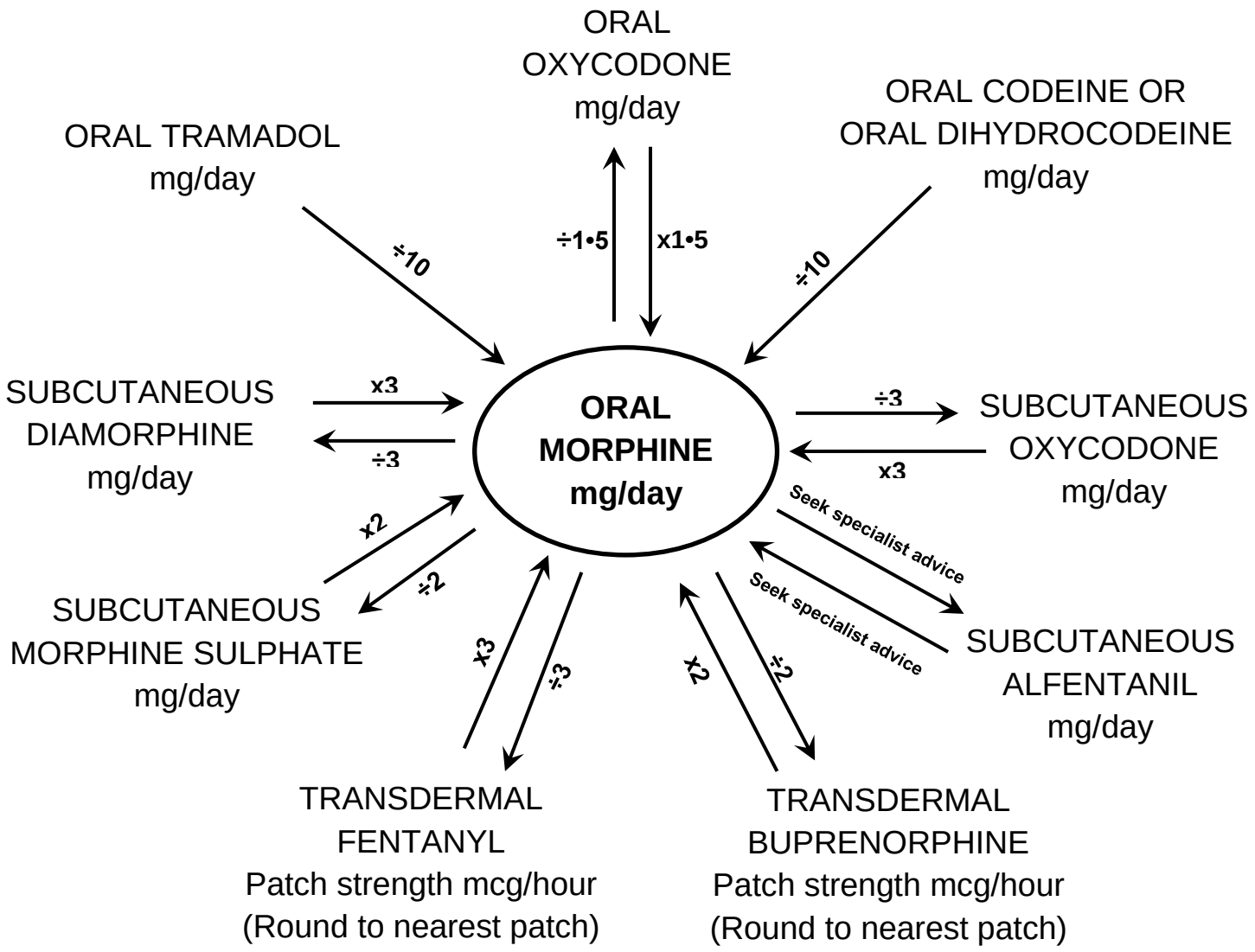
The Leeds Opioid Conversion Guide For Adult Palliative Care Patients



Always go through the centre of the chart (via oral morphine) when converting between opioids.

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NOTES : This chart is intended for guidance, prescribers are responsible for their own decisions.

All calculations and rationale must be documented in the patient's record, including those for prn doses.

Clinical judgement should be applied, considering: underlying clinical situation; comorbidity (e.g. renal or liver impairment); drug interactions, nature of pain and its opioid responsiveness; other pain interventions; symptoms being managed by opioid; toxicity of current opioid; previous opioid doses and adherence; rapidity of opioid escalation; use of larger doses; switches involving change of route; malabsorption issues; reason for switching. These factors **may** necessitate an empirical reduction in the dose of the replacement opioid and re-titration.

For further advice contact your local Specialist Palliative Care Service.

Conversions are based on Company Data, PCF6 and EAPC 2011 guidelines.

Adapted for Leeds citywide use April 2016 (Leeds Palliative Care MCN)

Reviewed February 2019 by LPCN