Opioids in Palliative Care - A Patient Information Leaflet

Version 2.0 [with MST example]

Introduction

This leaflet explains what **opioids** are and what we think you may want to know about them. There is quite a lot of information here, most of it is based on questions our medical teams have been asked over the years. Our leaflet does not replace conversations with your doctor, nurse or pharmacist. But reading this may help you decide what questions to ask when you next speak to someone from your medical team.

Usually, the first step to deal with pain is to try a simple pain medicine like paracetamol on a regular basis. Sometimes this is combined with a further medicine like Ibuprofen. If this is not effective then the next step is generally a stronger pain relief medicine like 'co-codamol' or 'tramadol'. If your pain is still not well controlled then your doctor will usually prescribe a 'strong opioid'. This can sound worrying to some people. In this leaflet we explain how opioids are a very useful way of helping you to feel more comfortable and with less pain so that you can go about your usual activities.

What am I being offered?

'Opioid' is a word used to describe strong pain relief medication, for example Morphine, Oxycodone, Hydromorphone and Fentanyl. It is medication used to treat moderate to severe pain. There are many different types and strengths of opioids available. A typically prescribed opioid, like morphine, is usually used in a combination of two forms:

- a long acting (or sustained-release) form and
- a fast acting (immediate-release) form.

Examples of long acting and fast acting forms of opioids are given in the boxes below. For this leaflet we mainly discuss **Morphine**, as it is usually the first strong opioid that doctors will offer you.

These are examples of opioids that are **long acting** and **slowly** release into your system:

- **MST Continus (Morphine Sulphate Tablets)**
- **Morphgesic SR**
- **Zomorph**
- **Oxycontin**
- **MXL**

And these are examples of opioids that are **fast acting**:

- **Oramorph**
- **Sevredol**
- **Oxynorm**

Note that some of the long and fast acting medicines sound quite similar.

What are you taking? Here is a space to write down your long and fast acting opioid:

Long acting Opioid= .....

Fast acting Opioid= .....

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Why am I being prescribed Morphine?

Most people who take Morphine have a lot of pain. The pain can be present for various reasons, such as cancer, heart or lung disease. They have usually tried a number of other pain medicines, for example regular Paracetamol and this may or may not have helped. Some may have taken codeine, or a codeine plus paracetamol combination called co-codamol. **Codeine is an opioid medicine that is available over the counter within the UK. It is converted to Morphine in our bodies, so many people have already been on a low dose of morphine.** Codeine and other simple pain medicines are sometimes not enough to control pain, and this is when Morphine can be a better option. Sometimes, pain can be a big reason for people not wanting to move, for example after a bone fracture. By improving this pain, morphine can help to achieve goals like walking, rehabilitation and being more independent.

But isn't Morphine just used in the last stages of life?

No. Morphine is widely used for pain control, not only by those who are very ill, but also those who still have a lot of living to do. Often people associate Morphine with the last stages of life, and this is sometimes due to stories from many years ago, reports in the media and personal stories. Some people are on the same dose of morphine for many years, as it helps them with their everyday life.

Will I become addicted to morphine?

No. If you feel you no longer need the morphine, please discuss this with your doctor who will work with you to reduce the dose gradually. You should not suddenly stop your morphine.

Will the effects wear off over time, meaning I will need more and more morphine?

This idea is called 'tolerance', meaning that as our bodies get used to a medicine over time, our bodies will stop responding to it. This does **not** happen with morphine. The effects of morphine when used for people who have moderate to severe pain do *not* wear off over time. Your pain may get worse, meaning that you may need higher doses of morphine. Equally if your pain gets better the dose of morphine can be reduced. Some people find that once they are on the correct dose of morphine for their pain, they stay on that dose for some time. Some people, depending on their disease use it for a few weeks and then gradually reduce the dose and stop it.

What are the side-effects?

Morphine does have side-effects. The most common ones are listed below:

Constipation: Nearly everyone taking morphine will get constipated, so it is important that anyone taking morphine takes laxatives as well. Constipation is the infrequent and difficult passage of bowel movements. For some people, this means they open their bowels every three days or even less often. Their bowel movements can be hard, craggy, and pellet-like and it can be painful and difficult to pass them. A diet high in fibre is not usually sufficient to prevent morphine related constipation. Taking laxatives regularly is very important. If you only take laxatives when you are already constipated, it is a lot more difficult to treat and may require suppositories and enemas. A lot of laxatives which are taken by mouth take a few days to take effect, so taking them regularly acts as 'an insurance' for not getting constipated in 2-3 days time.

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Sickness (or nausea and vomiting): Some people will feel sick when they start taking morphine, or even vomit. This is usually a side-effect in the first week of treatment and often goes away by itself. However, if you do feel sick, your doctor can offer you a medicine to stop this.

Drowsiness: Many people feel tired or find they cannot concentrate as well when they first start taking morphine, and/or when the dose is increased. This often wears off after a week of taking the morphine regularly. Occasionally, people do feel very drowsy and can rarely hallucinate (see or hear things that are not really there) when they take morphine. Try not to worry about this, but it is important that you contact a healthcare professional if this is the case. Also be aware that if your concentration is impaired, you should avoid manual tasks that involve heavy machinery or sharp implements.

