Resource pack 4: Reducing and stopping a gabapentinoid

Summary guide – Resource pack 4: Reducing and stopping a gabapentinoid

1. Indications for reduction or stopping

- Lack of meaningful improvement in pain or function after a therapeutic trial, or when the original indication has resolved.
- Development of adverse effects such as sedation, dizziness, weight gain, or cognitive impairment.
- Concurrent opioid, benzodiazepine or Z-drug use that increases risk of overdose and respiratory depression or reduced respiratory drive. Evidence or suspicion of misuse, diversion, or dependence.

2. Shared decision-making

- Explore the person's fears, expectations and concerns about reducing, and address these before planning any change.
- Explain that long-term benefits are uncertain, while risks such as sedation, falls, and dependence increase over time.
- Agree functional goals such as improved alertness, reduced falls, or fewer adverse effects. Provide written information and personalised tapering plan.
- Discuss non-drug options such as pacing, movement, sleep and mood support, physiotherapy, pain programmes and social prescribing (where available), while acknowledging variation in local service availability.

3. Principles of safe tapering

- Reduce doses gradually (e.g. by 50–100 mg pregabalin or 100–300 mg gabapentin, or approximately 10% of the total daily dose) every 1–2 weeks. Tailor tapering speed to the dose, duration, comorbidities, and tolerance.
- Go slower where people have long-term use, higher doses, frailty, or significant anxiety about reduction.
- Avoid abrupt discontinuation, which increases the risk of withdrawal.

4. Managing withdrawal symptoms

- Possible withdrawal symptoms include anxiety, agitation, irritability, headache, tremor, insomnia, sweating, gastrointestinal disturbance, nausea, pain rebound and, in rare cases, seizures.
- If symptoms are severe, pause the taper and stabilise at the current dose before resuming more slowly.
- Offer supportive strategies such as reassurance, sleep hygiene, relaxation techniques, and referral for psychological support if needed (e.g. ACT or CBT based approaches where available).
- Consider wellbeing resources, self-management through structured pain management programmes and self-education resources (for example Live Well with Pain, Pain Concern information, the Pain Toolkit, and EPP Cymru).

5. Documentation and follow-up

- Record the reason for reduction, the agreed plan, and patient consent.
- Document the tapering schedule and provide a written copy to the person.
- Arrange regular follow-up appointments to review progress, withdrawal symptoms, and functional outcomes.
- Ensure outcomes are recorded, including whether treatment was stopped, continued, or alternative therapies were introduced.

4.0 Reducing and stopping a gabapentinoid

Guidance from the General Medical Council[45] and NICE (NG215)[46] emphasises that prescribers must act in the person's best interests, which may include reducing or stopping a gabapentinoid even where this is not the person's preference. In practice, discontinuation is achievable for most people with gabapentinoid dependence when the risks of prolonged use and the benefits of stopping are clearly explained and discussed.

Share Appendix 4a: Patient information leaflet: Reducing gabapentin or pregabalin for pain. It explains why tapering is considered, outlines the importance of gradual reduction, and includes a template reduction plan.

4.1 Principles of safe reduction

- Shared decision-making: Discuss concerns and expectations, functional goals, and explain why dose reduction is being considered (limited long-term benefit and increasing risk over time).
- Flexible pace: Set the reduction speed based on dose, duration of use and overall health. Pause or slow the taper if withdrawal symptoms occur.
- Gradual reduction: As a general guide the dose should be reduced every 1–2 weeks, adjusting as needed based on symptoms.
- Safety advice: Explain tolerance reduces rapidly; returning to previous higher doses after reduction increases risk of overdose and respiratory depression.
- Support: Encourage non-drug approaches to pain management.

4.2 Indication for reduction or discontinuation

Circumstances prompting reduction or discontinuation

Lack of benefit:

- No improvement in pain or function after a therapeutic trial.
- Long-term use without clear ongoing benefit.

Resolved or inappropriate indication:

- The original painful condition has improved or resolved.
- Use for non-neuropathic pain or off-label indication without benefit.

Adverse effects or safety concerns:

- Side effects such as sedation, dizziness, cognitive impairment, weight gain, declining renal function or reduced respiratory drive.
- Co-prescribing with opioids, benzodiazepines, Z-drugs or other CNS depressants.
- Worsening of comorbidities (e.g. depression, sleep apnoea, frailty).

Misuse or dependence risks:

- Evidence, or strong suspicion, of misuse or diversion, including obtaining supplies elsewhere.
- Concerns raised by healthcare professionals, family or carers.

