

# Tapering Long-term Opioid Therapy in Chronic Noncancer Pain: Evidence and Recommendations for Everyday Practice

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## Abstract

Increasing concern about the risks and limited evidence supporting the therapeutic benefit of long-term opioid therapy for chronic noncancer pain are leading prescribers to consider discontinuing the use of opioids. In addition to overt addiction or diversion, the presence of adverse effects, diminishing analgesia, reduced function and quality of life, or the absence of progress toward functional goals can justify an attempt at weaning patients from long-term opioid therapy. However, discontinuing opioid therapy is often hindered by patients' psychiatric comorbidities and poor coping skills, as well as the lack of formal guidelines for the prescribers. The aim of this article is to review the existing literature and formulate recommendations for practitioners aiming to discontinue long-term opioid therapy. Specifically, this review aims to answer the following questions: What is an optimal opioid tapering regimen? How can the risks involved in a taper be managed? What are the alternatives to an opioid taper? A PubMed literature search was conducted using the keywords *chronic pain* combined with *opioid withdrawal*, *taper*, *wean* and *detoxification*. Six hundred ninety-five documents were identified and screened; 117 were deemed directly relevant and are included. On the base of this literature review, this article proposes evidence-based recommendations and expert-based suggestions for clinical practice. Furthermore, areas of lack of evidence are identified, providing opportunities for further research.

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Recent systematic reviews and meta-analyses suggest that long-term opioid treatment for chronic noncancer pain (CNCP) is supported by limited evidence.<sup>1-10</sup> First, the published studies of long-term opioid treatment for CNCP present the following issues, as reviewed in a recent Cochrane meta-analysis: few randomized clinical trials, a high discontinuation rate (up to 30%) of opioid therapy in the observed populations because of adverse effects or insufficient pain relief, and a relatively short observational period (6-48 months; mean, 15.15 months).<sup>5</sup> Second, the results of these trials provide only weak evidence that long-term opioid therapy can provide clinically significant pain relief and fail to provide any conclusive evidence for improved quality of life or function.<sup>5</sup>

Among the 4.3 million American patients prescribed opioids,<sup>11</sup> often for CNCP, many present an unfavorable risk-benefit ratio for this treatment.<sup>12</sup> Although noting situations when a taper might be necessary, current guidelines regarding long-term opioid treatment in CNCP, whether published by multidisciplinary expert groups such as the American Pain Society and the American Academy of Pain Medicine, or regulating organizations such as the Federation of State Medical Board, focus on how to prescribe safely and effectively but do not provide practical advice on opioid treatment discontinuation.<sup>13,14</sup> The burden of tapering long-term opioid treatment often falls on community pain practices and individual physician practices, where resources are relatively limited, rather than tertiary centers. Yet, practitioners face patients presenting with psychiatric comorbidities, such as personality disorders, somatic symptom disorder, substance use disorder (SUD),<sup>15-17</sup> and depression,<sup>18</sup> as well as poor coping abilities.<sup>19</sup>

The available literature was reviewed to formulate evidence-based recommendations on tapering long-term opioid treatment in CNCP, specifically aiming to answer the following questions: What is an optimal opioid tapering regimen? How can the risks involved in a taper be managed? What are the alternatives to an opioid taper?

## INDICATIONS FOR TAPERING OF LONG-TERM OPIOID TREATMENT

Adverse effects often outweigh the benefits of long-term opioid treatment: sedation, decreased

concentration and memory, drowsiness, changes in mood, constipation, dry mouth, abdominal pain, nausea, hormonal changes with consequences such as sexual dysfunction, and osteopenia may limit treatment tolerability.<sup>4,5</sup> The benefits of long-term opioid treatment can also be questioned when a patient reports inadequate analgesia despite high doses (tolerance), reduced function, quality of life, or absence of progress toward therapeutic goals.<sup>13</sup> Table 1 presents the indications for tapering long-term opioid treatment.<sup>14,20</sup> Tapering might also be considered for patients planning elective surgery. According to a retrospective trial, patients with CNCP undergoing long-term opioid treatment (N=30) experience more postoperative pain than controls without long-term opioid treatment (N=25).<sup>21</sup> However, there is no research yet on the effect of preoperative tapering on postsurgical pain outcomes.

Diversion and addiction are alarming but relatively uncommon considering the number of patients undergoing long-term opioid treatment.<sup>7,22-24</sup> Addiction (ie, SUD or more specifically opioid use disorder [OUD]) is a psychiatric diagnosis that involves use despite negative consequences and/or loss of control over use, compulsions, and cravings.<sup>25</sup> Among patients with chronic pain, adherence vs abuse can be seen on a spectrum,<sup>12</sup> and OUD is a difficult diagnosis to establish with certainty, justifying involvement of an addiction specialist for initial evaluation and follow-up.<sup>26,27</sup> Although the current review aims to focus on patients with CNCP, patients with cancer pain may develop similar difficulties related to opioid use.<sup>28</sup> Diversion (ie, any act that results in another individual receiving the medication than the one it was prescribed to) is a legal issue discussed further below.

## CENTRAL ISSUES DURING TAPERING OF LONG-TERM OPIOID TREATMENT

### Short-term Risks

**Withdrawal Syndrome.** Opioid withdrawal syndrome is characterized by signs and symptoms of sympathetic stimulation (due to decreased sympathetic antagonism by opioids), which has been well described in patients with SUD: anxiety, hypertension, tachycardia, restlessness, mydriasis, diaphoresis, tremor, piloerection, nausea, abdominal cramps, diarrhea,

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