Opioid Taper

Nicole Abbot, M.D., Talha Baloch M.D., Rohit Shah M.D., Kari Wolf M.D.

SIU MEDICINE
FORWARD. FOR YOU.

No financial disclosures.

We are not lawyers.

Information should not be used in place of proper legal counsel.

TAPERING OPIOIDS

- Length of taper depends on reason for initiation
  - Acute overdose
  - Signs of toxicity
  - Diversion or non-medical use
  - Lack of benefit after long term use
- Decrease dose by 10% per week
- If patient develops withdrawals
  - Adjust rate, or pause; avoid reversing taper

Interagency Guideline on Prescribing Opioids for Pain, 2015

CDC Guideline for Prescribing Opioids for Chronic Pain — United States, 2016

APPENDIX 1
Clinical Opiate Withdrawal Scale

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increase pulse rate would not add to the score.

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset**: *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9.

CASE EXAMPLE

- Ms. AM has been on chronic opioids for chronic back pain for 1 year.
  - hydrocodone/acetaminophen 10/325mg, 2 tabs
  - she has had increased sensitivity to pain and no improvement in function over the last 6 months.
  - 8 months ago she was treated for respiratory depression, and switched from Morphine sulphate to hydrocodone.

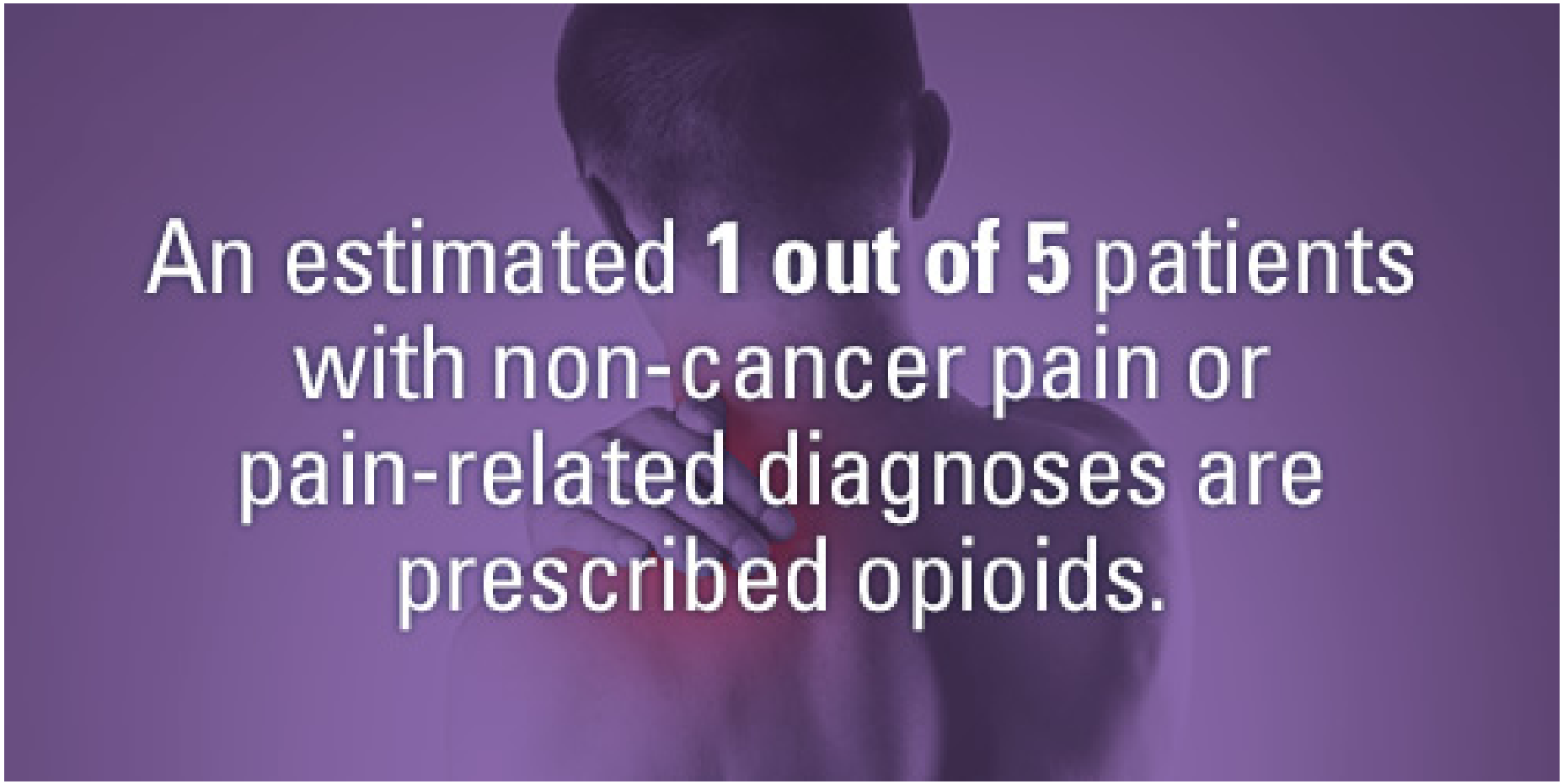
- Would you taper this patient?

