OPIOID MANAGEMENT
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PRESENTATION OBJECTIVES

• 1. Review how to select an appropriate opioid for patients based on medical and psychosocial information.
• 2. Review when and how to titrate opioids.
• 3. Review when and how to change (rotate) opioids.
Take a good pain history

<table>
<thead>
<tr>
<th>Location and radiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity (different pain scales available)</td>
</tr>
<tr>
<td>Timing, duration, and context</td>
</tr>
<tr>
<td>Quality</td>
</tr>
</tbody>
</table>

### Modifying factors
- Alleviating factors: how long does relief last? How much does pain go down?

### Associated signs and symptoms
- Numbness, tingling, electric shooting pains, burning
### Things I should know before I Rx

#### Type of pain
- Nociceptive
- Neuropathic
- Emotional/Spiritual

#### Patient-specific factors
- Medical comorbidities
- Psychosocial issues
- Available routes for administration

#### System issues
- Refills
- Further management (follow-up)
- Pharmacy (stock and availability)
Pain scale: Subjective or Objective?

Wong-Baker FACES® Pain Rating Scale

0  2  4  6  8  10
No Hurt  Hurts Little Bit  Hurts Little More  Hurts Even More  Hurts Whole Lot  Hurts Worst
Pain scale: Subjective or Objective?

IMPROVED PAIN SCALE

1. It might be an itch
2. I just need a bandaid
3. It's kind of annoying
4. This is concerning but I can still work
5. Bees?
6. Bees!
7. I can't stop crying
8. I can't move it hurts so bad
9. Mauled by a bear or ninjas
10. Unconscious
### Pain Scale

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Pain-free</td>
</tr>
<tr>
<td>2</td>
<td>Pain is hardly noticeable</td>
</tr>
<tr>
<td>3</td>
<td>Only notice pain if I focus on it</td>
</tr>
<tr>
<td>4</td>
<td>Pain is annoying but I can mostly ignore it</td>
</tr>
<tr>
<td>5</td>
<td>Moderate pain but no change in activity/concentration, may use guarded movements</td>
</tr>
<tr>
<td>6</td>
<td>Pain is troubling &amp; breaks through concentration</td>
</tr>
<tr>
<td>7</td>
<td>Pain is intense &amp; preoccupies my thinking but I can still complete tasks</td>
</tr>
<tr>
<td>8</td>
<td>Severe pain, makes concentration very difficult - crying, pacing, etc</td>
</tr>
<tr>
<td>9</td>
<td>Can't concentrate on anything else - sweating, spotty vision, difficulty thinking/talking</td>
</tr>
<tr>
<td>10</td>
<td>Excruciating, unable to move</td>
</tr>
</tbody>
</table>

- **Minimal/Mild**: regular functioning
- **Uncomfortable/Moderate**: may be more subdued/quiet than normal, may mention pain to others, consider using heat/ice or topical products
- **Distracting/Distressing**: noticeably tense/quiet, grumpy, potentially crying, consider medication in addition to other measures
- **Severe/Immobilizing**: trembling/shaking, groaning, asking for help from others
Set a FUNCTIONAL goal

**Example**

- “At what level of pain control do you think you could enjoy life and focus on things other than the pain?”
- What things are you not able to do because of pain?

**Usually 1-3/10**

- Some patients may quote higher numbers

**0/10 all the time is not a realistic goal**

- Medication side effects would be too burdensome

**For some patients, titration toward functional status rather than pain scale is best**

- “Chemical copers”
What kind of pain is it?

- Nociceptive
  - Somatic
  - Visceral
- Emotional/Spiritual
- Neuropathic
Neuropathic pain

- Oral medications
  - Antiepileptics
    - Gabapentin (NNT 4.1)
    - Pregabalin
  - Tricyclic antidepressants
    - Amitriptyline (NNT 2.3)
    - Nortriptyline
  - Opioids (especially methadone) (NNT 2.7)
  - SNRIs
    - Duloxetine (NNT 5.0)
    - Venlafaxine
- Topical medications
  - Capsaicin cream (NNT 6.6)
  - Lidocaine patch (NNT 4.4)
Emotional and Spiritual Pain

Appropriate interventions

• Counseling
• Social work consultation for financial/care support
• Chaplaincy consultation for spiritual support
• Antidepressants, if meeting criteria for diagnosis

Inappropriate interventions

• Opioids
• Procedures (e.g. nerve blocks, intrathecal pumps) and surgeries
The Opioid Epidemic

IN 2016...