Can I still drive if I am taking opioids?

Your ability to drive depends on many different factors, including your illness, what other medicines you are taking and what your car insurance company accepts. Use your judgement. For example, do you think you can do an emergency stop and step heavily on the brakes of your car if suddenly required? To ensure that you are covered by your car insurance you will need to tell them of any serious illnesses, failure to do so will mean that you are not covered. If in any doubt it is best to discuss this with your insurer.
With regard to morphine, you may well be able to drive when you have been taking the same dose of the medicine for five days or more. If you are sleepy or the side-effects are bothering you, it is best not to drive and to speak to your medical team. Discuss this with your doctor, who can help you make a judgement. If your doctor expresses concern about your fitness to drive, you should contact the DVLA. Here, you can find an advice leaflet with regard to driving and opioids:

http://www.stelizabethhospice.org.uk/documents/document_library/Strong_painkillers_and_driving.pdf

There is also some more general advice from the DVLA available from this website.
http://www.dft.gov.uk/dvla/medical/ataglance.aspx
or via their helpline: **Telephone:** 0300 790 6801.

How and when do I take Morphine?

Your doctor, nurse or pharmacist will explain how to take your medication. You will usually be given one of two options. Both options are used to work out the correct dose of pain medication specifically for you. This process is sometimes called 'titration'.
The first option is a fast acting (or immediate-release) medicine which is often prescribed in liquid form called **Oramorph** (the tablet form is called **Sevredol**). This **fast-acting morphine** is taken by mouth (or if you have a tube leading to your stomach then the liquid form is given via that tube). It starts working quickly, after about 15 to 20 minutes. It wears off after about three to four hours. Your doctor may suggest that you take this regularly every four hours over a 24 hour period. Additionally, you can have 'rescue or breakthrough doses' of the same medicine at the same dose, if you get additional pain. Doctors and nurses may use the term 'breakthrough pain' to describe occasional, unpredictable pain 'breaking through' despite you being on regular pain relief. You can take rescue doses between your regular doses of short-acting morphine, if the pain is bad.

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The second option is a **long acting form of morphine** (so-called 'sustained-release'). An example is 'Morphine Sulphate Tablets', often abbreviated to '**MST**'. They are also taken by mouth. They contain a substance that ensures that the Morphine is slowly and gradually absorbed over 12 hours and therefore helps to prevent ongoing pain. Long acting medication is usually taken twice a day, so for instance at 10am in the morning and 10pm at night. In addition to this long acting morphine, you should be given a fast-acting version like **Oramorph** or **Sevredol**, (for when your pain is bad despite the **MST)**, as rescue or breakthrough medication.

Can I use 'long-acting' and 'fast-acting' Morphine preparations together?

Yes. The MST aims to prevent your pain and is long acting, the Oramorph is taken when needed, when the pain is bad, even if you are already on MST. Long-acting medicine makes sure the medication is released slowly and gradually into your body over a certain time period. MST lasts for about 12 hours.

To help your doctor work out the correct dose of long and short acting medication for you, you may be asked to keep a diary. Here is an example of the first option (regular fast-acting morphine and as needed fast-acting morphine:

Mr Jones is started on liquid **Oramorph** 5 mg (fast-acting morphine) taken by mouth **every four hours**. Please take a moment to look at his diary.

Regular medication diary (Mr Jones' example):

Date	Time	Dose and Drug
12th July (Thurs)	10 am	5mgs Oramorph
12th July	2pm	5mgs Oramorph
12th July	6pm	5mgs Oramorph
12th July	10pm	5mgs Oramorph
13th July	2am	5mgs Oramorph
13th July	6am	5mgs Oramorph

At 2.30pm and again at 8 pm on the 12th July, he has a lot of discomfort and takes an extra rescue dose of liquid **Oramorph** 5 mg dose by mouth, which provides good relief each time.

Extra rescue (breakthrough) doses diary (Mr Jones' example)

Date	Time	Dose and Drug
12th July (Thurs)	2.30pm	5mgs Oramorph
12th July	8pm	5mgs Oramorph

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Here is an example of the second option (regular long-acting morphine twice daily and as needed fast-acting morphine):

Mr Jones found good pain-relief using regular **Oramorph**, but having to take it every four hours is a nuisance, especially the 6 am dose. His doctor starts him on **MST**, used for the same pain, but lasting 12 hours. He starts **MST** 15 mg tablets and also has the 'as needed' rescue doses of **Oramorph** 5 mg for any additional pain he might have.

Regular medication diary (Mr Jones' example):

Date	Time	Dose and Drug
12th July (Thurs)	10 am	15mg MST
12th July	10pm	15mg MST

Extra rescue (breakthrough) doses diary (Mr Jones' example):

Date	Time	Dose and Drug
12th July 2012 (Thurs)	6pm	5mgs Oramorph
12th July 2012	8pm	5mgs Oramorph

10 am **MST** tablet 15 mg by mouth.
(6pm Oramorph liquid by mouth for additional pain)
(8pm Oramorph liquid by mouth for additional pain)
10 pm **MST** tablet 15 mg by mouth.

