The Use of Oral Morphine Sulphate in Palliative Care

Indications for use	• First-line analgesic for moderate to severe opioid responsive pain • Breathlessness
Preparations	<u>Immediate release</u> • Oramorph® 10mg/5mL oral solution (100mL) • Oramorph® *Conc* 20mg/1mL oral solution (120mL) - *Caution 10 x potency* • Sevredol® 10mg, 20mg and 50mg tablets (56 tablets) <u>Modified release</u> • MST® 5mg, 10mg, 15mg, 30mg, 60mg and 100mg tablets (60 tablets) • MST Continus Suspension® 20g, 30mg and 60mg granules sachets (30 sachets)
Dose Titration	This should be used as a guide only and a clinical decision should be made based on individual patient requirements. The initial morphine dose is based on the previous medication used (if any), the severity of symptoms, and other patient factors such as presence of renal impairment, increasing age, or frailty. <u>Opioid naiive</u> • Start with 2.5-5mg orally every four hours as needed for pain or breathlessness [up to hourly may be needed if symptoms are severe or in the last days of life]. • Lower doses, e.g. 1.25 - 2.5mg may be required in the opioid-sensitive, elderly or frail patients and in those with renal impairment. • Monitor the patient carefully so that the dose can be adjusted if necessary. • Monitor for signs of opioid toxicity. • If 3 or more doses have been given within 4 hours with little or no benefit, review dose, increasing if appropriate and/or seek advice • If more than 6 doses are required in 24 hours, review dose and/or seek advice <u>Already on Opioids</u> If the patient is on a regular opioid, the breakthrough (PRN) dose is 1/6th of the 24-hour dose of the regular opioid. e.g. MST® 30mg BD = 60mg of morphine sulphate in 24 hours. PRN dose is 10mg Oramorph®/Sevredol® orally. Consider conversion to a modified release preparation where regular doses are required, i.e. divide the total amount of immediate release morphine required in the previous 24 hours by 2 and prescribe as modified release 12 hourly morphine e.g MST® , in addition to breakthrough dose as needed.
Renal & Hepatic Impairment	Because of the risk of impaired metabolism or elimination: • Lower than usual starting doses are advised in mild–moderate renal impairment and severe hepatic impairment • The use of a 'renally safer' opioid is generally advisable with severe renal impairment or end stage renal failure. If unavoidable, start with low doses and once the pain is controlled (seek advice or review)
Common Adverse Effects	Nausea and/or vomiting, Constipation, Skin reaction, Sedation See Summary of Product Characteristics on www.hpra.ie for further information.
Practice Points	• Doses of liquid preparations should always be clearly expressed as milligrams (mg) on prescriptions • Regular laxatives should be prescribed for patients on opioids • Anti-emetics should be prescribed initially as required • Modified release preparations should be swallowed whole. Do not crush or chew as this will lead to a rapid release of morphine. • Signs of opioid toxicity include hallucinations, myoclonic jerks, confusion, drowsiness • Switching from the oral route to the subcutaneous (SC) route would require the dose to be reduced by half for similar effect as the SC route is twice as potent as the oral route for morphine.