116 People died every day from opioid-related drug overdoses

11.5 m People misused prescription opioids

42,249 People died from overdosing on opioids

2.1 million People had an opioid use disorder

948,000 People used heroin

170,000 People used heroin for the first time

2.1 million People misused prescription opioids for the first time

17,087 Deaths attributed to overdosing on commonly prescribed opioids

19,413 Deaths attributed to overdosing on synthetic opioids other than methadone

15,469 Deaths attributed to overdosing on heroin

504 billion In economic costs

Sources: ¹ 2016 National Survey on Drug Use and Health, ² Mortality in the United States, 2016 NCHS Data Brief No. 293, December 2017, ³ CEA Report. The underestimated cost of the opioid crisis, 2017
The Opioid Epidemic and You

The Opioid Epidemic in America
The Research Behind Understanding, Preventing and Treating Addiction

Data from the U.S. National Institute on Drug Abuse indicates:

- Roughly 21-29% of patients prescribed opioids for chronic pain misuse them.
- Between 8-12% develop an opioid use disorder.
- An estimated 4-6% who misuse prescription opioids transition to heroin.
- Approximately 80% of people who use heroin first misused prescription opioids.

Abuse deterrents

• Physical/chemical deterrents: gelling agents or solvents to limit crushing, grinding, cutting, chewing, etc.
• Antagonists: interfere with euphoria
• Aversion: substances added to produce an unpleasant effect upon manipulation (e.g. nasal irritants to prevent snorting)
• Delivery system deterrents: e.g. sustained release depots

Winiecki, SK. Understanding abuse deterrent opioids.
fellowshipinternshipgraduatefacultyprograms/pharmacistudentexperientialprogramcder/ucm532123.pdf
Abuse deterrents

- Can still be crushed, snorted, injected, smoked, or dissolved for abuse
- The most common form of opioid abuse is by swallowing
- All are currently brand-name only (no generics)
WHO analgesic ladder for cancer pain

Step 1:
- Mild pain
- Nonopioid +/- adjuvant

Step 2:
- Moderate pain, or failed step 1 therapy
- “weak” opioid +/- nonopioid +/- adjuvant

Step 3:
- Severe pain, or failed step 2 therapy
- “strong” opioid +/- nonopioid +/- adjuvant

Step 4:
- Interventional pain procedures (nerve blocks, intrathecal pump, etc.)
Non-opioids and “Weak” Opioids

**Over the counter (non-opioids)**
- acetaminophen
- NSAIDs

**Adjuvants**

**Prescription (“weak opioids”)**
- Codeine/APAP: schedule III
- Tramadol: schedule IV
**Codeine**

- Used for pain, cough, and diarrhea
- Oral bioavailability variable (12-84%)
- Codeine binds weakly to mu receptors; efficacy depends on conversion to morphine by P450 CYP2D6
Tramadol

Inhibits noradrenaline and serotonin reuptake (risk: serotonin syndrome)

Increases seizure risk

Max: 50mg Q12h

Max: 200 mg/day
“Strong” Opioids

Triplicate prescription (schedule II):

- Morphine
- hydrocodone
- oxycodone
- oxymorphone
- hydromorphone
- methadone
- fentanyl
Morphine

MEDD (morphine equivalent daily dose) = opioids converted to the equivalent dose of PO morphine

IV morphine x 2.5 to 3 = PO morphine
Morphine

Extensively metabolized in liver to renally cleared active metabolites

M₃G: opioid-induced neurotoxicity
- Myoclonus → seizures (treatment: benzodiazepines)
- Hyperalgesia/allodynia
- Delirium

M₆G: analgesia and respiratory depression
- Effects reversed by naloxone
Hydrocodone

Daily doses limited by acetaminophen content (<3g/day) or NSAID content (risk of adverse effects such as gastritis)

• <2g/day in cirrhosis

Equianalgesic ratio (morphine:hydrocodone):

• 1.5:1 at low doses of hydrocodone (<40mg/day)
• 1:1 at high doses (>40mg/day)
Oxycodone

