1. Cross-tolerance with other opioids: this means that if one drug, say, morphine, is changed to another, say oxycodone, then there will be some tolerance to effects such as nausea, sedation etc. but this is not a complete tolerance and the differing strengths of the drugs must also be borne in mind.

Most doctors tend to start with one half the dose when switching to another opioid agonist. Switching to a partial agonist or a mixed agonist-antagonist may precipitate withdrawal in a patient who has previously been maintained on a full opiate agonist.

2. Central nervous system depressants: sedatives, hypnotics ,tranquillisers, tricyclic antidepressants (such as amitriptyline) and alcohol: these drugs can have a potentiating effect on the sedation and respiratory depression due to opiates.

3. Muscle relaxants: opioids may enhance the neuromuscular blocking action of skeletal relaxants and produce an increased degree of respiratory depression.

4. Monoamine oxidase inhibitors (MAOIs): possible increase in confusion, anxiety, respiratory depression. Opioids are not recommended for use in patients taking MAOIs or within 14 days of stopping them.

5. Diuretics: opioids can reduce the efficacy of diuretics by inducing the release of antidiuretic hormone (Adh).

6. Food: the bioavailability of opioids is generally not affected by food intake EXCEPT grapefruit juice: this was investigated by Johns Hopkins University some years ago to see if it could be developed as a potentiator as it can dramatically increase the availability of opioids:

however, it is highly unpredictable so not advisable to try at home!

7. Analgesic effect of opioids is enhanced by: chlorpromazine and methocarbamol.