Letters

More on The Conversion of Transdermal Fentanyl to Morphine

To The Editor:

It was with some surprise that I read Dr. Geoffrey W. Hanks' and Dr. Marie T. Fallon's letter in the February issue of the *Journal of Pain and Symptom Management*. Their recommendations for the dosage of transdermal fentanyl estimate the potency of these patches to be roughly twice what we estimate their potency to be here. Because chloroform water and multiple hospice beds in one room are both less popular on this side of the Atlantic than they are on the other, I wondered whether transdermal fentanyl patches might also be exhibiting cultural differences.

Seriously, I would like to offer the dosing recommendations that we use in order to avoid persistent pain due to underdosing with transdermal fentanyl. These points underscore those made by Dr. Richard Patt in the July 1993 issue of the *Journal of Pain and Symptom Management*.

1. Potency of transdermal fentanyl patches varies widely among patients, but can be estimated by using the dosages shown in Table 1, which is in keeping with the ratio of oral to parenteral morphine of 3:1.
2. When changing opioids or routes of administration, one may wish to reduce the dosage by as much as 50% because of concerns about limited cross tolerance or advanced age or sensitivity to opioids. In these situations, one would be using the potency ranges that Dr. Hanks and the manufacturer recommended, which are exactly twice that shown in column C of Table 1. It is important to use short-acting opioids for breakthrough discomfort and to realize that at least half of all patients will require a dose titration up to roughly the levels shown in Table 1. All patients on new opioids or routes of administration should be reassessed at least daily for the next few days.
3. If patients require rapid dose escalation because of severe pain or careful dose titration because of a high risk of respiratory or cognitive failure, transdermal fentanyl is *not* the method of analgesia of choice. Oral or subcutaneous morphine or hydromorphone would be much better in these situations because the dosage can be more tightly controlled.
4. By avoiding transdermal fentanyl where safety is of paramount concern, we can usually avoid starting at such a low dose that many patients will not achieve adequate analgesia for several days. My guess is that these principles of analgesic use apply equally well on both sides of the Atlantic.

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Table 1.
Proposed dosages of transdermal fentanyl

A. Transdermal fentanyl strength	B. Approximate 24-h IV/SC morphine equivalent	C. Approximate 4-h oral morphine equivalent using 3:1 conversion ratio	D. Easier-to-remember restatement of C
25 μg/h	8–22mg/h	4–11mg/4h	7.5±3mg/4h
50 μg/h	23–37mg/h	11–18mg/4h	15 ±3mg/4h
75 μg/h	38–52mg/h	19–26mg/4h	22.5±3mg/4h
100 μg/h	53–67mg/h	26–33mg/4h	30 ±3mg/4h

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