Treatment of chronic non-cancer pain (CNCP) over past 2 decades evolved to include a high rate of opioid analgesics

Evidence base for opioid use in CNCP slim and harms associated with use

Guidelines subsequently developed to guide opioid use for CNCP

Guidelines do not completely address the “legacy” patient already on chronic opioid therapy, often high dose or in combination with benzodiazepines or hypnotics

Providers and patients subsequently left with decisions to taper and/or discontinue chronic opioid therapy and opioid/benzodiazepine/hypnotic combination therapy
Benefits of opioid tapers

- Improved pain and functioning (Fishbain and Pulikal, 2019)
- Lessened risk of accidental overdose and death
- Lessened side effects from opioid use such as itching, constipation
- Lessened impairment of disease process such as in patients with lung disease, liver disease
- Improved risk profile in high risk populations such as youth and pregnant women
Risk of opioid tapers

- Worsened pain
- Unmasked opioid dependency in those patients with long term use
- Unmasked behavioral health conditions in those patients previously not diagnosed
- Precipitated withdrawal syndrome in those undergoing rapid tapering or abrupt discontinuation and the consequences thereof
Tapering scenarios

- The patient who voluntarily requests a taper
  - Uncommon
  - Engage the patient while motivated
  - Sometimes in response to adverse event or knowing others who have sustained an adverse event

- Provider – initiated taper
  - Most common scenario
  - Initiated after assessment that risk of treatment with opioids outweighs benefit
  - Also initiated when condition causing the CNCP has improved
Tapering strategies

- Shared decision-making and patient buy-in from the beginning including the following considerations:
  - Discussion of the reasons for tapering including long-term benefits
  - Protocols for tapering including discussion of tapering speed
  - Discussion about patient expectations during tapering including effects on pain and function
  - Discussion about withdrawal symptoms including assurances that symptoms can be addressed if occur
  - Motivational interviewing and importance of patient involvement (Lembke, 2018; Matthias et al., 2017)
Adjuncts to tapering

- Use of interdisciplinary teams (Epstein, 2014)
  - Benefits such as facilitation of multimodal pain management

- Tapering agreements (Berna, Kulich and Rathmell, 2015)
  - Suggested elements include endpoints of therapy, proposed speed of taper, listed benefits and risks of tapers, provisions for dealing with tapering failures including need for consultation
Speed of tapering

- Lack of evidence based research
- One size does not fit all
- Speed of taper should be inversely related to opioid dose and duration of use, i.e. the higher the dose the longer it will take
- 2016 CDC pain guideline as well as other guidelines have offered up suggestions such as 10% reduction from starting dose over 1-4 week intervals
- Tapering may require periodic slowing or pausing, preferably guided by objective assessments of pain and function such the PEG scale (Krebs, 2009) or Quality of Life Scale (American Chronic Pain Association)
- Endpoint of tapering often not the discontinuation of all opioids but a reduction to the lowest effective dose based on objective assessments
Behavioral health issues and tapering

- A significant percentage of CNCP patients on long-term opioid therapy have underlying behavioral health concerns although formal research is needed to better establish those percentages.
- Behavioral health concerns in this population include mood disorders such as depression, personality disorders, substance abuse disorders (SUD).
- Screening tools for behavioral health disorders readily available for use at initiation of tapering and at any point in tapering process.
- Strategies for dealing with behavioral health issues detected during tapering involve the use of nonpharmacologic therapies, pharmacologic therapies such as SSRIs/SNRIs and behavioral health consultation.
- SUD patients represent an important subset of CNCP patients undergoing tapering with the emphasis shifting from tapering to treatment of the SUD.
Adjunctive therapies in tapering

Nonpharmacologic:
- Cognitive behavioral therapy, particularly in select groups of patients (Gatchel et al., 2014, Knoerl, Lavoie, Smith and Weisberg, 2016)
- Other therapies include chiropractic therapy, trigger point injections, dry needling, physical therapy, exercise, regional anesthesia, mindfulness

Pharmacologic:
- NSAIDS, acetaminophen, antidepressants, anticonvulsants
- Gabapentinoids?

Goal of adjunctive therapies– optimize pain control in such a way that opioids have less utility for pain control and can be tapered
Summary

- Patients on preexisting long-term opioid therapy for CNCP should be considered for tapering.
- Successful tapering should result in lowering dosage to the lowest effective dose based on ongoing assessment of pain, function; this may not result in complete cessation of opioid therapy.
- Successful tapering may require months to years to accomplish and may involve intermittent slowing/pausing tapering efforts.
- Adjunctive strategies and adjunctive therapies should be optimized in the tapering process to assist in reducing the need for opioid therapy.
- Patient buy-in via education should be optimized with tapering success best achieved by a shared-decision making process.
- Multiple research gaps exist regarding opioid tapering and the mechanisms involved in that process.


