



## PALLIATIVE CARE CASE OF THE MONTH

### “Tapering a Cancer patient from Long Term Opioid Therapy”

by

**Mamta Bhatnagar MD, FAAHPM  
and Maria Lowry PharmD, BCPS, BCGP**

**Volume 24, No. 146**

**Case:** This case involves a 50-year-old woman with metastatic squamous cell carcinoma of the supraglottic larynx, diagnosed in October 2020. Her medical history includes chronic pain related to a motor vehicle accident (MVA). The patient was found to have a lobular left hypopharyngeal mass with regional metastasis to the neck, which led to deviation and compression of her airway. She underwent surgery in November 2020, which included the placement of a tracheostomy and a percutaneous endoscopic gastrostomy (PEG). During the same period, the cancer was found to have extended to the thyroid cartilage and the base of the tongue. A referral was placed to palliative care for symptom management. She completed chemotherapy with cisplatin and docetaxel but chose not to pursue further surgery after chemotherapy. Radiation therapy was completed in 2022. She has had no evidence of cancer since 2023 but has undergone repeated tracheal dilatations to facilitate removal of her tracheostomy. These have been unsuccessful, and she is likely to have a tracheostomy and PEG tube for the rest of her life.

When patient first started her care with us in 2020, she was receiving methadone 30mg PO TID and oxycodone 10mg PO q3h prn for pain, prescribed to her by an internist in Canonsburg, PA. At the time, she was also taking clonazepam and gabapentin, which were continued as home medications. She was seen by palliative care inpatient, at which time we elected to continue methadone and up-titrate oxycodone to meet her new and acute pain needs. Opioid regimen was: Methadone 40 mg PO three times daily and oxycodone 40-50 mg PO every three hours. She was transitioned to our outpatient clinic in November 2020 and we supported her through her surgery and systemic therapy. She currently does not follow with a primary care physician. In October 2023, we received an anonymous phone call reporting that the patient was selling her opioids and that she took ‘extra’ pills to make her urine drug screen concordant with prescribed medications. The caller requested not to be identified or for the call to be discussed with the patient.

So far, we had primarily managed this patient’s nociceptive pain from the tumor mass and subsequent tissue necrosis due to chemotherapy and radiation with opioid escalation. With disease improvement coupled with behavior flags for diversion it became necessary to taper.<sup>1</sup> Accordingly, we began our tapering efforts in 2023, which has been fraught with challenges. Below we describe common barriers to tapering opioids in palliative care and consider practice strategies to help mitigate barriers when considering and implementing an opioid taper plan.

**Background:** High doses of opioids are often used in palliative care for the management of cancer pain.

However, there is little evidence on the effectiveness and safety of opioids at high doses for people with chronic pain.<sup>2</sup> As some cancer patients have transitioned to survivorship, they have continued high dose opioid therapy, creating problems of opioid dependence and potential for opioid misuse.

#### **Barriers to Tapering Chronic Opioid Therapy:**

There is limited data among the palliative care population regarding tapering opioids. Qualitative studies among the primary care population can guide us to better understand the barriers that exist to tapering opioids.

#### **1. Physical Dependence:**

- **Tolerance:** Over time, patients on long-term opioid therapy develop tolerance, meaning they need higher doses to achieve the same level of pain relief. This can complicate tapering, as reducing the dose may lead to insufficient pain control.<sup>4</sup>
- **Withdrawal Symptoms:** Physical dependence on opioids can lead to withdrawal symptoms when the dosage is reduced. These symptoms can include nausea, vomiting, diarrhea, muscle aches, anxiety, and irritability. Fear of these symptoms often discourages both patients and providers from attempting a taper.<sup>5</sup>
- **Hyperalgesia:** Some patients may develop opioid-induced hyperalgesia, a condition where opioids paradoxically increase the sensitivity to pain. This can make the tapering process particularly challenging, as patients might experience heightened pain as the opioid dose decreases.

