<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>EQUIANALGESIC DOSE (for chronic dosing)</th>
<th>USUAL STARTING DOSES for ADULT &gt;50kg*</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IM/IV onset 15-30 min</td>
<td>PO onset 30-60 min</td>
<td>PARENTERAL</td>
</tr>
<tr>
<td>MORPHINE</td>
<td>10 mg</td>
<td>30 mg</td>
<td>2.5-5 mg SC/IV q3-4h (1.25--2.5 mg)</td>
</tr>
<tr>
<td>HYDROCODONE</td>
<td>Not available</td>
<td>30 mg</td>
<td>Not Available</td>
</tr>
<tr>
<td>OXYPHENTHALINE</td>
<td>Not Available</td>
<td>20 mg</td>
<td>Not Available</td>
</tr>
<tr>
<td>FENTANYL</td>
<td>100 mcg (single dose) 1/2 and duration of parenteral doses variable 24 hour MS dose 30-99 mg 60-134 mg 135-224 mg 225-314 mg 315-404 mg Initial patch dose 12 mcg/h 25 mcg/h 50 mcg/h 75 mcg/h 100 mcg/h 25-50 mcg IM/IV q1-3h (12.5-25 mcg) Transdermal patch 12 mcg/h q72h (use with caution in opioid naive and in unstable patients because of 12h delay in onset and offset) Transdermal patch (12,25,37.5,50,62.5,75,87.5,100mcg) If transitioning from IV fentanyl to patch, hourly rate is the patch dose; eg. if patient is on 50mcg/h IV, start with 50mcg patch. N.B. Incomplete cross-tolerance already accounted for in conversion to fentanyl; when converting to other opioid from fentanyl, generally reduce the equianalgesic amount by 50%. IV: very short acting; associated with chest wall rigidity. IR: Buccal tablet, Nasal solution, SL tablet, Lozenge; SL spray - Indicated for breakthrough cancer pain only. Seek consult. Acceptable in renal failure, monitor carefully if using long term.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HYDROMORPHONE</td>
<td>1.5 mg</td>
<td>7.5 mg</td>
<td>0.2-0.6 mg SC/IV q2-3h (0.2 mg)</td>
</tr>
<tr>
<td>OXYMORPHONE</td>
<td>1 mg</td>
<td>10 mg</td>
<td>1-1.5 mg IM/ SQ q4-6h (0.5 mg)</td>
</tr>
<tr>
<td>BUPRENORPHINE</td>
<td>Not available</td>
<td>24 hour MS dose &lt;30 mg 30-80 mg Initial patch dose 5 mcg/h 10 mcg/h</td>
<td>Not Available</td>
</tr>
<tr>
<td>CODEINE (Information provided for conversion to opioids only)</td>
<td>130 mg</td>
<td>200 mg</td>
<td>15-30 mg IM/SC q4-6h (7.5-15 mg) IV Contraindicated</td>
</tr>
<tr>
<td>METHADONE (see separate sheet with detailed dosing information)</td>
<td>1/2 oral dose 2 mg PO methadone = 1 mg parenteral methadone</td>
<td>Seek Consult</td>
<td>1.25-2.5 mg q8h (1.25 mg) Consider Palliative Care or Pain Service Consult 2.5-5 mg q8h (1.25-2.5 mg) Consider Palliative Care or Pain Service Consult</td>
</tr>
</tbody>
</table>

* - “Usual starting doses” applies to opioid naïve patients, not for patients who have been on opioids and whose starting dose should take their usual consumption into account.
GUIDELINES

1. Assess and manage pain in adult patients using the CPPM Adult Guide.

   **N.B.** Opioids are not first line for chronic pain, even moderate to severe pain, which should be managed with an active approach and non-opioid pain relievers whenever possible. When opioids are indicated, based on a careful risk assessment, combine with an active approach and other measures. Be wary of dose escalation over time due to tolerance.

2. How to dose opioids:
   A. Give baseline medication around the clock.
   B. For breakthrough pain order 10% total daily dose as a PRN given q 1-2h for oral and q 30-60 min for SC/IV.
   C. For continuous infusion, PRN can be either the hourly rate q 15 min or 10% of total daily dose q 30-60 min.
   D. Adjust baseline upward daily in amount roughly equivalent to total amount of PRN.
   E. Balance function vs. acceptable control of pain.

3. In general, oral route is preferable, then trans-cutaneous > subcutaneous > intravenous.

4. If parenteral medication is needed for mild to moderate pain, use half the usual starting dose of morphine or equivalent.

5. Use a short-acting medication for acute pain exacerbation. Switch to long-acting preparations when pain is chronic and the total daily dose is determined.

6. Avoid multiple agents of similar duration.

7. When converting from one opioid to another, some experts recommend reducing the equianalgesic dose by 1/3 to 1/2, then titrate as in #2 above.

8. Older adults, or those with severe renal or liver disease, should start on half the usual starting dose. Watch carefully for toxicity from accumulation.

9. Use care with combinations. Ensure total consumption of APAP from ALL sources & ALL purposes does not exceed 3 g/day (2-3 g for frail elders).

10. Patients with substance abuse history may need a higher starting dose due to tolerance. Monitor urine drug screenings. Consider abuse-deterrent opioids.

11. Refer to product information fentanyl use. Review CPPM methadone and buprenorphine guidelines.

12. Refer to Bassett protocol for naloxone use.

13. Avoid codeine and tramadol if breastfeeding.

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**Equianalgesic Table for Adults**

**Half-life, Duration, Dosing and Guidelines**

(Tailor care to individual needs.)

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**Community Principles of Pain Management**

Adapted by Specialty Advisory Group, 2002

Reviewed and approved every other year

Reviewed and adopted by AAHPM, 2009

Approved in April 2017.

Next scheduled update in 2019.

Additional pain management resources are available at CompassionAndSupport.org