Appendix 4H NHS Fife Quick reference guide:
Opioids for chronic non-malignant pain

Also see NHS Fife Appendix 4G NHS Fife Chronic Non-Malignant Pain – Strong Opioid Prescribing Guideline

Key prescribing points:
- There is limited evidence for use of opioids in long term management of chronic pain
- A trial period of 6 weeks at the maximum tolerated dose is adequate
- Patients on doses greater than 120mg morphine equivalent daily, should be referred to the pain service
- Constipation is common. Minimise by encouraging lots of fluids, fruit and fibre. Always prescribe laxatives (e.g. formulary stimulant laxative and stool softener)
- Opioids can cause possible long term endocrine / immunological effects.
- Opioids can cause hyperalgiesia where the patient may present with increased diffuse pain - reduce the opioid dose.
- Continue regular paracetamol

Before initiating opioid therapy

Use only as part of a wider management plan aimed at reducing disability and improving quality of life. Make it clear to patients that if the trial is unsuccessful, then opioid treatment will be discontinued. Treatment success is demonstrated by functional improvement.

- Give realistic expectations. Opioids are unlikely to give complete pain relief. Some pains do not respond to opioids.

Cautions
- Renal impairment. Dose reduction if eGFR < 30 ml/min. Seek specialist advice.
- Patients should not drive when starting opioids, adjusting dose. If they feel unfit to drive or they have consumed alcohol whilst taking opioids. Information leaflet for patients - New law on driving having taken certain drugs

Prescribing
- Be clear who is responsible for prescribing – ideally a single prescriber.
- Use regular dosing with oral modified release preparations only, NOT immediate release formulations. Morphine sulphate MR (Zomorph®) should be the first-line opioid and Oxycodone MR (Longtec®) second line.
- Start with low dose and titrate according to analgesia and side effects increasing no more frequently than every two weeks.
- Do not exceed maximum recommended doses. NHS Fife recommends that patients on doses greater than 120mg morphine equivalent daily, should be referred to the pain service (see table overleaf).
- A trial period of 6 weeks at the maximum tolerated dose is adequate. If inadequate response then withdraw gradually. Patient information leaflet - Reducing Opioids
- Discuss alternative strategies for exacerbations of pain as ‘short acting’ opioids are not appropriate for the majority of patients.
- Review patient regularly. Initially at least monthly and more often if there are concerns. When the patient is prescribed stable dose then monitor at least bi-annually.

Switching opioids
- Efficacy and adverse effects are similar for all opioids although patients may tolerate one opioid better than another.
- When switching opioids consider reducing the dose by 25-50% to allow for incomplete cross tolerance and monitor regularly. See the table and approximate opioid equivalences overleaf.
- Withdrawal symptoms (e.g. sweating, yawning and abdominal cramps) occur if an opioid is stopped/dose reduced abruptly. This is common with tramadol and can occur with weak opioids even after a short course.

Adverse effects
- See key prescribing points above.

Dependence and addiction
- Physical dependence is inevitable. Addiction (psychological dependence and craving) is rare.
- Pharmacological effects of physical dependence and ease of discontinuation helped by limiting maximum dose...
- The withdrawal of opioids should be done gradually. See link below to individual medication leaflets and reducing opioids leaflet.

More information

NHS Fife Chronic NonMalignant Pain Opioid Prescribing Quick Reference Guide
Date written: March 2015  Review date: March 2017

We would like to acknowledge: Roger Knaggs (Advanced Pharmacy Practitioner - Pain Management, NUH) for allowing NHS Fife to adapt Nottinghamshire APC’s ‘Opioids for persistent non-cancer pain’ guide.
### Maximum Recommended Doses

<table>
<thead>
<tr>
<th>Opioid Choice</th>
<th>Morphine Sulphate Sustained Release (Zomorph®)</th>
<th>Oxycodone Sustained Release (Longtec®)</th>
<th>Fentanyl (Matrifén®)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Starting Dose</strong></td>
<td>10mg BD</td>
<td>5mg BD</td>
<td>12mcg/hr</td>
</tr>
<tr>
<td><strong>Titration of dose if necessary</strong></td>
<td>Increase by 10-20mg BD Every 2 weeks</td>
<td>Increase by 5 – 10mg BD every 2 weeks</td>
<td>Increase by approx 12mcg/hr every 2 weeks</td>
</tr>
<tr>
<td><strong>Maximum Dose</strong></td>
<td>60mg BD</td>
<td>30mg BD</td>
<td>50mcg/hr</td>
</tr>
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</table>

**For non-cancer pain initiated in Primary care**

### Oral Morphine to Transdermal Opioid:

<table>
<thead>
<tr>
<th>Oral morphine equivalent (mg/24 hours)</th>
<th>30 to 60</th>
<th>60 to 90</th>
<th>90 to 120</th>
<th>120 to 180</th>
<th>180 to 240</th>
<th>240 to 300</th>
<th>300 to 360</th>
<th>360</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transdermal fentanyl (mcg/hour)</td>
<td>12</td>
<td>25</td>
<td>37</td>
<td>50</td>
<td>62</td>
<td>75</td>
<td>87</td>
<td>100</td>
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</tbody>
</table>

### Oral morphine to other oral analgesics

<table>
<thead>
<tr>
<th>Oral to Oral</th>
<th>Conversion Ratio</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine to Oxycodone</td>
<td>2:1</td>
<td>Oral Morphine 10mg = Oral Oxycodone 5mg</td>
</tr>
<tr>
<td>Morphine to Tramadol</td>
<td>1:5-1:10</td>
<td>Oral Morphine 10 mg = Oral Tramadol 50 - 100mg</td>
</tr>
<tr>
<td>Morphine to Codeine</td>
<td>1:10</td>
<td>Oral Morphine 10 mg = Codeine 100 mg</td>
</tr>
</tbody>
</table>

**N.B.** Published conversion ratios vary and these figures are a guide only. Morphine equivalences for transdermal opioid preparations have been approximated to allow comparison with available preparations or oral morphine. Patient response may be variable. Please check the most recent BNF for current conversion guide.