Provider Considerations for Dose Optimization of Opioids and Benzodiazepines

Opioids and benzodiazepines respectively play important roles in managing chronic pain and anxiety. However, dose optimization of both drug classes is essential to mitigate the inherent risks of long-term opioid and benzodiazepines use. These risks include dependence, cognitive decline, worsening disability, and accidental overdose due to respiratory depression. As described by the Centers for Disease Control and Prevention (CDC), inappropriate opioid and benzodiazepine use contributes to a growing and deadly national overdose epidemic. The FDA has issued a boxed warning regarding the risk of this combination. It is prudent to utilize the lowest effective dose and duration of treatment for these medications.

Opportunities for dose-reduction or discontinuation:

- Patients over the age of 65 (in whom the risk of falls and cognitive impairment are higher)
- Patients who demonstrate inadequate control of symptoms either due to tolerance to current dose or suboptimal agent selection
    - For example: Patients experiencing neuropathic pain may be more effectively treated with gabapentin rather than oxycodone.
    - Note: Pain perception can be altered by long-term opioid use, resulting in hyperalgesia. Long-term benzodiazepine use is associated with tolerance and refractory symptoms.
- Patients on concurrent opioid and benzodiazepine therapy (or other respiratory depressants)
- Patients who demonstrate signs of substance use disorder (i.e., work or family problems related to opioid use, difficulty controlling use, feelings of dependence)
- Patients who have experienced overdose or other serious adverse event (i.e., loss of consciousness, impaired thinking) or demonstrate early warning signs for overdose risk such as confusion, sedation, or slurred speech

General principles for dose reduction:

Individualize

- Dose reduction may not be appropriate for patients with cancer pain or those receiving end-of-life care. Consider trials of safer alternative medications before using opioids or benzodiazepines (i.e. SSRIs in place of benzodiazepines).
- Consider selecting agents with shorter half-lives to reduce accumulation of side effects.

Go Slow

- If both drug classes are involved, start taper with opioids and follow with benzodiazepines.
- For opioids, evidence supports dose reduction by 10% per week. A common tapering schedule for benzodiazepines include dose reduction by 25% every 1 to 2 weeks.
    - A less aggressive approach may be appropriate for patients who have taken the agent for an extended period of time. For example, consider dose reducing per month versus per week.
- Consult/coordinate with specialists and treatment experts as needed—especially for patients at high risk of harm such as pregnant women or patients with an opioid use disorder.
- The American Congress of Obstetricians/Gynecologists recommends opioid agonist pharmacotherapy in place of medical supervision alone for pregnant women with opioid use disorders because withdrawal is associated with higher relapse rates leading to worse outcomes.*

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Support

- Make sure patients receive appropriate psychosocial support. If needed, work with mental health providers, arrange for treatment of opioid use disorder, and offer naloxone for overdose prevention.
- Set a date to begin and set a reasonable date for completion. Provide information to the patient and establish behavioral supports prior to instituting the taper.
- Watch for signs of anxiety, depression, and opioid use disorder during the taper and offer support or referral as needed.

Encourage

- Let patients know that most people have improved function without worse pain after tapering opioids. Some patients even have improved pain after a taper, even though pain might briefly get worse at first.
- Tell patients "I know you can do this" or "I'll stick by you through this."

Follow up regularly

Have patients return frequently to determine whether opioids are meeting treatment goals and whether opioids can or should be reduced to lower dosage or discontinued. Consider use of urine drug screens, pill counts, and use of CSRS to aid in determining adherence.

Additional Considerations:

1. Adjust the rate and duration of the taper according to the patient's response.
2. Don't reverse the taper; however, the rate may be slowed or paused while monitoring and managing withdrawal symptoms.
3. Once the smallest available dose is reached, the interval between doses can be extended and opioids may be stopped when taken less than once a day

Additional Resources:

Oregon Pain Guidance: http://www.oregonpainguidance.org/app/content/uploads/2016/05/Opioid-and-Benzodiazepine-Tapering-flow-sheets.pdf

CDC Pocket Guide to Tapering Opioids:
https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

Intermountain Physicians Healthcare:
https://intermountainphysician.org/Documents/Opioid%20Tapering.pdf

CDC Guideline for Prescribing Opioids for Chronic Pain:
https://www.cdc.gov/mmwr/volumes/65/rr/rr6501e1.htm

* American Congress of Obstetricians and Gynecologists- Opioid Use and Opioid Use Disorder in Pregnancy https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Opioid-Use-and-Opioid-Use-Disorder-in-Pregnancy

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