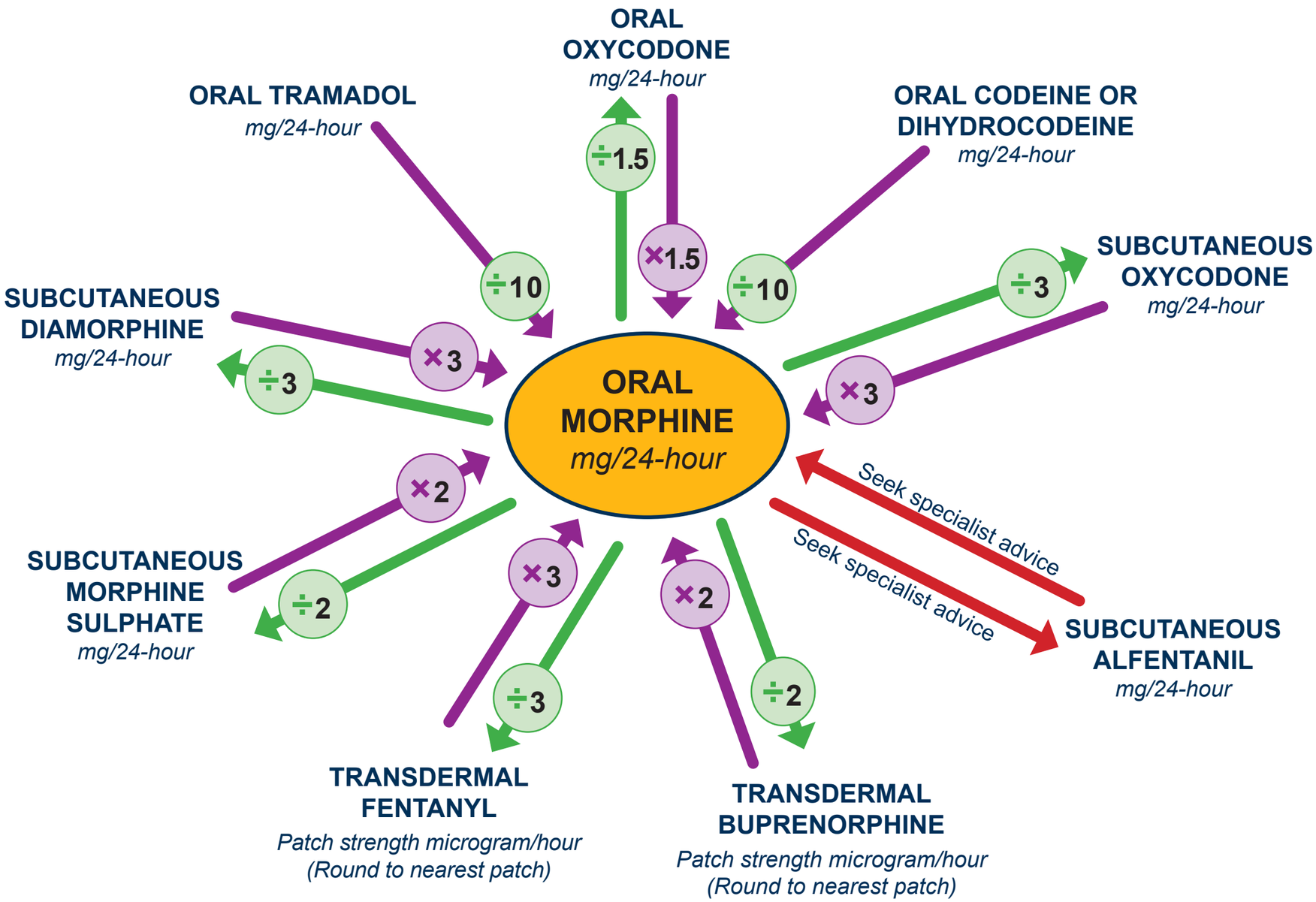
The Leeds Opioid Conversion Guide For Adult Palliative Care Patients

Note - Always go through the centre of the chart via oral morphine when converting between opioids.



Leeds Palliative Care Network

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NOTES:

- This chart is intended for guidance; prescribers are responsible for their own clinical decisions.
- All calculations and rationale must be documented in the patient's record.
- Apply clinical judgement, considering underlying clinical condition; comorbidities (e.g., renal or liver impairment); drug interactions, pain type and opioid responsiveness; other pain interventions; indication for opioid use; signs of opioid toxicity; previous opioid doses and adherence; rate of dose escalation; use of high doses; route changes or switching of opioids; and malabsorption.
- These factors may necessitate an empirical dose reduction when switching opioids, followed by re-titration.

Calculating breakthrough (rescue) opioid doses (PRN):

- Use an immediate-release (IR) opioid by the same route as the background opioid (e.g., PO with PO, SC with SC).
- **Calculate from the total 24-hour background dose:**
  - **Typical PRN dose = 1/6 to 1/10 of the 24-hour dose, titrated to effect.**

Prescribing notes:

- Specify the maximum frequency and a maximum number of doses in 24 hours.
- Use separate PRN prescriptions for each route (PO vs SC).
- Review PRN use regularly; if frequent, consider increasing background opioid dose.
- Adjust PRN dose if background dose is changed.

Example 1 (PO morphine):

- Total background = 120 mg/24-hour PO
- PRN 1/10 = 12 mg PO IR (round to practical dose, e.g., 10–15 mg)
- PRN 1/6 = 20 mg PO IR

Example 2 (SC morphine):

- Total background = 30 mg/24-hour SC
- PRN 1/10 = 3 mg SC
- PRN 1/6 = 5 mg SC

For further advice, contact your local Specialist Palliative Care Service. Conversions are based on the Palliative Care Formulary (current online edition), EAPC guidance (2012), and supporting international guidance.

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