

SA Palliative Care Community Pharmacy Update

A joint initiative of SA Palliative Care Services and Ambulatory & Primary Health

Opioids are a mainstay of treatment for controlling pain in people with terminal conditions.

Switching Opioids

Reasons for Switching

Patients may require switching their prescribed opioid and/or route of administration for a variety of clinical reasons including:

- > Change in available routes of administration e.g. inability to swallow
- > Poor adherence e.g. changing from an oral to transdermal preparation
- > Intolerable side effects e.g. intractable constipation
- > Suspected opioid induced hyperalgesia (increased responsiveness to pain stimuli) e.g. rotate to an alternate agent
- > Poorly managed pain e.g. using a continuous subcutaneous infusion to obtain stable plasma levels
- > Significantly changed clinical status e.g. changes in renal function
- > PBS availability/cost

Relative Potency/Dose Equivalence

Opioid agents differ by their potency, i.e. dose required to deliver an equivalent analgesic effect. Information regarding potency/dose equivalence can be found in a range of references and formats. It is important to familiarise yourself with the format of the reference you are using:

- > The AMH and Palliative Care Therapeutic Guidelines both contain published tables outlining *approximate dose equivalents* of a variety of agents relative to *parenteral* morphine.
- > Other references (e.g. UK references) may use *potency ratios* and/or may express dose equivalents relative to *oral* morphine

Data contained in these references has been determined following a single typical dose of opioid in healthy populations; the clinical situation is less predictable with marked inter-individual variability in response to opioids. Dose equivalence references must be used as an approximate guide only.

There is no specific dose equivalence relating to methadone. Switching to/from methadone should be supervised by palliative care or pain specialists.

Use a Systematic Process

A systematic process should be used to safely determine a new opioid dosing regimen. The following example is based on a reference that expresses dose equivalence relative to parenteral morphine (e.g. AMH):

1. Calculate the patient's total daily dose of their current opioid
2. Convert the calculated total daily dose of current opioid to the equivalent dose of parenteral morphine
3. Convert the total daily dose of parenteral morphine to the equivalent dose of the new opioid
4. Prescribe a conservative drug regimen of regular and breakthrough dosing, i.e. reduce the calculated dose by 25 to 50%. This approach avoids toxicity while any deficit in efficacy can be made up with breakthrough doses.
5. Monitor the patient by reviewing number of breakthrough doses required, patient reported pain scales and presence of adverse effects.
6. Titrate treatment up or down accordingly

Useful resources

- > Palliative Care Therapeutic Guideline, 3rd ed
Table 1.8 Approximate potencies of various opioids relative to 10 mg parenteral morphine
Table 10.9: Dose conversion ratio of transdermal fentanyl patches to morphine
- > Australian Medicines Handbook 2013, Opioid comparative information, Equianalgesic dosing
- > eqiV opioid conversion calculator (free registration required)
<https://www.eviq.org.au/OpioidCalculator.aspx>
- > SA Palliative Care Community Pharmacy Update #10: Incident and breakthrough pain

For more information

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