DEPRESCRIBING GUIDE FOR REGULAR LONG-TERM OPIOID ANALGESIC USE (>3 MONTHS) IN OLDER ADULTS

(including morphine, hydromorphine, fentanyl, oxycodone, buprenorphine, codeine)

This guide provides deprescribing information that can be applied to written and/or verbal communication (in the form of "preferred language") between clinicians, patients and/or carers. This guide is adapted for older adults (>65 years) in hospitals. It may not apply to programs targeting drugs of dependence (e.g. methadone programs) and palliative care. Adapt appropriately for individual patients.

CONSIDER TWO STEPS WHEN DEPRESCRIBING:

1 Should I deprescribe?

2 How do I deprescribe?

STEP 1

STEP 1: WHY SHOULD I DEPRESCRIBE? (PATIENT ASSESSMENT)

Deprescribing triggers:

- Inappropriate indication, no current indication, presence or risk of adverse events, drug interaction, drug-disease interaction, high drug burden index (DBI)[1], poor adherence, lack of adequate response, need for escalating dose without adequate response, aberrant behaviours developed, or patient preference.

1a) Is there a documented indication or symptom supporting continued use?

Inappropriate indication for continued use:

- Resolution of painful condition.
- Lack of adequate improvement in pain control (e.g. allodynia or hyperalgesia) and/or function.
- Medical (including mental health) conditions and other medicines that increase risk of opioid overdose.
- Treatment of painful conditions where opioid analgesics are not effective (e.g. low back pain, fibromyalgia).

Do not deprescribe as a sole provider and consider involvement of specialist pain management team or drug and alcohol services if:

- Complex severe pain is present.
- There are associated risks if weaned (e.g. substance use disorder, worsening of mental health conditions, unstable adverse social circumstances).[2,3]
- Response to non-opioid or non-drug therapeutic interventions has been poor.
- Enrolled in a drugs of dependence program.

1b) Are there adverse effects?

Consider potential adverse events from opioid therapy:

- Falls, dizziness, orthostatic hypotension, itch, dry mouth, meiosis, urinary retention, nausea, vomiting, dyspepsia, constipation, respiratory depression, headaches, cognitive impairment (e.g. confusion), drowsiness, over-sedation, impaired concentration (e.g. increase risk of car accidents), mood changes or dependence.[4]

1c) Is this medication likely to cause more harm than benefit?

Consider the risk of dose-related harm from opioid analgesics. This can be estimated using oral morphine equivalent daily dose (OMEDD), with a substantial increase in harm seen with OMEDD >20 mg.[5]

See Evidence-based advice for additional information on risks of harm and benefits of continued use.

1d) Does the patient/carer agree with the recommendation to deprescribe?

Following provision of information, discussion and shared-decision making, the patient or carer has communicated that they would like to proceed with or decline the deprescribing recommendation.[6]

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

_____ is currently taking _____
(patient name) (drug name: e.g. oxycodone/naloxone SR [Targin MR] 10/5mg bd)

for _____, and is currently experiencing/at risk of _____.
(indication: e.g. chronic back pain) (patient issue: e.g. adverse effects)

The _____ outweighs the _____ for continued use of _____.
(risk/benefit + rationale) (risk/benefit + rationale) (drug name: e.g. oxycodone/naloxone SR [Targin MR])

Discussed with _____ and _____ deprescribing recommendation.
(patient /carer name) (agreed/willing to trial/considering/declined)

STEP 2: HOW SHOULD I DEPRESCRIBE? (RECOMMENDATION AND MANAGEMENT)

2a) How to wean

Key Points

- Establish a supportive and trusting relationship with the patient to engage in complex/sensitive discussions.
- Use a multidisciplinary pain management approach concurrently. Accompany weaning with commencement of relevant pain self-management strategies. See Alternative management recommendations.
- In general, wean gradually by 5-25% of the daily dose every 1-4 weeks.
  - Initiate weaning faster if deprescribing due to adverse effects.
  - Initiate weaning slower if starting from a high dose and/or long duration of use.
- Consider judicious and appropriate use of simple analgesics.
- Involvement of and close liaison with patient's general practitioner (GP) with follow-up appointments (frequency determined by rate of weaning).
- Substitution with other opioid medicines for initial attempts to wean is not recommended as the same adverse effects and outcomes occur. However, in some circumstances, changing to another medication/ formulation that is easier to wean may be considered.

