# **Rotation to Methadone - MCPMF version of the** Scottish Model

**(T.R.O. and M.C. for Marshfield Clinic Palliative Medicine Fellowship)**

- Day #0 = admission: ECG is obtained - if one dated to prior 6 months is not available
  - QTc >500msec is a strong contraindication to the planned conversion
  - QTc >550msec is an absolute contraindication
  - Other QTc prolonging medications are either eliminated or discussed/considered in the risk/benefit consideration
  - QT Web-Site: http://crediblemeds.org/everyone/composite-list-all-qtdrugs/?rf=uS

- Perform and document score on Reverse Recitation Test (of 12 months of the year) a.k.a. Bedside Delirium Test
  - Subsequently, perform the RRT daily and if score decreases from the baseline, consider reduction of the methadone dose - if permitted by pain intensity

- ALL previous opioids are stopped
- Initial dose of methadone is 1/30th of (the equivalent of) last 24 hour oral morphine dose (3.33%) with a maximum of 30 mg of Methadone as a single dose
  - In other words, 1/30 of the last MEDD
  - Calculation of MEDD may be needed for the purpose of methadone dose determination if converting from non-morphine opioid (indirect dose calculation)
- Methadone doses are given every 3 hours as needed ONLY
  - Doses can be escalated every (2)3 days by adding 5 mg to the prn methadone dose
- For uncontrolled pain between Methadone doses, use either oxycodone or morphine (or fentanyl) - mid-methadone rescue dose:
  - Use 10% of the last pre-methadone MEDD,
  - Q3hrs, staggered between the available methadone doses
  - RN is to always preferentially use methadone if available according to the Q3hr prn schedule
- Order Full Vital signs Q shift, and RR check and document Q4 while awake and Q2 10PM-6AM
  - If RR<12 daytime or <10 nighttime, wake up and perform brief neuro/orientation and alertness check

- Day #5: divide the last total 48 h methadone dose by 6 and give every 8 hours
- For breakthrough dose after discharge/conversion, use:
  - either the most recent utilized non-methadone prn opioid dose Q2hrs – *safer*
  - Or 5-10% of the new 24hrs ATC methadone dose Q3hrs – *less costly*

- Day #5-6: Discharge if clinically permitted; order and document ECG and RRT score on D/C day
  - If RRT increased (worsened) by 1 or more points as compared to baseline or the lowest (best) score recorded during the conversion period, consider reducing the final (D/C) dose
  - If QTc>500 msec, reduce the dose (and/or discuss the cardiac risks with the pt/family); may need to discontinue (even if pain control improved) after informed dialog about risks vs benefits with the patient
- Days #7-10 (Post discharge, at home): Vigilance is required, regardless of setting, to monitor for late onset respiratory depression
  - Until day #10, instruct the family (or NH/AL staff) to carry out neuro-checks once every night
    - If nocturnal RR =20% less than hospital established baseline, family member is instructed to attempt to wake the patient up and confirm baseline orientation and alertness
      - If patient is arousable, allow to fall sleep
      - If patient awakens but uncontrollably falls asleep within few seconds, call RN
      - If the patient is not arousable, call 911
    - If daytime somnolence is observed, family is instructed to call hospice/PM RN who then performs RRT and other clinical, neurological assessment as needed

The Scottish Reference: Cornish CJ, Keen JC. An alternative low-dose ad libitum schedule for conversion of other opioids to methadone. Palliat Med 2003;17:643-644.