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Guidance for Oral Opioid Reduction in Primary Care

BACKGROUND

Opioids are essential in treating the severe acute pain, and pain associated with cancer and end-of-life; however, in the last 10 years, numerous studies have shown that there is little evidence of benefit for long-term opioids in patients with chronic non-cancer pain as regards pain, quality of life or functioning. Nowadays, there is better understanding of the risks, which include dependence and opioid-related mortality amongst others. For this reason, the International Association for the Study of Pain (IASP) supports the use and availability of opioids at all ages for the relief of severe pain during short-lived painful events and at the end-of-life. Healthcare professionals play an important role in minimizing overuse and overdosing as well as understanding morphine equivalent dosing in an effort to help reduce the likelihood of such potential morbidity and mortality associated with opioids.

INDICATIONS FOR OPIOID TAPERING AND/OR DISCONTINUATION

The clinician should always review the patient's progress while on opioids, including any new information about the cause of pain as well as the patient's overall health and function.[1] Discontinuing or tapering of opioid therapy may be required for many reasons. Some indications that would sound the alarm for stopping opioids are seen in Table 1.

OPIOID ANALGESIC DEPENDENCE

Indicators that suggest the possibility of dependence should be explored in those patients on long-term opioid prescription (these may not necessarily preclude the use of opioids for pain, but prolonged use needs close supervision). Such indicators for dependence may include: previous history of addiction; family history of addiction; reluctance to acknowledge psychological contributors to

Table 1: Selected indications that could warrant stopping opioids

OPIOID CESSATION INDICATIONS	
Patient request to stop opioids	Underlying painful condition resolves or stable for ≥3 months
> 120mg oral morphine equivalent per day	Side effects intolerable or impair function
Opioids not providing useful pain relief	Patient receives a definitive pain relieving intervention e.g. joint replacement for osteoarthritis
Opioid trial goals not met	Strong evidence that the patient is diverting their medication
Medical complications	Non adherence to treatment plan or indicators showing dependence behaviour
Overdose risk increased	Opioids used to regulate mood instead of regulating pain

Table 2: Assessing the risk

Patient Factors
Depression, anxiety and history of mental illness
History of alcohol and substance abuse
History of opioid or prescription drug misuse
Inability to engage in services to meet educational and psychological health needs

Prescribing Factors
High doses > 120mg morphine equivalent/day
Multiple opioids
Multiple formulations of opioids
More potent opioids
Concurrent benzodiazepines, gabapentinoids or sedatives

pain; psychiatric comorbidity; correlation of increasing pain with requests for increased opioid dose; psychological deterioration; reliance on pharmacological treatment only without any self-management such as exercise, physiotherapy and psychological support; incidence of lost prescriptions/dropped bottles/extra medications needed for trips abroad; and continued use despite side effects such as constipation and sedation.

ASSESSING THE LOW RISK VS HIGH RISK PATIENT FOR OPIOID THERAPY CESSATION

A low risk patient can easily be managed within the Primary Care sector but in the case of a high risk patient one should consider seeking specialist advice (Table 2). Consider also using an **Opioid Risk Tool**[2] which is a brief, self-report screening tool designed for use in adult patients in primary care settings. This can be done in less than one minute and has been validated for both male and female patients. This scoring system will categorise patient as low or high risk of having an abusive drug-related behaviour.[2]

MORPHINE EQUIVALENT DAILY DOSE

Morphine equivalent dosing (MED) determines a patient's cumulative intake of any opioid drug over 24 hours.

The daily dose of opioids can be calculated by:

1. Determine the daily amount of each opioid the patient takes
2. Convert each opioid to morphine equivalent dose
3. Add them together

The British Pain Society recommends a maximum of 120mg morphine equivalent dose in 24 hours. *At this dose or higher, one can assume that the pain is not opioid sensitive and they should be reduced or stopped in a cautious manner.*

DOSE CALCULATOR: CALCULATION OF MORPHINE EQUIVALENT DAILY DOSE (MED)

An easy way to calculate the total amount of morphine equivalent dose is by using an online calculator found online: *https://www.mdcalc.com/morphine-milligram-equivalents-mme-calculator*.

Opioids Aware (*https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware*[3]) is a website resource for patients and healthcare professionals to support safe prescribing of opioid medicines for pain (Table 3). It was developed in collaboration with Public Health England, the Faculty of Pain Medicine, and the British Pain Society with representatives from the Royal College of General Practitioners, the Royal Pharmaceutical Society, and the Faculty of Addictions, Royal College of Psychiatrists.

Table 3: Opioids Aware - Five Headline Points

1. Opioids are very good analgesics for acute pain and for pain at the end-of-life but there is little evidence that they are helpful for long-term pain.
2. A small proportion of people may obtain good pain relief with opioids in the long term if the dose can be kept low and especially if their use is intermittent (however it is difficult to identify these people at the point of opioid initiation).
3. The risk of harm increases substantially at doses above an oral MED of 120mg/day, but there is no increased benefit.
4. *If a patient is using opioids but is still in pain, the opioids are not effective and should be discontinued, even if no other treatment is available.*
5. Chronic pain is very complex and if patients have refractory and disabling symptoms, particularly if they are on high opioid doses, a very detailed assessment of the many emotional influences on their pain experience is essential.

(Adapted from *https://www.fpm.ac.uk/faculty-of-pain-medicine/opioids-aware*[3]).

SIX PRACTICAL CONSIDERATIONS FOR PHYSICIANS TO REDUCE HIGH DOSE OPIOIDS

1. Education: Explain the Importance of Reducing Opioids to the Patient

Identifying the side effects from opioids, especially if they are relevant to their personal life such as constipation, day-time somnolence or poor night-time sleep is essential in order for the patient to understand the risks of opioids and comply with a reduction plan.

