How's your knowledge of opiate prescribing?

Do you agree that…

- **Mild pain** requires a **non-opiate** (acetaminophen, NSAID)
- **Moderate pain** requires a **weak opiate** (codeine, acetaminophen with codeine, acetaminophen with oxycodone)
- **Severe pain** requires a **strong opiate** (morphine, hydromorphone (Dilaudid ™), oxycodone alone, fentanyl)

Are you aware that…

- In general, patients should always be **started on short acting** opiates (**dosed routinely--not prn**) **q 4h around the clock**, and switched to the long-acting equivalent AFTER their pain is controlled?
- **Only one opiate** should be used at a time? There is no need for a patient to be on more than one.
- A breakthrough dose of the **same opiate** (but always in **SHORT ACTING FORM**) should be offered **q 1 hour prn**—the amount of each breakthrough would be 10% of the total daily dose.

****Practice Tip: Are you still ordering breakthrough opiates q 2-4h prn?**
Current thinking is q 1h**

- Patients with uncontrolled pain should **NEVER** be started on **Duragesic ™**—their pain should be controlled with another preparation and they should then be **switched** for convenience. Duragesic takes **too long** to work when pain is out of control.
- Duragesic should **NOT BE ADDED** to another opiate, even when (**ESPECIALLY when**) pain is out of control.
- Duragesic may cause **less sedation** and **less constipation** than other opiates.
- **Parenteral** morphine or hydromorphone are **no more effective** for pain control than **oral**? (you just need **twice as much** of these two drugs orally as parenterally for the same effect).

How's your knowledge of opiate prescribing?
Cont'd…

****Practice Tip: The reason for using parenteral opiates is that the oral route is not available (nausea, vomiting, obstruction)****

- There is **no limit** to the amount of morphine, hydromorphone or oxycodone that can be given—it is safe to increase by about **30% at a time, every few days** until pain is controlled---BUT THE WEAK OPIATES (see above) ARE LIMITED BY A CEILING EFFECT OR BY TOXICITY.

Are you aware that meperidine (Demerol ™) should never be used in palliative care? In fact it should probably never be given to anyone over 65, or with poor renal function, or for more than 2 or 3 days in succession.

Do you have the following table of equivalent doses committed to memory?

DRUG	ORAL/RECTAL DOSE	SC/IV DOSE
Morphine	10mg	5mg
Hydromorphone	2mg	1mg
Oxycodone	10mg	Rarely used
Codeine	100mg	Rarely used

And do you know that if you switch from one opiate to another you should take the equivalent dose and reduce it by 30-50%?

Do you remember to prescribe Senokot (not docusate) every time you write a prescription for an opiate?

**** Practice tip: You need stimulant laxatives, not softeners, to overcome the paralysis of the gut caused by opiates****

Want to learn more? Call us: Palliative Care Community Advice Line: (905) 548-5565 — available 24 hrs a day.

We're here to help you.