



BEDSIDE PAIN MANAGER

Conversions & Information
for Pain and Symptom Control

Here's a look at partial contents of some of the sections in the 2008 BEDSIDE PAIN MANAGER.

MU AGONIST OPIOID ANALGESIC CHART

Information in columns to the right is based on the first dosage, in bold.

	Equivalent dose of oral morphine	# Tabs or cc's QD to convert to fentanyl 25 mcg patch	Dosing Duration: hours	Onset: minutes	Peak: minutes	Half-life: hours	# Tabs = to acet 4000 mg or ASA 6000 mg	Cost
Opana ER - CR - oxymorphone 5 mg (5, 7.5, 10, 15, 20, 30, 40 mg) <i>Do not crush</i>	16 mg	4-8	12	no data	varies <i>e</i>	9-21	NA	\$\$\$
FENTANYL:								
Fentora - buccal tablet - fentanyl citrate 100 mcg (100, 200, 400, 600, 800 mcg) <i>d</i>	5 mg	NA	2-5	15	20-30	2.5-11	NA	\$\$\$\$

IV/PO EQUIANALGESIC CHART

Values are approximate; use only as a guideline.

	Equi-analgesic Dose	Usual Starting Dose	Duration: hours	Onset: minutes	Peak: minutes	Half-life: hours
MORPHINE: IV/IM/SC.....\$	IV/IM/SC 10 mg	IV/IM/SC 5-10 mg	3-4	IV 5-10 IM/SC 10-20	IV 15-30 IM/SC 30-60	2-4
morphine (immediate release) - (10, 15, 30 mg).....\$	PO 30 mg	PO 10-30 mg	3-6	15-60	60-90	2-4
HYDROMORPHONE: IV/IM/SC\$	IV/IM/SC 1.5 mg	IV/IM/SC 0.5-2 mg	3-4	IV 5 IM/SC 10-20	IV 10-20 IM/SC 30-90	2-3

NSAID CHART

Generic name in bold (Brand name and how supplied in parentheses; brands in color are discontinued, left in to aid with recognition)

	Recom- mended starting dose: mg	Dosing schedule: hours	Max daily PO dose: mg	Half-life: hours	Cost
diclofenac/misoprostol (Arthrotec 50/200) (Arthrotec 75/200) <i>misoprostol is gastroprotective</i>	50	8	150 diclof 800 misop	2 (diclof only)	\$\$\$
SELECTIVE COX-2 AGENT: <i>less effect on bleeding mechanisms than non-COX-2 drugs</i> celecoxib (Celebrex 50, 100, 200, 400 mg)	100	12-24	800	11	\$\$

HYDROCODONE w/ ACETAMINOPHEN:

For all drugs below:
Dosing duration: 3-4 hours
Onset: 30-60 minutes
Peak: 60-90 minutes
Half-life: 4 hours

	Equi- valent dose of oral morphine: mg	# Tabs or cc's QD to convert to fentanyl 25 mcg patch	# Tabs = to acet 4000 mg or ASA 6000 mg	Cost
5/325 - NORCO	7	8-19	12	\$\$
5/500 - Vicodin, Lortab 5/500	9	7-15	8	\$

ADJUVANT MEDS:

- **pregabalin** (Lyrica 25, 50, 75, 100, 150, 200, 225, 300 mg) 50 mg TID; titrate to 100 mg TID in 7 days; *max 600 mg QD*; Note: reduce dose if low creatinine clearance**liquid**.....\$\$\$

PAIN MANAGEMENT PEARLS

1. "Pain is whatever the experiencing person says it is, existing whenever he says it does." Margo McCaffery 3-McCaffery, p. 17
26. Gabapentin combined with an opioid achieved better results in clinical studies than either as a single agent. 16-Gilron, pp. 1324-34
37. Non-drug approaches to pain, consider: TENS unit (*not recommended with pacemaker*), heat or cold, or alternating heat and cold, massage, bath/hot tub, changing position, meditation, acupuncture
1. Extensive survey data suggests that the equianalgesic dose for PO morphine is 60 mg for acute dosing and 30 mg for chronic dosing, possibly due to the accumulation of active metabolites. 2-PDR; 21-Portenoy
6. The Hopkins Opioid Program has a free and easy to use on-site opioid conversion tool. Sign-in is required. www.hopweb.org

Naloxone (Narcan) Guidelines

1. CRITERIA FOR ADMINISTRATION

- sedation: patient unresponsive to physical stimulation (assessment must consider patient's baseline status and other co-existing diagnoses and symptoms. Sedation involves a patient's level of arousal and wakefulness, not mentation or clarity)
- respiratory depression: decrease in rate and depth of resp from baseline

NAUSEA – Consider:

- **nabilone** (Cesamet)
PO (1 mg) 1-2 mg BID for chemo induced nausea.....\$\$\$\$

ANALGESIC MEDICATIONS ▸ PROS & CONS OF AVAILABLE ROUTES

Transdermal	PRO	CON
	<ul style="list-style-type: none"> • analgesia generally even • low incidence of nausea • low incidence of constipation • less frequent dosing to remember (every 3 days with transdermal fentanyl) • because of infrequent dosing, patient can focus less on pain and pain meds (IONSYS - fentanyl iontophoretic transdermal system - available for hospitalized patients only - see IV Insert side 2 for more information) 	<ul style="list-style-type: none"> • must have an accurate record of patient's 24 hour pain control medication regimen to determine patch dose • limit to the number of patches that can be applied • can have skin reaction to medication or adhesive • must be able to remember every third day dosing • diaphoresis can interfere with absorption • requires a stable subQ tissue mass for absorption • application site can affect transdermal absorption (see Pearl 22)

OTHER ROUTES COVERED: • Oral - Short-Acting • Oral - Long-Acting • Rectal • SubQ & IM: Injection and Infusion Pump