SESLHD PROCEDURE COVER SHEET

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KEY TERM	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 when opioid therapy is interrupted.

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 agonist therapy (e.g. methadone and buprenorphine).

It is not a guideline on management of opioid withdrawal in patients with an opioid use disorder, for management of these patient refer to NSW Health Policy Directive PD2006_049 - Opioid Dependent Persons Admitted to Hospitals in NSW - Management[1].

2.1 Definitions

Opioids: All drugs, naturally occurring or synthetic, that have morphine-like actions[2].

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]

3. RESPONSIBILITIES

3.1 Nursing Staff will:

- Monitor patient for signs of opioid withdrawal
- Document Clinical Opiate Withdrawal Scale (COWS) found in eMR inpatient assessment forms.
- Escalate if signs of opioid withdrawal are present
- Administer prescribed medication
- Document accordingly in patients notes.

3.2 Medical staff will:

- Review patient and assess patient for signs and symptoms of opioid withdrawal
- 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 due to neuroadaptation, which is a process where the body becomes reliant on the externally provided opioid.
- Patients will likely develop an opioid withdrawal syndrome if[2]:
  (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[1, 2]

- 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 Experience

- The withdrawal experience 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[2]
- In patients who are concomitantly on pharmaceutical opioids and benzodiazepines, abrupt cessation of benzodiazepines may cause a withdrawal experience as well, especially if the patient has been on benzodiazepines for a prolonged period of time. Abrupt cessation of high dose benzodiazepines (more than 30 mg of daily diazepam equivalency) may lead to significant complications such as seizures. Please contact the SESLHD Drug and Alcohol Services for further advice if there are concerns about benzodiazepine doses.

4.4 Management/Avoidance of Withdrawal

- Do not stop all opioids abruptly, every effort should be made to reduce the development of withdrawal reactions
- 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 Clinical Opiate Withdrawal Scale (COWS) found in eMR inpatient. Escalate to a Medical Officer to identify the management strategy (see Table 1)
- In general, reduce the dose of an opioid by 20 to 30% every two to three days to

prevent withdrawal reactions[2]

- 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. 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
    - Opioid rotation
    - Further provision of analgesia

Table 1. lists symptomatic measures that can be used for withdrawal symptoms[1] .

Caution: Medical officer to consider drug interactions and prescribe only after thorough assessment of patient. Refer to MIMs for any precautions and contraindications.

Table 1: ***Symptomatic treatments that can be prescribed for withdrawal symptoms***

Symptoms	Suggested treatments
Muscle aches/pains	Paracetamol 1 g PO every six hours (maximum 4 g in 24 hours)
	OR
	Ibuprofen 400 mg PO every six hours prn if no contraindication and to be taken with food (maximum 1600 mg in 24 hours)
Nausea or vomiting	Metoclopramide 10 mg PO every four to six hours prn (maximum 30 mg in 24 hours)
	OR
	Prochlorperazine 5 mg PO every four to six hours prn (maximum 20 mg in 24 hours)
	Note: Second line treatment for severe nausea/vomiting: *Ondansetron 4 mg to 8 mg PO every 12 hours prn* *(maximum 16 mg in 24 hours)*
Abdominal cramps	Hyoscine butylbromide 20 mg PO every six hours prn (maximum 80 mg in 24 hours)
Diarrhoea	Loperamide 2 mg PO prn after each loose bowel motion (maximum 16 mg 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 5 mg PO every six hours prn (maximum 20 mg in 24 hours) Omit if drowsy.
Restless legs	Diazepam 5 mg PO every six hours prn (maximum 20 mg in 24 hours) Omit if drowsy
Hypertension, sweating, agitation	Clonidine 75 to150 microgram PO every six hours (maximum 600 microgram in 24 hours)[3].

5. DOCUMENTATION

Electronic Medical Record (eMR)
Electronic Medication Management (EMM)
Clinical Opiate Withdrawal Scale (COWS) found in eMR inpatient

6. AUDIT

Monitoring IMS+ reports

7. REFERENCES

- NSW Health Policy Directive - PD2006_049 Opioid Dependent Persons Admitted to Hospitals in NSW - Management (1)
- NSW Health - Centre for Alcohol and Other Drugs webpage 'Clinical guidance for withdrawal from alcohol and other drugs'

EXTERNAL REFERENCES

Number	Reference
2	Janicki PK, Parris WC. Clinical Pharmacology of Opioids. In: Smith HS (Ed), Drugs for Pain, Hanley & Belfus Inc, Philadelphia, 2003, p153-155.
3	POWH Pain Management Senior Clinician Consensus
	Macintyre P.E., Ready L. B. 2001, Acute Pain Management. A Practical Guide. *W.B.* Saunders, p15 & 182

8. VERSION AND APPROVAL HISTORY

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June 2018	0	Endorsed for publishing by SESLHD Quality Use of Medicine Committee and SESLHD Clinical and Quality Council.
December 2021	1	Minor review. Endorsed by Executive Sponsor. Endorsed by SESLHD Quality Use of Medicine Committee. Processed by SESLHD Policy for publishing.
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