# Part V. Reducing or Discontinuing Chronic Opioid Analgesic Therapy (COAT)

## Reasons to Discontinue COAT and Considerations Prior to Taper

Not all patients benefit from opioids, and a prescriber frequently faces the challenge of reducing the opioid dose or discontinuing opioids altogether. Patients on COAT can be reluctant to change, and many who agree to try will have difficulty as the dose is reduced. Such reluctance and difficulty in tapering often reflect anxiety. There may be apprehension about worsening of pain and withdrawal symptoms or, if there is opioid use disorder, about reduced access to the drug. Exploring each of these possibilities in a non-judgmental manner helps the provider understand the patient's perspective and helps the patient have realistic expectations. This, in turn, strengthens the therapeutic relationship and supports future strategies.

**Table 8. When to Reduce, Taper, or Discontinue COAT**

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| Patient requests opioid taper. |
| Patient is maintained on opioids for at least 3 months, and there is no sustained clinically meaningful improvement in function (CMIF), as measured by validated instruments (Appendix B: Validated Tools for Screening and Assessment) |
| Patient's risk from continued treatment outweighs the benefit (e.g. decreased function and increased risk for opioid-related toxicity from concurrent drug therapy or comorbid medical conditions) |
| Patient has experienced a severe adverse outcome or overdose event |
| Patient has a substance use disorder (except tobacco) |
| Use of opioids is not in compliance with DOH's pain management rules or consistent with the AMDG Guideline |
| Patient exhibits aberrant behaviors (Table 9) |

### Clinical Recommendations

1. Help the patient understand that chronic pain is a complex disease, and opioids alone cannot adequately address all of the patient's pain-related needs. Exploring the patient's resistance to discontinuing opioids will guide taper strategy. Motivational interviewing skills may be useful when having this conversation.
2. Consider tapering patients in an outpatient setting if they are not on high dose opioids or do not have comorbid substance use disorder or an active mental health disorder, as this can be done safely and they are at low risk for failing to complete the taper.
3. Seek consultation from a pain management specialist or Structured Intensive Multidisciplinary Pain Program (SIMP; described in Non-opioid Options) for patients who have failed taper in an outpatient setting or who are at greater risk for failure due to high dose opioids, concurrent benzodiazepine use, comorbid substance use disorder or any active mental health disorder. If SIMP is not available, engage patients in activities that emulate the biopsychosocial approach of such a program. Rarely, inpatient management of withdrawal may be necessary.
4. Refer patients with aberrant behaviors (Table 9) for evaluation and treatment.

## How to Discontinue Opioids

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, strategies implemented at the beginning of COAT such as setting clear expectations and development of an exit strategy are most likely to prevent later behavioral problems if a taper becomes necessary.

### Clinical Recommendations

1. Consider sequential tapers for patients who are on chronic benzodiazepines and opioids. Coordinate care with other prescribers (e.g. psychiatrist) as necessary. In general, taper off opioids first, then the benzodiazepines.
2. Do not use ultra-rapid detoxification or antagonist-induced withdrawal under heavy sedation or anesthesia (e.g. naloxone or naltrexone with propofol, methohexital, ketamine or midazolam).
3. Establish the rate of taper based on safety considerations:
    a. Immediate discontinuation if there is diversion or non-medical use,
    b. Rapid taper (over a 2 to 3 week period) if the patient has had a severe adverse outcome such as overdose or substance use disorder, or
    c. Slow taper for patients with no acute safety concerns. Start with a taper of ≤10% of the original dose per week and assess the patient's functional and pain status at each visit.
4. Adjust the rate, intensity, and duration of the taper according to the patient's response (e.g. emergence of opioid withdrawal symptoms (Table 10).
5. Watch for signs of unmasked mental health disorders (e.g. depression, PTSD, panic disorder) during taper, especially in patients on prolonged or high dose opioids. Consult with specialists to facilitate a safe and effective taper. Use validated tools to assess conditions (Appendix B: Validated Tools for Screening and Assessment).
6. Consider the following factors when making a decision to continue, pause or discontinue the taper plan:
    a. Assess the patient behaviors that may be suggestive of a substance use disorder
    b. Address increased pain with use of non-opioid options.
    c. Evaluate patient for mental health disorders.
    d. If the dose was tapered due to safety risk, once the dose has been lowered to an acceptable level of risk with no addiction behavior(s) present, consider maintaining at the established lower dose if there is CMIF, reduced pain and no serious adverse outcomes.
7. Do not reverse the taper; it must be unidirectional. The rate may be slowed or paused while monitoring for and managing withdrawal symptoms.
8. Increase the taper rate when opioid doses reach a low level (e.g. <15 mg/day MED), since formulations of opioids may not be available to allow smaller decreases.

9. Use non-benzodiazepine adjunctive agents to treat opioid abstinence syndrome (withdrawal) if needed. Unlike benzodiazepine withdrawal, opioid withdrawal symptoms are rarely medically serious, although they may be extremely unpleasant. Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued (Table 10).
10. Refer to a crisis intervention system if a patient expresses serious suicidal ideation with plan or intent, or transfer to an emergency room where the patient can be closely monitored.
11. Do not start or resume opioids or benzodiazepines once they have been discontinued, as they may trigger drug cravings and a return to use.
12. Consider inpatient withdrawal management if the taper is poorly tolerated.

