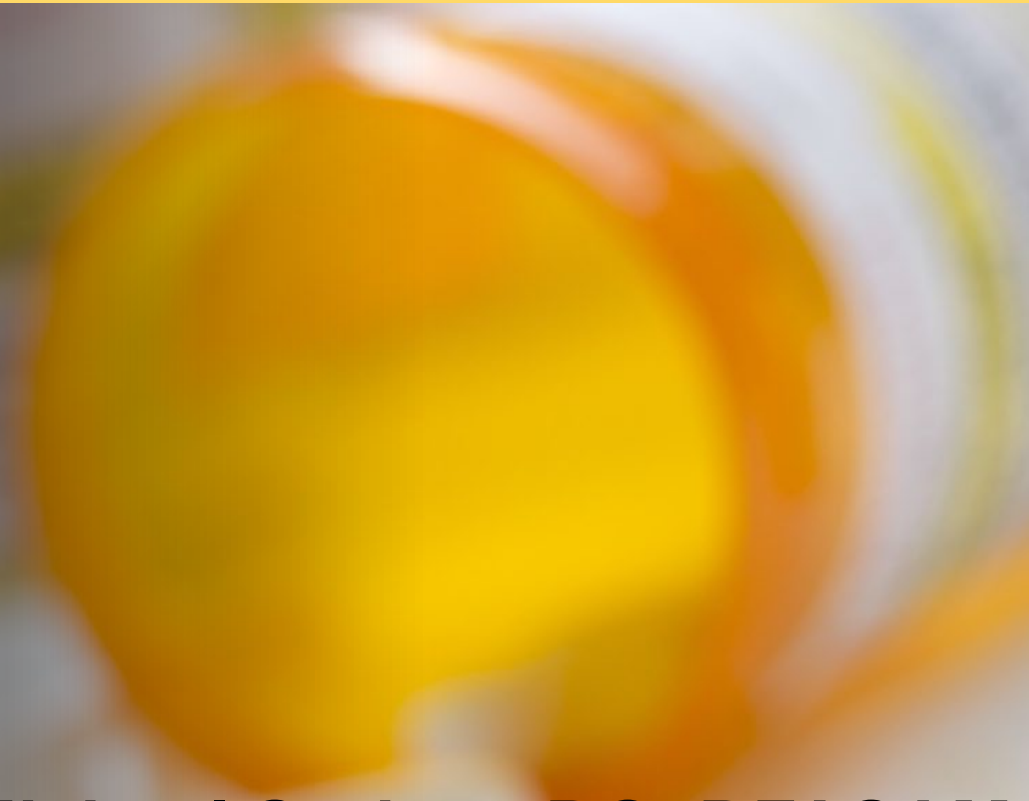
Texas Pain Society| The Woodlands, TX| October 24, 2025

OPIOID TAPERING/ DEPRESCRIBING:

How To Do It Safely and Ethically



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FINANCIAL DISCLOSURES

- Cellarian, Inc. (Founder and CEO)
- Spark BioMedical (Consultant/Advisory Board)
- Advanced Genomics Laboratory (Board Member/equity)
- Clinical Care Options (Speaker)
- Patch Technologies (Consultant/Advisory Board)
- Bridge Therapeutics (Individual stock purchase)
- Affect Therapeutics (Individual stock purchase)
- Tafalgie Therapeutics (Consultant)

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OBJECTIVES

01

Describe Reasons to Taper vs Deprescribe vs Transition to a safer option

02

Define opioid withdrawal management and identify symptoms of OWS

03

Demonstrate understanding of OWM tools and techniques

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WHY DO YOU WANT TO TAPER/ DISCONTINUE?

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WHY TAPER/ DEPRESCRIBE?

