Opioid Conversion Charts (note: - rounded to convenient doses)

	Morphine mg				Diamorphine mg		Oxycodone mg			
Route	Oral		SC		SC		Oral		SC	
	24hr total	4 hrly	CSCI 24hr*	4 hrly	CSCI 24hr*	4 hrly	24hr total	4 hrly	CSCI 24hr*	4 hrly
Dose	30	5	15	2.5	10	2.5	15	2.5	10	2.5
	60	10	30	5	20	5	30	5	20	5
	90	15	45	7.5	30	5	45	7.5	30	5
	120	20	60	10	40	5	60	10	40	5
	150	25	75	12.5	50	7.5	75	12.5	50	7.5
	180	30	90	15	60	10	90	15	60	10
	240	40	120	20	80	15	120	20	80	15
	360	60	180	30	120	20	180	30	120	20
	480	80	240	40	160	25	240	40	160	25
	600	100	300	50	200	30	300	50	200	30
	800	130	400	65	260	40	400	65	260	40
	1000	160	500	80	330	60	500	80	330	60
	1200	200	600	100	400	70	600	100	400	70

* CSCI = Continuous Subcutaneous Infusion

This table does **not** indicate incremental steps. Increases are normally in 30-50% steps - as indicated by "when required" doses given.

Conversion factors:

From **oral morphine** to **SC morphine - divide by 2**
From **oral morphine** to **SC diamorphine - divide by 3**
From **oral morphine** to **oral oxycodone - divide by 2**
From **oral oxycodone** to **SC oxycodone - divide by 1.5**
From **oral tramadol/codeine/dihydrocodeine** to **oral morphine - divide by 10**

Dose of oral morphine over 24hrs (mg)	Fentanyl Transdermal (microgram/hr)
30	12
60	25
90	37
120	50
150	62
180	75
240	100
300	125
360	150
420	175
480	200
540	225
600	250
660	275
720	300

Dose of oral morphine over 24hrs (mg)	Buprenorphine Transdermal (microgram/hr)
12	5 (7 day patch)
24	10 (7 day patch)
36	15 (7 day patch)
48	20 (7 day patch)
84	35 (4 day patch)
126	52.5 (4 day patch)
168	70 (4 day patch)
252	105 (70+35) (4 day patch)

This advice is for converting patients on stable oral doses to the transdermal route.

For patients who are unstable/new to opioids, different conversion ratios may be more appropriate. Please seek specialist advice.

Conversion factors and charts from Greater Manchester Strategic Clinical Network Palliative Care Plan and Symptom Control Guidelines. Last revised June 2015.

Please Note: - these are guidelines only and other publications may vary.
There is debate around exact conversion ratios and expert clinical advice is readily available for clinicians to consult if required in individual circumstances. When making conversions always use caution in considering dose choices between opioids.