Popular drug of abuse

no IV form available

PO Oxycodone x 1.5 = PO morphine
Hydromorphone

metabolized to H3G in liver, which is also excreted by kidneys

• Generally still better to use in renal insufficiency than morphine

Equianalgesic ratios:

• 4-8 times stronger than morphine
• IV Hydromorphone x 2 to 5 = PO hydromorphone
• IV Hydromorphone x 10 = PO morphine
• IV hydromorphone x 5 = IV morphine
Oxymorphone

Much longer half-life (8h) compared to morphine (1.5h)
- Oxymorphone IR should be dosed Q6h
- Oxymorphone ER should be dosed Q12h

Has metabolites that accumulate in renal insufficiency

Taking with food can increase serum levels by up to 50%; must take 1-2 hours before eating

Equianalgesic ratios:
- PO oxymorphone x 3 = PO morphine
- IV oxymorphone x 10 = IV morphine (lipophilic)
Methadone

Good opioid for neuropathic pain

Takes 48-72 hours to reach maximum analgesia

All forms (pills, liquid, IV solutions) are long-acting!

QTc prolongation generally insignificant until doses >200 mg/day
Methadone

Equianalgesic ratios:

• Methadone becomes more potent at higher doses!
• Get a pain specialist (acute or chronic pain, palliative) to manage

<table>
<thead>
<tr>
<th>Total 24-hour Morphine Dose</th>
<th>Conversion ratio (oral morphine : oral methadone)</th>
<th>Percent Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30 mg/d</td>
<td>2:1 (2mg morphine to 1mg methadone)</td>
<td>50% reduction</td>
</tr>
<tr>
<td>30-100 mg/d</td>
<td>4:1</td>
<td>75% reduction</td>
</tr>
<tr>
<td>100-300 mg/d</td>
<td>8:1</td>
<td>87.5% reduction</td>
</tr>
<tr>
<td>300-500 mg/d</td>
<td>12:1</td>
<td>92% reduction</td>
</tr>
<tr>
<td>&gt;500 mg/d</td>
<td>20:1</td>
<td>95% reduction</td>
</tr>
</tbody>
</table>
Fentanyl IV

Safest option to try in true morphine or codeine allergy

IV fentanyl has duration of action of 0.5 to 1 hour (rapidly redistributed)

morphine IV (mg) x 10 = fentanyl IV (mcg)
Fentanyl transdermal patch

Equianalgesic ratio: fentanyl patch (mcg/h) x 2 = MEDD (mg)

Absorption increases with body temperature!

Can only be titrated Q48-72h due to dosing → not ideal for patients with acute or unstable pain

8-12 hours to provide effective analgesia

12-24 hours for 50% reduction

Absorption increases with body temperature!
Fentanyl transmucosal

Onset to analgesia 5-10 minutes

Somnolence, nausea, dizziness, falls

Doses START at 100 mcg!!!

Effective doses unpredictable, not based on MEDD

www.TIRFREMSaccess.com

Transmucosal Immediate-release Fentanyl Risk Evaluation and Mitigation Strategy (TIRF REMS)

CONTRAINDICATED for opioid-naïve patients

Opioid-tolerant cancer patients ONLY

NOT for acute or post-op pain

Patient-prescriber agreement form required, renewed Q2 years

ALL patients should be initiated at the lowest dose

Different TIRF brands CANNOT be converted mcg for mcg
Opioid potency comparison chart

Potency compared to oral morphine

- Morphine: 1 oral, 2.5 IV
- Oxycodone: 1.5 oral, 1.5 IV
- Hydrocodone < 40 mg: 1 oral, 1.5 IV
- Hydrocodone > 40 mg: 1 oral, 1 IV
- Oxymorphone: 3 oral, 5 IV
- Hydromorphone: 25 oral, 25 IV
- Methadone (MEDD < 30): 10 oral, 10 IV
- Methadone (MEDD > 500): 20 oral, 20 IV
Tailoring therapy:

OPIOID SELECTION
QUESTION

• A 48-year-old man with advanced head and neck cancer comes to palliative care clinic for the evaluation and treatment of chronic pain. He has facial nerve neuropathy as well as chronic right jaw pain. He also has chronic renal insufficiency from diabetes, with a baseline serum creatinine of 2.5 mg/dL. Trials of nonopioid pain medication and adjuvants for neuropathic pain have been unsuccessful, and today he tells you that he has resumed using heroin in an effort to control his pain.