1. Patient request
2. Behavioral reasons
3. Medical reasons
4. Failure of Chronic Opioid Therapy
5. Simple Persistent Opioid Dependence (SPOD)[1]
   - Physical dependence
6. Complex Persistent Opioid Dependence (CPOD)[2]
   - Declining functional status
   - Physical and psychological dependence
7. OUD
   - Meets DSM-V criteria

1. Rudolf G. Management of co-occurring substance use disorder and chronic pain. In: Substance Use Disorder - New Research Perspectives in the Diagnosis, Treatment, and Prognosis. London, UK: IntechOpen; 2023. doi:10.5772/intechopen.105721.
2. Manhapra A, Sullivan MD, Ballantyne JC, MacLean RR, Becker WC. Complex Persistent Opioid Dependence with Long-term Opioids: a Gray Area That Needs Definition, Better Understanding, Treatment Guidance, and Policy Changes. *J Gen Intern Med*. 2020;35(Suppl 3):964-971. doi:10.1007/s11606-020-06251-w

DOSE DECREASE

VS

DISCONTINUATION

VS

BUP TRANSITION

1. What is your long-term goal with this patient? Why?
2. What does your patient want?
3. What is best for the patient?

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RISKS OF DISCONTINUATION

1. OWS
2. Worsening of pain
3. Overdose
4. Relapse to active SUD
5. Patient perception of failure
6. Transition to other drugs
7. Increase alcohol and/or benzo use
8. Loss of patient to follow-up

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TAPERING/DE PRESCRIBING - WITHDRAWAL MANAGEMENT

VS

Slowly decreasing a medication over time to minimize withdrawal symptoms

Medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence[1]

1) Clinical Guidelines for Withdrawal Management and Treatment of Drug Dependence in Closed Settings. Geneva: World Health Organization; 2009. 4, Withdrawal Management. Available from: https://www.ncbi.nlm.nih.gov/books/NBK310652/

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TAPERING STILL REQUIRES WITHDRAWAL MANAGEMENT

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OPIOID WITHDRAWAL SYMPTOMS

PHYSICAL

- Agitation
- Sweating
- Dilated pupils
- N/V/cramping/diarrhea
- “Goosebumps”
- Diffuse body pain/myalgias
- Insomnia
- Tremor
- CV abnormalities

OPIOID WITHDRAWAL SYMPTOMS

AFFECTIVE

- Dysphoria
- Anxiety
- Depression
- Hopelessness
- Anhedonia
- Possible suicidal ideations

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CLINICAL OPIATE WITHDRAWAL SCORE (COWS)

Patient's Name:_____ Date and Time ____/____/____:_____

Reason for this assessment:_____

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81-100 2 pulse rate 101-120 4 pulse rate greater than 120	**GI Upset:** *over last 1/2 hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *Observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable or anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing assessment: _____

Score: 5-12 = mild; 13-24 = moderate; 25-36 = moderately severe; more than 36 = severe withdrawal

This version may be copied and used clinically.

Journal of Psychoactive Drugs Volume 35 (2), April - June 2003

Source: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS). *J Psychoactive Drugs*, 35(2), 253–9.

TRANSITIONING FROM FULL -MU AGONISTS TO BUPRENORPHINE

- Benefits
  - Safer
  - May provide enough analgesia for chronic pain
  - May initiate directly from full mu-opioids
  - Greater patient acceptance/compliance
- Risks
  - Still an opioid-> OD risk
  - Does not prevent misuse/abuse of other drugs, including opioids
  - Still must monitor for OUD/SUD issues

FACTORS THAT IMPROVE SUCCESS

1. Motivated patient
2. Social support
3. Pain can be managed with other therapies
4. No one else at home using opioids

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FACTORS THAT IMPROVE SUCCESS

5. Active recovery program (if relevant)
6. Engaged or open to BH therapy
7. Employed
8. Something to lose

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HOW DO I START?

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KEY POINTS FOR SUCCESS - TAPERING

1. The benefits no longer outweigh the risks
2. Shared decision-making improves the chance of success
3. OUD/SUD? → encourage recovery

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SHARED DECISION - MAKING

1. Give taper schedule in advance- ask if achievable?
2. Give “what to expect” document
3. Visualization of success
4. Suggest Behavioral Health Therapy (even if there is no SUD)

RESOURCE:
www.samhsa.gov/brss-tacs/recovery-support-tools/shared-decision-making

IF DISCONTINUATION IS FOR OUD/SUD

1. Refer to/consult with an Addiction Medicine specialist.
2. Is patient appropriate for outpatient OWM?
3. Motivational interviewing- assess willingness to change
4. Encourage participation in any type of recovery activity
5. Consider transition to buprenorphine instead

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BEFORE YOU START OWM

1. H&P
2. COWS score
3. Check PDMP
4. Urine drug test
5. Other Labs-
   - Pregnancy
   - LFT’s
   - Hep B &C
   - HIV

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OPIOID WITHDRAWAL MANAGEMENT BASICS

