Opioid Conversion in Palliative Care

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Outline of the session

- What are the issues in Opioid prescribing?
- Case Scenario
- Opioid Conversion
- Case scenario
- Discussion
What are the important issues with opioid prescribing?

- What is the relationship between Background (long acting) opioids & PRN opioids? OR How to Calculate B/T dose?

- How do we recognise opioid toxicity symptoms?
  - Involuntary Muscle jerks & Visual Hallucinations
  - In severe cases: Respiratory rate < 10/min (& Drowsiness + pin-point pupil)

- Causes for the Toxic symptoms
  - ? Over dose of Opioids;
  - ? Renal Failure – Poor Clearance;
  - ? Severe Infection – (No Research Evidence)

- How do you manage opioid toxicity?
  - Either ‘Opioid dose reduction’ OR ‘Opioid Switch’

- What is the main issue with prescribing multiple opioids?

- Prescribing any opioid in ‘Palliative care patients’ or ‘dying people’; Is this right? What is “doctrine double effect”?

  Using a drug clearly shortening the life of your patient (e.g.: giving morphine regularly to a patient with eGFR of 9). Is it ethically right? Can we be legally challenged?
64 years old, Mrs F referred for pain assessment. She was diagnosed with metastatic breast carcinoma with multiple liver metastasis. RUQ ache (pain score of 4 - 5/10) with sharp shooting exacerbations for few seconds (pain score = 9 - 10/10) on movements.

She was given Norspan patch of 10mcg/hr and morphine mixture 5mg prn (4hourly) by her GP. Patient find patch give some relief to her constant ache (pain score = 2 - 3 /10) and top-ups are not helping for sharp pain. She is using 5 top-ups /day and it make her sleepy throughout the day.

1. What type / types of pain we consider here?

2. Why Morphine mixture is not helping on her sharp shooting pain?

3. What is her opioid requirement? How to calculate?

4. How do we manage this patient?
Answer

1. (a) A Constant ache likely to be Liver capsular pain
   (b) Sharp shooting pain (for few seconds) on movements likely be due to neuropathic element

2. Morphine mixture take 20-30 minutes to work but this pain last for seconds

3. Opioid Requirement & Calculation
   
   Morphine = \( \frac{\text{Norspan dose (mcg/hr)} \times 24 \text{ (hrs)} \times 60 \text{ (Conversion ratio)}}{1000 \text{ (mcg to mg)}} \)
   
   = \( \frac{10 \times 24 \times 60}{1000} \)
   
   = 14.4 mg for 24 hours from Norspan patch
   
   Total opioid / 24 hrs = 14.4 + (5mg x 5) = 39.4 mg
   
   ➔ Using 39.4mg /24hours but still having pain

4. Fentanyl patch 12mcg/hr approx. equal to 45 mg of morphine (oral)

My Management will be
(a) Stop Norspan patch & start Fentanyl patch 12mcg/hr every 3 days
(b) Top-up Morphine mixture 1/6 of total dose = 45mg/6 =7.5mg prn (4 hourly)
(c) Dexamethasone 8mg po mane to reduce the size of enlarged liver (↓capsular pain)
(d) Reduce liver size may improve the sharp pain & if not, consider adding a neuropathic agent, if no response to above treatment
Two types on the basis of the mechanism by which pain is produced

- **Nociceptive Pain**
  - **Visceral Pain**
    - Capsular
    - Bowel
    - Cardiac
  - **Somatic Pain**
    - Bone
    - Soft Tissue

- **Neuropathic Pain**
  - Nerve Compression
  - Nerve Injury
  - Peripheral
  - Central
  - Sympathetically maintained
Pain history taking & Pain Evaluation

We need to know the pain response *objectively* to provide ‘better pain control’

To measure the pain objectively… we need ‘pain measurement tools’

**Numeric Rating Scale**

**Faces Pain Scale**

**Visual Analogue Scale**

**Verbal Descriptor Scale**
Pain Management

- Non Pharmaceutical management
  - Heat pads; TENS; Massage therapy
  - Cognitive Behavioural therapy (Relaxation, Guided imagery, music, prayer)
  - MDT approach for ‘Total Pain’

