APPENDIX E: SUPPORT FOR WITHDRAWAL AND WEAN-DOWN MANAGEMENT

Tapering Patients off Opioids

WHEN TO TAPER PATIENTS OFF OPIOIDS

1. Inadequate analgesia – with severe pain and disability despite a high dose (greater than Morphine Oral equivalent dose of 200 mg/day)
2. Side Effects or medical complications – include sedation, sleep apnea, overdose, severe myoclonic jerking, constipation despite treatment and falls in the elderly
3. Opioid Misuse and addiction – those who are found to get opioids off the street, those who persistently have other drugs in their urine drug screens – they may be better served on the methadone/buprenorphine programs
4. Be careful if considering tapering pregnant patients as this may result in preterm labour and spontaneous abortion, they are better off on methadone
5. Warn patients that once they are off they are at increased risk of overdosing if they take their previous dose if they relapse

WHEN CAN OPIOIDS BE ABRUPTLY DISCONTINUED?

It is felt that if patients are obtaining most of their opioids from another source or diverting the prescriptions, it is reasonable to stop prescribing the opioids abruptly.

CLINICAL FEATURES OF OPIOID WITHDRAWAL

Physical signs/symptoms	lacrimation, rhinorrhea, yawning
	Dilated pupils, nausea/vomiting
	Diaphoresis, chills, piloerection, mild tachycardia, HBP
	Myalgias, abdominal cramps, diarrhea
Psychological symptoms	anxiety and dysphoria
	Cravings for opioids
	Restlessness, insomnia, fatigue

ONSET AND DURATION OF SYMPTOMS OF OPIOID WITHDRAWAL

<8 hours (peak 36-72h)	anxiety, fear of withdrawal, drug craving, diaphoresis, chills, lacrimation, rhinorrhea, yawning
12 hours on – peak 72 h	piloerection, anorexia, dilated pupils, anxiety, irritability, dysphoria, restlessness, insomnia, tremor, mild tachycardia, hypertension, abdominal cramps
24-36 h - peak 72 h	diarrhea, myalgias, muscle spasms, nausea, vomiting, diarrhea, severe insomnia, violent yawning

Physical withdrawal symptoms generally resolve by 5-19 days

Psychological symptoms may last weeks to months

Methadone withdrawal may start at 24 hours but the withdrawal symptoms are prolonged up to 3 weeks or more

TAPERING PROTOCOL

Formulation	Sustained release opioids until lowest does is reached
Dosing Interval	Scheduled doses rather than prn until lowest dose is reached
Rate of Taper	Taper slowly: 10% every two to four weeks The longer the patient has been on opioids the longer the taper Taper even more slowly when patient is on 1/3 of starting dose
Frequency of pharmacy dispensing	If patient runs out early then dispense weekly, alternate daily or daily
End point of taper	Less than 200 mg. equivalent morphine oral dose as long as goals of treatment are being met. Wean off if there is no benefit (*See table on next page for equivalent doses information*)
Frequency of visits	If possible, prior to each patient dose decrease
Approach at each visit	Ask about withdrawal symptoms, pain, benefits such as alertness, less fatigue and less constipation

Use of other medications to ease withdrawal

Nausea and vomiting	Dimenhydinate 25-100 mg po/pr q4h prn
	Prochlorperazine 5-10 mg po q4h prn
Diarrhea	Loperamide 2-4 mg po prn max dose 16 mg/24
Myalgias	Acetaminophen 500 mg po bid prn
	Naproxen 500 mg po bid prn with meals
Anxiety, lacrimation, rhinorrhea	Hydroxyzine 25-50 mg po tid prn
Insomnia	Trazodone 50-150 mg po qhs prn
Other general withdrawal	Clonidine 0.1 m,g po x 1 dose – If BP greater than 90/60 proceed to use – use 0.1 mg po qid prn for up to 14 days

EQUIANALGESIC OPIOID CONVERSION FOR CHRONIC PAIN

DRUG	ORAL (PO)	PARENTERAL (IV,IM,SC)
Morphine	10 mg	5 mg*
Codeine	100 mg	65 mg
Hydromorphone	2 mg	1 mg*
Oxycodone	5 – 7.5 mg	---
Methadone	1 mg but highly variable ratio & complex**	Not readily available
Fentanyl	25 mcg patch ≈ 60 – 134 mg total oral Morphine Equivalent Daily Dose (MEDD)*** e.g. morphine 10 mg po q4h = 25 mcg patch	
* Common ratio PO:IV/IM/SC is 2:1, but some patients may be 3:1		
** Rotation to methadone from morphine is complex, including delayed accumulation to steady state. Ratio varies from morphine:methadone 5:1 at low doses to 10:1 or up to 20:1 at higher doses. Must be individualized.		
*** Manufacturer suggests a range of possible doses. See Table below.		

***Recommended Initial Dose Conversion to Fentanyl Patch	
Oral 24-Hour Morphine Equivalent Daily Dose (mg/day)	Fentanyl Dose Equivalent (mcg/hour)
60 – 134	25
135 – 179	37
180 – 224	50
225 – 269	62
270 – 314	75
315 – 359	87
360 – 404	100

The above table is designed to be conservative when switching to a fentanyl patch. It must therefore be used with great caution when switching **from** a fentanyl patch **to** another opioid. Use of this table for such a conversion could overestimate the dose of the new agent and over dosage may occur.

Note: The 12 mcg/h dose is not included in this table because it generally should not be used as the initiating dose, except in the case of patients for whom clinical judgment deems it appropriate. Fentanyl transdermal systems are contraindicated in opioid-naïve patients.

The above information is copied, unaltered, from the following source: ***Authors:*** *Dr. Greg McKelvie, Pharm D, Pharmacy Practice Council and End of Life Quality Council, Island Health Interprofessional Practice & Clinical Standards.*

REFERENCES

1. Medical Care of the Dying, 4th edition, page 195
2. Health Canada Bulletin. Important Changes to the Dose Conversion Guidelines for Fentanyl Transdermal Systems. Authorized by Janssen-Ortho Inc., Cobalt Pharmaceuticals Inc., Novopharm Limited, Ranbaxu Pharmaceuticals Canada Inc., Ratiopharm Inc., January 2, 2009