

E. Strong opioids (step 3 analgesics)

4. METHADONE

Indications

1. Mixed nociceptive / neuropathic pain refractory to standard opioids.
2. Morphine responsive pain where dose escalation is limited by toxicity:

Examples of toxicity include - sedation and confusion

- hallucinations and agitation

spasmodic contractions of the muscles. - myoclonus and allodynia - *skin sensitivity*

- chronic nausea

Starting doses

Methadone is available as oral solution or injection.

Oral solution exists as: 1 mg, 10 mg and 20 mg / ml.

Methadone has an unpredictable duration of effect.

Therefore the 'rules' of starting methadone are:

slow, individualised conversion with frequent assessments

If converting from morphine:

Calculate a fixed dose of methadone as 10% of usual daily morphine dose. The methadone dose should not exceed 50 mg.

e.g. 30 mg bd MST = 60 mg daily MST = 6 mg methadone fixed dose

1. Stop all regular opioids.
2. Give the fixed dose of methadone at the patient's request with onset of pain but **not more than 3 hourly**. As the patient's pain reduces the dosing frequency will reduce.
3. A steady state is reached in about 4 days. Calculate the average 24 hour methadone requirement (the previous 48 hrs consumption divided by 2) and give as daily or twice daily dose.
*e.g. 6 doses of 10mg in 48 hours = 30mg methadone daily
= 15mg b.d.*

Cautions

Unpredictable half-life requires careful initiation in specialist unit.

Accumulation of methadone likely in the elderly (>75 years)

Interactions include:

cimetidine = inhibits metabolism (enhances effect)

phenytoin = increases metabolism (reduces effect)

Titration

As per morphine, increase dose by 30-50% not frequency. Sometimes daily dosing needs to be increased to b.d.

Breakthrough

Give next methadone dose early if within a few hours of next dose.

If frequent breakthrough pain is occurring, oramorph is safer to use but regular methadone dose should be titrated as above.