#### **2. Psychological Dependence:**

- **Psychological Dependence:** Opioids not only alleviate physical pain but can also provide psychological relief, especially in patients with coexisting conditions such as anxiety or depression. This dual role can lead to psychological dependence, where patients become reliant on opioids to cope with emotional distress.<sup>6</sup>
- **Fear of Pain:** Many patients fear that tapering opioids will leave them with unmanaged pain, leading to a reduced quality of life. This fear is often rooted in past experiences of severe pain and the belief that opioids are the only effective treatment.<sup>7</sup>
- **Stigma and Identity:** For some patients, particularly those who have been on opioids for many years, their identity may become intertwined with their pain management regimen. They may resist tapering due to a fear of losing control over their condition or because they perceive opioids as integral to their daily functioning.<sup>7</sup>

*Personal details in the case published have been altered to protect patient privacy.*

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 412-647-7243, pager # 8511, Shadyside, 412-647-7243, pager # 8513, Perioperative/ Trauma Pain, 412-647-7243, pager # 7246, UPCI Cancer Pain Service, pager 412-644-1724, Magee Women’s Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 412-688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children’s pager 412-456-1518

With comments about “Case of the Month” call Dr. Robert Arnold at (412) 692-4834.



### **3. Complex Pain Conditions:**

- **Chronic Pain Syndromes:** Patients with complex chronic pain conditions, such as fibromyalgia, neuropathic pain, or pain from multiple sources (e.g., arthritis, back pain), may find it particularly difficult to taper. These conditions often require multifaceted pain management strategies, and opioids might have become a key component of that strategy.
- Tapers may be unsuccessful due to unrecognized opioid use disorder (OUD) or complex persistent opioid dependence (CPD) without opioid use disorder.<sup>8</sup> CPD is a newly recognized phenomenon, for which continued interdisciplinary care and the use of buprenorphine products have been proposed as management options.<sup>9</sup>
- **Multimorbidity:** Patients with multiple chronic conditions may have pain from various sources, making it harder to taper opioids without exacerbating some aspect of their overall health.

### **4. Lack of Access to Alternatives:**

- **Non-pharmacologic Therapies:** Access to effective non-pharmacologic pain management options can be limited due to cost, insurance coverage, or availability. For example, some patients may benefit from physical therapy, cognitive behavioral therapy, or other non-pharmacological treatments, but these may not be readily accessible or affordable.<sup>8</sup>
- **Adjuvant Medications:** While adjuvant medications (e.g., antidepressants, anticonvulsants) can be helpful in managing pain, they may have their own side effects and risks, leading to patient reluctance to try or tolerate them.

### **5. Healthcare System and Provider Barriers:**

- **Inadequate Training:** Some healthcare providers may lack the training or experience necessary to effectively manage opioid tapering, leading to overly aggressive or overly cautious tapering plans.<sup>9</sup> This can result in either withdrawal symptoms or a prolonged taper that frustrates the patient and the provider.
- **Time Constraints:** Tapering opioids requires careful planning, frequent follow-ups, and a patient-centered approach. However, many healthcare systems are under-resourced, with providers facing time constraints that make it difficult to provide the level of care necessary for successful tapering.
- **Provider Reluctance:** Some providers may be hesitant to initiate tapering due to concerns about patient backlash, fear of litigation, or uncertainty about how to manage the patient's pain effectively without opioids.

### **6. Societal and Environmental Factors:**

- **Social Support:** The presence or absence of social support can significantly impact a patient's ability to successfully taper opioids. Patients with strong support systems may find it easier to cope with the challenges of tapering, while those who are isolated may struggle more.<sup>10</sup>

- **Socioeconomic Factors:** Patients from lower socioeconomic backgrounds may face additional barriers, such as limited access to healthcare, financial stress, and unstable living conditions, all of which can complicate the tapering process.

### **7. Regulatory and Policy Barriers:**

- **Regulatory Pressure:** Increasing regulatory scrutiny and guidelines aimed at reducing opioid prescriptions can create a sense of urgency in tapering, sometimes leading to abrupt tapering that is not aligned with best practices.
- **Insurance Limitations:** Insurance companies may impose restrictions on the types and duration of pain management therapies they will cover, pushing patients toward opioid tapering without sufficient support or alternatives.

