**Opioid questions**

A 54 year old man known to have lung cancer with bone metastasis is admitted with increased pain in his chest and constipation. He is on regular co-codamol 30/500 2 tablets 4 times a day and has been taking multiple dose of oramorph 5mg with some effect.

Choose the best management option from the list below:

1. Switch from co-codamol to a 12 micrograms/ hour fentanyl patch ( Explanation-avoid patches in uncontrolled pain- for guidance on switching please seen palliative care intranet)
2. Stop co-codamol and start Morphine sulphate MR 15 mg bd and add senna at night
3. Await the outcome of chest X-ray before increasing his background analgesia
4. Stop co-codamol and start morphine sulphate 15 mg SC over 24 hours (Explanation- give oral analgesia if possible)

You are asked to see a patient with a history of cirrhosis and newly diagnosed Hepatocellular carcinoma. He is drowsy, confused and has ascites. His respiratory rate is 12. There has been concern that he may be in pain and he has been give 3 doses of oramorph 5 mg over the past 24 hours.

What advice would you give about opioids?

1. Consider Naloxone as morphine may have precipitated encephalopathy. (Explanation-Avoid naloxone because of risk of precipitating withdrawal. If needed use low dose- as per palliative care intranet page)
2. Reduce the dose of Oramorph to 2.5 mg as needed ( Explanation-Likely will need less often)
3. Switch to oxycodone 2.5 mg orally as needed
4. Start morphine sulphate MR 5 mg twice a day

A 46 year old lady with metastatic breast cancer has a pathological fracture of her right humerus which is to be managed conservatively. She is already taking Morphine sulphate MR 50 mg twice a day and Oramorph 10 mg for breakthrough pain. She is reluctant to consider increasing her dose because of fear of addiction and of becoming drowsy.

What could you say to her?

1. Reassure her that she will not become dependent on morphine and suggest increase in the back ground dose to Morphine sulphate MR 70 MG twice a day. ( Explanation-as addiction and dependence are different. Could consider increasing the background dose but likely to continue to need as needed opioid and risk of toxicity if keep increasing the background dose)
2. Agree she should continue on this relatively low breakthrough oramorph dose if it is effective for her
3. Ensure the nurses know not to give more than 4 doses of as needed oramorph in 24 hours (Explanation 1. with incidence pain may be acceptable to have more than 4 doses in 24 hours if they are tolerated. 2. Good practice usually to suggest maximum of 4 doses in 24 hours- but this can be reviewed and have more if not opioid toxic and if as needed doses are working)
4. Discuss avoiding need for analgesia by minimising activity