- Pharmaceutical management
  - WHO analgesic ladder approach
  - Available medications for pain relief
  - Opioid Management
“Total Pain”: The experience of pain is influenced by physical, emotional, social, & spiritual factors.
Pharmacological Pain management

➤ Non-opioid medications for pain relief

➤ Opioid medications for pain relief

➤ WHO analgesic ladder approach
   1) By the mouth - Oral Dx 1st
   2) By the clock - Regular interval
   3) By the ladder – Step approach

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Non-opioid Pain Medications used in palliative care

- Paracetamol ........................ (as a pain adjuvant)
- NSAIDs ............................... (Ibuprofen / Ketoralac for bone pain)
- Biphosphonates ..................... (Zolendronic acid for bone pain)
- Antidepressants .................... (Amitriptyline for nerve pain)
- Benzodiazepines ................... (Clonazepam for Nerve pain)
- Anaesthetics ........................ (Versalis topical patches for nerve pain)
- NMDA Antagonist ................. (Ketamine for complex nerve pain)
- Anticonvulsant ..................... (Carbamazepine for neuralgia pain)
- Corticosteroids .................... (Dexamethasone for liver capsular pain)
- Antibiotics ........................... (for Cellulitis pain / discomfort)
- Skeletal muscle relaxants ....... (Baclofen for muscle spasms)
- Antispasmodics ..................... (Buscopan for smooth muscle spasms)
- Calcium-channel Blocker ....... Nifidipine } for Oesophageal
  Nitrates .............................. GTN spray } Spasms / Haemorrhoids
- Misc. others: ....................... Sucralfate suspension /PPI /Capsaicin cream
Background – Opioid!

- A psychoactive chemical that works by binding to opioid receptors which are principally in the Central, Peripheral nervous system and GI tract.

- The receptors (μ, δ and κ) in the organ systems mediate the benefits & side effects of opioids.

- The analgesic effects of opioid due to decreased perception of pain, decreased reaction to pain as well as increased pain tolerance.

- Common side effects include Nausea, Vomiting, Drowsiness, Itching, Dry mouth, Miosis, Constipation, Dizziness, Headache, Confusion.

- Rarely it can leads to....... Dose-related respiratory depression, Hallucinations, Myoclonus –jerks; Delirium, Urticaria, Hypothermia, Brady/tachycardia, Orthostatic Hypotension, Ureteric/biliary spasms, Urinary retention, Flushing (due to histamine release.... except fentanyl), Opioid-induced Hyperalgesia
Background & B/T Opioids

❖ Background Opioids:
   Providing Pain relief – evenly over a long period of time (12 hrs or 24 hour or 3 days or one week)
   **Example**: MS Contin; Oxycontin; Norspan Patch or Fentanyl patch

❖ B/T or PRN Opioids:
   Providing pain relief for shorter time (approx. up to 4 hrs)
   **Example**: Morphine Mixture, Oxynorm
Calculation of Breakthrough doses

Oral Breakthrough dose (4 hourly) = Total 24 hour dose

A Patient is on 60mg Morphine-SR PO BD; what is his oral morphine B/through dose:

= 120mg (24hours) / 6
= 20mg 4 hourly PRN

The same opioid’s oral / parenteral potency ratios are different!

Parenteral Breakthrough dose is also given with same frequency

Example: The above mentioned patient has swallowing difficulty & needed inj

Morphine Sulphate Inj = Oral Breakthrough dose = 7.5 -10mg inj
2 or 3

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Opioids Used in Palliative Care

0 Weak Opioids
  ▪ Codeine Preparations
    ➢ Codeine Phosphate
    ➢ Codeine + Paracetamol (Panadeine / Panadeine Forte)
      8/500; 30/500
  ▪ Tramadol

0 Strong Opioids
  ▪ Morphine Preparations
  ▪ Oxycodone Preparations
  ▪ Methadone Preparations
  ▪ Hydromorphone Preparations
  ▪ Fentanyl / Sufentanyl / Alfentanly Preparations
Weak Opioids

(a) Codeine & Oral morphine
(The dose conversion ratios have been provided only a rough guide. There is considerable variation in what provides an “equi-analgesic” dose.

