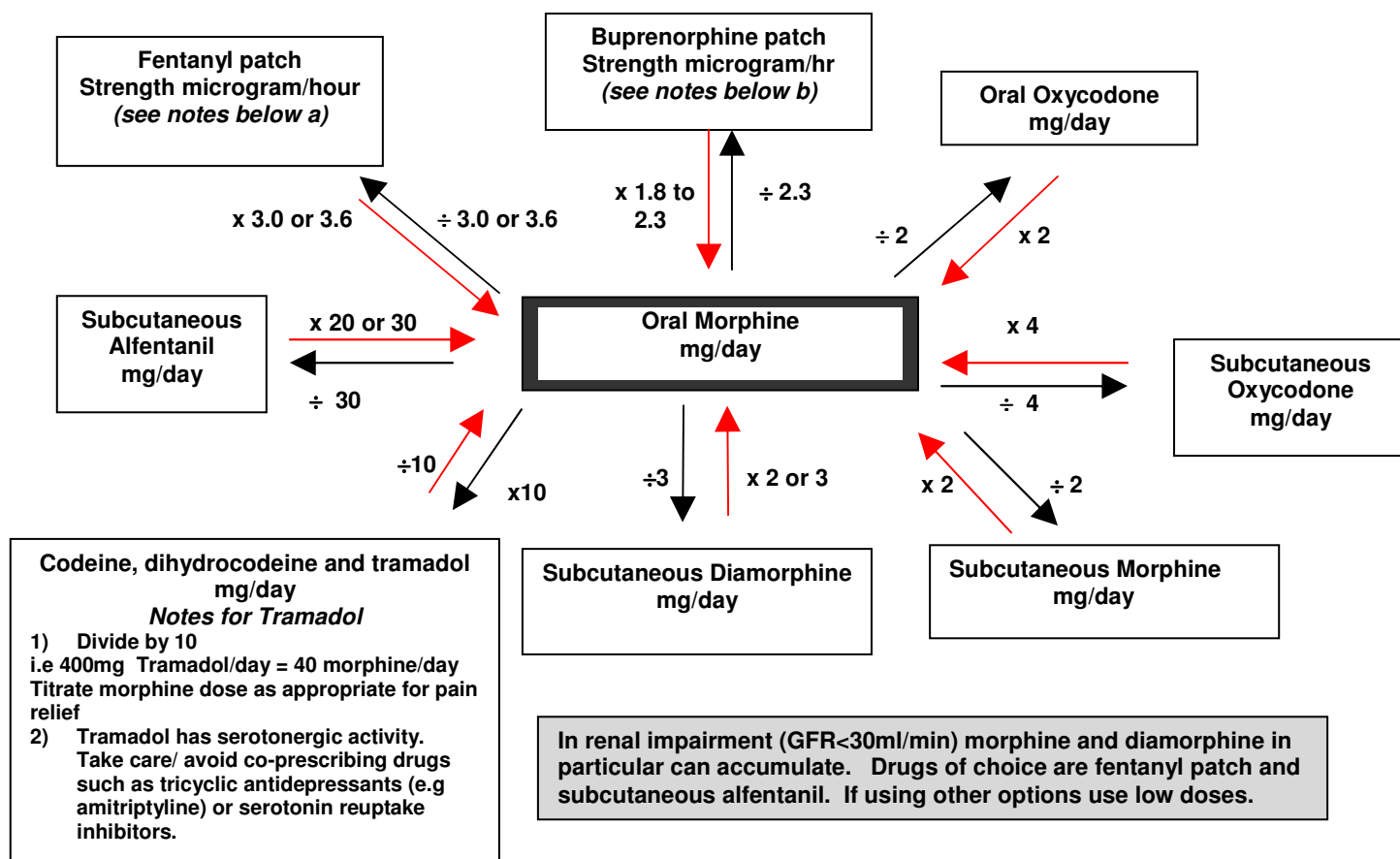


## Palliative care analgesic dose conversion chart

To make any conversion from one opiate to another always convert the dose back to an equivalent oral dose of morphine first

These conversions are a guide only. At high doses, conversion from one opiate to another must always be reviewed cautiously to avoid sudden opiate toxicity. Take particular care if converting high doses of oral opiates to subcutaneous (s.c.) infusions. It may be better to give the smaller calculated s.c. dose and titrate up using adequate break through analgesic cover. Calculations must be documented in the medical records.



### a) Fentanyl patches:

To convert from morphine (mg) to fentanyl (microgram/hour) **Divide by**

- 3.0 if the morphine dose is **less than 250mg** and
- 3.6 if the morphine dose is **250mg or more**

To convert from fentanyl (microgram/hour) to morphine (mg) **Multiply by**

- 3.0 if the fentanyl patch strength is less than 75 microgram/hour and
- 3.6 for patches 75 microgram/hour or more

### b) Buprenorphine patches:

**Patients on weak opiates e.g co-codamol, codeine, dihydrocodeine:**

Switch to **BuTrans** patch 5 micrograms/hour **every 7 days** and consider 10 micrograms/hour **every 7 days** if on regular high dose weak opiate (240mg codeine) & titrate upwards not more often than every 3 days.

In patients reaching the maximum strength of 20 microgram/hr the next titration, if continuing on buprenorphine, should be to **Transtec** patch 35 microgram/hr patch **every 4 days**.

**Patients on stronger opiates:** Use the conversion above to calculate the approximate equivalent strength of buprenorphine patch, **but note** patients on a dose equivalent to

- **less than 120mg morphine** should usually be started on **Transtec 35 microgram/hr every 4 days**.
- **120mg morphine** usually may start on **Transtec 52.5 microgram/hr patch every 4 days**.