Initiation

Reduce dose rapidly by 10-25% of the daily dose each week, or slowly by 5-25% each month.[3]

Option 1: Rationalise the regimen to a single modified release opioid. When stabilised, the dose should be reduced.

Option 2: Keep the modified-release dose stable first and wean down the immediate release as needed (prn) doses. When stabilised, reduce the modified-release dose by around 5-10% per dose per week. May need limited prn immediate release during weaning. However, increasing the prn doses would negate the effect of the modified-release wean.

Adjustments depend on response

Adjust according to pain response and tolerability of adverse drug or withdrawal effects (see Monitoring recommendations).

- If no withdrawal symptoms continue to wean and stop, otherwise pause longer between changes.
- Use slower weaning when reducing to the final lowest doses. End treatment 2-4 weeks after administering the lowest dose.
- If recurrent pain symptoms occur when all dosing has stopped, then restarting at the lowest tolerated dose may be reasonable.
- Consider alternate day dosing to aid weaning if dosage forms are limited.
- Monitor laxative requirements throughout weaning.

Adjustments in the case of recurrent symptoms

In the case of recurrent/withdrawal symptoms, revert to the previous lowest tolerated dose. Recommence weaning after 6-12 weeks at lower weaning rate (e.g. 5-10% of daily dose each month) then stop.

(Based on recommendations in References[2-17])

PREFERRED LANGUAGE:

(Adapt for each patient and medicine as appropriate)

Recommend pain self-management strategies to reduce reliance on regular use of opioid medicines.

Recommend gradually reducing to _____ (drug: e.g. oxycodone/naloxone SR [Targin MR] 10/5mg mane, 5/2.5mg nocte) **for** _____ (timeframe: e.g. 1 week) **and reassess.**

Recommend further tapering by _____ (proportion: e.g. 25%) **every** _____ (timeframe: e.g. week) **with further adjustments guided by response. Follow up with GP** _____ (timeframe: e.g. fortnightly) **after discharge.**

Note: *Examples of preferred language are provided for 'Option 1' and can be adapted to cover other regimens.*

2b) Alternative management

Pain self-management skills training

A multidisciplinary approach to improve pain self-management skills including psychological (e.g. cognitive behavioural therapy including goal setting, pacing, flare-up plan and monitoring unhelpful thoughts and emotions to pain), physical (e.g. graded exercise program to improve range of motion, muscle strength and posture) and other approaches (e.g. counselling, meditation, relaxation, massage and dietary changes).[18,19]

For advice on pain self-management strategies, refer to [AMH Aged Care Companion-Pain management] and [Pain Management Network – Management of chronic pain] and [NSW TAG-Preventing and managing problems with opioid prescribing for chronic non-cancer pain].

Switching within drug class or consider alternative therapy

Consider indication, duration of therapy, type of formulation and patient risk factors when switching or weaning.

If weaning a transdermal patch, wean to the lowest tolerable patch strength, then consider switching to an alternative oral modified-release opioid and continue to wean with frequent monitoring.[13]

Refer to opioid conversion tables at [AMH-Opioid comparative information].

PREFERRED LANGUAGE:

Use **pain self-management strategies** including **psychological, physical and other approaches** concurrently.

2c) Monitoring

Monitor short term (within 1-3 days)	Monitor long term (>1 week)
Withdrawal symptoms can occur within 1-3 days of dose reductions.	**Recurrence of previous or new pain symptoms** may occur within 1-2 weeks of dose reductions.

- Common withdrawal symptoms (e.g. nausea, vomiting, sweating, anxiety, craving, dilated pupils, goose pimples, diarrhoea, cramps, muscle aches, restlessness, insomnia, tearing, tachycardia, increased BP) are usually mild, highly variable and can last up to 6-8 weeks.
- If severe symptoms (e.g. dehydration due to nausea, vomiting, profuse and persistent sweating, tachycardia, severe anxiety, or severe insomnia), restart at the previous lowest effective dose.
- To refer to opioid withdrawal treatment, refer to [AMH-Opioid dependence].
- Continue to reduce medications even if pain returns. For a flare-up plan, refer to [Pain Management Network – Flare-Up Plan] and [NSW TAG-Preventing and managing problems with opioid prescribing for chronic non-cancer pain].

