Factors to consider when using this chart

1. All these conversions are provided as an **approximate** guide to equivalencies.
2. Individual patient variability needs to be considered when switching from one opioid to another.
3. Always convert to the equivalent dose of **oral Morphine** when converting between opioids.
4. It is safer to convert to a **lower dose** and titrate up with PRN analgesia, to avoid opioid toxicity. Give PRN doses equivalent to one sixth of the total daily dose of opioid.
5. Consider co-morbidities such as **renal or hepatic impairment**. Morphine and Diamorphine can accumulate in the body in poor renal function. Consider using **Oxycodone** in mild to moderate impairment. Seek advice before prescribing any opioids in severe renal impairment where the Creatinine Clearance (calculated using Cockroft and Gault formula) is less than 30ml/min.
6. Patches can take **24 to 48 hours** to be fully effective. Apply the patch at the same time as the last dose of long acting opioid and give PRN doses if necessary. See Medicine of the Month "A Focus on Opioid Patches" Sept 2017.
7. Contact **Medicines Information** or the **Palliative care team** for further guidance.

References:

1. Palliative Care Formulary 5

2."The Leeds opioid conversion guide for adult palliative care patients" produced by Leeds teaching hospitals NHS trust, St Gemma's Hospice, Leeds, Wheatfields Hospice and Leeds community healthcare NHS Trust.

Author: Debra Yule, Advanced Clinical Pharmacist for Pain Management and Palliative care Review date: July 2020

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The Mid Yorkshire Hospitals NHS Trust