2. Engagement and Preparation for Dose Reduction: The Patient should be Involved in the Decision of Opioid Reduction

It is essential that the patient is involved in opioid reduction and preparation for dose reduction. This will help give them more control of the reduction plan which will ultimately result in a more successful process and ultimately cessation of these drugs.

Preparation for dose reduction may also include hospital admission or discussing with other specialities with regards to any possible deterioration to their physical and mental health co-morbidities. It is also essential that the patient's pain is monitored during the tapering process and other non-opioid options are considered. Non-opioid pharmacological agents may include paracetamol, NSAIDs as well as anti-depressants including duloxetine, amitriptyline or other TCAs, and anti-convulsants such as gabapentin and pregabalin. Non-drug related pain management strategies like mindfulness and cognitive behavioural therapy should also be considered.

The manner in which opioids are tapered is irrelevant as long as the overall daily dose continues to decrease. It is essential that all physicians caring for the same patients are informed of the opioid reduction plan so that they do not inadvertently increase the opioid doses.

3. Choice of Opioid Reduction Scheme

There are two methods for reducing opioids in patients taking immediate or sustained-release formulations[4];

1. The first choice involves initially *weaning down the immediate release* (IR) PRN doses.
   a. Frequency of IR opioids are kept constant but dose is reduced weekly (e.g. from 15mg to 10mg to 5mg);
   b. The same dose is maintained but the frequency is reduced (e.g. from QDS to TDS to BD).
2. The second option involves the *reduction of the modified release* (MR) dose by approximately 10% per week whilst keeping the same IR dose. The patient is advised against increasing the PRN doses as this would contradict the weaning process of the MR formulation. Allowing the patient to choose whether the morning or evening dose is reduced first is advisable as this will give more control. Table 4 gives an example of how to reduce morphine slow release tablets (MST).

Table 4: Tapering of morphine slow release tablets

	MORNING MST AM (MG)	EVENING MST PM (MG)
Week 1	80	80
Week 2	70	80
Week 3	70	70
Week 4	60	70
Week 5	60	60

3. Fentanyl patches are available as 12, 25, 50, 75 and 100mcg/hr patches. 12.5mcg/hr of fentanyl is equivalent to 45mg of oral morphine per day (12.5mcg/hr patches are labelled as 12mcg/hr to avoid confusion with the decimal places). The duration of each patch should last between 48 to 72 hours and therefore they are prescribed every 3 days. Fentanyl patches dose is reduced by 12.5mcg/hr every fortnight.

4. The Weaning Plan

Switching to the tablet form of opioids also helps the weaning process. Having the whole bottle available may facilitate abuse since it is tempting and easier to have a 'sip' from the bottle rather that measuring the doses. Morphine sulphate oral solution contains alcohol, therefore one has to think also of alcohol dependence; the patient may not even be aware of this.

5. Emotional Impact and Expectations:

Any associated anxiety and depression should be managed effectively. Physicians should also ensure that patients understand that the tapering process can be difficult, and that they would need additional support, including mental health specialists. Patients with untreated depression and other mental health

disorders are at increased risk for misuse or abuse of controlled medications, including addiction and overdose. Additionally, untreated depression can interfere with the resolution of pain.[5,6]

6. Withdrawal Symptoms

Opioid withdrawal symptoms can be various although in general are not life threatening. However, these symptoms may cause patients to seek opioids from other clinicians or non-medical sources. Therefore it is essential that good communication is present between the patient and the clinician and that the patient is made aware of such symptoms. Withdrawal symptoms can occasionally be unpleasant. They can be similar to flu-like symptoms including sweating, chills, headache, myalgia, arthralgia and fatigue which can start from 6 to 36 hours following the last opioid dose and diminish over 3 to 7 days, although most patient will report a feeling of malaise for several weeks particularly if they have been taking very high doses.[7] The use of muscle relaxants, antiemetics, anti-diarrhoeal agents such as loperamide and non-opioid analgesics may be considered.[8]

The **Clinical Opiate Withdrawal Scale (COWS)** is an 11-item scale that can help clinicians both in the outpatient and inpatient setting. Rating common signs and symptoms of opioid withdrawal as well as monitoring these symptoms over time will help clinicians determine the severity of opioid withdrawal.[9]

CONCLUSION

The termination of opioid therapy should not mark the end of treatment, but should continue with other modalities, either through direct care or referral to other healthcare specialists, as appropriate.[10-12] Physicians should consider referral at any stage for optimisation of non-pharmacological pain management strategies and/or education and support for opioid tapering which all ultimately aim for the same goal, that of opioid cessation.

USEFUL RESOURCES

- The Pain Toolkit by Pete Moore gives practical advice and techniques to manage pain: www.paintoolkit.org
- An excellent five minute overview of chronic pain by the Hunter Integrated Pain Service in Australia: www.youtube.com/watch?v=5KrUL8tOaQs
- Follow-up video called *Understanding Pain: Brainman stops his opioids*: https://www.youtube.com/watch?v=MI1myFQPdCE
- Managing chronic pain – supported by NHS
  Sheffield Persistent Pain - https://www.sheffieldachesandpains.com/persistent/persistent-pain
- Support for patients with pain
  British Pain Society - www.britishpainsociety.org
  Pain Concern - http://painconcern.org.uk
- Videos about chronic pain and how to manage it
  Chronic pain - www.healthtalk.org
- WHO animated videos
  Depression - www.youtube.com/watch?v=XiCrniLQGYc

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