Palliative Care Education Snap Sessions

Darling Downs – South Burnett
Cairns & Hinterland – Atherton Tableland
South West HHS

First session: Tuesday 28th June 2016
Last session: Tuesday 30th August 2016
14.30 – 14.50 hours each week
Housekeeping

- Pre-workshop survey?
- Have all attendees signed the attendance sheet?

- Please mute your microphone
- Questions will be taken at the end of the session
- Please let me know if you can not see the presentation

email for survey link: kym.griffin@health.qld.gov.au
Palliative Care Education Snap Sessions
Darling Downs – South Burnett
Cairns & Hinterland – Atherton Tableland
South West HHS

Understanding morphine in palliative pain management

Tuesday 26th July 2016
14.30 – 14.50 hours
"Opium teaches only one thing, which is that aside from physical suffering, there is nothing real." André Malraux, ‘Man’s Fate’

Reported % of patients with cancer receiving opioid analgesia at end of life ranges from 25%-99%

Role of opioids in relieving pain has been known and used since around 3400BC.

OPIOID ANALGESICS

1. morphine
2. codeine
3. oxycodone
4. hydromorphone
5. fentanyl
6. tramadol
7. methadone
8. diamorphine (heroin)
# APPROXIMATE EQUIANALGESIC OPIOID DOSES

<table>
<thead>
<tr>
<th></th>
<th>Parenteral</th>
<th>Oral</th>
</tr>
</thead>
<tbody>
<tr>
<td>morphine</td>
<td>10mg</td>
<td>30mg</td>
</tr>
<tr>
<td>codeine</td>
<td>-</td>
<td>240mg</td>
</tr>
<tr>
<td>hydromorphone</td>
<td>1.5mg</td>
<td>6-7.5mg</td>
</tr>
<tr>
<td>oxycodone</td>
<td>10mg</td>
<td>20mg</td>
</tr>
<tr>
<td>methadone</td>
<td>complex</td>
<td>complex</td>
</tr>
<tr>
<td>tramadol</td>
<td>80mg</td>
<td>120mg</td>
</tr>
<tr>
<td>fentanyl</td>
<td>100-150mcg</td>
<td></td>
</tr>
</tbody>
</table>
MORPHINE
ALWAYS USE LAXATIVES WITH MORPHINE AND OTHER OPIOIDS
Considered the gold-standard for opioid initiation by WHO

It is the cheapest and most widely available opioid in the world, so is generally the opioid best known to clinicians.
PRINCIPLES OF MORPHINE USE IN PALLIATIVE CARE

Conversion ratio:

Morphine oral to parenteral

3:1
BREAKTHROUGH DOSES

Palliative patients should always have prn doses ordered in case of pain breakthrough.

Commonly: 1/12 total daily dose q2h

e.g. 60mg MS Contin bd = 120mg/day

BT dose = 120/12 = 10mg q2h prn

Some physicians use 1/6 daily dose q4h but for a prn is good practice to have it available more often.
MORPHINE TOXICITY

Myoclonic jerks

Increased somnolence

Nightmares/hallucinations

Confusion
PAIN - OPIOPHOBIA

PROFESSIONAL OPIOPHOBIA

1. Morphine should only be used when the patient is dying
2. Morphine hastens death
3. Morphine causes respiratory depression

Woodruff, 1999
PROFESSIONAL OPIOPHOBIA

1. ‘Morphine doesn’t work’ – belief usually related to:
   i. Incorrect administration
   ii. Opioid insensitive pain
   iii. Ignoring psychosocial aspects of care

2. ‘Morphine causes unacceptable side effects’ – usually because of experience of opioids causing:
   i. Constipation, nausea, somnolence
   (all should be avoidable/able to be minimal)

3. Fear of tolerance, physical dependence, psychological dependence – none should be an issue when opioids used appropriately

Woodruff, 1999
PAIN - OPIOPHOBIA

PATIENT OPIOPHOBIA

1. That means I’m going to die soon
2. Nothing left for when the pain gets worse
3. I’ll become an addict
4. I’m allergic to morphine
5. The morphine didn’t work
   i. Incorrect administration
   ii. No instructions for breakthrough pain
   iii. Morphine-insensitive pain
   iv. Ignoring the psychosocial factors
6. I couldn’t take the morphine
   i. Somnolence, confusion, nausea, constipation

Woodruff, 1999

Health professionals working with people at end of life should have the knowledge to answer such concerns.
Palliative care, and therefore analgesia, should be a basic human right. However, 2007 global survey showed:

Level 4 (integrated into mainstream health care & govt planning)
e.g. Uganda, UK, Mongolia, Australia, USA, Singapore

Level 3 (localised provision only)
e.g. China, India

Level 2 (moves to develop, but no provision yet)
e.g. Rwanda, Papua New Guinea

Level 1 (no provision, no plans)
e.g. Greenland, Somalia, Monaco

OPIOIDS IN DEVELOPING COUNTRIES

Latin America (35 countries with 551 million people) no provision at all, though significant devts in several countries e.g. Argentina. Most countries in region do not recognise palliative care as a medical speciality.

India: world’s largest producer of legal raw opium but less than 0.4% of its 1.2 billion population has access to oral morphine for pain control

Uganda: few doctors to prescribe opioids; amendment passed to opioid legislation allowing specialist palliative care nurses to prescribe morphine

Questions?
Next week . . .

Other options in pain management
Centre for Palliative Care Research and Education

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