**Codeine: Morphine ratio varies as 6-10**

\[
\text{Codeine (total dose /24hours)} = \frac{\text{Oral morphine /24 hours}}{10}
\]

[the conversion ratio is taken as 10… why not 6? Bigger the ratio, 24 hr morphine dose will be small & therefore, side-effect profile will be low!]

**Question:**
Mr B has been taking Panadeine Forte 30/500 2 tablets PO qid for his cancer pain for three months. His pain is increased for few days and he needs opioid review?

How do you decide the dose & what is your rationale for this dose?

Codeine tablets 30mg 2 tabs QDS  =  240 mg of Codeine / 24 hours  
=  24 mg Oral morphine / 24 hours

So......... His pain is not controlled with 24 mg of Morphine /24 hours  
You need to give slightly higher & Therefore ,

**Morphine SR preparation 15mg PO bd**  [ Total 30mg /24 hours]
Weak Opioids

(b) **Tramadol & Oral Morphine Potency Ratio**

Tramadol (Total dose for 24 hours) = Oral Morphine / 24 hours

5

Question:
Mrs W diagnosed with Lung Cancer; Her GP started Tramadol 100mg Po Qid for her pain. In spite of her medications, she developed more pain with disease progression. You are her new GP & thinking of starting morphine mixture.

a) What is the starting dose you consider?
b) What are the advices you give to the patient regarding using opioids?

100mg x 4 => 400 mg of Tramadol => 80 mg of Morphine

Morphine Mixture => 80mg /6 => 13.33

Starting Dose of Morphine Mixture => 15 -20mg Po 4 Hourly

( 15 x 6 = **90 mg /24 hours** or 20mg x 6 = **120 mg /24 hours**)

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Different (Strong) Opioid Groups
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td><strong>Oxycodone</strong></td>
<td><strong>Methadone</strong></td>
<td><strong>Hydromorphone</strong></td>
<td><strong>Fentanyl / Buprenorphine/ Alfentanil</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Morphine</strong></td>
<td><strong>Oxynorm Liquid [HCL]</strong></td>
<td><strong>Morphine Sulphate inj</strong></td>
<td><strong>Actiq Lozenges</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Oxynorm capsules</strong> 5, 10, 20 mg [20] RPBS</td>
<td><strong>Endone tablet</strong> 5mg [20] PBS / RPBS</td>
<td>**Morphine Sulphate HCL Supps 10; 15; 20 &amp; 30 mg</td>
<td><strong>Instadyl nasal Fentanyl spray 50 mcg; 100 mcg; 200 mcg /dose</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Endone tablet</strong> 5mg [20] PBS / RPBS</td>
<td><strong>injectable Preparations:</strong></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>PenFent nasal Fentanyl spray 100; 400 mcg /dose</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Injectable Preparation:</strong></td>
<td><strong>Dilaudid Tablets [HCL]</strong></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>Injectable Preparations:</strong></td>
<td><strong>Injectable Preparations:</strong></td>
</tr>
<tr>
<td><strong>Dilaudid inj</strong> PBS / RPBS</td>
<td><strong>2mg/mL 1mL [5]</strong></td>
<td>**Morphine Sulphate HCL Supps 10; 15; 20 &amp; 30 mg</td>
<td><strong>Dilaudid inj</strong> PBS / RPBS</td>
<td><strong>Alfentanil inj</strong> 500mcg/ml (2ml &amp; 10ml) + 5mg/ml (1ml vial)</td>
</tr>
<tr>
<td><strong>Injection Preparation:</strong></td>
<td><strong>20mg/2ml amp [5]</strong></td>
<td><strong>injectable Preparations</strong> Morphine Sulphate HCL</td>
<td><strong>Methadone inj</strong> PBS / RPBS</td>
<td><strong>Long acting or Sustained Release:</strong></td>
</tr>
<tr>
<td><strong>2mg/mL 1ml amp [5]</strong></td>
<td><strong>50mg /ml amp</strong></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>Methadone inj</strong> PBS / RPBS</td>
<td><strong>Oral Preparations:</strong></td>
</tr>
<tr>
<td><strong>10mg/ml 1ml amp [5]</strong></td>
<td></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>Methadone inj</strong> PBS / RPBS</td>
<td><strong>Transdermal Preparations:</strong></td>
</tr>
<tr>
<td><strong>Long acting or Sustained Release:</strong></td>
<td></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>Methadone inj</strong> PBS / RPBS</td>
<td><strong>Fentanyl Patch (72 hours)</strong></td>
</tr>
<tr>
<td><strong>oral Preparations:</strong></td>
<td></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>Methadone inj</strong> PBS / RPBS</td>
<td><strong>Durogesic DTrans 12; 25; 50; 75; 100 mcg/hr</strong></td>
</tr>
<tr>
<td><strong>MS Contin tablets:</strong> 5, 10, 15, 30, 60, 100, 200mg</td>
<td></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>Methadone inj</strong> PBS / RPBS</td>
<td><strong>Buprenorphine Patch (weekly)</strong></td>
</tr>
<tr>
<td><strong>MS Contin Suspension 20, 30, 100 mg sachet</strong></td>
<td></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>Methadone inj</strong> PBS / RPBS</td>
<td><strong>Norspan Patch 5; 10; 20 mcg/hr</strong></td>
</tr>
<tr>
<td><strong>Kapanol Capsule 10, 20, 50, 100mg</strong></td>
<td></td>
<td><strong>suppository</strong> Morphine Sulphate HCL</td>
<td><strong>Methadone inj</strong> PBS / RPBS</td>
<td></td>
</tr>
</tbody>
</table>
Morphine

