SESLHD PROCEDURE COVER SHEET

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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Dr Greg Keogh SESLHD Clinical Stream Director Surgery, Peri-operative, Anaesthetics Greg.keogh@health.nsw.gov.au
AUTHOR	Bernadette Bugeja CNC Pain Management, Prince of Wales Hospital
POSITION RESPONSIBLE FOR THE DOCUMENT	Bernadette Bugeja Bernadette.Bugeja@health.nsw.gov.au
KEY TERMS	Opioid withdrawal, chronic/persistent pain, physical dependence
SUMMARY	Guidelines for managing withdrawal reactions in patients on long term opioid therapy.

Opioid withdrawal in patients on long term opioid medications

SESLHDPR/603

1. POLICY STATEMENT

This guideline is for identifying and managing withdrawal reactions in patients on long term opioid therapy for medical use.

2. BACKGROUND

This guideline is for identifying and managing withdrawal reactions in patients on long term opioid therapy for medical use. This includes patients on opioid therapy for the treatment of chronic/cancer pain or patients on opioid substitution therapy (e.g. methadone and buprenorphine).

It is not a guideline on management of opioid withdrawal in patients with an opioid addiction see NSW Ministry of Health Policy - PD2006_049 Opioid Dependent Persons Admitted to Hospitals in NSW - Management.

2.1 Definitions

Opioids: All drugs, naturally occurring or synthetic, that have morphine-like actions[2 p83].
Physical dependence: A physiological adaptation to a drug, characterised by the emergence of a withdrawal syndrome if the drug is abruptly stopped, reduced in dose or antagonised[1 p182].

3. RESPONSIBILITIES

3.1 Nursing Staff will:

- Monitor patient for signs of opioid withdrawal
- Document Clinical Opiate withdrawal scale scores on the Brief Opioid Review Form
- Escalate if signs of opioid withdrawal are present
- Administer prescribed medication
- Document accordingly in patients notes.

3.2 Medical staff will:

- Review patient
- Prescribe symptomatic measures that can be used for withdrawal symptoms
- Refer to the Pain Management team as required.

4. PROCEDURE

4.1 Patients on Long Term Opioids

- All patients on long term opioids will have some degree of physical dependence (not the same as addiction – psychological dependence). This is an adaptation process where the body becomes reliant on the externally provided opioid.
- Patients will develop an iatrogenic 'drug class-specific withdrawal syndrome' if: [2 p 154]
  (1) The opioid medication is ceased abruptly. For example, when patients develop an unrelated condition such as pneumonia or reduction in consciousness that causes concern
  (2) The dose of the opioid is reduced too rapidly. For example, inappropriate dose conversion or route conversion from one opioid to another or too large of a dose decrease during tapering process
  (3) The medication administered is an opioid antagonist. For example, a large

dose of naloxone such as 400 microgram IV is used to reverse opioid induced respiratory depression.

4.2 Symptoms and Signs of Withdrawal [2 p153 , 4 p37]

- Agitation
- Anxiety
- Muscle aches
- Increased tearing
- Insomnia
- Runny nose
- Sweating
- Yawning
- Dilated pupils
- Increased sensitivity to pain

In more severe cases, tachycardia, abdominal cramping, diarrhoea, nausea, vomiting, insomnia and craving for opioids may follow.

4.3 Withdrawal Process

- The withdrawal process could be extremely uncomfortable but is rarely life-threatening
- Onset of withdrawal reactions after cessation of the drug will depend on the duration of action of the opioid. Generally, the withdrawal signs and symptoms peak at about 48 to 72 hrs and can last up to 10 days[2p154]
- In patients receiving mixed opioid and benzodiazepine treatment, possible withdrawal reactions from benzodiazepine should always be considered as life-threatening seizures may occur. Adequate benzodiazepine replacement should be provided in such cases[1 p193, 2 p154].

4.4 Management of Withdrawal

- Where a patient presents with one or more of the signs and symptoms of withdrawal together with a history of opioid therapy for medical use, nursing staff are to complete the Brief Opioid Review Form and report the Clinical Opiate Withdrawal Scale (COWS) Score to the Medical Officer to identify the management strategy (see Table 1)
- Every effort should be made to reduce the development of withdrawal reactions
- Do not stop all opioids abruptly
- In general, reduce the dose of an opioid by 20 to 30% every two to three days to prevent withdrawal reactions[2 p155]
- If changing from one opioid to another (opioid rotation), commence with 50% to 75% of the calculated equianalgesic dose and then titrate to response
- The patient should be monitored closely to ensure adequate pain relief with no withdrawal reactions [p155]. Replacement of opioid (even at half the previous dose) will terminate a withdrawal reaction
- Supportive measures should be taken to minimise the discomfort (refer to table 1).
- The Pain Management Team should be consulted regarding:

