Withdrawal Symptoms & Tapering Recommendations

While withdrawal symptoms may be uncomfortable, they are not life-threatening and may not even be seen with a gradual taper. Symptoms may take longer to resolve depending on the half-life of the medication (e.g., methadone).

Short-acting opioids: Withdrawal symptoms typically begin 8-12 hours after last use and peak 48-72 hours after last use
Long-acting opioids: Withdrawal symptoms typically begin more gradually, starting in the first 24-48 hours, a peak in symptoms in 3-5 days after last use, and some symptoms continuing for up to a few weeks

Early Symptoms (Hours to Days)	Late Symptoms (Days to Weeks)	Prolonged Symptoms (Weeks to Months)
Generally resolve 5-10 days following dose reduction/cessation: ▪ Anxiety/restlessness ▪ Rapid short respirations ▪ Runny nose, sweating, tearing eyes ▪ Insomnia ▪ Dilated reactive pupils	▪ Runny nose, tearing eyes ▪ Rapid breathing, yawning ▪ Tremor, diffuse muscle spasms/aches ▪ Piloerection ▪ Nausea, vomiting, diarrhea ▪ Abdominal pain ▪ Fever, chills	▪ Irritability, fatigue ▪ Bradycardia ▪ Decreased body temperature ▪ Craving ▪ Insomnia

DO NOT treat withdrawal symptoms with an opioid or benzodiazepine

A common taper involves **dose reduction by 5-20% every 4 weeks** to minimize withdrawal symptoms for the patient who has been on opioids long-term

Suggested Tapers for…			
Methadone	Morphine ER/CR	Oxycodone CR	Hydrocodone
1. Decrease dose by 20-50% per day until you reach 30mg/day 2. Then decrease by 5mg/day every 3-5 days to 10mg/day 3. Then decrease by 2.5mg/day every 3-5 days until off	1. Decrease dose by 20-50% per day until you reach 45mg/day 2. Then decrease by 15mg/day every 3-5 days until off	1. Decrease dose by 20-50% per day until you reach 30mg/day 2. Then decrease by 10mg/day every 2-5 days until off	1. Can decrease the dosage (i.e. 10/325mg to 7.5/325mg) and keep the frequency the same until on 5/325mg tabs. Then decrease the frequency gradually until off 2. Alternately, can decrease the frequency and then decrease the dosage

Other considerations:

- In general, the longer the patient has been on opioids, the slower the taper should be
- Taper any long-acting opioids first, then the short-acting. Benzodiazepines should follow after opiates
- Patients taking opioids on a non-daily, as-needed basis can usually discontinue the medication without a taper
- Fentanyl patches can be rotated to a long-acting morphine or methadone for an easier taper. Otherwise, the patches can be tapered down to the 12mcg patch and then a brief supply of short-acting opioids given to complete the taper
- Consider the use of adjuvant medications during the taper to help reduce withdrawal symptoms
- Reassure, reassure, reassure the patient that the withdrawal symptoms will resolve

When opiates are discontinued or tapered, withdrawal symptom can occur. Short-term use of oral medication can assist with managing withdrawal symptoms.

Indications	Treatment Options
Autonomic symptoms (sweating, tachycardia, myoclonus)	**First Line** • Clonidine 0.1 to 0.2 mg orally every 6 to 8 hours; hold dose if blood pressure <90/60 mmHg (0.1 to 0.2 mg 2 to 4 times daily is commonly used in the outpatient setting) ➢ Recommend test dose (0.1 mg oral) with blood pressure check 1 hour post dose; obtain daily blood pressure checks; increasing dose requires additional blood pressure checks ➢ Re-evaluate in 3 to 7 days; taper to stop; average duration 15 days **Alternatives** • Baclofen 5 mg three times daily, may increase to 40 mg total daily dose ➢ Re-evaluate in 3 to 7 days; average duration 15 days ➢ May continue after acute withdrawal to help decrease cravings ➢ Should be tapered when it is discontinued • Gabapentin start at 100 to 300 mg and titrate to 1800 to 2100 mg divided in 2 to 3 daily doses* ➢ Can help reduce withdrawal symptoms and help with pain, anxiety, and sleep • Tizanidine 4 mg three times daily, can increase to 8 mg three times daily
Anxiety, dysphoria, lacrimation, rhinorrhea	• Hydroxyzine 25 to 50 mg three times a day as needed • Diphenhydramine 25 mg every 6 hours as needed**
Myalgias	• NSAIDs (e.g., naproxen 375 to 500 mg twice daily or ibuprofen 400 to 600 mg four times daily)*** • Acetaminophen 650 mg every 6 hours as needed (not to exceed 3000 mg/24 hours) • Topical medications like menthol/methylsalicylate cream, lidocaine cream/ ointment
Sleep disturbance	• Trazadone 25 to 300 mg orally at bedtime as needed • Mirtazapine 7.5 mg daily at bedtime as needed • Hydroxyzine 25 to 50 mg at bedtime as needed
Nausea	• Prochlorperazine 5 to 10 mg every 4 hours as needed • Promethazine 25 mg orally or rectally every 6 hours as needed • Ondansetron 4 mg every 6 hours as needed
Abdominal cramping	• Dicyclomine 10 to 20 mg every 6 to 8 hours as needed (not to exceed 160 mg/24 hours)
Diarrhea	• Loperamide 4 mg orally initially, then 2 mg with each loose stool, not to exceed 16 mg daily • Bismuth subsalicylate 524 mg every 0.5 to 1 hour orally, not to exceed 4192 mg/day

*adjust dose if renal impairment; **avoid in patients >65 years old; ***caution in patients with risk GI bleed, renal compromise, cardiac disease

References

U.S. Department of Veteran Affairs/Veterans Health Administration. (2016). *Pain Management Opioid Taper Decision Tool.* Washington, DC: VA Academic Detailing Service.

U.S. Department of Veterans Affairs and U.S. Department of Defense. (2013). *2010 VA/DoD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain: Tapering and Discontinuing Opioids Factsheet*. Washington, DC: Author.