- Plan Ahead- How are you going to treat their pain?
- Easy, Cowboy
  - Don’t taper too fast (even if patient insists)
  - 10-15% until the last mile
- Drug test before, and intermittently→ especially alcohol
- **Don’t stop benzos or smoking at same time**

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OPIOID WITHDRAWAL MANAGEMENT BASICS

- Respond to patient or family calls quickly
- Strongly encourage Behavioral Health support
- Be flexible and nonjudgmental

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“TRADITIONAL” ⅞ CUT - DOWN

1. Only decrease 10-15% per week
   - Preferred only if very motivated patient with good support
2. Creates a state of persistent, low-level withdrawal
   - Must manage OWS
3. Comfort meds are essential

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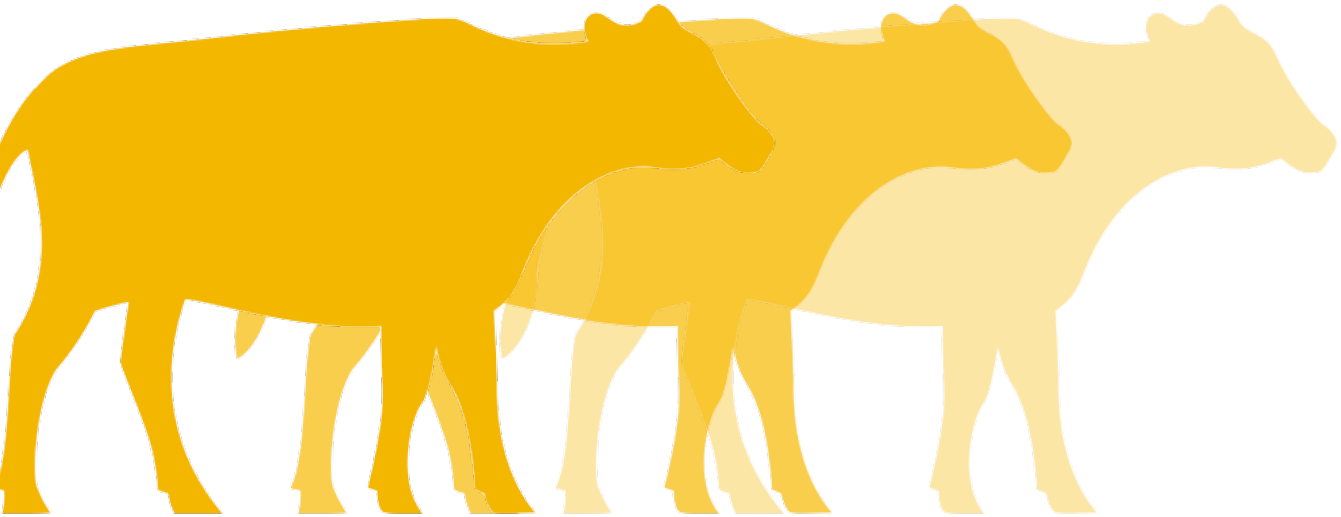
CLINICAL OPIATE WITHDRAWAL SCORE (COWS)



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BUPRENORPHINE/NALOXONE

1. Better success vs other "traditional" taper protocols
2. Multiple protocols are now available
   - Very low dose (min. withdrawal) vs standard induction dose
   - In-office vs at-home
3. Use COWS- let it guide you.

