

Test your practical understanding of opioid and benzodiazepine tapers in clinical practice

1. All of the following about tapering opioids is TRUE except:
- Opioid withdrawal symptoms can be highly distressful but are rarely medically serious; slow tapers decrease and often eliminate withdrawal symptoms.
 - In general, the longer the duration of opioid therapy, the slower the taper unless there is a safety issue.
 - Non-opioid medications (e.g., NSAIDs and acetaminophen) and non-meds (e.g., cognitive behavioral therapy, meditation) can be used to manage withdrawal pain.
 - Tapers may be slowed or paused, according to patient's response.
 - People who taper opioids to reduced dose or discontinuation often suffer from increased pain that does not decrease over time.

The answer is E. Many people who taper opioids have improved function without any increase in pain and may have less pain, even if pain increases temporarily. It is important to have a plan in place to manage withdrawal symptoms if they occur, including withdrawal pain. Sharing with patients that many do better at reduced dose or discontinuation helps open the conversation about initiating a taper.

2. All of the following about tapering benzodiazepines is TRUE except:
- Benzodiazepine withdrawal symptoms can be life-threatening; slow tapers help minimize withdrawal symptoms and increase the likelihood of successful discontinuation.
 - It is important to have a plan in place to manage emergent or rebound insomnia and anxiety, including cognitive behavioral therapy and sleep hygiene advice (even if the benzodiazepine is not being used to treat insomnia).
 - Switching to a longer acting benzodiazepine for the taper may be a consideration if the current medication does not allow for dose reduction (e.g., capsules, tablets difficult to split).
 - The second half of a benzodiazepine taper is usually shorter than the first half; i.e., the reduction rate or total mg/day dose reduction increases during the second half of the taper.
 - People who successfully discontinue benzodiazepines, especially older patients, often experience less daytime fatigue, improved alertness and decreased risk of falls.

The answer is D. The last part of the benzodiazepine taper is often the most difficult for the patient, which is also true for opioids and other psychoactive drugs. Slowing down the benzodiazepine taper may be necessary even in very motivated patients.

3. All of the following help engage patients in conversation about an opioid or benzodiazepine taper | EXCEPT:

- a. Express safety concerns.
- b. Listen to and acknowledge a patient's fears about reducing or discontinuing medication.
- c. Circumvent patients on any decisions about the tapering process.
- d. Share that patients often do better at a reduced dose or discontinuation
- e. Reassure the patient you will not abandon them.

The answer is C. It is important to make the patient a part of the tapering plan and engage them throughout the process. Motivational interviewing techniques can help you and the patient makes decisions as equals when clinically appropriate. For example, when the patient is on both a long-acting and a short-acting opioid, patient preference about which to taper first along with safety, mental health diagnoses and medical history are all considerations for the individualized taper.

4. It can be life-saving to co-prescribe naloxone with opioids to which of the following patients?

- a. A patient who is on both an opioid and a benzodiazepine
- b. A patient whose total daily opioid dose is ≥ 50 Morphine Milligram Equivalents (MME)/day, especially if ≥ 90 MME/day
- c. A patient who is successfully tapering opioids, but remains at risk of returning to full dose street or prescribed opioids
- d. A patient with a history of substance use disorder or history of overdose
- e. All of the above

The answer is E. All these patients would benefit from having naloxone on hand and instruction on proper use. Offering naloxone as a rescue to patients at risk for opioid overdose includes those on a taper. Tolerance to respiratory depression develops rapidly and is lost rapidly, in as little as 1 to 2 weeks. Patients tapering off opioids need to be educated on this loss of tolerance and risk of overdose if they return to a previous higher dose. Co-prescribing naloxone has not increased opioid use.