So, Mr Jones had two additional pain episodes at 6 pm and at 8 pm, for which he took additional **Oramorph** liquid 5 mg by mouth.

Why does the doctor keep increasing my dose of morphine?

Different people need different doses of pain relief medication. It is therefore not possible to say what dose you may need from the outset. This means that your doctors and nurses will work with you to work out the right dose of opioid for you.

Keeping a **diary** (as above) will help you and your doctor.
Some people are on MST 20 mg twice daily, others on MST 90 mg twice daily, others are on MST 400 mg twice daily. Being on a higher dose does not mean you are more ill. There is a lot of difference between people and the way they absorb and process this medication.

How many doses of 'rescue' (also called 'breakthrough' or 'as needed') fast-acting morphine can I take in a 24 hour period?

Often people need one or two doses of the fast-acting 'rescue doses' of morphine (like Oramorph) over a 24 hour period, in addition to their regular morphine. If you need three or more extra 'rescue' doses, please do take them but you should also let your doctor know. This is because your regular morphine dose may not be sufficient and may need to be reviewed. Some people keep a diary of their extra-doses and this is really useful for the doctor or nurse looking after you.

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Can I take opioids with other medication?

Yes, morphine does not usually cause problems with your other, regular medication. In fact, it is often prescribed in addition to other pain medicines, such as regular Paracetamol or regular Ibuprofen, and they work in different ways to help reduce your pain. If you are on codeine, your doctor may decide to switch you to morphine and stop the codeine. This is because codeine and morphine are very similar and taking both may not be beneficial to your pain.

Does morphine always work for pain?

Although it is a strong pain-relieving medicine, it does not work for all types of pain. Other treatments may be needed and if you have tried morphine and it has not worked, your doctor can discuss other options with you. The local palliative care team, who are specialists in the control of pain, will be able to guide your treatment. You can ask your doctor or nurse to refer you to the local palliative care specialist if you wish.

What if morphine works for the pain, but has a lot of side-effects?

There are a number of other medications, similar to morphine, available. Your doctor may suggest stopping the morphine and trying other medications, like **'Oxycodone', 'Hydromorphone', 'Buprenorphine' or 'Fentanyl'**.

Who will keep a check on the morphine?

The doctor and medical team that have first prescribed the morphine should give you information on follow-up. Usually, in the initial phases of taking morphine, your medical team may see you frequently, to establish the right dose for you. Ask your medical team about follow-up if you are unsure. Your medical team might be your GP practice, an oncologist or your specialist palliative care team. It is helpful to keep a record of your key professionals, and your GP should always be informed about medication changes.

What if something goes wrong outside normal working hours, when my 'usual' team are not around?

If you are in hospital, call the nurse and explain what you are experiencing.
If you are at home and this is the case, contact your Out-of-Hours GP service. Their phone number is available locally and your GP surgery's answer-phone message should provide you with their phone number. Your doctor may also provide you with contact details for your local specialist palliative care team. **If you, your family or carer(s) are worried that there is something seriously wrong, you must call 999 straight away.** It is worth writing all these local contact numbers down and keeping them close to hand, ideally by your landline phone or stored in your mobile telephone.

Your GP: .....

Your Community District Nursing Service: .....

GP Out-of-Hours medical provider number: .....

Community Palliative Care Team: .....

Palliative Care Out-of-Hours advice line: .....

Other (state who) .....: .....

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Can I drink alcohol?

Yes, you can drink small amounts (1-2 units per day), but you may find it makes you more sleepy and some people find it has a stronger effect on them.

How do I store morphine?

You should store morphine safely, in a cool, dark place. Make sure it is well out of reach of children, vulnerable adults and pets.

Other opioid pain medicines:

Most people find that morphine suits them well. However other strong pain medicines may suit a few people better. It is difficult to predict from the outset who will get side-effects from morphine. Here are some of the alternatives, that doctors may offer you:

Oxycodone or Hydromorphone:

These come as similar long-acting and short-acting medicines to morphine and are used in the same way. They are usually taken as tablets or liquid.

Fentanyl or Buprenorphine:

Fentanyl or Buprenorphine come in the form of a patch (or plaster) that sticks to your skin, which is useful for example for people who cannot swallow normally. These patches, depending on their type, are changed every few days. There are also short-acting preparations of fentanyl for breakthrough pain. These include tablets that dissolve under the tongue or on the inside of your cheeks, a mouth lozenge and a nose spray.

This leaflet

This leaflet has been written with the guidelines on strong opioids from the UK's National Institute of Clinical Excellence (NICE) in mind. You can find more information including a patient section on their website:
www.nice.org.uk/cg140
Their patient leaflet is here:
http://guidance.nice.org.uk/CG140/PublicInfo/doc/English

Any other questions?

Please write down any further questions you have and bring them to your doctor's or nurse's attention.

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Diary (here you can start writing what opioid you are taking on a daily basis)

Date	Time	Name and Dose of Opioid

- *Please continue on extra sheet-*

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