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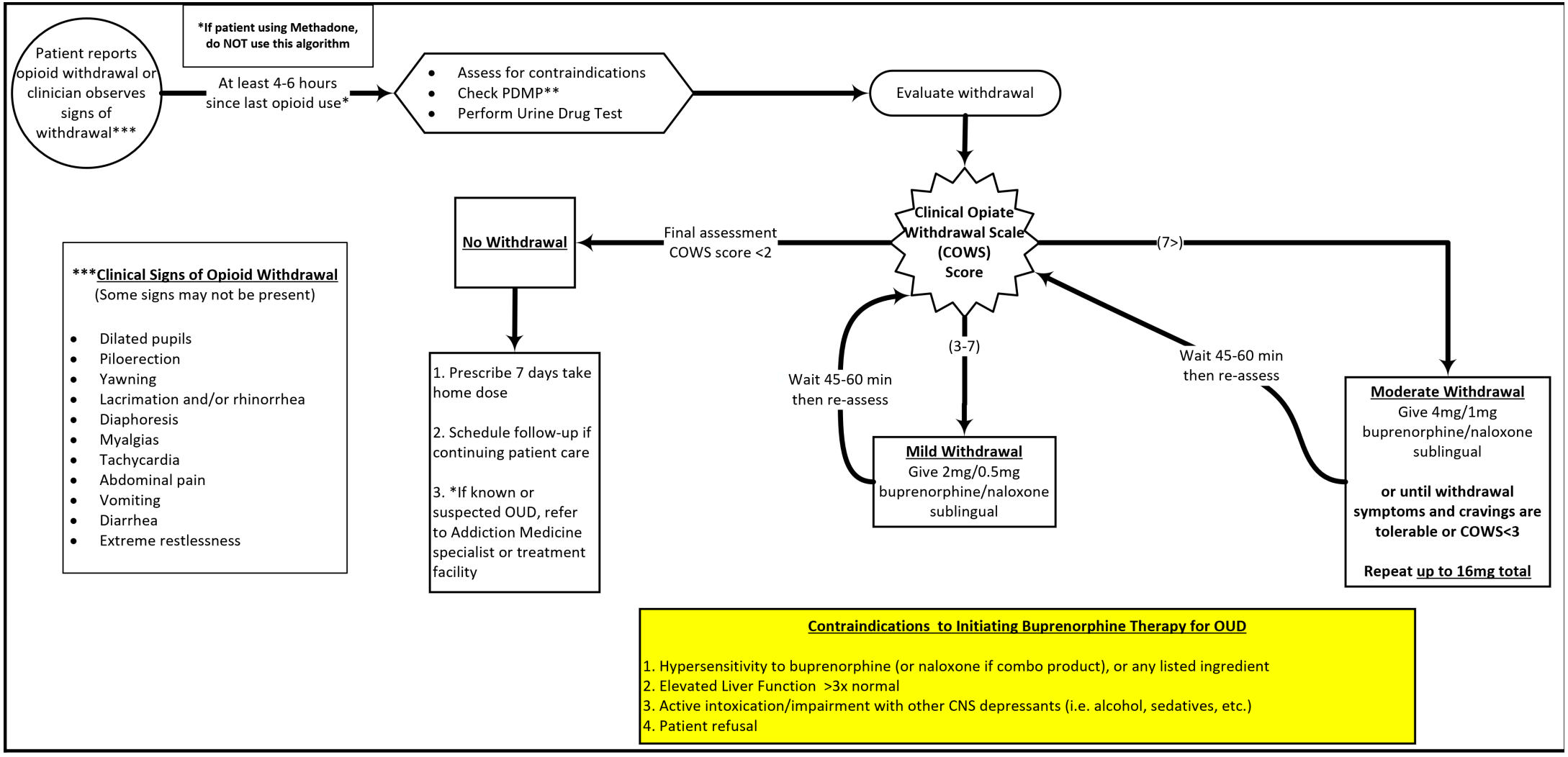
BUPRENORPHINE/NALOXONE

Standard Induction Model:

1. Ask patient when withdrawal starts, adjust induction based on that
   - Avg 6- 12 hrs after last opioid dose
2. Use COWS
3. Make sure patient has clinical withdrawal signs.
4. Start low with first dose

BUPRENORPHINE OUTPATIENT INDUCTION



Kohan L, Potru S, Barreveld AM, Sprintz M, et al. Buprenorphine management in the perioperative period: educational review and recommendations from a multisociety expert panel. *Reg Anesth Pain Med*. 2021;46(10):840-859. doi:10.1136/rapm-2021-103007

OPIOID WITHDRAWAL MANAGEMENT BASICS

- Consider Non-pharmacological tech for Adjunct OWS management
  - Transcutaneous Auricular Neurostimulation(tAN)
- Prescribe comfort meds BEFORE induction starts
- Chocolate, hot showers

