Dose reduction of long-term opioids:

our duty as clinicians

We are all aware of the harm associated with long-term prescriptions of opioids and the potential for opioid dependence. Protracted use of opioids is associated with a host of adverse effects, including a 7-fold increase in mortality in patients taking 100 mg/24 hour of morphine (or equivalent), compared with doses equivalent to <20 mg/24 hour.[1] Moreover, long-term opioid use does not improve quality of life, pain, or functioning in patients with chronic non-cancer pain.[1–3] Where pain remains uncontrolled with doses equivalent to 120 mg/24 hour morphine, the patient should be considered non-opioid responsive.[3] In view of the evidence, can we honestly say that we are doing enough to encourage reduction and withdrawal of opioids in our patients?

REVIEWING MEDICATION

Medication reviews are an essential part of practice, but with overrun surgeries it is often easier to take the path of least resistance and continue or up-titrate analgesia. Patients are often not provided with the correct information to make an informed decision, including that their opioids may be ineffective or potentially worsening their pain. Personal experience of working with patients dependent on opioids in primary care has highlighted that many are wanting and willing to change if the right approach is taken. It is our responsibility as healthcare professionals to provide them with the means and encouragement to think it is possible.

PATIENT ACTIVATION

Patients should be made aware that the aim of managing chronic pain is not eradication of pain, but to enable them to live and function well with the pain. Although the risks must be outlined, placing too much emphasis on the consequences can be damaging.[4] Research has demonstrated that patient activation is key to any behaviour change, yet many clinicians remain sceptical with regards to its effectiveness.[4,5] Clinician beliefs directly influence clinician behaviour and those who strongly believe in patient activation are more likely to involve patients in the decision-making process and arrange regular follow-up.[5] Conversely, those who undervalue patient activation are more likely to emphasise the serious risks associated with continuing without change. Not unsurprisingly, there is a correlation between clinician behaviours and levels of patient activation. Greene *et al* identified five key clinician behaviours that correlated with increased patient activation: emphasising patient ownership; partnership with patients to encourage setting of their goals; setting small, achievable targets; regular follow-up visits to cheer successes and problem solve; and showing care.[4]

REDUCING SLOWLY

A recent article in the *BMJ* advises that we should consider tapering opioids in patients where no clinically meaningful improvement is seen, where signs of a substance disorder is apparent, where serious adverse effects are seen, or where used in combination with benzodiazepines.[6] A slow dose reduction is essential to any success and regular reviews are needed to ensure that the patient is well supported. Most importantly, both the clinician and patient should be aware that an unsuccessful attempt does not mean defeat, and continued efforts to engage the patient in further attempts should be made.

PATIENT INVOLVEMENT

The Faculty of Pain Medicine advocates for a collaborative patient–clinician approach, advising that patient involvement provides an element of control, allowing them to feel that change is achievable.[3] Five core principles of opioid reduction are: education, engagement, effecting the weaning plan, and managing emotional impact and patient expectations.[2] Giving the patient control over how this daily dose reduction is achieved: *'gives them more control and ownership of the process, improves their engagement and is more likely to succeed'*.[1]

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PERSISTENCE

Next time you see a patient on high-dose opioids, strongly consider exploring a dose-tapering regime. This does not have to be initiated instantly, but persistence is key. More importantly, the key message is to think twice before initiating an opioid in any patient. We are so ready to consider pharmacological management of pain before exploring non-pharmacological options. Finally, it is our duty to ensure that patients are well informed of the consequences of these medications and the little evidence of their benefit.

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