Available:
Many preparations & forms (Tablets / Suspension / Suppository / Injection)

Preparations:
Short acting – Every four hourly
Long acting – Once (24hr) or Twice (12 hr) a day

Potency Ratio:

☐ Within oral & Injectable preparations

Oral : Injectable Morphine = (2 or 3) : 1
Oxycodone

Available as Targin & Oxynorm preparations....

- Oxynorm: available as short acting Capsules / Suspension; Sustained Released tablet (Oxycontin) and injectable preparations for B/Ts & for Syringe Driver use

- Targin: developed to reduce the GI side-effect of constipation

  Clearly improves the constipation in palliative population

BUT... Limited use with

(a) No short acting preparation available -“Top-ups” with Endone or Oxynorm

(b) Unable to give higher doses due its naloxone component!

  ➔ Maximum dose of Targin 40/20mg PO BD
How Targin Prevent Constipation?

1. 12-hourly oral tablets deliver oxycodone CR / naloxone CR
2. Due to its high binding affinity, naloxone prevents or reverses the effects of oxycodone in the GI tract, reducing OIC
3. During first pass, at least 97% of naloxone is metabolised in the healthy liver, while up to 87% of oxycodone passes into circulation unchanged
4. Oxycodone exerts a central analgesic effect equivalent to oxycodone alone

CNS = Central Nervous System; CR= Controlled Release; GI= Gastrointestinal; OIC= Opioid-Induced Constipation.


This diagram obtained from Mundipharma’s lecture series & Thank you!
Oxycodone

Potency Ratio:

- **Within oral & Injectable preparations**

  Oral : Injectable Oxycodone = (2) : (1)

  [20mg tablet /suspension is equal to 10mg inj. Oxynorm]

- **Potency Ratio with Morphine**: (Varies from 1.5 to 2)

  Morphine (Oral) : Oxycodone (Oral) = (2) : (1)

  Total 24 hour Oral Morphine ÷ 2 = Dose of Oxycodone for 24 hour
Hydromorphone

0 Potency Ratio:

- Potency Ratio with Morphine: (varies with 5-7 : 1)
  (Generally taken as 6:1)

