Morphine overdose (opioid toxicity)

Opioid toxicity

- This is quite commonly seen in the acute hospital setting or on the wards. The basic steps in management are the same but they differ slightly in naloxone dosing:

1. Opioid toxicity in patients on regular long term opioids

- Remember these patients are **opioid dependent** and may go into withdrawal if opioids are stopped completely – assess analgesic requirements and discuss with specialist palliative care team.
- This should be treated this as an emergency: contact the palliative care team immediately.
- Treat from an ABCDE perspective including:
    - Head tilt / jaw thrust / chin-lift +/- airway adjuncts if signs of airway compromise
    - Oxygen if sats <95%)
    - IV access
    - Check pupils and glucose
- Stop opioids and remove any patches (e.g. fentanyl or buprenorphine – ensure ALL have been removed)
    - If there is evidence of reduced GCS and respiratory depression it may be necessary to administer naloxone to reverse some of the toxic effects.
    - Respiratory depression can be defined as:
        - Respiratory rate <12 AND cyanosed or difficult to rouse
        - Respiratory rate <8
- The recommended dose for adults who are receiving chronic opioid/opiates is **100 to 200 micrograms (1.5 to 3 micrograms/kg) by intravenous injection**.
    - If there is little or no response this can be repeated every 2 minutes.
    - **NB. Higher doses of naloxone than this in chronic may result in a cardiac arrest**
    - Note that if the patient is not compromised from an airway or breathing perspective it may be appropriate to simply stop all opiates, remove any patches and wait for the opiate effects to wear off (naloxone may not be necessary)
- Treat the underlying cause of the toxicity e.g. infection/ acute renal failure secondary to dehydration

2. Opioid toxicity in patients who are not on regular long term opioids

- Assess from an ABCD perspective as above
- Stop any opioids that have been recently started – remember to look for any new patches
- If there is evidence of reduced GCS and respiratory depression (see above) you will need to give naloxone to reverse the toxic effects
    - The dose of naloxone recommended by the BNF *for patients not on long-term opiates* is 400 micrograms to 2mg via intravenous injection
    - If there is no response, the initial 400mcg dose can be repeated at intervals of two to three minutes to a maximum of 10mg