Opioids de-mystified



MORPHINE



Still the first-line opioid of choice, unless eGFR is <30, or in case of morphine allergy

What if the eGFR is less than 30?

Alfentanil (parenterally) or fentanyl (transdermally or parenterally) are least likely to accumulate and cause toxicity

Patches: Top Tips

- Doses via transdermal patches are more variable
- The conversion in the table (right) are for the lowest guaranteed dose
- Transdermal patches are not recommended for unstable pain
- Seek palliative care advice for use of patches at the end of life

What about patches?

Buprenorphine Patch (mcg/hr)	Fentanyl Patch (mcg/hr)
5	-
10	•
10	12
20	12
n/a	25
n/a	50
n/a	75
	Patch (mcg/hr) 5 10 10 20 n/a n/a

- This principles in this infographic are primarily for palliative care patients
- In non-palliative chronic pain situations, always be aware of the MME (milligram of morphine equivalent): the risk of harm increases above 120 MMEs/day. Review opioids regularly, and wean off them if they aren't achieving meaningful reduction in pain
- Visit the RCoA "Opioids Aware" website for more info!

Remember...

When switching between strong opioids, consider reducing the calculated dose of the new drug by 33-50% initially, depending on patient's age, co-morbidities, and previous side effects

Tramadol Dihydrocodeine Codeine



x5 but change from mg to mcg

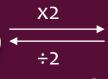
Fentanyl (SC) Not often used: volume quickly limits use

Hydromorphone

Conversions are complex:

÷5 but change from mcg to mg





Dose conversions to/from oral morphine

x30

Oral oxycodone

> **Parenteral** diamorphine

Full-resolution PDF available: www.lindadykes.org/downloads seek advice!

Parenteral alfentanil

SEEK ADVICE/FOLLOW LOCAL **GUIDELINES** when converting to hydromorphone, alfentanil or fentanyl: there is little consensus and much room for error!

Parenteral oxycodone