Case Study: Opiate Deprescribing in a Multimorbid Elderly Patient

Disclaimer: This case is intended for educational use by Healthcare Professionals. Treatment decisions must always be based on individual patient needs, local protocols and up to date clinical evidence

Patient Profile

•**Name**: Mr John Smith
•**Age**: 78
•**Sex**: Male
•**Living situation**: Lives alone in a two-bedroom ground floor council flat in an inner-city area of Greater Manchester. His wife passed away five years ago. He has one daughter, Sarah, who visits three times a week to help with shopping, appointments, and medication reminders.
•**Functional status**: Frail, slow mobility (uses a walking frame), recent falls

- **Social History**:
  - Former factory worker; retired at age 65.
  - Smoked 20 cigarettes a day for 40 years, quit 10 years ago.
  - Drinks occasionally — 1–2 units per week.
  - Not digitally literate — relies on paper calendars and handwritten notes.
  - Feels increasingly isolated, especially since COVID-19 lockdowns.

Medical History

- Type 2 Diabetes Mellitus (diagnosed 14 years ago) – sub-optimally controlled
- Hypertension – well controlled
- COPD (GOLD stage 2) – stable, managed in primary care
- Chronic lower back pain due to spinal osteoarthritis and spinal stenosis
- CKD stage 3a
- Constipation, mild cognitive impairment (MoCA 23/30)
- No cancer or palliative diagnosis

Current Medication List

(Repeat issues over last 6 months reviewed via prescribing system)

Medication	Dose	Frequency	Indication	Duration
Oxycodone MR	40mg	Twice daily	Chronic pain	> 3 years
Oxycodone IR	10mg	Up to 4 times daily PRN	Breakthrough pain	Weekly repeat
Paracetamol	1g	QDS	Pain adjunct	> 3 years
Lisinopril	10mg	OD	Hypertension	Stable
Amlodipine	5mg	OD	Hypertension	Stable
Metformin MR	500mg	BD	T2DM	Long-standing
Tiotropium inhaler	18mcg	OD	COPD	Good technique
Salbutamol inhaler	100mcg	PRN	COPD	Infrequent use
Senna	7.5mg	ON	Opioid-induced constipation	Regular
Lactulose	10ml	BD	Constipation	Regular
Calcium + Vit D	1 tablet	OD	Bone protection	Long-term

Recent Investigations and Monitoring

Parameter	Result	Normal Range / Target	Notes
HbA1c	67 mmol/mol	< 58 mmol/mol (elderly relaxed)	Suboptimal
eGFR	52 ml/min/1.73m²	> 60 = normal	CKD 3a
BP (clinic)	128/72 mmHg	< 140/90 mmHg (NICE)	Well-controlled
MRC Dyspnoea score	2	0–5	Stable
COPD CAT score	12	< 10 = controlled	Mildly symptomatic
MoCA	23/30	≥ 26 = normal	Mild cognitive impairment
Falls risk assessment	High	-	Fall x2 in past 3 months
Bowel chart	Irregular motions	-	Intermittent constipation
OME total dose	~160mg/day	>120mg/day = high-risk	Flagged

Clinical Problem

- Mr Smith is an elderly, frail patient on high-dose opioids (approx. 160mg OME/day) for chronic non-cancer pain. He has multimorbidity including T2DM, hypertension, and COPD. There are growing concerns around:
- Falls risk (opioids are contributory)
- Cognitive slowing and impaired memory
- Ongoing constipation and polypharmacy
- Questionable benefit of high-dose opioids in chronic pain
- MHRA alert and NICE guidance on high OME (>120mg/day) and falls/fractures in elderly
- No pain specialist input for over 2 years

Diagnosis and Guidance

- Chronic non-cancer pain with opioid overuse in a frail elderly patient, resulting in functional decline, increased falls risk, and constipation.

NICE & UK Guidance Summary

- **NICE NG193** (Chronic Pain in Over 16s): recommends against opioids for chronic primary pain
- **NHS SPS/PrescQIPP**: recommends OME >120mg/day be flagged for review
- **NICE CG123** (Osteoarthritis): first-line is non-drug measures and paracetamol
- **NICE NG136** (Falls): reduce sedative burden including opioids
- **MHRA 2020/2023**: opioids linked with dependence, falls, and cognitive effects in elderly
- **STOPP/START criteria**: prolonged opioid use in elderly is potentially inappropriate

Management Plan

1. Immediate Actions

- **Patient education**: Discuss OME risk and impact on memory/falls
- **Start opioid deprescribing plan**: Reduce oxycodone MR by 10mg/week
- **Review need for breakthrough oxycodone IR**: Remove from repeat, use only if needed
- **Introduce opioid withdrawal monitoring plan**: Assess for mood changes, withdrawal symptoms weekly

2. Adjunctive Support

- **Pain management referral**: for review and non-pharmacological input
- **Physiotherapy referral**: reconditioning and movement support
- **Review paracetamol**: continue scheduled regular use
- **Consider capsaicin cream or lidocaine patches** (as per local formulary)

3. Optimise Comorbidities

- **T2DM**: Revisit self-care and dietary input, consider simplifying regime if cognition declines

Management Plan

- **Hypertension**: Continue as is
- **COPD**: Inhaler review shows good adherence and technique; no escalation needed