### **8. Individual Variability in Response to Tapering:**

- **Genetic Factors:** Individual differences in genetics can affect how patients metabolize opioids, their susceptibility to dependence, and their response to tapering. Some patients may experience more intense withdrawal symptoms or pain flare-ups due to these differences.
- **Psychosocial Factors:** Each patient's unique psychosocial background, including their history of trauma, mental health status, and coping mechanisms, plays a significant role in how they handle opioid tapering. Personalized approaches that take these factors into account are essential for successful tapering.<sup>11</sup>

### **Strategies to Overcome Barriers:**

To address these challenges, a multidisciplinary approach is essential. This involves collaboration among palliative care specialists, pain management experts, pharmacists, psychologists, physical therapists, social workers, and nursing colleagues to support the patient through the tapering process.

#### **1. Set expectations up front about intended duration and indication of opioids on first opioid prescription, when possible**

#### **2. Getting patient buy-in:**

- Patient education plays a critical role, as the patient needs to understand the benefits of tapering, including improved quality of life and reduced side effects.<sup>2</sup> Involving the patient in the decision-making process helps to ensure they feel empowered and supported.
- Utilize communication framework, "FRAME", to initiate a conversation regarding deprescribing<sup>11</sup>. The FRAME acronym refers to Fortify trust, Recognize patient, Align deprescribing conversations to goals of care, Manage cognitive dissonance, Empower patients and caregivers to continue the conversation.

*Personal details in the case published have been altered to protect patient privacy.*

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 412-647-7243, pager # 8511, Shadyside, 412-647-7243, pager # 8513, Perioperative/ Trauma Pain, 412-647-7243, pager # 7246, UPCI Cancer Pain Service, pager 412-644-1724, Magee Women's Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 412-688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children's pager 412-456-1518

With comments about "Case of the Month" call Dr. Robert Arnold at (412) 692-4834.



### 3. Deciding on a tapering process:

- The taper should be slow enough to minimize symptoms of withdrawal. Typically, the longer the duration of opioid therapy, the slower the taper should be. For patients on Long Term Opioid Therapy (LTOT) for over a year, a ~10% reduction (of the original dose) per month taper is often appropriate.<sup>3</sup>
- Have an idea what a successful taper means to you. Is it complete cessation of opioid therapy? Or is it rather to decrease the dose to safe and effective OME?

### 4. Add adjuvants/strategize other pain management techniques where possible:

- Add non-opioid analgesics and adjuvants, such as NSAIDs, gabapentinoids, or antidepressants to help manage pain.
- Non-pharmacological interventions like physical therapy, cognitive-behavioral therapy, and relaxation techniques should also be considered.
- Referral to Chronic pain specialists and Physical Medicine and Rehabilitation specialists can also be helpful to look at more specialized, localized pain management techniques.

### 5. Regular monitoring of the patient:

- During visits, looking at patient pain levels, withdrawal symptoms, and psychological states is crucial, alongside continuous emotional and psychological support to address any fears or anxieties that may arise.
- Answering patient phone calls, scheduling more frequent visits if feasible for the patient are important provider actions that can make the patient feel reassured.

### Conclusion:

Tapering chronic opioid therapy in a palliative care patient with complex pain and a history of high-dose opioid use is challenging. In collaboration with the palliative care pharmacist, we discussed with our patient the need to start tapering, and we provided assurance that she would continue to receive care from us and that we would listen to her concerns throughout the process. We started out by tapering the patient by 10% of her dose and targeted oxycodone pill amounts. She continued to follow up every 3 months at her request. She became more symptomatic as we cut back until she reached a point at which she refused further tapering of oxycodone. At that point, we switched her to a higher dose, but with a lower pill count. We have resumed tapering, and we are now tapering methadone with a 10% dose reduction, proceeding at a rate of 10% per month.

