Opioid search strategies in practice

Search for	Why?
Opioid doses >120mg MED* 120mg morphine = 60mg oxycodone = 25 - 37.5mcg/hour fentanyl = 52.5mcg/hour buprenorphine 40mg morphine = tramadol 400mg 20mg morphine = 8 tablets co-codamol 30/500 = 240mg Codeine / Dihydrocodeine	Doses greater than 120mg MED are associated with little increased analgesic benefit but significantly greater risk of harm
Combination of 'weak' and/or 'strong' opioids 'Weak' opioids = codeine, dihydrocodeine, buprenorphine <25mcg/hour, tramadol up to 200mg/day 'Strong' opioids = morphine, oxycodone, fentanyl, tapentadol, tramadol >200mg/day, buprenorphine >25mcg/hour	If a patient does not get satisfactory effect from one medication, adding another without removing the ineffective medication will not provide additional benefit but will increase the risk of harm. If a drug doesn't work it needs to be stopped and another one tried *in its place* if appropriate. If a 'weak' opioid has failed then stop and move to a single 'strong' one for a trial of effect. 'Weak' opioids do not 'top up' the effects of a 'strong' opioid
Opioids in combination with benzodiazepines	Co-ingestion of opioids and benzodiazepines is associated with higher rate of deliberate or inadvertent overdose, falls and fractures Use of benzodiazepines is often associated with patients with co-morbidities which make them more susceptible to potential misuse e.g. mental health issues, inadequately managed pain
Opioids in combination with anti-depressants, anxiolytics, anti-psychotics	The use of anti-depressants etc can point to patients having more complex psycho-social needs and who may be more susceptible to misuse of medication, increasing debilitation etc

	Opioid use, particularly at higher doses is known to cause anxiety and depression as can pain – may indicate the need to refer to specialist services for additional support
Known history of addiction / misuse	People with a history of misuse are more likely to be given opioid medication when complaining of pain. However, their requirements might be higher than those without a similar history and their risk of further misuse is also high. A history of addiction / misuse is not a reason to deny treatment for a genuine pain condition but consideration should be given to setting tight parameters of use from the outset, limiting supply, setting minimum re-order times etc.
Opioids in combination with drugs for erectile dysfunction or testosterone replacement	Opioids of any type can cause hypogonadism – particularly with long-term use or if used in people who have a predisposition. It is often overlooked as a cause of sexual dysfunction, even within erectile dysfunction clinics etc. The effects of opioids on sexual functioning are generally reversible with cessation of the medication although can take time to resolve. The effects of replacement therapy will be limited at best, if the causative agent is not stopped.