• Which of the following opioid analgesics is safest and most likely to be effective for this patient?
  a. Hydromorphone
  b. Oxycodone
  c. Extended-release morphine
  d. Acetaminophen with codeine
  e. Methadone
Things I should know before I Rx

Type of pain
- Nociceptive
- Neuropathic
- Emotional/Spiritual

Patient-specific factors
- Medical comorbidities
- Psychosocial issues
- Available routes for administration

System issues
- Refills
- Further management (follow-up)
- Pharmacy (stock and availability)
Factors affecting pharmacokinetics

- CNS sensitivity to opioids
- Hepatic clearance of opioids by ~50% by age 70
- Unpredictable effects
- Reduce opioid doses if concerned
Factors affecting pharmacokinetics

- **Preferred**: fentanyl, methadone
- **Caution**: hydromorphone, oxycodone, oxymorphone, hydrocodone
- **Avoid**: morphine, codeine
Opioid selection: patient factors

History of “chemical coping” or drug abuse

• Limit-setting

Available routes of administration

• PO
  • Preferred whenever patient is able to swallow
• IV
  • Available in hospitals and LTACs only
  • Oxycodone does not have IV form
• IM
  • Available in most settings except home
  • Not preferred due to pain of administration
• PR
  • Most opioids can be used PR effectively
Patients with NGT/PEG tube

Most long-acting oral opioids CANNOT be crushed!
- Only long-acting due to formulation

Long-acting opioid options for NGT/PEG patients:
- Methadone: elixir or crush tablets
- Morphine extended-release pellets with capsule: unscrew capsule and put pellets in liquid or soft solids
- Fentanyl transdermal patch

Short-acting opioids: can use elixir or crush
Morphine extended-release pellets
Subcutaneous route

Available in some hospitals, most hospice settings (including home)

- Family members can be trained to give SQ meds through a SQ catheter

Not available in most nursing homes (require RN to give)

SQ depot prolongs duration of action

- Intermittent administration of opioids SQ Q4h approximates the effect of IV PCA
- Exception: fentanyl SQ is still short-acting, and must be given as a fentanyl IV PCA
- Exception: methadone SQ still has duration of 8-12h (also, beware possible skin toxicity)

Many comfort medications and hydration can be given subcutaneously at home with hospice services
Opioid selection: system issues

Refills
• No refills can be given on triplicate prescriptions
• Refills cannot be faxed or called in to pharmacy

Follow-ups
• Travel to appointments may be burdensome
• Monthly follow-ups needed to refill strong opioids

Pharmacy stocks
• Limited dosages or formulations available
• Limited amounts available
A 48-year-old man with advanced head and neck cancer comes to palliative care clinic for the evaluation and treatment of chronic pain. He has facial nerve neuropathy as well as chronic right jaw pain. He also has chronic renal insufficiency from diabetes, with a baseline serum creatinine of 2.5 mg/dL. Trials of nonopioid pain medication and adjuvants for neuropathic pain have been unsuccessful, and today he tells you that he has resumed using heroin in an effort to control his pain.

- a. Hydromorphone
- b. Oxycodone
- c. Extended-release morphine
- d. Acetaminophen with codeine
- e. Methadone
Prescribing:
OPIOID INITIATION
QUESTION

• A 56-year-old woman with widely metastatic lung cancer presents to the emergency department (ED) in severe respiratory distress. She was initially wheezing and had O2 saturation of 85% on arrival. Her current medications include sustained-release morphine, 100 mg every 12 hours, and immediate-release morphine, 20 mg every hour as needed for pain control. She has required 5 doses of her rescue morphine in the past 24 hours for pain control. The ED physician provided the patient with nebulized beta-agonists, IV steroids, and oxygen at 100% FiO2. Her oxygen saturations have improved to 92%, but the patient is still tachypneic and in distress. The patient and her husband are clear that intubation is not an option. The ED physician calls an urgent palliative care consultation.

