Tapering Resource

The objective of a taper is to prevent significant withdrawal symptoms while reducing or discontinuing opiates.

Potential Reasons to Taper Opioids

- Patient request
- Lack of improvement in pain and/or function
- Nonadherence to treatment plan
- Signs of misuse and/or abuse
- Serious adverse events

Recommendations for Tapering

There is no evidence to support one tapering strategy over another. Any tapering protocol should be individualized as some patients may tolerate a more rapid taper, while others will require a more gradual decrease in medication. In general, the longer the patient has been on opiates, the more conservative (slow) the taper will need to be to minimize or avoid withdrawal symptoms. It is important to remember that tapering is unidirectional, and should not be reversed. However, tapering can be slowed or paused if needed. A starting point for tapering is to decrease the dose 10-20% every 1-2 weeks and adjust the rate according to patient response. Once the patient has reached about 1/3 of the original dose, smaller decreases of 5% every 2-3 weeks may be necessary.

For individuals on high dose or multiple opioids, switching to a single long acting opioid or methadone can be considered (see conversion table). Once stable on the long-acting regimen, proceed with a slow taper, 10-20% every 1-2 weeks, followed by an even slower taper once 1/3 of the original dose is reached. A worksheet to record and track doses for tapering is provided in this toolkit.

Caution patients that they may quickly lose their tolerance to opioids, so they are at risk for overdose if they abruptly resume their original dose.

It is important to note that pregnant patients on chronic opiate therapy should not be weaned due to risks to both the mother and the fetus. Patients with signs of misuse and/or abuse who are pregnant should be considered for MAT.

Management of Withdrawal

Physical withdrawal symptoms generally resolve 5-10 days after dose reduction/cessation, while psychological symptoms may take longer. Not all patients will experience the same withdrawal symptoms. The goal is to minimize these symptoms with a gradual taper. There are additional treatments that may help with specific symptoms (see chart below).

Additional Resources

CDC Tapering Pocket Guide
http://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

VA Tapering Fact Sheet
http://www.healthquality.va.gov/guidelines/Pain/cot/OpioidTaperingFactSheet-23May2013v1.pdf

Washington State Guideline
http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf

Stage	Grade*	Physical Signs and Symptoms	Treatment Options
Early Withdrawal (8-24 hrs after last use)	1	Lacrimation, Rhinorrhea, Diaphoresis, Yawning, Restlessness, Insomnia	- Antihistamines or trazodone for insomnia/restlessness
	2	Piloerection, Myalgias, Arthralgias, Abdominal pain	- NSAIDs/Acetaminophen for muscle and joint pain - Loperamide/bismuth subsalicylate for abdominal cramping
Fully Developed Withdrawal (1-3 days after last use)	3	Tachycardia, Typertension, Tachypnea, Fever, Anorexia, Nausea	- Clonidine for autonomic symptoms - Ondasetron/H2 blockers for nausea
	4	Diarrhea, Vomiting, Dehydration, Hypotension	- Loperamide for diarrhea - Oral rehydrating solutions
Post Acute Withdrawal Syndrome (PAWS)		Mood swings, Anxiety, Irritability, Anhedonia, Fatigue, Poor concentration, Insomnia	- Recovery services - Relapse prevention strategies

**The severity of opioid withdrawal is defined by symptoms and described by four categories or grades.*

Opioid Tapering Worksheet

Current Dose: _____

Target Dose: _____

Timeline: _____

Medication: _____

Date	Dose	Frequency	# of weeks	Total dose/day
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg
	mg			mg