

## Analgesic Tapering Guidelines

### For adult patients with persistent pain patients taking strong opioids and/or gabapentinoids

<p>Clinical evidence shows limited effectiveness and patient safety concerns due to the risks associated with long-term use of opioids and gabapentinoids.<sup>1</sup></p>
<p>The risk of harm substantially increases at doses at an oral morphine equivalent (OME) of 120mg/day and above, but there is no increased analgesic benefit.<sup>2</sup></p>
<p>If a patient is using opioids but is still in pain, or is experiencing side effects, it is safest to reduce and, where possible, stop the medication, even if no other drug treatment is available<sup>3</sup>.</p>
<p>Medication should only be continued when a person is demonstrating pain reduction and functional improvement. Always aim for the lowest effective dose and intermittent use only.</p>
<p>Lessening effect even with increasing dose is a potential sign of treatment failure. Evidence suggests reducing medication to lowest tolerated dose or stop, rather than continuing or increasing doses further.</p>
<p>The aim of management of persistent pain is empowerment of people to self-manage pain and increase function using safer and more effective methods. Non-pharmacological methods of managing persistent pain include increasing activity and physical fitness, physiotherapy, hot or cold pack application, cognitive behavioural therapy (CBT) and meditation techniques such as mindfulness.</p>
<p>A detailed assessment of the emotional influences on the person's pain experience is essential for people with persistent pain who also have refractory and disabling symptoms, particularly if they are prescribed high opioid doses. These people may need specialist support.</p>
<p>Pain medication should be regularly reviewed and reduced to stop where the underlying condition has resolved (e.g. OA knee pain resolved due to a knee replacement) or there is strong evidence that the patient is diverting medications to others.</p>

Discuss and document the decision to reduce the medication with the patient including:

1. The rationale for stopping opioids including the potential benefits of opioid reduction.
2. Agreed aims of tapering e.g. reducing to 120mg/day morphine equivalence, or stopping opioid completely.
3. Arrangements for monitoring and support during tapering programme.

*Some patients will choose not to engage with a reduction, yet you have evidence to support that reduction is the safest option. We suggest that you document these reasons and seek advice with specialist teams via advice and guidance.*

Ideally, a multi-disciplinary discussion (which may include a GP, pharmacist, specialist in opioid prescribing) should agree whether an enforced wean is appropriate. Document reasons for embarking on an enforced wean, and on attempts to gain patient agreement. Consider discussion, via Advice and Guidance, with Somerset Community Pain Management Services (SCPMS) and/or Somerset Drug and Alcohol Service (SDAS) at this point.

Additional Information <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent>

Where patients are taking different types or forms of opioid consider referring to Somerset CCG “Consolidation guidelines” to convert into one form, to prepare for dose reduction.

Discuss with the patient that reduction can be paused, but not reversed.

Total daily opioid dose should be reduced gradually when a person has been prescribed a strong opioid for longer than two weeks. The total daily dose can be reduced by 10% of the original dose weekly or every two weeks<sup>2</sup>, but it is generally accepted this may be too rapid when dose reductions are undertaken in Primary Care.

Reduce one medication at a time, deciding with the person which medication they would like to reduce first. Doses  $\geq 120$ mg OME daily should be highlighted as a priority.

Make small dose changes, which are less likely to cause withdrawal symptoms and will build confidence in the tapering process. *Always try to engage the person in deciding which dose they would like to reduce initially, i.e. morning / evening dose.*

Dose reductions can be made weekly (except in the instance of transdermal fentanyl), two weekly or monthly, and should be guided by what the person can manage. Frequency of dose reduction can change during the tapering process to maintain tolerance and patient engagement.

Repeat prescriptions of opioids are discouraged. It is important for the tapering process that only acute prescriptions are used for opioids and all opioids are removed from the repeat medication list.

When reducing prescribe exact quantities, clearly document the dose reduction on the medication dosing instructions and provide adequate medication for no more than 2 reductions at a time.

People reducing their opioid or gabapentinoid dose should be reviewed regularly (usually this is at least every two weeks), with assessment of pain, level of function, and signs of withdrawal. See flow diagram below for further details.

Clinicians are encouraged to signpost people with persistent pain to [www.somersetpain.co.uk](http://www.somersetpain.co.uk) and [My Live Well With Pain](#).

Tapering opioid and gabapentinoid medication doses safely is potentially time-consuming, but is extremely worthwhile. People generally report quality of life improvements with medication tapering in persistent pain.

**Please refer to individual documents for dose reduction of each medication**

**Codeine suggested tapering regime**

**Dihydrocodeine suggested tapering regime (includes co-dydramol advice)**

**Tramadol suggested tapering regime**

**Transdermal fentanyl suggested tapering regime**

**Morphine suggested tapering regime**

**Oxycodone suggested tapering regime**

**Tapentadol suggested tapering regime**

## Suggested approach to review when reducing analgesic medication<sup>4</sup>

### *Clinical Review*

- Frequency of review depends on rate of taper and degree of support required.
- Ask about reduction in side-effects, improvement in alertness, daily living, mobility and emotional wellbeing as well as withdrawal symptoms and pain.
- Ideally the same prescriber should review the patient (telephone/face to face) prior to decreasing the dose.

#### **Successful tapering**

#### **Escalation of pain or worsening mood.**

Discuss with the patient:

- You will work closely with them to help with mood and pain.
- The importance of non-drug related pain management strategies.

- **Hold the tapering dose.**

Avoid reversing the reduction.

- Don't add in other medications.
- Consider specialist referral/discussion with specialist team.

#### **Withdrawal symptoms.**

Discuss with the patient:

- You will work closely with them to help manage withdrawal symptoms.
- Reassure them: symptoms are unpleasant and rarely medically serious.
- Most settle within a few weeks (although some can persist for up to 6 months after stopping).
- The importance of non-drug related pain management strategies.

- Hold the tapering dose. Consider slowing the rate of reduction.

- Consider specialist referral/discussion with the specialist team.

Specialist teams to refer to or discuss with are :  
Somerset Community Pain Management Services (SCPMS) and/or Somerset Drug and Alcohol Services (SDAS).

## Acknowledgements and references

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References for this document include:

- [Deprescribing.org - Optimizing Medication Use](http://Deprescribing.org)
- [Medicines and your patient - Live Well With Pain](#)
- [BNF British National Formulary - NICE](#)
- [NICE guideline 193 Chronic pain in over 16s. April 2021](#)
- [Guidance for opioid reduction in primary care \(ouh.nhs.uk\)](http://ouh.nhs.uk)
- [Top-Ten-Tips-Dependence-Forming-Medications-April-2019.ashx \(rcgp.org.uk\)](http://rcgp.org.uk)
- [analgesics-chronic-pain.pdf \(bma.org.uk\)](http://bma.org.uk)
- [PrescQipp 218. Reducing opiate prescribing 2.0 \(prescqipp.info\)](http://prescqipp.info)
- [Pain Management - Somerset CCG](#)
- <https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/decision-making-and-consent>