Opioid Deprescribing Guideline Algorithm

2022

Why is the person taking an opioid?

- **Acute pain**
  - Has the person been taking the opioid short term (e.g. <1 week) or infrequently?
    - **Yes** → **Opioid may be discontinued** without gradual tapering
    - **No** → **Engage the person** (discuss potential risks and benefits of deprescribing, **establish a deprescribing plan** O)
- **Chronic non-cancer pain**
- **Chronic cancer-survivor pain**
- **End-of-life pain or dyspnoea**

Does the person have a severe opioid use disorder?

- **Yes** → **Avoid deprescribing** O+++
  Provide evidence-based care, such as transition to, or referral for, medication assisted treatment of opioid use disorder
  → Review therapy and continue opioid if appropriate O
- **No**

Does the person fulfill one or more of the following criteria? O+*, O**

a) A lack of overall and clinically meaningful improvement in function, quality of life or pain
b) A lack of progress towards meeting agreed therapeutic goals
c) Experiencing serious or intolerable opioid-related adverse effects in the physical, psychological or social domains

OR

Does the person have one or more of the following clinical characteristics? O

a) Co-morbidities that may increase risk of opioid-related harms e.g. sleep-disordered breathing or sleep apnoea, chronic obstructive pulmonary disease (COPD).
b) Concomitant use of medicines or substances with sedating effects e.g. benzodiazepines, alcohol, gabapentinoids, antipsychotics and sedating antidepressants.
c) High doses of prescribed opioids.

*Chronic non-cancer pain, **Chronic cancer-survivor pain

- **Yes** → **Engage the person** (discuss potential risks and benefits of deprescribing, **establish a deprescribing plan** O)
- **No** → Review therapy and continue opioid if appropriate O

Initiate deprescribing

- Gradually taper opioids. Abrupt cessation without prior dose reduction may increase risks of harm O++
- Tailor the deprescribing plan based on the person's clinical characteristics, goals and preferences O+
- Conduct regular monitoring and review O
- Use interdisciplinary or multidisciplinary care, or a multimodal approach which emphasises non-pharmacological & self-management strategies O++
- Consider the use of evidence-based co-interventions to support opioid deprescribing O+ (e.g. cognitive behavioural therapy)

Key

O Recommendation for, O Recommendation against, O Conditional Recommendation for, O Conditional Recommendation against, O Consensus Recommendation

+ Very Low Certainty Evidence, ++ Low Certainty Evidence, +++ Moderate Certainty Evidence, ++++ High Certainty Evidence (**from systematic evidence review and GRADE approach**).

Langford, et al. Evidence-based Clinical Practice Guideline for Deprescribing Opioid Analgesics. 2022. Available from: https://www.opioiddeprescribingguideline.com/guideline

Opioid dose equivalence

	Oral (swallowed)							Rectal	Sublingual	Transdermal	
Current opioid	Morphine (mg/day)	Oxycodone (mg/day)	Hydromorph-one (mg/day)	Codeine (mg/day)	Dextroprop-oxyphene (mg/day)	Tramadol (mg/day)	Tapentadol (mg/day)	Oxycodone (mg/day)	Buprenor-phine (mg/day)	Buprenor-phine (mcg/hr)	Fentanyl (mcg/hr)
Conversion factor	1	1.5	5	0.13	0.1	0.2	0.3	1.5	40	2	3

To calculate an oral Morphine Equivalent Daily Dose (oMEDD), **multiply the daily dose of opioid by the listed conversion value**. Oral morphine equivalents of different opioids can be calculated using The Faculty of Pain Medicine of the Australian New Zealand College of Anaesthetists (ANZCA) **online opioid equianalgesic calculator**.

Engaging the person

The use of an opioid deprescribing conversation guide may assist healthcare professionals to initiate and continue conversations about opioid deprescribing.

- Discuss treatment goals.
- Ask about side effects.
- Tailor discussion about benefits and harms to the individual.
- Explore fears and concerns about deprescribing.

Monitoring advice

The success of opioid deprescribing may be measured by assessing progress in relation to goals achieved over time.

Monitor and document:

- Cognitive and functional status, behavioural and psychological symptoms, and how these have changed over time.
- Monitor and manage parameters including function, pain, sleep, mood, withdrawal effects and dependence.
- Discuss the increased risk for overdose on abrupt return to a previously prescribed higher dose after deprescribing.
- Consider the provision of **naloxone** for persons taking opioids at risk of opioid overdose when prescribing or deprescribing opioids.

Tapering advice

Tailor the deprescribing plan based on the person's clinical characteristics, goals and preferences. Consider:

- **<3 months use**: reduce the dose by 10 to 25% every week
- **>3 months use**: reduce the dose by 10 to 25% every 4 weeks
- **Long-term opioid use (e.g., >1 year) or on high doses:** slower tapering and frequent monitoring

Symptomatic medications for use in opioid withdrawal

(adapted from the 2018 Alcohol and other Drug Withdrawal: Practice Guidelines, 3rd ed.)

Symptoms	Symptomatic Medication(s)
Nausea and vomiting	Antiemetics such as metoclopramide 10 mg three times a day as required for up to three to four days or prochlorperazine 5 mg three times a day for 4–7 days, best 30 minutes before food or as required, ondansetron 4–8 mg, every 12 hours as required. Note: Also encourage fluids and a simple diet
Diarrhoea	Anti-diarrhoeals such as loperamide
Abdominal cramps	Antispasmodics such as hyoscine butylbromide
Muscles and joint pains	Non-steroidal anti-inflammatory agents such as ibuprofen (avoid if contraindications are present) or paracetamol

Langford, et al. Evidence-based Clinical Practice Guideline for Deprescribing Opioid Analgesics. 2022. Available from: https://www.opioiddeprescribingguideline.com/guideline