Opioid Switching Tool

This advice is intended to be used with the Isle Of Wight Opioid Strategy.
Only opioids advised within that strategy should be used.
Other opioids equivalences are included to allow safer conversion to those included in strategy & to improve understanding of relative potencies.

Indications for switching:

- Unmanageable side effects
- Poor response to alternate opioid when trialled
- Developing opioid tolerance
- Alternative route administration required

Consider:

- Are opioids still required?
- Is it safe to switch (now?/ In this healthcare setting?)
- Is there any indication aberrant drug use?
- Has the pain changed?
- Has the level of risk changed?

REMEMBER IT IS SAFER TO UNDER DOSE:

- Opioid withdrawal symptoms are unpleasant but not life threatening – opioid overdose is life threatening
- It is important to remind patient (relative / carer) about signs of over dose:
    - Slurred or drawling speech
    - Ataxia (reduced co-ordination)
    - Nodding off during conversation or activity
    - Increased snoring / apnoea spells at night
- Consider 3 day "Tolerance check": contact patient 3d after starting new opioid to check for signs of over sedation and ensure pain relief reasonable
- Patients at risk of overdose include:
    - Elderly
    - Those on BDZ
    - Renal/hepatic impairment
    - COPD/sleep apnoea
    - Cognitive impairment
- CAUTION DURING PREGNANCY

There is considerable inter individual variation in response to opioids – these conversion factors should be used as guidance only.

How to switch:

1. **Determine ALL current opioids taken (Total Daily Dose)**
   i. Regular
   ii. Prn
   iii. OTC

   = total daily dose of each opioid in MG for oral meds
   (For patches: convert straight from strength in microgram/hour)

2. **Convert to the equivalent morphine dose (MEq dose)**

N.B: this equivalence table contains opioids not recommended for first or second line use within Primary Care. (Recommended drugs highlighted in Green)

Converting to Morphine Equivalents (MEq)			
Drug	Dose (mg)	Conversion factor	MEq (mg)
Oral medication			
Codeine	30	X 0.15	4.5
DHC	30	X 0.25	7.5
Tramadol	50	X 0.2	10
Morphine	10	X 1	10
Oxycodone	10	X 1.5	15
Tapentadol	50	X 0.4	20
Patch medication			
Conversions are from MICROGRAMS / hour (patch "strength") to MG oral morphine			
Buprenorphine	5mcg / hr	X 1.8	9 mg
	10 mcg / hr		18 mg
	20 mcg / hr		36 mg
Calculation: 5 mcg x 24 = 120microgram / day buprenorphine = 0.12 milligram / day buprenorphine Conversion factor x 75 (0.12 x 75) = 9mg oral morphine / day (total conversion = (dose x24) x 75 / 1000) = dose x 1.8)			
Fentanyl	25 mcg / hr	X 2.4	60 mg
	50 mcg / hr		120 mg
	75 mcg / hr		180 mg
Calculation: 25 mcg x 24 = 600mcg / day fentanyl = 0.6 milligram fentanyl / day Conversion factor x 100 (0.6 x 100) = 60 mg oral morphine / day (Total conversion = (dose x 24) x 100 / 1000 = dose x 2.4)			
Sublingual medication			
buprenorphine		X 30	
fentanyl		X 0.13	

3. **Determine Total Daily Morphine Equivalent in MG / Day = MEq (mg)**

4. **Determine proportion dose to be converted (50 – 70%)**
   - ALWAYS REDUCE DOSE BY AT LEAST 30% to reduce risk overdose
   - Recommended reduce by 50% if elderly / frail

   New Dose = MEq x 0.7

5. **Use recommended conversion factor to convert to new opioid**

Converting MEq to new opioid			
Oral Medication			
MEq	Conversion factor	Dose (mg)	drug
3	X 10	30	Codeine
6	X5	30	DHC
10	X 5	50	Tramadol
10	X 1	10	Morphine
15	X 0.667 (MEq/1.5)	10	Oxycodone
20	X 2.5	50	tapentadol
Buprenorphine Patch :			
MEq < 30mg	5 mcg / hr	These recommended conversions are to LOW doses: additional analgesia will be required during dose titration. (No significant reduction other opioid activity at these levels)	
MEq 40-80mg	10 mcg / hr		
Fentanyl Patch:			
Use LEVY's RULE: Patch strength (mcg / hr) = half total daily dose oral morphine (round down to nearest patch strength)			
MEq = 60	60 / 2 = 30	25mcg / hr fentanyl	

6. **Define new regime: regular unit doses / frequency & prn opioid medication**
   E.g. 12 hourly dosing = daily dose / 2.
   Round down to nearest unit dose available: no more than 10% as prn

7. **Schedule review (consider 3 day Tolerance check)**
   -tolerance check re: overdose & tolerability
   - do not schedule dose increase for at least 10 days.

Fentanyl Patches

- Not to be prescribed for opiate naïve patients
- Codeine & Tramadol are pro-drugs. Some are unable to metabolise to opioid metabolite. Therefore they will still be opioid naïve.
- **Do NOT prescribe fentanyl patches to those who have only taken codeine or tramadol.**

- **All patches have increased uptake with heat**
  - Fever
  - Externally applied heat (hot water bottle etc)
- Risk of sedation increased if already on sedative drugs