

- Resolution or healing of the underlying painful condition;
- Emergence of intolerable side effects;
- Failure to achieve anticipated pain relief or functional improvement (Confirm that this failure is not the result of inadequate treatment);
- Failure to improve the patient's quality of life despite reasonable titration;
- Deteriorating function;
- Evidence of non-medical or inappropriate use;
- Failure to comply with monitoring, such as urine drug screening (Confirm that this failure is not the result of a cost issue);
- Failure to comply with a pain management agreement[1];
- Indications of drug-seeking behaviors or diversion, such as:
    - Selling prescription drugs;
    - Forging prescriptions;
    - Stealing or borrowing drugs;
    - Aggressive demand for opioids;
    - Injecting oral/topical opioids
    - Unsanctioned use of opioids;
    - Unsanctioned dose escalation;
    - Concurrent use of illicit drugs;
    - Getting opioids from multiple prescribers and/or multiple pharmacies; or
    - Recurring emergency department visits for chronic pain management.

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[1] If a patient is dismissed for not honoring treatment agreements, consider referral to addiction resources.

Because the experience of pain and the symptoms of withdrawal that accompany an opioid taper vary from one person to the next, there is no "one size fits all approach." No single option is appropriate for everyone. The approach to, and rate of taper in patients on opioid therapy, should be based on the individual patient's needs and circumstances. Patients on opioid therapy may be reluctant to change and can experience difficulty as the dose is reduced. Patients may become anxious, concerned about the worsening of pain and withdrawal symptoms or, if there is opioid use disorder, about reduced access to the drug. Exploring each of these possibilities with the patient helps the physician understand the patient's perspective and helps the patient have realistic expectations. Opioid withdrawal symptoms are uncomfortable, but are generally not life threatening.

If discontinuance or tapering of opioid therapy is warranted, the patient who has become physically dependent should be provided with a safely structured tapering regimen. Selecting the optimal timing and approach to tapering depends on multiple factors. The rate of opioid taper should be based primarily on safety considerations, and special attention is needed for patients on high dose opioids, as too rapid a taper may precipitate withdrawal symptoms or drug-seeking behavior. In addition, behavioral issues or physical withdrawal symptoms can be a major obstacle during an opioid taper. Patients who feel overwhelmed or desperate may try to convince the provider to abandon the taper. Although there are no methods for preventing behavioral issues during taper, "exit strategies" implemented at the outset of opioid therapy may help alleviate behavioral problems should discontinuance or taper become necessary.

When opioids are reduced or discontinued, a taper slow enough to minimize symptoms and signs of opioid withdrawal (e.g., drug craving, anxiety, insomnia, abdominal pain, vomiting, diarrhea, diaphoresis, mydriasis, tremor, tachycardia, or piloerection) should be used. Several factors should be considered when selecting the speed of taper. For example:

- Slower, more gradual tapers are often the most tolerated and can be completed over several months based on the duration of use and dose. In general, a slower taper will produce fewer unpleasant symptoms of withdrawal and should be used for patients with no acute safety concerns.
- The longer the duration of previous opioid therapy, the longer the taper may take.
- More rapid tapers may be required in certain instances such as drug diversion, non-medical use, illegal activities, or situations where the risks of continuing the opioid outweigh the risks of a rapid taper, including instances concerning patient safety (e.g., patients who have experienced overdose on their current dosage).

Tapers may be considered successful as long as the patient is making progress. A decrease of 10% of the original dose per week is a reasonable starting point, but keep in mind that tapering plans need to be individualized based upon patient goals and concerns. Patient "buy-in" and collaboration is important if tapering is to be successful. Also, at times, tapers might have to be may be slowed or paused while monitoring for and managing withdrawal

symptoms – but never reverse the taper; it must be unidirectional.[2] Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less frequently than once a day. Always be sure to document the rationale for the opioid taper and the opioid taper schedule in the patient's medical record. If there are concerns of abuse or addiction and a need to quickly discontinue opioids because of the patient's safety, withdrawal can be managed either by the prescribing physician or by referring the patient to an addiction specialist.

One means of tapering/discontinuing opioid therapy is the use of medication-assisted treatment ("MAT"). MAT is one of many options for treating opioid use disorders and involves the use of medications in combination with counseling and behavioral therapies for the treatment of substance use disorders and is often effective in helping people sustain recovery. Several medications are used in MAT for opioid use disorders. One of the most common medications is Buprenorphine. When used properly, buprenorphine-containing medications can both alleviate unpleasant opioid withdrawal and decrease associated cravings**.**

Unlike methadone treatment, which must be performed in a highly structured clinic, buprenorphine is permitted to be prescribed or dispensed in physician offices, significantly increasing treatment access. Under the Drug Addiction Treatment Act of 2000 ("DATA 2000"), qualified U.S. physicians can offer buprenorphine for opioid dependency in various settings, including in an office, community hospital, health department, or correctional facility. In fact, buprenorphine may be the only practical option for patients in rural areas where methadone treatment programs and structured pain programs are difficult to access. Just recently, the DEA raised the cap on the number of patients a "Data Waived" doctor can treat with buprenorphine from 30 to 100 in the first year, and from 100 to 275 in subsequent years.

In addition, , advanced practice nurses and physician assistants can now become DATA-Waived qualifying practitioners, giving them authority to prescribe and dispense the opioid maintenance drug buprenorphine from their offices. In order to be able to offer a complete range of services to your patients, consider becoming DATA Waived. For further information, see the below links.

- https://www.deadiversion.usdoj.gov/pubs/docs/dwp_buprenorphine.htm
- https://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver

Another medication used in medication-assisted treatment is Naltrexone, an injection administered by a physician or another medical provider once a month. Naltrexone blocks opioids from acting on the brain, so it eliminates the possibility of euphoria, takes away the

[2] Inpatient withdrawal management should be considered if the taper is poorly tolerated. Referral to a crisis intervention system or transfer to an emergency room may be appropriate if a patient expresses serious suicidal thoughts with plan or intent.

reward of getting high. Naltrexone can only be used to prevent relapse in people who have been detoxified from opioids. For additional information, visit:

https://www.samhsa.gov/medication-assisted-treatment/treatment/naltrexone

Lastly, it is important to become familiar with the resources and initiatives in your community designed to help those struggling with opioid addiction.

https://www.nj.gov/humanservices/dmhas/home/hotlines/index.html