Total 24 hr Oral Morphine ÷ 6 = Dose of oral Hydromorphone for 24 hr

Total 24 hr SC Morphine ÷ 6 = Dose of SC Hydromorphone for 24 hr

- Within oral & Injectable preparations of Hydromorphone

  Oral : Injectable Hydromorphone = (2 -3) : (1)
# Methadone

## Potency Ratio:

- **Potency Ratio with Morphine:**
  
  **Oral Morphine : Oral methadone = Complex,... Variable with doses**

<table>
<thead>
<tr>
<th>Oral Morphine/24 hrs</th>
<th>Conversion Ratio</th>
<th>Oral Methadone / 24 hrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 100mg</td>
<td>3 : 1</td>
<td>0-30mg of Methadone</td>
</tr>
<tr>
<td></td>
<td>[3mg Morphine : 1mg Methadone]</td>
<td></td>
</tr>
<tr>
<td>101 – 300 mg</td>
<td>5 : 1</td>
<td>20 to 60 mg</td>
</tr>
<tr>
<td>301 -600 mg</td>
<td>10 : 1</td>
<td>30 -60 mg</td>
</tr>
<tr>
<td>601 – 800 mg</td>
<td>12 : 1</td>
<td>50 – 65 mg</td>
</tr>
<tr>
<td>801 – 1000 mg</td>
<td>15 : 1</td>
<td>50 -65 mg</td>
</tr>
<tr>
<td>&gt; 1000 mg</td>
<td>20 : 1</td>
<td>50 mg</td>
</tr>
</tbody>
</table>

*Adapted from Ayonrinde & Bridge, MJA, 2000*

- **Within oral & Injectable preparations of Methadone**
  
  **Oral : Injectable Methadone = (2) : (1)**
Opioid Switch

Example:

Patient on MS Contin 60 mg PO BD and he needed opioid switch to Oxycontin

(1) Change his MS Contin to Oxycodone SR (2:1)
   Total Morphine 120mg /24 hr = Oxycodone 60 mg /24hr

   ➔ It can be given as Oxycodone SR 30mg PO BD

(2) What is the Breakthrough dose of oral Oxycodone?
   Total oral Oxycodone for 24 hours ÷ 6 => 60 ÷ 6 = 10mg

(3) What is the Breakthrough dose of Sub cut inj Oxycodone?
   Oral breakthrough dose of Oxycodone ÷ 2 = SC Oxycodone inj
   In this example, it is 5mg
Alfentanil

- **Why Alfentanil?**
  - Short acting; Analgesic effect lasts for 5-10 Minutes
  - Faster onset than fentanyl & compare to fentanyl small volume needed for continuous sub cut. infusion (S/driver)

- **UK** ➔ Alfentanil is used in the patients with Stage 4 or 5 CKD

- **ANZSPAM Conference – 2012 (NZ)** ➔ Alfentanil is recommended for End of life care renal failure patients or Stage 4 or 5 CKD patients for pain Rx

- **Potency Ratio - Comparing Morphine**

  \[
  \text{Morphine : Inj Alfentanil} = 30 : 1
  \]

**Example:**
Patient is using 90mg morphine /24 hours. He became very drowsy and subsequent investigations revealed that he has renal failure with eGFR= 9. No further active treatment & according to his ACP, he wants only comfort care. How do you manage his pain?

  S/driver with 3 mg (90mg / 30) Alfentanil inj over 24 hours
Patches

Transdermal Fentanyl patch and oral Morphine

Conversion Calculation:

Transdermal Fentanyl patch : Oral Morphine = 1: 100-150

Example: Patient is on 25 mcg / hour Fentanyl patch
What is the Oral Morphine [Ordeine Susp] B/T dose?

= \[25 \text{ mcg / hour patch} \times 24 \text{ hours} \times 150 \text{ conversion ratio}\]

1000 [to make milligrams] \times 6 [to find the B/through dose]

= 15mg Ordeine Suspension
Transdermal Buprenorphine patch and oral Morphine

Conversion Calculation:

Transdermal Norspan patch : Oral Morphine = 1 : 60-100

Example: (a) Patient is on 10 mcg / hour Norspan patch.

What is the Oral Morphine B/T dose?

= \(10 \text{ [mcg / hour patch]} \times 24 \text{ [hours]} \times 60 \text{ [conversion ratio]}\) \(1000 \text{ [to make milligrams]} \times 6 \text{ [to find the B/through dose]}\)

= 2.4 mg Oral Morphine
Conversion from Morphine to Buprenorphine patch

Conversion Calculation:

Oral Morphine ➔ Transdermal Buprenorphine patch

Example: Patient is on 30 mg over 24 hours; planning to discharge home with Buprenorphine patch?

