

Management of Opioid Overdose in the Community

Policy Statement

Strong opioids are commonly used to control pain for patients with advanced, life limiting disease (i.e. to palliate problems related to that advanced disease), and to manage chronic, severe pain. Overdosage leading to serious toxicity is rare because of the care with which morphine and other opioids are initiated, and the care taken with titration up, paced according to need for relief of symptoms (usually relief of pain; occasionally relief of breathlessness). This policy identifies the features of serious opioid toxicity - as opposed to the features of advanced progressive disease per se, and identifies a strategy for managing suspected serious opioid toxicity in patients with advanced disease. It identifies the place for naloxone, an opioid antagonist, in the management of suspected serious opioid toxicity within a patient with advanced disease.

Features of serious opioid toxicity and important differential diagnoses

Features of serious opioid toxicity include drowsiness and respiratory depression (respiratory rate of less than 8 per minute).

However patients who are reaching the end of their life are often drowsy due to the advanced stage of their illness so that sometimes it might feel difficult to know whether drowsiness is a result of opioid toxicity – or advanced illness/dying.

One clear difference is that serious opioid toxicity usually emerges over a period of hours-whereas dying emerges over a period of days and respiratory rate changes in advanced illness and in the dying phase are characterised by irregular, shallow or Cheyne-Stokes type breathing as opposed to respiratory depression.

Dangers in treating advanced illness/dying changes as opioid toxicity

If decline due to advancement of illness is interpreted as serious opioid toxicity, and naloxone is administered, a pain crisis can be precipitated resulting in poor symptom management for the patient. Carers might witness the patient, previously comfortable and pain free, becoming uncomfortable, agitated and distressed which is very distressing in itself for a watching friend, family member or professional carer. There will be no gain in terms of length of or quality of life, just distress.

Management plan

If a patient on opioids for palliation of symptoms begins to become more sleepy, re-evaluate the situation:

- Are they iller? (*did you expect this in the context of the illness?*) Might there be
 - New, or escalating disease e.g. brain metastases (*can this escalation of disease be modified? Are investigations needed?*)
 - New metabolic changes e.g. hypercalcaemia, uraemia, liver failure (*would it be appropriate to explore via blood screening?*)
 - Decreased need for analgesia and thus a need to reduce the regular amount taken (*look for **complete** comfort as a backdrop. Subtle emergent features of new toxicity such as hallucinations, dreams are often present. Can you trial a gentle reduction in the regular opioid dose?*)
 - Does their current strong opioid not suit? (*a clue that this is the case is continued pain but features of toxicity: somnolence, hallucinations. Solution:*

change in pain regime e.g. a switch in opioids requiring Specialist Palliative Care Team advice and support)

Or...

- Are they dying now?

If the care team is experiencing difficulty in evaluating a complex situation they should consider seeking involvement of or support from the local Specialist Palliative Care Team.

If the patient is recognised to be dying now, supportive care tools such as the Liverpool Care Pathway offer excellent guidance for the care team in managing the care needs of a dying patient in the best way possible.*

If the above are explored and do not apply, and/or opioid toxicity is suspected the following management plan should be employed.

A conservative approach to managing opioid toxicity is recommended.

- If respiratory rate is 8/minute or more, and the patient is easily rousable and not cyanosed, adopt a policy of 'wait and see'; consider reducing or omitting the next regular dose of morphine and reducing the ongoing dose of regular opioid by 1/3. ('Safety net' against emergent pain by ensuring the availability of prns in the house calculated to be congruent with the new regular dose).
- If respiratory rate <8/minute but the patient is rouseable and not cyanosed, omit the next regular dose of morphine and reduce the ongoing dose of regular opioid a/a.
- If respiratory rate <8/minute and the patient is barely rousable/unconscious and/or cyanosed:
 - Stop the opioid
 - Administer Oxygen by face mask if available
 - Dilute a standard ampoule containing naxolone 400microgram to 10ml with sodium chloride 0.9%
 - Administer 0.5ml (20 microgram) IV every 2 minutes until the patient's respiratory status is satisfactory. The aim is for slow, paced administration of the drug to avoid a surge of pain from complete antagonism of opioid.
 - Consider whether it is appropriate to manage the patient in the community, or whether transfer to hospital is needed. Some people will have directed the care team to avoid hospital now, even for management of crises ('preferred place of care' in crisis time is home). However naloxone is shorter-acting than morphine so that if the patient is to stay at home, the patient will need observation to ensure that the signs of overdose do not recur. Further boluses of naloxone may be necessary.

**Following treatment, advice must be sought from the local Specialist Palliative Care Team whether in the community still, or on transfer to hospital, since a plan for future symptom management is essential.
Please do refer to the Specialist Palliative Care Team.**

* For further information regarding the Liverpool Care pathway please contact either your local specialist palliative care team or End of Life Care Programme managers Ian McQuarrie and Kirsty Macpherson Tel: 020 7377 7241.