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SYMPTOM MANAGEMENT

SYMPTOM MANAGEMENT

Withdrawal symptoms	Drug class	Medication (dosage)	Comments and precautions
Autonomic arousal/ agitation	α-2 adrenergic agonists	Clonidine (0.1–0.3 mg PO q 6–8 h to max of 1.2 mg/d)	Hypotension common with clonidine, particularly with nausea/vomiting/diarrhea leading to dehydration; monitor vital signs, encourage fluids (see below)
		Lofexidine (0.6–2 mg/d in 2–3 divided doses)	
Anxiety/restlessness			
	Antihistamines	Diphenhydramine (50–100 mg PO q 4–6 h, max 300 mg/d)	
		Hydroxyzine (100–150 mg PO q 6 h, max 600 mg/d)	
	Benzodiazepines	Clonazepam (0.5–2 mg PO q 4–8 h, max 6 mg/d)	Avoid if patient has OUD/SUD
		Oxazepam (15–30 mg PO q 4–6 h, max of 180 mg/d)	Avoid if patient has OUD/SUD
		Lorazepam if parenteral (IM, IV) administration needed	Avoid if patient has OUD/SUD
Insomnia	Sedating antidepressants	Trazodone (50–150 mg PO at hs)	
		Doxepin (50–100 mg at hs)	
	Nonbenzodiazepine hypnotics	Zolpidem (10 mg PO at hs)	Avoid if patient has OUD/SUD
		Eszopiclone (3 mg PO at hs)	Avoid if patient has OUD/SUD
	Sedating atypical neuroleptics	Quetiapine (50–200 mg PO at hs)	
Musculoskeletal pain	NSAIDs	Ibuprofen (400 mg PO q 4–6 h, max 2400 mg/d)	Gastric irritation - consider prophylaxis with H2 antagonist (e.g., ranitidine) or proton pump inhibitor (e.g., omeprazole)
		Aspirin (650 mg PO q 4—6 h, max 4 g/d)	
		Ketorolac (30 mg IM q 6 h, max 120 mg/d for a total of 5 days)	
	Aniline analgesics	Acetaminophen (650–1000 mg PO q 4–6 h, max 1 g/d)	Use with caution if liver damage or active hepatitis
	Antispasmodics	Cyclobenzaprine (5–10 mg PO q 4–6 h, max 30 mg/d); others include baclofen, tizanide, methocarbamol	
GI distress (nausea, vomiting, diarrhea)	Oral hydration	Sports drinks (contain electrolytes), diluted fruit juice, bouillon	Dehydration is common given nausea, and possible fluid losses (vomiting, diarrhea) - actively encourage fluid intake; monitor vital sign for postural hypotension
		IV fluids as backup if needed	
	5-HT3 antagonist	Ondansetron (8–16 mg PO or IM q 8–12 h)	
	Miscellaneous	Loperamide (2 mg PO after each loose stool, max 16 mg/d)	
		Bismuth subsalicylate (2 tablets PO q 1 h, max 10 tablets/d)	
	Neuroleptic antiemetics	Prochlorperazine (5–10 mg PO or IM q 3–1 h, max 40 mg/d)	
		Promethazine (25 mg PO or IM q 4–6 h, max 50 mg/d)	

Sigmon SC, Bisaga A, Nunes EV, O'Connor PG, Kosten T, Woody G. Opioid detoxification and naltrexone induction strategies: recommendations for clinical practice. *Am J Drug Alcohol Abuse*. 2012;38(3):187-199. doi:10.3109/00952990.2011.653426

NEW TECH FOR OWS MANAGEMENT

Transcutaneous Auricular Neurostimulation (tAN)

- Targets Vagus and Trigeminal nerves
- Stimulates release of endogenous endorphins to stop withdrawal
- Proven efficacy in neonatal abstinence syndrome as well
- FDA-Cleared for opioid withdrawal
- **Non-pharmacological treatment

Shows great evidence as adjunctive symptom therapy

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NEW TECH FOR OWS MANAGEMENT

Percutaneous nerve stimulator (PNFS)

- Targets branches of Cranial Nerves V, VII, IX and X, and the occipital nerves
- Uses acupuncture needle tips
- Contraindicated in patients with hemophilia, pacemakers and psoriasis vulgaris
- FDA-Cleared for Opioid withdrawal

**DO NOT USE SCS BILLING CODES

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IT WILL BE OK….

- Don’t avoid the patient
- Non-judgmental; be patient (pun intended)
- Figure out what happened, then:
  - Treat symptoms of OWS
  - Refer
  - Reconsider transition to buprenorphine

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BE AN ADVOCATE FOR YOUR PATIENT

- Stopping long-term opioids is a BIG DEAL
- Acknowledge their success!
- Acknowledge YOUR OWN SUCCESS!!

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