4. Falls Prevention

- Refer to Falls clinic
- Check Vitamin D status (retest annually)
- Check orthostatic hypotension at next review

5. Monitoring

Follow-up plan:

- Weekly nurse/pharmacist check-in during deprescribing phase
- Full medication review at 4 and 8 weeks
- Repeat MoCA in 6 months
- Annual COPD and diabetes review

Tapering Plan: Oxycodone Reduction for Mr John Smith

Current Regimen

- Oxycodone MR 40mg twice daily
- Oxycodone IR 10mg PRN
- Total OME ≈ 160mg/day

Tapering Principles

- **Go slow and monitor**: Frail, elderly patients are at increased risk of withdrawal and destabilisation.
- **10%–20% reduction of original dose every 2–4 weeks** is safest.
- Maintain function > full withdrawal
- Co-prescribe bowel support and assess mood, sleep, pain, and function regularly.
- Shared decision-making throughout

Suggested 10-Week Tapering Schedule

Week	Oxycodone MR Dose	Oxycodone IR Use	Total Oxycodone (mg/day)	Total OME (mg/day)	Notes
0	40mg BD	30mg/day (3 doses/day)	80 + 30 = **110mg**	110 × 1.5 = **165mg**	Baseline. Assess patient understanding. Document actual IR use.
1–2	40mg BD	Reduce to 20mg/day (2 doses)	80 + 20 = **100mg**	**150mg**	Begin with IR taper. Reassure patient and support function-based goals.
3–4	40mg BD	10mg/day (1 dose/day)	80 + 10 = **90mg**	**135mg**	Optional safety net PRN use. Monitor closely.
5–6	30mg AM / 40mg PM	None	70mg	**105mg**	Now tapering MR. Start with morning dose. Educate about withdrawal signs.
7–8	30mg BD	None	60mg	**90mg**	Below 100mg threshold. Monitor mood, mobility, bowel habit.
9–10	20mg AM / 30mg PM	None	50mg	**75mg**	Patient may request hold here — shared decision-making recommended.
11–12	20mg BD	None	40mg	**60mg**	If pain remains stable, continue.
13–14	10mg AM / 20mg PM	None	30mg	**45mg**	Optional reduction step. Smallest MR tablet needed.
15–16	10mg BD	None	20mg	**30mg**	Consider switching to IR regular or complete withdrawal depending on needs.
17+	10mg OD or Stop	None	10mg or 0	15mg or 0	Evaluate pain vs function. May remain on low-dose long-term if justified.

Key Notes

1

Taper speed: 10–20% every 2–4 weeks is ideal

2

If withdrawal occurs: hold, don't reverse

3

Use non-opioid adjuncts (e.g. paracetamol, topical agents, physio)

4

Weekly review initially, then fortnightly

5

Involve daughter/carer for adherence and support

6

Adjust bowel regimen as opioids reduce

Withdrawal Monitoring

(Weekly Review OR as appropriate)

- Mood, cognition, alertness
- Sleep quality
- Return of pain — score using PEG or Brief Pain Inventory
- Any new anxiety, sweating, GI symptoms, cravings
- Falls or dizziness

Support Measures

- Keep paracetamol QDS
- Encourage activity (mobility and engagement)
- No abrupt withdrawal — hold taper if patient destabilises
- Offer referral to pain management or geriatrician if concerns arise
- Use opioid withdrawal scale or clinical judgement to assess tolerance

References & Resources – Opioid Tapering in Older Adults

Clinical Guidelines & Policy Sources

- NICE NG193 – Chronic pain (primary and secondary) in over 16s: assessment of all pain and management strategies https://www.nice.org.uk/guidance/ng193
- NICE NG249 – Falls: assessment and prevention in older people and in people 50 and over at higher risk https://www.nice.org.uk/guidance/ng249ww
- NICE NG226 – Osteoarthritis in over 16s: diagnosis and management https://www.nice.org.uk/guidance/ng226
- NHS Specialist Pharmacy Service (SPS) – Opioid dose conversions and opioid safety reviews https://www.sps.nhs.uk/articles/estimating-dose-equivalence-from-oral-morphine-to-other-opioids/
- PrescQIPP Bulletin 336 – Reducing opioid prescribing in chronic pain https://www.prescqipp.info/our-resources/bulletins/bulletin-336-reducing-opioid-prescribing-in-chronic-pain/

References & Resources – Opioid Tapering in Older Adults

Educational & Safety Resources

- Faculty of Pain Medicine – Opioids Aware (FPM, RCoA) – Guidance for safe prescribing and tapering
- BNF (British National Formulary) – Opioid dosing, interactions, and tapering https://bnf.nice.org.uk/
- MHRA Drug Safety Update (2020 & 2023) – Dependence and risk with opioid use, especially in elderly https://cpd.mhra.gov.uk/opioids/CON143740_12/
- Rockwood Clinical Frailty Scale – Tool to assess frailty in older adults https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2022/02/rockwood-frailty-scale_.pdf

Tools & Calculators

- OME Calculator (UK) – NHS SPS printable conversion chart https://www.sps.nhs.uk/articles/estimating-dose-equivalence-from-oral-morphine-to-other-opioids/
- Pain Management Resources – NHS Inform Patient Guides https://www.nhsinform.scot/illnesses-and-conditions/brain-nerves-and-spinal-cord/chronic-pain/living-with-chronic-pain/