Dihydrocodeine suggested tapering regime

This document is to be used in conjunction with the following guidance document:

Analgesic Tapering Guidelines for adult patients with persistent pain patients taking strong opioids and/or gabapentinoids

As with all opioids, the dose used should be the lowest possible for benefit, for the shortest possible time.

Long term use of opioids in non-malignant pain (longer than 3 months) carries an increased risk of dependence and addiction, so at the end of treatment the dosage should be tapered slowly to reduce the risk of withdrawal effects; tapering from a high dose may take weeks or months.

Immediate release oral dihydrocodeine is licenced in the UK for moderate to severe pain and chronic severe pain.[1] The modified release forms DHC Continus and DF118 Forte are only licensed for chronic severe pain.[1]

Dihydrocodeine is often considered equivalent to codeine, in terms of dosing. However, licensed doses have changed over recent years, potentially resulting in inadvertent 'off-license' prescribing. The maximum dose of modified-release dihydrocodeine (40mg 60mg, 90mg and 120mg modified release tablets) is 240mg per day, compared to 180mg per day of standard release 30mg tablet preparations.[1]

100mg of dihydrocodeine is equivalent to approximately 10mg of oral morphine.[2]

Special caution needs to be exercised when prescribing co-dydramol tablets due to the risk of paracetamol overdose. They are available as 10/500, 20/500 and 30/500 and all with a maximum dose of 8 tablets a day. This provides up to 240mg dihydrocodeine per day. Changing to standard release dihydrocodeine tablets, even if the dose is off-licence, is likely to be safer than continuing a known paracetamol overdose.

If paracetamol is considered necessary to continue, consider giving it separately to dihydrocodeine and reinforcing the safety messages of NOT EXCEEDING 8 PARACETAMOL TABLETS a day and avoiding paracetamol from other sources e.g. cold and flu preparations.

A suggested regime for reducing immediate release dihydrocodeine is included on page 2. If the patient takes a modified release dihydrocodeine (SR or MR formulation), convert to immediate release formulations before tapering starts. Alternatively, a suggested regime for reducing modified release dihydrocodeine is provided on page 3.

Tapering dihydrocodeine immediate release preparations

Dose changes should be individualised to the person. There are no recommendations as to the speed of reduction. A suggested regime for a patient who is already taking dihydrocodeine 2x30mg tablets 4 times daily is included below. (If the patient is taking a lower dose than 60mg QDS then start the process further down the table and follow the suggested tapering guidance.)

Before starting:

- Where possible, ensure any reduction is discussed and agreed with the patient.
- Agree the speed of dose reduction with the patient.
- Typically one change per week is recommended. Some patients will need space to acclimatise to the new dose so the dose changes may be every one to two weeks. Inform the patient that reduction can be slowed but not reversed.

Agreed dose reduction interval: weekly / fortnightly				
Change	***Morning Dihydrocodeine dose***	***Midday Dihydrocodeine dose***	***Afternoon Dihydrocodeine dose***	***Evening Dihydrocodeine dose***
1	1x 30mg	2x 30mg	2x 30mg	2x 30mg
2	1x 30mg	2x 30mg	1x 30mg	2x 30mg
3	1x 30mg	1x 30mg	1x 30mg	2x 30mg
4	1x 30mg	1x 30mg	1x 30mg	1x 30mg
5	STOP	1x 30mg	1x 30mg	1x 30mg
6	STOP	1x 30mg	STOP	1x 30mg
7	STOP	STOP	STOP	1x 30mg

Notes

- The Faculty of Pain Medicine recommends reducing opioids by no more than 10% every 1-2 weeks[3].
- In the UK there are no readily available dihydrocodeine preparations to allow this approach throughout the reducing regime.
- This leads to a larger reduction as the regime progresses.
- This may mean that some patients want to slow the speed of the reduction as the regime progresses.

Tapering dihydrocodeine modified-release preparations

Dose changes should be individualised to the person. There are no recommendations as to the speed of reduction. A suggested regime for a patient who is already taking dihydrocodeine 120mg tablets twice daily is included below. If the patient is taking a lower dose than 120mg BD then start the process further down the table and follow the suggested tapering guidance.

Before starting:

- Where possible, ensure any reduction is discussed and agreed with the patient.
- Agree the speed of dose reduction with the patient.
- Typically one change per week is recommended. Some patients will need space to acclimatise to the new dose so the dose changes may be every one to two weeks. Inform the patient that reduction can be slowed but not reversed.

Agreed dose reduction interval: weekly / fortnightly				
Change	***Morning Dihydrocodeine dose***	***Midday Dihydrocodeine dose***	***Afternoon Dihydrocodeine dose***	***Evening Dihydrocodeine dose***
1	1 x 90mg (MR)			1 x 120mg (MR)
2	1 x 90mg (MR)			1 x 90mg (MR)
3	1 x 60mg (MR)			1 x 90mg (MR)
4	1 x 60mg (MR)			1 x 60mg (MR)
CHANGE TO STANDARD RELEASE DIHYDROCODEINE TABLETS				
5	1 x 30mg	1 x 30mg	1 x 30mg	1 x 30mg
6	STOP	1 x 30mg	1 x 30mg	1 x 30mg
7	STOP	1 x 30mg	STOP	1 x 30mg
8	STOP	STOP	STOP	1 x 30mg
9	STOP	STOP	STOP	STOP

References

1, Medicines containing the active ingredient dihydrocodeine tartrate - (emc)accessed 15/3/21

2. Dose equivalents and changing opioids | Faculty of Pain Medicine (fpm.ac.uk) accessed 15/3/21

3. Tapering and stopping | Faculty of Pain Medicine (fpm.ac.uk) accessed 15/3/21