POSSIBLE TAPER SCHEDULE:

- 10% per week: 10% of 80 = 8mg
- Difficult dosing schedule with 8mg, try 10mg (12.5%) and monitor closely for withdrawals

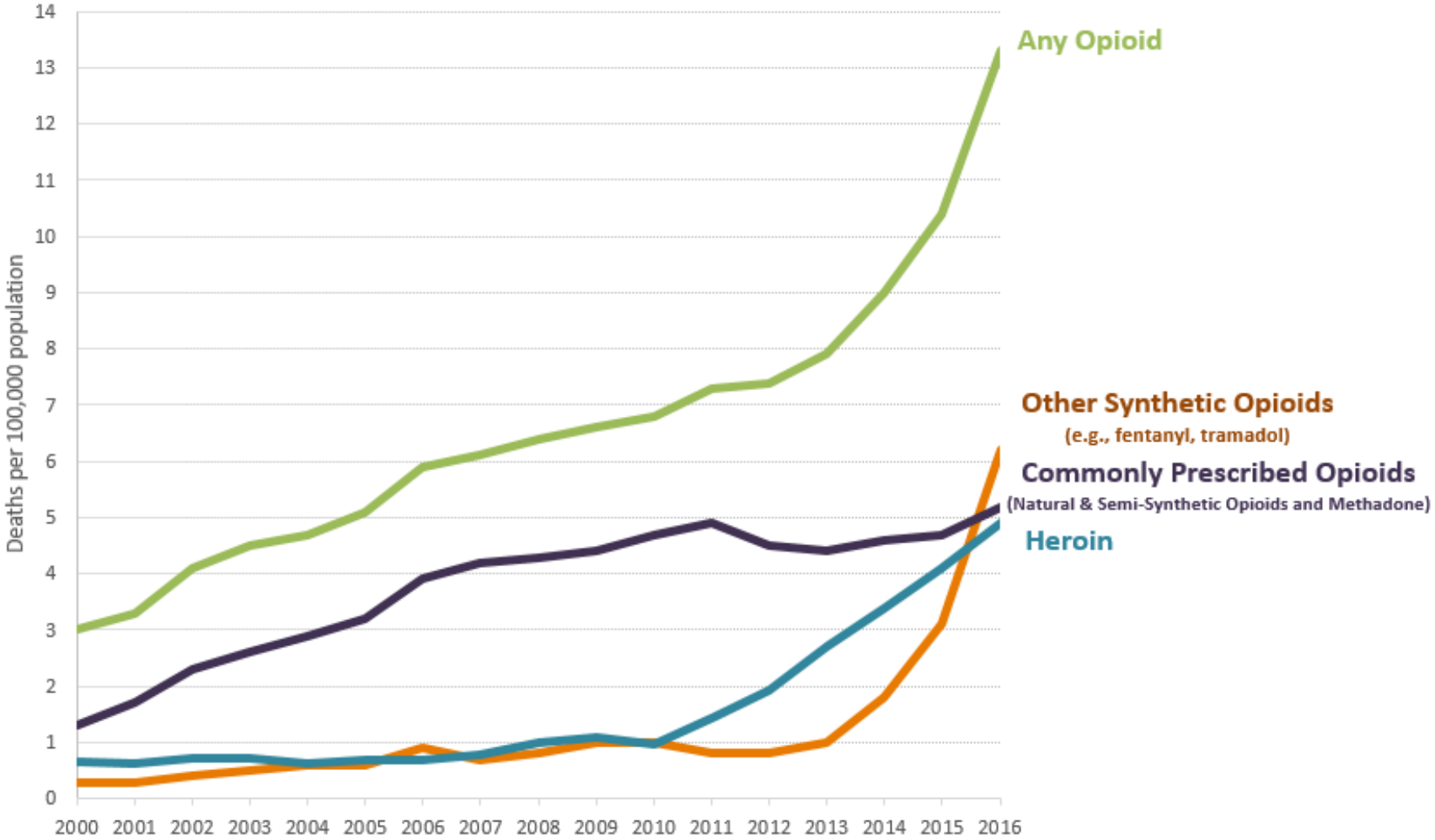
Week	Dose	# of Tablets
1	70mg	7 x 10/325mg
2	60mg	6 x 10/325mg
3	50mg	5 x 10/325mg
4	40mg	4 x 10/325mg
5	30mg	3 x 10/325mg
6	20mg	2 x 10/325mg
7	10mg	1 x 10/325mg

NON-OPIOID THERAPIES FOR PAIN



CDC

Overdose Deaths Involving Opioids, United States, 2000-2016



SOURCE: CDC/NCHS, National Vital Statistics System, Mortality. CDC WONDER, Atlanta, GA: US Department of Health and Human Ser vices, CDC; 2017. https://wonder.cdc.gov/.

www.cdc.gov
Your Source for Credible Health Information

- The CDC Guidelines do not recommend opioids for chronic pain outside of cancer pain, palliative, or end-of-life care

- The CDC indicates that there is no evidence that opioids are effective for chronic pain

- Non-Pharmacological Treatments
  - Complementary
  - Alternative
  - Therapy based

slantedflying.com

- Pharmacological Treatments
  - Analgesics
  - Interventional
  - Anticonvulsants
  - Antidepressants
  - Topical

dreamstime.com

CASE STUDY

55 year old male presents with a complaint of R knee pain for the past six months. He has a history of obesity. Physical examination is significant for pain upon flexion of R leg, with limited range of motion. Imaging demonstrates arthritic changes of the R knee. He has tried heat packs with some relief. What is the best treatment option?

A) Oxycodone 5 mg qday

B) Acetaminophen 600 mg TID

C) Recommend physical therapy

D) Recommend yoga, exercise