  - Opioid dose-tapering schedules
  - Further provision of analgesia
  - Other methods of assisting with opioid detoxification for pain (not opioid addiction).
- In the case of relapsing chronic neuropathic pain the following treatment might be considered in consultation with the Pain Management Team :
  - Ketamine infusion 0.125 to 0.3mg/kg/hr subcutaneous or IV, for three to four days[5 p1736]. Refer to SESLHDPR/371 Ketamine Infusions for Adult Patients with Acute and Chronic Non-Malignant Pain - Pain Management
  - Amitriptyline 25mg PO at night
  - Gabapentin 300mg PO three times per day (off-label indication) or
  - Pregablin 75mg bd.

The following table lists symptomatic measures that can be used for withdrawal symptoms[4 p40]:

Table 1: *Symptomatic measures that can be used for withdrawal symptoms*[4 p40]

Symptoms	Suggested treatments
Muscle aches/pains	Paracetamol 1g PO every six hours (maximum 4g in 24 hours) OR Ibuprofen 400mg PO every six hours prn if no contraindication and to be taken with food (maximum 1600 mg in 24 hours).
Nausea or vomiting	Metoclopramide 10mg PO every four to six hours prn (maximum 30 mg in 24 hours) OR Prochlorperazine 5mg PO every four to six hours prn (maximum 20 mgs in 24 hours). Second line treatment for severe nausea/vomiting: Ondansetron 4mg to 8mg PO every 12 hours prn (maximum 16 mg in 24 hours).
Abdominal cramps	Hyoscine butylbromide 20mg PO every six hours prn (maximum 80 mg in 24 hours).
Diarrhoea	Loperamide 2mg PO prn after each loose bowel motion (maximum 16mg in 24 hours).
Sleeplessness	Temazepam 10 to 20 mg PO at night (maximum 20 mg in 24 hours). Cease after three to five nights.
Agitation or anxiety	Diazepam 5mg PO every six hours prn (maximum 20 mg in 24 hours). Omit if drowsy
Restless legs	Diazepam 5mg PO every six hours prn (maximum 20 mg in 24 hours) Omit if drowsy OR Baclofen 10 to 20 mg PO every eight hours; omit if drowsy (maximum in 60 mg in 24 hours).
Hypertension, sweating, agitation	Clonidine 75-150 microgram PO every six hours (maximum 600 microgram in 24 hours)[9].

Caution: Medical officer to consider drug interactions and prescribe only after thorough assessment of patient.

5. DOCUMENTATION

National Inpatient Medication Chart
eMM
Health Care Record
Brief Opioid Review Form

6. AUDIT

Monitoring *IIMS* reports

7. REFERENCES

- NSW Ministry of Health Policy - PD2006_049 Opioid Dependent Persons Admitted to Hospitals in NSW - Management (4)
- SESLHDPR/371 Ketamine Infusions for Adult Patients with Acute and Chronic Non-Malignant Pain - Pain Management (6)
- NSW Ministry of Health Guideline - GL2008_011 Drug and Alcohol Withdrawal Clinical Practice Guideline NSW (8)

EXTERNAL REFERENCES

Number	Reference
1	Macintyre P.E., Ready L. B. 2001, Acute Pain Management. A Practical Guide. *W.B.* Saunders, p15 & 182
2	Janicki PK, Parris WC. Clinical Pharmacology of Opioids. In: Smith HS (Ed), Drugs for Pain, Hanley & Belfus Inc, Philadelphia, 2003, p153-155.
3	Gowing L, Farrell M, Ali R, White JM. Alpha2-adrenergic agonists for the management of opioid withdrawal. Cochrane Database of Systematic Reviews 2016, Issue 5. Art. No.: CD002024. DOI: 10.1002/14651858.CD002024.pub5
5	Hocking, G., Cousins, M. Ketamine in Chronic Pain Management: An Evidence-Based Review. Anaesthesia and Analgesia. 2003;97:1730-9
9	POWH Pain Management Senior Clinician Consensus

8. REVISION AND APPROVAL HISTORY

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February 2018	DRAFT	Draft for Comment
April 2018	DRAFT	Processed by Executive Services prior to submission to SESLHD Quality Use of Medicine Committee and SESLHD Clinical and Quality Council.
June 2018	0	Endorsed for publishing by SESLHD Quality Use of Medicine Committee and SESLHD Clinical and Quality Council.