= 30 mg Morphine over 24 hours

= 30 ÷ 60 (Conversion) = 0.5 mg Buprenorphine

= Convert 0.5mg to micrograms by x 1000

= 500mcg Buprenorphine over 24 hrs = 20.8333 mcg /hour

= approx. 20 mcg/hour Buprenorphine patch
Question - 2:

(a) Mr Lucas was diagnosed as Carcinoma of the prostate with bony metastasis. He was on Panadeine Forte 30/500 2 po qid. Last 3 days, he got more pain. How do you manage him?

Codeine tablets 30mg 2 tabs qid  =  240 mg of Codeine / 24 hours
= 24 mg Oral morphine / 24 hours

His pain is not controlled with 24 mg of Morphine /24 hours
You need to give slightly higher  & Therefore ,

Morphine SR preparation 15mg PO bd
[ Total 30mg /24 hours]

Or

Morphine Mixture  5 mg PO  4 Hourly
( 4 Hourly means 6 times in 24 hours ➔ 5 x 6 = 30mg / 24 hours)
(b) You suggested Ordine Suspension 5mg (2.5ml) PO every 4 Hrly. Use of Ordine suspension reduced his pain. (His worst pain score was 9/10 & now the pain score is 4-5/10).

On 2nd visit, you increased the Ordine suspension dose to 10mg PO 4 hrly as he is sensitive to opioids. In two days you receive a panic call from wife regarding his drowsiness & confusion.

How are you going to manage him now?
1. Look for any toxicity symptoms;
   ⇒ At least one of the major symptoms (visual hallucinations / involuntary muscle jerks or clinical evidence of respiratory depression [RR = <10/min]) and other symptoms like drowsiness / confusion / pin point pupils)
2. See whether he has pain or not......
3. Reduce or switch the opioid dose (Not to stop it completely; withdrawal can be equally troublesome! + it will also increase the pain levels)

how do you manage the situation now?
1. If Respiratory depression → Hospitalisation & Naloxone inj
2. If no Respiratory depression but toxic......

Management:-
(a) Opioid toxicity + No pain → Reduce the opioids by 30-50% of total 24 hrs dose
(b) Opioid toxicity + Have more pain → Opioid Switch

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(c) No pain & therefore, Opioid reduction done; Ordine Suspension reduce to 7.5 mg from 10mg. His pain score return to 2/10 in 48 hrs; ‘bearable pain’ & No toxic symptoms.

After 3/12, patient come back to you with increasing pain levels again with visible muscle jerks & Drowsiness with the same dose (7.5mg po 4 hourly) & no additional top-ups.

What are the possibilities now? and How do we manage now?

- Same dose & No Top-ups but Toxic.....
  (a) Look for renal impairment? Morphine excrete via kidney & impairment can Produce toxic picture? [eGFR & Cr]
  (b) Any on-going infection (UTI/RTI) can also give similar picture...

- If renal impairment is the cause, Change the opioids to ‘renal friendly opioids’
  Depending on the stage of patient’s cancer journey (?) decide the medication
  Hydromorphone / Norspan patch / Fentanyl patch / Fentanyl or Alfentanly S/driver

Found poor renal function with B/L Hydronephrosis; eGFR = 10 & Cr = 312. within two days he deteriorated with AKPS= 30 % (Bed bound). How do you manage now?

- Oral or Patch or S/Driver? What is the drug of choice?
- Why not to continue with his Morphine... Any way he is going to die....?
Hope this lecture can give you answers to:

- What is the relationship between Background (long acting) opioids & PRN opioids? or How to Calculate B/T dose?
- How do you recognise opioid toxicity symptoms?
- How do you manage opioid toxicity?
- What is the main issue with prescribing multiple opioids?
- Prescribing any opioid in ‘dying people’ or ‘Palliative care patients’; Is this right? What is “doctrine double effect”?

Using a opioid clearly shortening the life of your patient (E. g. : giving morphine regularly to a patient with eGFR of 9). Is it ethically right? Can we be legally challenged?

- Are you comfortable to convert Codeine to Morphine or Morphine to Hydromorphone?