Opioid Medication in Palliative care

A guide for patients and carers

Always there to care

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Introduction

This section explains what opioids are and what we feel you may want to know about the. The content is based on commonly asked questions, but does not replace conversations you may have with health professionals involved in your care. You may wish to go back to your healthcare provider to ask more specific questions about your situation.

Benefits

PAIN

Opioid medication is primarily known for it's benefits in managing pain. Often simple pain may be managed with simple pain killers that can be purchased over the counter, however if pain is not well managed with these drugs, a stronger pain killer may need to be prescribed. Opioid medications are a good 'all round' pain killer, but your health professional may choose to prescribe a more targeted pain killer for your particular pain either instead, or alongside an opioid.

BREATHLESSNESS

There is lots of evidence to suggest that pain and breathlessness share some common pathways within the brain, and as such we know that many people with breathlessness can be helped with opioid medication. It is important to be assessed by a health professional for this, to ensure the reason for your breathlessness does not require further investigation and treatment.

Types of opioid medications

Weak opioid Codeine and tramadol are examples of weak opioid medications. These may be used for pain that is not relieved by simple pain killers. It would not be usual practice to combine a weak opioid and strong opioid together.

Strong opioids Strong opioids include morphine, oxycodone, fentanyl and buprenorphine.

Strong opioids can be divided into long acting (working for between 12hrs and 72hrs) or short acting (usually effective for 4-6hours)

It would be usual to manage the bulk of background pain or breathlessness with a long acting preparation and then use a short acting preparation for 'top up' pain.
When first commencing strong opioids and over time, the doses may need to be titrated (adjusted) to find the best regimen to manage your symptoms.

Side effects

The aim of any health professional is to manage symptoms as much as possible, with as few side effects as possible. As with all medications, opioids do have some common side effects, which include:

Drowsiness/dizziness *
Nausea *
Constipation
Hallucinations

*Often these may settle after a few doses once the body gets used to the medication.

If you experience side effects, it is important to report these to your healthcare professional. It may be that you need another medication e.g. laxative, to counteract the adverse effect, or it may be an alternative opioid may suit you better.

Common Myths

"Opioid medications are just for the end stages of life"

This is a common misconception. We look after lots of people who can live for many months are years with better controlled symptoms owing to their opioid medication

"Will I get addicted?"

Addiction in our society has association of behaviour patterns than people worry they will inherent with taking opioid medication. These behaviours are a consequence of psychological addiction. When people take opioid medication under the care of a trained health professional to manage specific symptoms, the psychological addiction is not usually a problem. People taking opioid medications in this way do not develop the drug seeking behaviours associated with psychological addiction. It is true the body will become physically dependant on opioid medications when taken regularly, but this simply means the medication cannot be abruptly stopped and would need to be steadily reduced if no longer needed. Physical dependence is not the same as psychological addiction.

"I've heard you become tolerant to opioid medications"

In practice many people with stable symptoms can continue on the same doses of opioid medication for a long time. For some people, as their underlying health changes, can notice a change in their symptoms that requires an adjustment in their medication. A very small number of people do show some signs of tolerance, but this is certainly not a common problem, and may often be linked to increased anxiety. If you are worried about any changes in your symptom control, you should discuss this with your healthcare provider.

Frequently Asked Questions

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 this 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 for five days or more. If you are sleepy or the side effects are bothering you, it is best not to drive until you have spoken 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.
There is some more general advice from the DVLA available from the website http://www.dft.gov.uk/dvla/medical/ataglance.aspx

How and when do I take Opioid medication?

Your doctor, nurse or pharmacist will explain how to take your medication. You will usually be given one or two options. Both options are used to work out the correct dose of 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 a 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 15-20 minutes. It wears off after about 4 hours. Your doctor may suggest you can take this regularly, every one to two hours **ONLY IF NEEDED**. You will be told the dose to take. It is important to write down the time and the amount taken every time you need to take a dose to allow the team to calculate the amount of long-acting morphine you will need.

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 the Morphine is released slowly and it is steadily absorbed over 12 hours and therefore helps to prevent ongoing pain.

Long-acting medication is usually taken twice a day, for example at 10 am in the morning and 10 pm at night. In addition to this long-acting morphine, you should be given a fast-acting version like **Oramorph** or **Sevredol** (for when the pain is bad despite the **MST**) as a rescue or breakthrough medication. Doctors and nurses use the term 'breakthrough pain' to describe occasional, unpredictable pain that occurs despite being on regular pain relief. Medication taken to manage this pain is called 'rescue' 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 (or sevredol) 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 period of time. MST lasts for about 12 hours.

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