PREFERRED LANGUAGE:

Within 1-3 days of dose reduction, monitor for **withdrawal** of symptoms which can be **mild** (e.g. *nausea, vomiting, sweating, anxiety, craving, insomnia*) or **severe** (e.g. *dehydration due to nausea, vomiting, profuse and persistent sweating, tachycardia, severe anxiety, or severe insomnia*).

Monitor for **recurrence** or **flare-up** of *pain* within *1-2 weeks* of dose reduction.

With **severe** symptoms, consider the value of restarting at lowest tolerated dose with a retrial of deprescribing at *6 weeks*. Develop a pain **flare up plan** or seek further assistance prior to trying again.

EVIDENCE-BASED ADVICE

Effectiveness and safety

The relative potency of opioids can be estimated by converting to an approximate oral morphine equivalent daily dose (OMEDD).[3] National and state guidelines state that OMEDD of >60 mg in general, or >30 mg in older adults, those with impaired respiratory, renal or hepatic function and those taking other medicines with sedating effects are considered high risk and specialist advice is recommended.[2,3]

The risk of serious harm (e.g. accidental overdose, death, hospitalisation, unconsciousness, respiratory failure) increases substantially for patients taking opioid analgesics >20 mg OMEDD for chronic non-cancer pain.[5] In a cohort study (mean age ± SD 54 ±17 years), compared with patients taking 1-20mg OMEDD, the risk of serious harm was almost 1.5 times higher for those taking 20-50 mg OMEDD (hazard ratio [HR]=1.44, [95% CI; 0.57-3.62]); almost 4 times higher in those taking 50-100 mg OMEDD (HR=3.73, [95% CI; 1.47-9.50]); and almost 9 times higher in those taking >100 mg OMEDD (HR=8.87, [95% CI; 3.99-19.72]).[20]

In people aged over 65 years, opioids are associated with an 88% increased risk of overall fractures (RR=1.88; 95% CI 1.51-2.34) and 2-fold increased risk of hip fractures (RR=2.00; 95% CI 1.84–2.19).[21]

In a meta-analysis of patients with osteoarthritis of the knee or hip, in whom oral or transdermal opioids were deprescribed, only 24 out of 1000 people (2.4%) experienced withdrawal symptoms. For 1 person to experience withdrawal symptoms, 65 patients needed to be withdrawn from an opioid (i.e. number needed to harm [NNH 65]; 95% CI 42 - 110).[22]

One in three patients will benefit from chronic opioid treatment, where opioids generally reduce pain intensity by 30-50%. Eighty percent of people on opioids long-term will develop adverse effects.[9]

Over 90% of people report willingness to stop their medicines if recommended by their physician.[23]

Recommended duration of use

Limit opioid treatment to short-term use (<3 months). While opioids are effective in treating acute pain, their role in chronic non-cancer pain is limited.

Opioids are associated with significant harm (e.g. falls, fractures), and long-term use is not recommended, especially in older adults.

SUMMARISED PHRASING DURING HOSPITAL ADMISSION AND/OR AT DISCHARGE

When communicating deprescribing decisions to GPs at discharge, written and verbal communication should include information in the sequence of:

"Medicine, Intention, Rationale, Clear Plan (dose change, duration, follow up), Patient agreement"

PREFERRED LANGUAGE

(write in GP follow up plan and medication list):

_____ : _____ **due to** _____ **outweighing effects** _____.

Medication(s) prior to weaning (e.g. Oxycodone/naloxone SR [Targin MR]) | stopped/ reduced with aim of stopping | specific rationale (e.g. delirium) | of/on current indication (e.g. on chronic pain)

If weaning: _____ **reduced by** _____ **for** _____**, then** _____.

dose prior to weaning (e.g. Oxycodone/naloxone SR [Targin MR] 10/5mg BD) | proportion (e.g. x%) | timeframe (e.g. 1 week) | follow-up action (e.g. GP follow up, consider physiotherapy review)

Patient/Carer agreed.