Patient preference:

- The person wishes to reduce or stop treatment.

Routine consideration:

- Consider every 6–12 months for people on long-term treatment for pain.
- Where possible, after improvement in pain and function following dose stabilisation.

4.3 Preparing the person for tapering

Key discussion points

Rationale for reduction:

- Explain that long-term benefit is often limited and risks such as dependence increase with time.
- Highlight dose reduction may lead to improved cognition, more energy and improved overall functioning.

Timing of reduction:

- Where possible, begin dose reduction during a period of relative stability, taking account of mental health and wider circumstances.
- A practical tip is to begin reductions early in the week, ensuring support is available if symptoms emerge.
- Unnecessary delay should be avoided where treatment is ineffective or causing harm.
- Emphasise this is not stopping treatment – it's changing the approach.

Ongoing pain management:

- Agree how pain will be managed during dose reduction, including non-pharmacological approaches.
- Where available, consider referral to social prescribing or community wellbeing services, recognising that access and waiting times may vary.

Withdrawal symptoms:

- Explain that withdrawal symptoms may occur, including anxiety, sleep disturbance, sweating, nausea or pain flares.
- These are usually temporary and manageable.
- The pace of reduction can be adjusted if symptoms arise.

Agree outcomes of tapering:

- This may involve reducing to the lowest effective dose, rather than stopping treatment completely, to minimise adverse effects.

4.4 Tapering approach and schedule

Suggested reduction schedules for gabapentin and pregabalin are shown in Table 12. The manufacturers recommend pregabalin and gabapentin are discontinued gradually, over at least one week[4,5]. A more gradual dose reduction allows observation of emergent symptoms that may have been controlled by the drug and is likely to be better tolerated by the person.

Table 12. Suggested reduction schedules for gabapentin and pregabalin

Drug	Reduction schedule
Gabapentin (Total daily dose > 900 mg)	Reduce total daily dose by 300 mg every 2 weeks (range 7–14 days)
Gabapentin (Total daily dose ≤ to 900 mg)	Reduce total daily dose by 100 mg every 2 weeks (range 7–14 days)
Pregabalin	Reduce total daily dose by 50–100 mg every 2 weeks (range 7–14 days)

Notes

- An alternative regimen is to reduce by around 10% of the total daily dose every 7–14 days, re-calculating the dose at each step. Reductions should be individualised, made no more frequently than weekly, and adjusted according to patient tolerability. Dose adjustments should take into account the available formulations.
- Gabapentin is available as 100 mg, 300 mg and 400 mg capsules, and 600 mg and 800 mg tablets. The liquid formulation should be avoided, as levels of propylene glycol, acesulfame K and saccharin sodium may exceed recommended WHO daily intake limits in low weight adults, potentially leading to electrolyte disturbances[47].
- Pregabalin is available as 25 mg, 50 mg, 75 mg, 100 mg, 150 mg, 200 mg, 225 mg and 300 mg capsules and tablets. The liquid formulation should generally be avoided due to its comparatively high cost.

Risk of overdose following tapering

Warn the person of the **risk of overdose or death** if a higher dose of gabapentin or pregabalin is taken following tapering as **tolerance is reduced**.

4.5 Management of withdrawal symptoms

- If withdrawal symptoms occur (e.g. anxiety, insomnia, sweating or nausea), slow the taper by using smaller dose reductions or increasing the interval between changes.
- Slower tapering schedules (e.g. monthly reductions) are often associated with fewer withdrawal problems, particularly when using small dose reductions (e.g. 100 mg for gabapentin or 25 mg for pregabalin).
- A temporary pause at the current dose may help symptoms to settle.
- Re-escalation to a higher dose is rarely required; symptoms can usually be managed by adjusting the speed of tapering.
- Advise against taking extra doses during periods of stress or increased pain, as this increases the risk of overdose.

4.6 Re-emergence of neuropathic pain

- A mild or temporary increase in pain symptoms can occur and does not necessarily mean a gabapentinoid is still required. This may reflect short-term effects of dose reduction or natural fluctuation in chronic pain rather than ongoing benefit from the medicine.
- Encourage the use of non-pharmacological strategies and self-management approaches.
- As the dose is reduced, each step down represents a larger proportion of the remaining dose. Reductions may therefore feel more difficult at lower doses and people may experience returning pain. If this happens, consider smaller reductions as the dose decreases but avoid unnecessarily prolonging tapering.
- If pain continues, consider holding the current dose for longer and review the overall pain pattern and function. Advise against extra doses as this increases this risk of overdose.
- If complete withdrawal of treatment is not successful, consider maintaining the current dose in the reduction regimen. Discuss long term goals and non-pharmacological management. Re-attempt tapering in 3–6 months depending on patient and clinical factors.

