PALLIATIVE CARE NETWORK OF WISCONSIN

FAST FACTS AND CONCEPTS #413
TAPERING OPIOIDS IN PATIENTS WITH SERIOUS ILLNESS: WHO TO TAPER
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Background This *Fast Fact* discusses decision-making around tapering opioids in patients with a history of serious illness on chronic opioid therapy (COT). *Fast Fact* #414 discusses practical approaches to tapering. In general, this discussion applies to patients with longer and indefinite prognoses; opioid tapering in patients in their final months of life is rarely indicated. This *Fast Fact* does not discuss opioid tapering in patients with opioid use disorders (OUD). Patients with OUD should be offered standard-of-care OUD therapy including medication, and the approach to tapering is quite different.

Important Caveat Deciding who to taper is a complex, individualized assessment, which includes the patient's own preferences. It defies standardization. The following comments provide a general outline when considering who to taper and are based mostly on expert opinion.

Scenarios for chronic pain after treatment for serious illness Ongoing pain is common after definitive treatment of a painful serious illness (such as a localized cancer or life-threatening trauma). For instance, approximately 5-10% of all cancer survivors have chronic pain that interferes with functioning (1). Chronic pain after serious illness can be the result of surgery, radiation, chemotherapy, hormonal therapy, osteoporosis, bisphosphonates, and fractures. Syndromes include surgical neuralgias, neuromas, phantom pain, cystitis, fibrosis of skin or myofascia, plexopathies, chemotherapy-induced peripheral neuropathy, osteonecrosis, fistulae, and pelvic insufficiency fractures (1). There are no high-quality clinical data to guide clinicians about the safety or efficacy of COT in these patients, and decisions to treat with COT are empiric and individualized. Additionally, some patients who are started on COT for a serious illness want to continue COT for a pre-existing chronic pain syndrome (e.g., chronic back pain, etc.) even after resolution of the serious illness. In this situation the clinician should remind the patient that the intention of the initial prescription was for pain related to the serious illness. Further evaluation for definitive treatment of pre-existing conditions may now be warranted.

Clinician assessment of risks vs benefits of continuing COT Typically clinicians have a lot of objective, individualized 'data' about the risks and benefits of opioids for a patient who has been on COT for some time: side effects, function, hospitalizations, motor vehicle crashes, refill history, and patient's mood, coping, and social well-being. Ask yourself, do you, as the treating clinician, fundamentally think tapering is in the patient's best interests? This is likely to be a far more clinically useful question than "*Does the patient continue to have severe pain?*" Even in the setting of ongoing pain, tapering may be indicated. Opioids are ineffective long-term treatments for many pain syndromes. Patients may have poor pain control and high pain interference despite being on COT. Indeed, in the chronic noncancer pain literature, a significant number of patients report reduced pain and/or improved function after tapering high-dose COT (over 120 mg of oral morphine a day or its equivalent) (2). Patients may have severe side effects or high medical risk with ongoing COT that does not outweigh any analgesic benefit in the opinion of the prescribing clinician (e.g., patients with severe sleep apnea, CO2 retention, chronic benzodiazepine use, falls, active nonopioid substance use disorders). Clinicians may worry about harmful, maladaptive opioid use (e.g. 'chemical coping') or aberrant opioid behaviors (e.g. frequent requests for early refills, hoarding pills), even if a patient does not have an OUD. Conversely, a patient may appear to be safely benefitting from COT and a clinician may judge that tapering is not indicated.

Patient motivation to taper Despite ongoing pain some patients do not want to continue COT due to ongoing side effects or concerns about addiction. Others are fearful about tapering, but are willing to try it with encouragement, education, and support. Available evidence shows that patients who participate in the tapering plan using shared decision making have better outcomes than those who are forced to taper (3). In fact, recent federal tapering guidelines discourage forcing most patients on COT to taper without patient cooperation. If the clinician supports the patient's choice to taper, they should give the patient guidance on how to taper while minimizing side effects, and plan for how to manage pain with lower doses of opioids, or no opioids entirely. For patients for whom clinicians believe tapering is indicated, but who are reluctant to taper, motivational interviewing techniques can be useful to assess perceived

barriers (4), provide education about potential benefits of tapering, and continue the discussion over subsequent clinic visits (5). This is often the best approach for patients who continue to demonstrate overall safe opioid use and there is time over several visits to build up motivation to taper. Other times it is necessary to taper a patient even without their agreement. Typically, this is because the prescribing clinician judges ongoing opioid exposure is unsafe (e.g., comorbid active alcohol use disorder, a patient who has suffered an inadvertent overdose).

Patient prognosis The benefits of opioid tapering are greater for patients with longer prognoses, since they are more likely to experience long-term adverse effects of COT including tolerance, hyperalgesia, and OUD. However, certain patients with shorter prognoses (e.g., less than a year), may benefit or want to taper opioids due to side effects, improvement of their underlying pain, or other reasons.

Summary Severe, functionally impairing pain is common even after resolution of a serious illness. Clinicians should make an individualized decision about opioid tapering, based on their own assessment of the risks/benefits of COT, patient preferences, and prognosis.

References:

1. Glare PA, Davies PS, Finlay E, et al. Pain in cancer survivors. *J Clin Oncol.* 2014;32(16):1739–1747. doi:10.1200/JCO.2013.52.4629
2. Davis MP, Digwood G, Mehta Z, McPherson ML. Tapering opioids: a comprehensive qualitative review. *Ann Palliat Med.* 2020;9(2):586–610. doi:10.21037/apm.2019.12.10
3. Frank JW, Lovejoy TI, Becker WC, et al. Patient Outcomes in Dose Reduction or Discontinuation of Long-Term Opioid Therapy: A Systematic Review. *Ann Intern Med*. 2017;167(3):181–191. doi:10.7326/M17-0598
4. Crawley A, Murphy L, Regier L, Mckee N. Tapering opioids using motivational interviewing. *Can Fam Physician*. 2018;64(8):584-587.
5. U.S. Department of Health and Human Services. HHS Guide for Clinicians on the Appropriate Dosage Reduction or Discontinuation of Long-Term Opioid Analgesics. U.S. Department of Health and Human Services. Available at: https://www.hhs.gov/opioids/sites/default/files/2019-10/Dosage_Reduction_Discontinuation.pdf. Published October 2019. Accessed Dec 1, 2020.

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