• What initial dose and route of morphine would you recommend?
  a. 2 mg oral solution
  b. 10 mg oral solution
  c. 2 mg nebulized
  d. 10 mg nebulized
  e. 2 mg IV push
  f. 10 mg IV push
IV PRN medications

- In general: morphine IV equivalent of 1 or 2mg is a good starting dose for MOST people
  - Geriatric starting dose is 0.5mg IV
  - Reduce doses by 50% in high risk patients
Scheduling IV medications

- IV medications:
  - typically schedule Q6h or Q4h
  - Use a smaller dose than your PRN (your PRN should be 10-15% of the total scheduled medication they receive throughout the day at most)
  - Add up how much PRN they received and make sure you schedule less than that
  - Example: morphine sulfate 2mg IV Q4h PRN, received 8 doses in last 24 hours
    - 2mg x 8 doses = 16mg
    - $16/6 = 2.67$ mg Q4h (max you would want to schedule)
    - Schedule 2mg IV Q4h
Scheduling oral medications

• Immediate release (IR) medications:
  • typically schedule Q6h or Q8h (Q4h in PEG/NGT only)
  • Use a smaller dose than your PRN (your PRN should be 10-15% of the total scheduled medication they receive throughout the day at most)
  • Add up how much PRN they received and make sure you schedule less than that
  • Example: morphine sulfate 2mg IV Q4h PRN, received 8 doses in last 24 hours
    • 2mg x 8 doses = 16mg
    • 16/4 = 4 mg Q4h (max IV you would want to schedule)
    • 4mg IV x 3mg PO/1 mg IV = 12
    • Schedule 10mg PO Q6h (this would be liquid) OR 15mg PO Q6h (pills)
Opioid initiation

A good starting dose for an opioid naïve patient is an MEDD of 30 (long-acting)

- Morphine sulfate ER 15mg PO Q12h (MEDD 30)
- Oxycodone ER 10mg PO Q12h (MEDD 30)
- Fentanyl patch 12mcg (MEDD 25)
- Morphine sulfate 0.5 mg/h drip (MEDD 30)
- Hydromorphone 0.1 mg/h drip (MEDD 24)

Breakthrough pain medication (short-acting)

- 10-15% of total long-acting daily dose every ___ hours PRN
- Dosing interval based on expected duration of action
# Onset and duration of action

<table>
<thead>
<tr>
<th>Route</th>
<th>Onset</th>
<th>Duration</th>
<th>Dosing interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV*</td>
<td>15 minutes</td>
<td>1-2 hours</td>
<td>Q1-2h</td>
</tr>
<tr>
<td>SQ*</td>
<td>15-30 minutes</td>
<td>2-4 hours</td>
<td>Q2-4h</td>
</tr>
<tr>
<td>PO*</td>
<td>30-45 minutes</td>
<td>2-4 hours</td>
<td>Q2-4h (short-acting) Q8-12h (ER/CR/SR)</td>
</tr>
<tr>
<td>Methadone</td>
<td>30-45 mins (IV/PO)</td>
<td>72 hours</td>
<td>Q8-12h</td>
</tr>
<tr>
<td>Fentanyl patch</td>
<td>6-12 hours</td>
<td>72 hours</td>
<td>Q48-72h</td>
</tr>
<tr>
<td>Fentanyl lozenge</td>
<td>5-10 minutes</td>
<td>30 minutes</td>
<td>Depends on brand</td>
</tr>
</tbody>
</table>

*Except methadone (longer half-life) and fentanyl (shorter half-life)*
Breakthrough dose example:

- **Long-acting:** morphine sulfate ER 60mg PO Q12h

  - \(\text{MEDD} = 60 \times 2 = 120\)

  - 10% \(\text{MEDD} = 12\)

  - **Rx:** morphine sulfate IR 15mg PO Q2-4h PRN
QUESTION

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  d. 10 mg nebulized
  e. 2 mg IV push
  f. 10 mg IV push

MEDD: 100 x 2
= 200 [morphine PO]

Breakthrough dose = 10-15% MEDD:
= 20-25 [morphine PO]

Morphine IV = morphine PO ÷ 2.5 or 3
Refining therapy:

OPIOID TITRATION
Pain management strategy
Role of long-acting opioid
Breakthrough: IV
Breakthrough: PO
Long-acting dose too low...
Multiple breakthroughs needed
Solution: titrate long-acting dose!
Opioid titration

Rule of thumb:

Adjust breakthrough dose after titrating!

4 or more breakthroughs per day

30% of MEDD
Opioid titration

How often can I titrate?