### References:

1. Wesley Jones DO, Scott Junkins MD, Drew A Rosielle MD. Tapering Opioids in Patients with Serious Illness: Who to Taper. Fast Fact Number: 413. January 1, 2021. Available at: <https://www.mypcnow.org>

2. Frank, Joseph W., et al. "Patients' perspectives on tapering of chronic opioid therapy: a qualitative study." *Pain medicine* 17.10 (2016): 1838-1847.
3. Kuntz, Jennifer L., et al. "Factors associated with opioid-tapering success: A mixed methods study." *Journal of the American Pharmacists Association* 61.3 (2021): 248-257.
4. Reduction or Discontinuation of Long-Term Opioid Analgesics HHS Guide for Clinicians...Reduction or Discontinuation of Long-Term Opioid Analgesics 1 HHS Guide for clinicians. [https://www.hhs.gov/system/files/Dosage\\_Reduction\\_Discontinuation.pdf](https://www.hhs.gov/system/files/Dosage_Reduction_Discontinuation.pdf)
5. Savage, S. R., Kirsh, K. L., & Passik, S. D. (2008). Challenges in using opioids to treat pain in persons with substance use disorders. *Addiction Science & Clinical Practice*, 4(2), 4-25
6. Berna, C., Kulich, R. J., & Rathmell, J. P. (2015). Tapering long-term opioid therapy in chronic non-cancer pain: Evidence and recommendations for everyday practice. *Mayo Clinic Proceedings*, 90(6), 828-842
7. Volkow, N. D., Jones, E. B., Einstein, E. B., & Wargo, E. M. (2019). Prevention and treatment of opioid misuse and addiction: A review. *JAMA Psychiatry*, 76(2), 208-216.
8. Vowles, K. E., et al. (2015). Rates of opioid misuse, abuse, and addiction in chronic pain: A systematic review and data synthesis. *Pain*, 156(4), 569-576
9. 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 Dec;35(Suppl 3):964-971. doi: 10.1007/s11606-020-06251.
10. Manhapra A. Complex Persistent Opioid Dependence-an Opioid-induced Chronic Pain Syndrome. *Curr Treat Options Oncol*. 2022 Jul;23(7):921-935.
11. Maria Felton PharmD, Cara Tannenbaum MD, MSc, Mary Lynn McPherson PharmD, MA, MDE, BCPS, CPE, Jennifer Pruskowski PharmD. Communication Techniques for Deprescribing Conversations. Fast Fact Number: 369. June 26, 2019. Available at: <https://www.mypcnow.org>
12. Dowell, D., Haegerich, T. M., & Chou, R. (2016). CDC guideline for prescribing opioids for chronic pain-United States, 2016. *JAMA*, 315(15), 1624-1645
13. Kertesz, S. G. (2017). Turning the tide or riptide? The changing opioid epidemic. *Substance Abuse*, 38(1), 3-8
14. Garland, E. L. (2018). Restructuring reward processing with mindfulness-oriented recovery enhancement: Novel therapeutic mechanisms to address the opioid crisis. *Psychology of Addictive Behaviors*, 32(5), 532-541
15. Wesley Jones DO, Scott Junkins MD, Drew A Rosielle MD. Tapering Opioids in Patients with Serious Illness: How to Taper. Fast Fact Number: 414. January 15, 2021. Available at: <https://www.mypcnow.org>

Personal details in the case published have been altered to protect patient privacy.

For palliative care consultations please contact the Supportive and Palliative Care programs at PUH/MUH, 412-647-7243, pager # 8511, Shadyside, 412-647-7243, pager # 8513, Perioperative/ Trauma Pain, 412-647-7243, pager # 7246, UPCI Cancer Pain Service, pager 412-644-1724, Magee Women's Hospital, pager 412-647-7243 pager # 8510, VA Palliative Care Program, 412-688-6178, pager # 296. Hillman Outpatient: 412-692-4724. For ethics consultations at UPMC Presbyterian-Montefiore and Children's pager 412-456-1518

With comments about "Case of the Month" call Dr. Robert Arnold at (412) 692-4834.