Information about Opioid Use in Long Term Care and Supportive Living

Consult pharmacist or appropriate reference for more complete information about opioids

- **Generally with opioid use for seniors, we START LOW, GO SLOW and keep monitoring.**
- **With appropriate doses, opioids do not shorten life and rarely cause respiratory depression.**
- **Opioids may be prescribed for dyspnea (shortness of breath).**
- **Medical use of opioids for pain or dyspnea rarely leads to opioid addiction.**
- **Opioids are high alert medications. Double check: right dose, right drug, right route, right client, right time, right purpose, right documentation (Note: client has right to refuse medication).**

Side effects: dry mouth, increased sweating, urinary retention, pruritis. Constipation almost always occurs and should be addressed with any new opioid prescription or increase in opioid dose. Nausea and sleepiness may occur initially but often resolve after a couple of weeks of opioid use.

Contact physician or Nurse Practitioner (NP) with signs of possible toxicity. Symptoms that require more assessment include myoclonic spasms, delirium, confusion /hallucinations /nightmares, unexplained escalating pain.

Immediately contact physician, NP or EMS with signs of overdose– i.e. new respirations < 8/min, newly difficult to rouse/overly sedated **that can't be explained by something else.**

Commonly Used Opioid Medications

Generic Name	Short Acting Trade Name	Combination Drug	Long Acting Trade Name
Morphine	Statex, Doloral, M.O.S.IR, MS-IR, others		M-Eslon, MS Contin, Kadian, M.O.S.-SR, others
HYDROmorphone	Dilaudid		Hydromorph Contin, Jurnista
oxyCODONE	Supeudol, Oxy-IR	Percocet/Oxycocet (both have acetaminophen 325mg + oxyCODONE 5mg), generics	OxyNEO, OxyCODONE SR
Codeine *		Tylenol #2 (acetaminophen 300mg + Codeine 15mg), Tylenol #3 (acetaminophen 300mg + Codeine 30mg), numerous others	Codeine Contin
traMADoL	Ultram	Tramacet (traMADol 37.5mg + acetaminophen 325mg, generics	Durela, Ralivia, Tridural, ZytramXL

*Codiene must be metabolized to its active metabolite, morphine to produce therapeutic effect. Due to individual genetics, some people are poor metabolizers (they experience very poor analgesic effects) or ultra-rapid metabolizers (are at risk of very serious adverse effects) of codeine.

FentaNYL Transdermal: manufacturer's recommendations used for dosing

- NOT recommended unless client already on significant amount of opioid. NOT **started** at end of life.
- Onset of action 12 – 17 hrs, therefore scheduled and prn analgesics usually continue for 12-17 hrs.
- After 3 days of use, fentaNYL patch still has significant drug: patch must be removed and disposed safely in sharps container or per facility policy.

Parenteral form of fentaNYL can be used sublingually or subcutaneously for incident pain or dyspnea in select clients.

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Guide to Opioid Equivalencies‡

This chart gives *approximate* dosing equivalences between medications.

It is to be used as a guide only. Opioid prescribing or changes require a prescription from an authorized prescriber.

Medication	Opioid equivalency dose				
Morphine	1mg	2.5mg	3mg	5mg	10mg
HYDROmorphone	0.2mg	0.5mg	0.6mg	1mg	2mg
oxyCODONE	-	-	-	2.5mg	5mg
codeine	-	-	30mg	**-**	100mg
traMADol	-	-	30mg	**-**	100mg

Equivalent to (≈) implies not equal to but approximate

Oral to Subcutaneous routes: Clinical experience suggests using **2:1** to **3:1** ratio of oral:subcu

- Using ratio of **2:1**→ (morphine 2mg oral ≈ morphine 1mg subcu)
- Using ratio of **2:1**→ (HYDROmorphone 1mg oral ≈ HYDROmorphone 0.5mg subcu)

Subcutaneous Equivalency:

- Morphine 2.5mg subcu ≈ HYDROmorphone 0.5mg subcu
- Morphine 5mg subcu ≈ HYDROmorphone 1mg subcu

‡ When one opioid is rotated to another (e.g. oral morphine to oral HYDROmorphone) the new opioid equivalent dose is decreased by 20-30% to account for incomplete cross tolerance between drugs.

Practice Points

- Renal or hepatic dysfunction may impact opioid choice.
- Scheduled analgesia are used for persistent pain; prn(s) are used for sporadic or breakthrough pain.
- If more than 3 prn doses/24 hrs, consider scheduled dosing. If more than 3 breakthrough doses/ 24 hrs, discuss increase in scheduled dosage or shortened scheduling interval with physician/NP.
- **Breakthrough dose is safe to give regardless of when next scheduled dose due – <u>do not hold scheduled dose.</u>**
- Long acting opioids (controlled release) used ONLY after establishing total effective daily dose of short acting opioid.
- Reassess if pain or dyspnea not relieved with scheduled and prn medications (consider opioid toxicity, delirium, new pain).
- Most reported 'allergies' to opioids are not true allergies but adverse effects (e.g. itch, confusion, hives, nausea...).
- Oral route for opioid administration may need to be changed if swallowing becomes impaired.

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