4.7 Reviews during taper

The timing of reviews should be agreed between the prescriber and the person. At each review:

- Ask about any withdrawal symptoms or new symptoms they may be experiencing.
- Check for changes since the last dose reduction including any improvement in pain, function, or overall wellbeing.
- Agree whether to continue reducing, pause, or maintain the current dose, based on the person's response and readiness.
- Review use of non-pharmacological pain-management strategies and encourage continued engagement.

4.8 Resistance to reduction

The General Medical Council (GMC) guidance, *Good practice in proposing, prescribing, providing and managing medicines and devices*, notes that doctors should decline to prescribe medication if they do not believe it is safe, clinically indicated, or in the person's best interests[48]. Where concerns arise about ongoing prescribing, this should be addressed through open and honest communication with the person.

Resistance to tapering is common and discussions about dose reduction can be challenging. The first and most important step is to explore *why* the person is reluctant. Understanding their fears, expectations and previous experiences allows the prescriber to address concerns directly, build trust and work towards a shared and appropriate plan of care.

Addressing reluctance to reduction

- **Explore the person's concerns:** Ask what they are worried about (e.g. pain worsening, withdrawal, loss of control, past failed reductions). Validate these concerns and provide clear information.
- **Address misconceptions or fears:** Explain that dose reduction is gradual, flexible, and can be paused. Reassure the person that pain flares or withdrawal symptoms can be managed and that support will be available.
- **Agree a small "test" reduction:** A minor decrease can help the person experience that symptoms often remain stable, increasing confidence in the process.
- **Offer gradual, flexible reductions:** Provide a clear plan, adapt the pace as needed, and maintain frequent contact (e.g. telephone or brief in-person reviews).
- **Reinforce holistic support:** Emphasise the use of non-drug approaches, such as pacing, sleep and mood support, physiotherapy, rehabilitation, and social prescribing where available.

Where prescribers determine that dose reduction is required for safety despite patient reluctance, they should explain the rationale clearly and act in the person's best interests. The patient information leaflet on planned reduction for safety reasons can be used (Appendix 4b) to support these discussions. This leaflet provides a more directive explanation of the rationale for deprescribing, outlining the expected benefits of reduction, how withdrawal symptoms will be managed, and the support

that will be offered. Where it is deemed necessary, use of a Record of agreement (Appendix 4c) can also be considered.

4.9 Discontinuation in people with dependence or ongoing reluctance

People who are dependent, at higher risk, or reluctant to reduce their gabapentinoid dose may need a slower plan with more support and closer follow-up.

Key principles:

- **Use a slower, individual taper:** Smaller dose reductions and longer intervals are often needed to minimise withdrawal symptoms.
- **Review benefits and risks regularly:** Revisit treatment goals and discuss the risks of long-term use at each stage.
- **Monitor closely:** Regular contact helps identify withdrawal symptoms or concerns early.
- **Encourage non-drug approaches:** Discuss self-management strategies and non-pharmacological support to help manage symptoms during reduction.
- **Offer reassurance:** Dose reduction can be slowed or paused if symptoms become difficult to manage.

If the person does not engage or attend reviews

- **Make reasonable attempts to contact the person**, including telephone calls and written communication.
- **Use written communication to clearly explain the need for review**, the reasons for dose reduction, and the proposed dose reduction plan.
- **Consider planned dose reduction** where it is in the person's best interests.
- **Record all contact attempts, decisions, and the agreed plan** in the clinical record so that other colleagues can see the plan.

Special circumstances:

People taking doses above the recommended maximum, or those with a history of substance use, severe medical or psychiatric illness, or previous withdrawal seizures, may require specialist advice. Where specialist or substance use services are available and appropriate, referral should be considered. In areas where such services are limited or do not accept referrals for prescribed medicines, management should be planned carefully within available local resources.

4.10 Documentation at discontinuation

- Decision to reduce or stop the medicine, made in the person's best interest.
- The rationale behind this decision, such as lack of benefit, adverse effects, or safety concerns.
- Agreed outcomes of gabapentinoid tapering (e.g. complete cessation or reduction to a lower effective dose).
- Agreed tapering schedule (with dates and dosage steps).
- Monitoring and support plans during dose reduction.
- Follow-up dates for scheduled reviews.
- Educational resources provided to the person (e.g. information leaflets, contact details for support groups).