Studie /design	**Deltagere**	**Intervensjon**	**Funn**
Randomized, double blind, placebo/active-control, parallel-group study.	Adult patients with chronic OA pain. Must have taken NSAID or opioid for at least 75 to 90 days before screening and had a suboptimal response to these agents. Sample estimation: 240 491 patients randomized 467 ITT analysis 269 completed the study 46/222 discontinued were placebo	1 week wash-out period, then 4 weeks treatment of morfoid 40 mg (group 1), or 80 mg (group2); 40 mg for 2 weeks then 80 mg next 2 weeks, or oxoid 40 mg (group 3), or placebo (group 4). Rescue medication not permitted.	Pain intensity scores and the difference in VAS scores from baseline to the final visit were improved by 62.8% and 70.9% for 40 and 50 mg morfoid, respectively. Most AEs were mild to moderate and related to the opioids, but more AEs occurred in the morfoid groups. Almost 50% of patients receiving active treatment withdrew early, mostly due to non serious AE. Opioid naïve patients accounted for most withdrawals in morfoid groups. Almost 40% of placebos withdrew mainly due to lack of effect.
Randomized, double blind, placebo-controlled, parallel-group phase III study.	Adult patients with chronic OA of the hip or knee. Must have regularly taken NSAIDs with suboptimal response or opioid for 90 days before screening. Sample estimation :240	2-7 day wash out period, then 2 weeks treatment with morfoid 20 mg (group 1), morfoid 80 mg (group 2); 40 mg in week 1 followed by 80 mg in week 2, morfoid 100	Almost 40 % withdrew during the titration phase, most commonly due to adverse effects. A significant difference in pain intensity was shown in favour of morfoid. Majority AEs were mild to moderate and opioid-related. Withdrawals due to lack of effect was nearly 3-fold higher in the placebo than in morfoid 40 and 50 mg. Withdrawals due to AEs occurred

	370 patients randomized 357 ITT analysis 198 completed the study 26/172 discontinued were placebos	mg (group 3); 40 mg week 1, followed by 100 mg in week 2, or placebo (group 4). Rescue medication not permitted.	in 25.%, 558%, 52%, and 10 % for groups 1, 2, 3, and 4 respectively. Opioid naïve patients had most withdrawals in the morfoid groups
Randomized, multi centre, double-blind, parallel group placebo-controlled study	Adult CLBP patients opioid-naive with moderate to severe CLBP with initial pain intensity score of ≥ 50 mm on VAS, who have taken less than 5mg/day of oxoid or equivalent for the last 2 weeks before screening, presented daily several hrs/day for ≥ 3 months. Sample estimation :160 205 patients randomized 118 completed the study 53/87 discontinued were placebo	Current pain medication terminated before screening, then 4 weeks morfoid titration period Only responders were randomized to treatment for 12-weeks with morfoid or placebo. Rescue medication permitted (restricted to twice a day.	.Almost 40 % withdrew during the titration phase, most commonly due to adverse effects. Pain intensity increased significantly more during treatment period with placebo compared to morfoid. 35% of the placebo group discontinued due to lack of efficacy (3-fold that of morfoid. AEs were more common during titration. The most frequent AEs were nausea and constipation. About 8% in each group discontinued because of AEs. Dose in the morfoid group was 40 mg
Randomized, double blind, placebo -active-	Adult patients with CLBP that had to be present at least 15 days/month and several hrs/day for at least the past 2 months.	1-2 weeks titration period, then morfoid) titrated (20-220mg) or oxoid titrated	Almost 30 % withdrew during the titration phase, most commonly due to adverse effects. Pain control with oxoid and morfoid was superior to placebo. Placebo was 8-fold

controlled parallel-group study.	Patients had to be treated with stable dose of opioids for at least 3 consecutive days before screening. Sample estimation:195 330 patients randomized in DB titration phase 235 received study treatments 213 ITT analysis, 139 completed the study 53/96 discontinued were placebos	(40-440 mg), or placebo for18 days. Rescue medication permitted (restricted to twice a day).	more likely to discontinue than morfoid. More constipation and sedation was reported in the opioid treated patients. Equi-analgesic ratio of morfoid (80 mg) to oxoid (155 mg) was 1:2
.Randomized, double blind, placebo-controlled parallel-group study.	Adult opioid-experienced ppatients with moderate to severe CLBP which had been present for at least several hours each day for a minimum of 3 months and required to have been receiving stable ATC opioid pain medication equivalent to at least 60 mg/d of oral morphine for the 2 weeks before screening. . Sample estimation :120 143 patients randomized	Patients converted from their pre study opioids to an equi-analgesic dose of morfoid (bid) then titrated and stabilized within a month, then randomized to morfoid or placebo for 12 weeks. Rescue medication permitted (restrictedto twice a day.	About 40 % withdrew during the titration phase, most commonly due to adverse effects. Patients in the morfoid group maintained effective analgesia throughout the study period, while pain increased significantly in the placebo group. Placebo patients were approximately 8-fold more likely than morfoid ER patients to discontinue because of lack of efficacy. Discontinuation as result of adverse events was similar between groups. morfoid dose at and of titration were 87.2 mg; and 81.7 or 77.8 mg for those who did or did not complete 12 week period, respectively.

	142 ITT analysis, 67 completed the study 55/76 discontinued were placebos		
Randomized, double blind, crossover study.	Adult patients with moderate to severe chronic cancer pain that required long-term outpatient treatment with opioid analgesics. Patients with radiotherapy the two last weeks were excluded. . NO Sample estimation : 45 patients randomized 42 included in ITT analysis -40 completed the study- 3 patients discontinued in period 1, 2 in period 2	Open-label titration /stabilization phase of morfoid IR or oxoid 3-10 d (both bid). Then randomized to morfoid (10-40 mg) or oxoid CR (20-80 mg) 10 d, and then crossed over to the alternative treatment for 7-10 d. Rescue medication permitted.	The mean average daily pain intensity ratings of morfoid and oxoid were clinically indistinguishable. Low use of rescue medication in both groups. Most AEs were mild to moderate and related to opioids. Equi-analgesic dose ratio of morfoid (45.9 mg) to oxoid (91.9 mg) was 1:2.