- Depends on half-life of the opioid
- Reach close to maximal analgesic effect before titrating
  - Short-acting oral opioids: can titrate daily
  - Most oral long-acting opioids: can titrate daily with caution, otherwise around 48 hours
  - Fentanyl and methadone: typically titrate after 72 hours
  - IV PCAs/drips: reach steady state after 8 hours and can be titrated Q8h
Opioid withdrawal

Dose needed to prevent opioid withdrawal is 25% of MEDD

- Some sources quote 75% of MEDD

Withdrawal symptoms:

- Anxiety, nervousness, irritability, insomnia
- Chills and hot flushes, gooseflesh
- “Wetness”: salivation, lacrimation, rhinorrhea, sweating, sneezing
- Nausea/vomiting, cramping, diarrhea
- Multifocal myoclonus (rare)

Onset of withdrawal:

- Range: 6-12h with short-acting opioids to 36-48h with methadone

Duration of withdrawal:

- Few days with short-acting opioids but can last weeks with methadone
Opioid titration: scenario

Patient continues to report 10/10 pain, taking maximum breakthroughs

- Chemical coping
- Addiction
- Drug diversion
- Undertreated pain
Opioid titration: scenario

Patient continues to report 10/10 pain, taking maximum breakthroughs

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Opioid titration: scenario

Patient continues to report 10/10 pain, taking maximum breakthroughs

- Chemical coping
- Addiction
- Drug diversion
- Undertreated pain
Drug diversion

Prescription opioids can be more potent than illegal opioids (heroin)

Prescription opioids have government oversight and are manufactured with quality control by pharmaceutical companies → perceived as safer than illegal opioids

DEA: 6 million Americans abuse prescription drugs; 70% of them obtain the drug from friends and family (2011 Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health (NSDUH))

Disposal: many narcotics can be flushed down the toilet

- list at DEA website
Drug diversion: “street pharmacists”

Caveat: this information is gleaned from Google.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Price per mg ($)</th>
<th>Potential value for 30 tabs ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>morphine</td>
<td>0.1 - 0.5</td>
<td>45 – 225 (15 mg tabs)</td>
</tr>
<tr>
<td>oxycodone</td>
<td>0.5 - 1</td>
<td>75 – 150 (5 mg tabs)</td>
</tr>
<tr>
<td>hydrocodone</td>
<td>0.3 - 1</td>
<td>45 – 150 (5/325 mg tabs)</td>
</tr>
<tr>
<td>hydromorphone</td>
<td>1 - 5</td>
<td>60 – 300 (2 mg tabs)</td>
</tr>
<tr>
<td>Fentanyl patch</td>
<td>30 – 50 (per patch)</td>
<td>300 – 500 (for 10 patches)</td>
</tr>
</tbody>
</table>
A 45-year-old man with newly diagnosed prostate cancer develops left leg pain and is found to have a proximal femur bone metastasis. Prior to this he has never had significant problems with pain other than tension headaches, which he manages with intermittent use of ibuprofen. He has never used opioids. His oncologist tells him to take ibuprofen around-the-clock, and although his pain is improved, it remains quite bothersome. He then starts oxycodone 5 mg PO every 4 hours as needed for pain. His pain is well controlled with this regimen, but he becomes nauseous 30 to 60 minutes after each oxycodone dose. The patient is referred to the palliative care clinic, but the nausea persists after 2 weeks despite around-the-clock metoclopramide and trials of haloperidol and ondansetron. The patient has regular bowel movements.

Which of the following should be considered next in the management of this patient?

a. Add around-the-clock prochlorperazine.
b. Discontinue oxycodone and manage pain with ibuprofen alone.
c. Arrange for a trial of intrathecal opioids due to dose-limiting nausea.
d. Switch the patient to an equianalgesic dose of morphine.
e. Initiate a trial of subcutaneous octreotide for refractory nausea.
Changing therapy:

OPIOID ROTATION
Opioid adverse effects

- **Central Nervous System**
  - Hyperalgesia
  - Allodynia
  - Myoclonus
  - Seizures
  - Delirium
  - Sedation/drowsiness
  - Respiratory depression

- **Gastrointestinal**
  - Nausea and vomiting
  - Constipation

- **Cutaneous**
  - Itching
  - Sweating

- **Autonomic**
  - Xerostomia
  - Urinary retention
  - Postural hypotension
Opioid adverse effects

