



Introduction

The following pages explain 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 guide 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 another pain relief medicine like ibuprofen. If this is not effective then the next step is generally a pain relief medicine like 'co-codamol' (codeine combined with paracetamol) or 'tramadol'. If your pain is still not well controlled then your doctor will usually prescribe a different opioid like morphine. This can sound worrying to some people. However, opioids are useful pain relief medicines that can help you to feel more comfortable and experience less pain so that you can go about your usual activities.

What is an opioid?

"Opioid" is used to describe pain relief medication such as morphine, oxycodone, hydromorphone and fentanyl, which are 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 (modified-release, prolonged-release 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 guide we mainly discuss **morphine**, as it is usually the first opioid medicine that doctors will offer you for moderate to severe pain.

These are examples of opioids that are **long acting** and **slowly** release into your system, usually over 12 hours:

- MST Continus (Morphine Sulfate Tablets)
- Morphgesic SR
- Zomorph
- Oxycontin
- Longtec
- Oxypro

These are sometimes also referred to as modified-release, prolonged-release or sustained-release preparations

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

- Oramorph
- Sevredol
- Actimorph
- Oxynorm
- Shortec
- Abstral



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

Long acting opioid =

Fast/Immediate acting opioid =

Why am I being prescribed morphine?

Most people who take morphine have a lot of pain that is affecting their daily activities. The pain can be present for various reasons, such as cancer, or heart or lung disease. They have usually tried a number of other pain medicines first, for example regular paracetamol or ibuprofen, and this may or may not have helped. Some may have taken codeine, or a codeine and 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 effectively 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 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, but this is not always the case. 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?

Very few people who use opioids for pain relief ever become addicted or dependent on them. Most will find that the opioid helps them get around and be more active, by improving pain control. If you feel you no longer need morphine, please discuss this with your prescriber 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?

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, even years. 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, but please also read the patient information leaflet that comes with your medication.

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.

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 may not be covered. If in any doubt it is best to discuss this with your insurer.

It's an offence to drive if you have over the specified limits of certain drugs in your blood and you have not been prescribed them. So, consider having some evidence in your vehicle that these are prescribed medicines from your team, such as a letter, or the packaging of your medication.

With regard to morphine and other opioids, you may well be able to drive when you have been taking the same dose of the medicine for five days or more, and are on the above mentioned 'modified-release preparations'. If you are sleepy or the side-effects are bothering you, you should not drive, and instead speak to your medical team. Each driver should do a 'risk-assessment' before they drive any type of vehicle. Discuss this with your clinical team, who can help you make a judgement. If your clinician expresses concern about your fitness to drive, you must contact the DVLA. The DVLA have stated that the best policy is "If in doubt, do not drive", and there are now also certain limits for prescribed drugs in the blood stream. More information here: <https://www.gov.uk/drug-driving-law>

The DVLA have also produced a video to help guide drivers if they are not sure whether they can drive: <https://www.youtube.com/watch?v=Bz0tnwiYv4w>





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** or **Actimorph**). 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.

The second option is a **long acting form of morphine** (so-called 'modified-release', 'sustained-release' or prolonged release). An example is 'Morphine Sulfate prolonged-release tablets', often referred to as '**MST**' or '**MST continus**'. They are also taken by mouth. They ensure 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 modified-release 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 10mg/5ml**. He takes 2.5 ml (5 mg) (fast-acting morphine) 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
12 th July (Thurs)	10 am	5mg Oramorph
12 th July	2pm	5mg Oramorph





12 th July	6pm	5mg Oramorph
12 th July	10pm	5mg Oramorph
13 th July	2am	5mg Oramorph
13 th July	6am	5mg 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
12 th July (Thurs)	2.30pm	5mg Oramorph
12 th July	8pm	5mg Oramorph

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

Mr Jones experienced 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
12 th July (Thurs)	10 am	15mg MST
12 th July	10pm	15mg MST

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

Date	Time	Dose and Drug
12 th July 2012 (Thurs)	6pm	5mg Oramorph
12 th July 2012	8pm	5mg 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 can be 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 clinician 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.

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 (codeine is in fact made into morphine in your body by your liver). Taking both may not be beneficial to your pain and may increase the risk of side effects.

Does morphine always work for pain?

Although it is used for moderate to severe pain, 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 clinical 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 assess 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, contact 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 or 111. 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):



Can I drink alcohol?

Yes, you can drink small amounts (1-2 units per day), but you may find the alcohol effects feel stronger, for example some people say it makes them more sleepy.



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.

Return unused or out of date medicines to your pharmacy or dispensary for safe disposal.

Other opioid pain medicines:

Most people find that morphine suits them well. However other opioid medicines used for moderate to severe pain may suit people better. It is difficult to predict who will get side-effects from morphine. Below are some of the alternatives that doctors may offer you, and clinicians may refer to this as 'opioid rotation':

Oxycodone or Hydromorphone:

These come as similar long-acting and short-acting medicines to morphine and are used in the same way (some examples are given on page 1). They are usually taken as tablets or liquid.



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