Refer to http://www.nswtag.org.au/deprescribing-tools/

Example:

Oxycodone/naloxone SR [Targin MR] 10/5mg: reduced with aim of stopping due to delirium outweighing effects on chronic pain. Oxycodone/naloxone SR [Targin MR] 10/5mg BD reduced by 25% for 1 week, then follow up with GP and consider physiotherapy referral. Patient agreed. Refer to http://www.nswtag.org.au/deprescribing-tools/

GO TO SECTION:

- Indication
- How to wean
- Alternative management
- Monitoring
- Evidence-based advice
- Summarised phrasing during admission and/or at discharge
- References

1. Hilmer SN, Mager DE, Simonsick EM, et al. A drug burden index to define the functional burden of medications in older people. Arch Intern Med. 2007 167(8):781-787. Available at https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/412262 **2.** NSW Agency for Clinical Innovation (ACI). ACI Pain Network. Quick steps to manage chronic pain in primary care: GP Plan. 2018. Available at https://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/quick-steps-to-manage-chronic-pain-in-primary-care **3.** NSW Therapeutic Advisory Group Inc. Preventing and managing problems with opioid prescribing for chronic non-cancer pain. New South Wales, Australia. July 2015. Available at http://www.nswtag.org.au/wp-content/uploads/2017/07/pain-guidance-july-2015.pdf **4.** Australian Medicines Handbook (AMH). Opioid analgesics. 2018. **5.** Bohnert AS, Valenstein M, Bair MJ, et al. Association between opioid prescribing patterns and opioid overdose-related deaths. JAMA. 2011;305(13):1315-21. **6.** Dowell D, Haegerich TM. Changing the Conversation about Opioid Tapering. Ann Intern Med. 2017;167(3):208-209. **7.** AMH Aged Care Companion: Pain management. 2018. **8.** NPS Medicinewise. Safe Use of Benzodiazepines, antipsychotics and opioids in older people. 2013. **9.** eTG complete. Chronic pain: pharmacological management, Analgesics for chronic non-malignant pain management. Therapeutic Guidelines. 2018. **10.** Alfred Health. Oral Opioid Dose Reduction for Inpatients guideline. 2015. **11.** Veterans Affairs/Department of Defense. Va/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain, v3.0. 2017. Available at https://www.healthquality.va.gov/guidelines/Pain/cot/VADoDOTCPG022717.pdf **12.** Busse, Jason. The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain. The National Pain Centre. 2017. Available at http://nationalpaincentre.mcmaster.ca/documents/Opioid%20GL%20for%20CMAJ_01may2017.pdf **13.** Kral L, Jackson K, Uritsky T. A practical guide to tapering opioids. Mental Health Clinician. 2015;5(3):102-108. **14.** Guidance for opioid reduction in primary care. Oxford University Hospitals, NHS foundation trust. 2017. Available at https://www.ouh.nhs.uk/services/referrals/pain/documents/gp-guidance-opioid-reduction.pdf **15.** Medstopper. Available at http://medstopper.com **16.** The Royal Australian College of General Practitioners (RACGP). Prescribing drugs of dependence in general practice- Part C2: The role of opioids in pain management. Available at https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/prescribing-drugs-of-dependence/prescribing-drugs-of-dependence-part-c2 **17.** Pain Management Network. Management of chronic pain. Agency for Clinical Innovation. 2018. Available at https://www.aci.health.nsw.gov.au/chronic-pain/health-professionals/management-of-chronic-pain **18.** Nicholas MK and Blyth FM. Are self-management strategies effective in chronic pain treatment? Pain Manag. 2016;6(1):75-88. **19.** Pain Management Network. What is an upgrade plan? What is a flare-up plan? Agency for Clinical Innovation. 2018. Available at https://www.aci.health.nsw.gov.au/chronic-pain/painbytes/pain-and-physical-activity/what-is-an-upgrade-plan-what-is-a-flare-up-plan **20.** Dunn KM, Saunders KW, Rutter CM, et al. Opioid prescriptions for chronic pain and overdose: a cohort study. Ann Intern Med. 2010;152(2):85-92. **21.** Teng Z, Zhu Y, Wu F, et al. Opioids contribute to fracture risk: a meta-analysis of 8 cohort studies. PloS one. 2015;10(6). **22.** Nüesch E, Rutjes AW, Husni E, et al. Oral or transdermal opioids for osteoarthritis of the knee or hip. Cochrane Database Syst Rev. 2009;4(4). **23.** Reeve E, Wiese MD, Hendrix I, et al. People's attitudes, beliefs, and experiences regarding polypharmacy and willingness to deprescribe. J Am Geriatr Soc. 2013;61(9):1508-1514.