Central:
- Hallucination
- Confusion
- Fainting
- Dizziness
- Loss of appetite
- Lightheadedness
- Drowsiness
- Headache
- Mood changes

Eyes:
- Swelling
- Smaller pupil
- Redness

Face:
- Swelling

Mouth, tongue or lips:
- Swelling
- Dryness

Skin:
- Hives
- Rash
- Flushing
- Sweating
- Itching

Respiratory:
- Difficulty breathing
- Slowed breathing

Intestinal:
- Constipation

Hands, feet, ankles, or lower legs:
- Swelling

Throat:
- Hoarseness
- Swelling
- Difficulty swallowing

Heart:
- Fast or slow heartbeat

Muscular:
- Seizures
- Weakness

Gastric:
- Nausea
- Vomiting

Red color - more serious effect
Use of naloxone: respiratory depression

Reverses respiratory depression, sedation, and ANALGESIA

Respiratory Rate < 8
OR
Respiratory insufficiency
Opioid rotation

When to rotate

- Opioid toxicity
  - Hyperalgesia/allodynia
  - Delirium due to opioids
  - Severe myoclonus/seizures due to opioids
- MEDD escalation above 300-500 (risk of hyperalgesia causing the escalation)
- High dosages burdensome (e.g. too many pills per breakthrough dose)

Incomplete cross-tolerance

- Opioids bind to different mu subtypes; tolerance to one opioid only confers partial tolerance to another opioid
- **Must reduce MEDD by 30-50%** when rotating opioids to prevent toxicity
  - Generally, reduce by 50%
  - Use 30% if pain uncontrolled at time of rotation
QUESTION

• An 82-year-old woman with moderate cognitive impairment was admitted 5 days ago for end-stage heart failure. The palliative medicine consult team met with the family and determined that the family wants to focus on making the patient comfortable. Accordingly, all her cardiac medications were stopped, including the diuretics, because she was no longer responding to the diuretic medications. The patient had been on long-acting morphine sulfate, 15 mg every 12 hours, as an outpatient. Because she is unable to swallow, she was started on a morphine drip at 1 mg/hour.

• Two days later, the primary team calls you (palliative care physician) for help with agitation. They report that she was initially very comfortable and pain free but then slowly became progressively agitated.
QUESTION, cont...

• At the bedside you notice that the patient is now confused, agitated, thrashing in her bed, and moaning, without a furrowed brow. Her respiratory rate varies from 10 to 14, her heart rate is 90, and her blood pressure is 98/70. She is receiving 2 L of oxygen per minute via nasal cannula. There is frequent twitching of her eyebrows and arms. Extremities reveal slowed capillary refill but no cyanosis or mottling. The morphine infusion is now at 4 mg/hour. The nurses confirm that she has had 20 cc of urine output in the last 24 hours. The patient’s daughter is in the room and, clearly distressed, shares with you that this is not what her mother was ever like before. She asks you whether you can increase the morphine to better manage her mother’s suffering.
BOARD QUESTION, cont...
What is the most appropriate next step in management?

a. Stop the morphine and administer midazolam.
b. Increase the morphine infusion to 6 mg/hour.
c. Stop the morphine infusion and start ketorolac administration.
d. Maintain the morphine drip and start a midazolam infusion after obtaining consent for palliative sedation.
e. Change the morphine infusion to a fentanyl infusion and add lorazepam.
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BOARD QUESTION CALCULATION

• On morphine drip 4mg/h

MEDD: 4mg/h IV x 24 hours in a day
   = 96 mg IV over one day

Conversion: morphine IV (mg) x 10 = fentanyl IV (mcg)

96 mg IV morphine x 10
   = 960 mcg IV fentanyl over one day

Dose reduce!!! 50%

960 mcg IV fentanyl ÷ 2
   = 480 mcg IV fentanyl per day

Breakthrough:
10-15% of “long-acting” dose

480 mcg IV fentanyl ÷ 24 hours
   = 20 mcg IV fentanyl/h

480 x 0.1 = 48 mcg IV fentanyl Q1h PRN
Prescribing opioids?

Rx: LAXATIVES
References

• How to dispose of unused medicines. FDA Consumer Health Information. Available: www.fda.gov/ForConsumers/ConsumerUpdates.
References