



Morphine: Dispelling the Myths

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Reference: Hospice Net – www.hospicenet.org

Myth #1: Morphine is offered to patients only when death is imminent.

It is not the stage of a terminal illness, but the degree of pain that dictates which medicine to use. We start with the mildest medicine and if it works, stop there. If it doesn't we move on, to morphine when it's appropriate. Some people never need morphine, while others will require it for quite a while. You can live for a long time on morphine.

Myth #2: People who take morphine will become addicted.

Drug addicts are people who are driven by their needs for narcotics; they may commit crimes or harm others to get their needs met. Hospice patients usually don't have drug-seeking behavior. When their pain is in good control, they don't desire more opiates. Sometimes we can even decrease the dosage. If patients take morphine for a while, their body does become used to it and it should not be suddenly stopped, because side effects could occur. However, hospice patients on morphine are not considered to be addicts.

Myth #3: People who take morphine will become so sedated (sleepy) that they can't function.

When patients start to take drugs like morphine, they often feel drowsy for a few days. But their bodies usually will very quickly build up a resistance to the sedating effects. Most patients whose pain is well-controlled on morphine are not bothered by unusual sleepiness. Some people, however, notice a difference in their alertness and might choose somewhat less than perfect pain control as a tradeoff.

Myth #4: People who take morphine die sooner because morphine causes them to stop breathing.

Fortunately, patients quickly adjust to any effect that morphine may have on their breathing. We prescribe a small initial dose, gradually increasing it if needed. So rarely do breathing problems occur, they are usually not even listed as side effects. In fact morphine is a drug of choice for breathing distress in people with end-stage heart or lung disease: it makes their breathing more comfortable.

Myth #5: I'm allergic to morphine: once I had a shot of morphine after an operation and I felt very strange.

Of course you can be allergic to morphine just like any other medicine. But feeling strange is not a sign of morphine allergy usually. Some people may have unpleasant mental sensations temporarily when they start to take morphine. But that is not an allergy; and it might never reoccur. There are other opiates available for those people who are truly allergic to morphine.

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Myth #6: Morphine must be given by injection.

We used to think that opiates were not effective unless administered by injection. Even people who required injections of morphine in the hospital (the most common way of giving morphine there) will probably be able to be well controlled on oral morphine at home. There are also long-acting preparations of morphine which can be given every twelve hours, or opiate skin patches which can be applied every 72 hours, to simplify the routine of pain control.

Myth #7: People should wait until their pain is bad to take morphine so it will be effective when it's really needed.

There is no upper dose limit to the use of morphine or other opiates. If pain increases we can increase the dose; this is true of very few other medications. Using it when it's needed early in the course of a terminal illness does not mean that it won't continue to work later in the disease.

Morphine, one of the oldest drugs in existence, has found a well-deserved place in the new field of palliative care: the relief of pain and other symptoms. We recommend opiates for pain control only if they are needed. When they are needed, they are often successful in controlling the pain and suffering of terminal illness.

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