**Table 9. Aberrant Behaviors**

| Less suggestive for addiction but are increased in depressed patients | More suggestive of addiction and are more prevalent in patients with substance use disorder |
|---|---|
| • Frequent requests for early refills; claiming lost or stolen prescriptions<br>• Opioid(s) used more frequently, or at higher doses than prescribed<br>• Using opioids to treat non-pain symptoms<br>• Borrowing or hoarding opioids<br>• Using alcohol or tobacco to relieve pain<br>• Requesting more or specific opioids<br>• Recurring emergency room visits for pain<br>• Concerns expressed by family member(s)<br>• Unexpected drug test results<br>• Inconsistencies in the patient's history | • Buying opioids on the street; stealing or selling drugs<br>• Multiple prescribers ("doctor shopping")<br>• Trading sex for opioids<br>• Using illicit drugs, +UDT for illicit drugs<br>• Forging prescriptions<br>• Aggressive demand for opioids<br>• Injecting oral/topical opioids<br>• Signs of intoxication (ETOH odor, sedation, slurred speech, motor instability, etc.) |

Adapted from Passik, S. 2006

**Table 10. Symptoms and Treatment of Opioid Abstinence Syndrome (withdrawal)**

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| **Restlessness, sweating or tremors** | Clonidine 0.1-0.2 mg orally every 6 hours or transdermal patch 0.1-0.2 mg weekly (If using the patch, oral medication may be needed for the first 72 hours) during taper. Monitor for significant hypotension and anticholinergic side effects. |
| **Nausea** | Anti-emetics such as ondansetron or prochlorperazine |
| **Diarrhea** | Loperamide or anti-spasmodics such as dicyclomine |
| **Muscle pain, neuropathic pain or myoclonus** | NSAIDs, gabapentin or muscle relaxants such as cyclobenzaprine, tizanidine or methocarbamol |
| **Insomnia** | Sedating antidepressants (e.g. nortriptyline 25 mg at bedtime or mirtazapine 15 mg at bedtime or trazodone 50 mg at bedtime). Do not use benzodiazepines or sedative-hypnotics. |

## Evidence

Some patients on COAT have adverse effects or the prescriber feels that current treatment is not benefiting the patient, and the patient may do better with tapering of the dose or discontinuing opioid therapy.[215-217] Dose reduction, discontinuation of opioids, or transition to medication-assisted treatment for opioid use disorder frequently improves function, quality of life, and even pain control.[218] Because the experience of pain and the symptoms of withdrawal that accompany an opioid taper vary from one person to the next, there is not a one size fits all approach. The approach to and rate of taper in patients on COAT is based on the individual patient's needs and comorbidities. Expert opinion, rather than systematic reviews or RCTs have informed these "best practice" recommendations.

Many pharmacologic therapies have been studied for use as adjunctive agents during opioid taper to palliate opioid abstinence syndrome (withdrawal) as well as emergent insomnia and anxiety. [219-224]

A multidisciplinary approach to pain, including psychotherapy (behavioral activation, problem solving therapy, etc.), physical therapy, chiropractic, social work, and occupational therapy have been proven to improve function. Multidisciplinary pain programs have strong clinical efficacy and empirical data supporting their cost-efficiency. [94,95,225-228] These programs, while neither widely available nor well reimbursed, provide significant benefit to many patients. In addition, a multidisciplinary approach may be considered to address the psychosocial and cognitive aspects of chronic pain together with patients' physical rehabilitation.[229]

High quality evidence of safety and comparative efficacy is lacking for ultra-rapid detoxification, or for the use of antagonist drugs, with or without sedation. [230]

Extremely challenging behavioral issues may emerge during an opioid taper.[231] Special care must be taken by the prescriber to preserve the therapeutic relationship during opioid tapering. Otherwise, the taper can precipitate doctor-shopping, illicit drug use, or other behaviors that pose a risk to patient safety. Although there are no fool-proof methods for preventing behavioral issues during an opioid taper, strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioral problems if an opioid taper becomes necessary. Patients who exhibit aberrant behaviors during the taper may have (Opioid Use Disorder).[232] Also, serious suicidal ideation (with plan or intent) should prompt engagement of the crisis system or, if available, urgent psychiatric consultation. [233]

If the patient doesn't have substance use or any other active mental health disorder and is not on chronic high dose opioids, taper can usually be done safely in an outpatient setting.

Surprisingly, opioid tapers rarely cause significant and long term increases in pain. If these occur, they tend to be during and immediately following completion of the opioid taper. In addition to antidepressant medications, anti-inflammatories and anticonvulsants can be used to address increased pain in patients who have no contraindications.

Office-based buprenorphine treatment is an effective **evidence-based** option which should be considered for patients with both chronic pain and opioid use disorder. [234] Buprenorphine may be the only practical option for patients in rural areas where methadone treatment programs and structured pain programs are difficult to access.