Palliative Care Opioid Conversion Guide

Waitemata District Health Board
Te Wai Awhina

These conversion factors are approximations and the patient must be observed for toxicity or breakthrough pain when changing opioids. Dose titrations may be necessary.

oxycodone oral : morphine oral
1 : 2

Example: oxycodone 10mg → (x 2) → morphine 20mg

oxycodone oral : morphine subcutaneous

When converting from oral oxycodone to a subcutaneous morphine syringe driver, the morphine dose will be two thirds of the total daily oxycodone dose (divide oxycodone dose by 1.5)

Example: oxycodone oral 30mg → (÷ 1.5) → morphine subcutaneous 20mg

codeine oral : morphine oral
10 : 1

Example: codeine 240mg/24 hr* → (÷ 10) → morphine 24mg/24 hour

* For practical reasons, if the maximum daily dose of codeine (240mg) is ineffective the patient should be initiated on the recommended starting daily dose of oral morphine (30mg/24 hours as per guidelines over page)

tramadol oral : morphine oral
10 : 1

Example: tramadol 100mg → (÷ 10) → morphine 10mg

Note: If converting from the maximum tramadol daily dose (400mg/24 hour) consider starting at a lower morphine dose and up-titrating dose as required. In pain associated with cancer, morphine is more effective than tramadol

morphine oral : morphine subcutaneous
2 : 1

Example: morphine oral 20mg → (÷ 2) → morphine subcutaneous 10mg

Note: If converting to a morphine subcutaneous syringe driver—use **half** of the **total daily** oral morphine dose. Refer to BPAC Guidelines for information about syringe drivers and dose adjustments

Breakthrough short-acting oral morphine dose for patient on fentanyl patches

Patients on fentanyl patches will need to have short-acting oral morphine prescribed for breakthrough pain. This can be approximately calculated using the strength of the fentanyl patch prescribed for the patient:

- ► Take the ***strength of the fentanyl patch*** and ***divide by 2***
- ► This will approximately be the ***dose in mg of oral morphine*** (PRN dose) required for breakthrough pain

Example: Patient is on fentanyl patch ***75 mcg/hour***. Short-acting oral morphine PRN dose will approximately be ***35mg***

- ► It can take 12-24 hours to reach therapeutic plasma levels when patch is ***first applied*** - apply the first patch at the same time as the last dose of long-acting opioid and accept that patient may also require PRN morphine for days 1 and 2. If more than two PRN morphine doses are required after day 2 - increase strength on next patch by 25mcg
- ► Once established on a patch strength, if patient gets breakthrough pain before day 3 - increase strength of next patch

Notes

Converting to transdermal fentanyl patches

Fentanyl patches are usually initiated by a palliative care specialist. For dose conversions from morphine to fentanyl patches please refer to the BPAC Guidelines (Pain Control in Palliative Care).

Methadone

Methadone has advantages in neuropathic pain and in patients with renal impairment. It has a longer half life and complex pharmacokinetics. It can accumulate on repeated doses. Dose conversions are complex - seek specialist advice.

Pethidine

Pethidine is a short-acting opioid and is not suitable for use in palliative care.

Important: *The information contained herein is intended solely to assist clinicians with the management of palliative care patients. It is not intended to replace the consultation process of clinicians with their patients. Clinicians must consider current best practice when making clinical decisions with each individual patient at all times.*

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