



# Management of Opioid Adverse Effects

**Common adverse effects:** constipation, nausea, vomiting, dry mouth, drowsiness, confusion, delirium

**Less common adverse effects:** urinary retention, myoclonus, respiratory depression

## Drowsiness

Common with initiation of opioid therapy and may lessen with continued therapy. If persists, the opioid dosage should be decreased.

## Delirium/Cognitive Impairment

The opioid dosage should be decreased or a different analgesic should be tried.

## Respiratory Depression: partial reversal of opioid effects in palliative patients (if declining respiratory rate < 8/minute or deteriorating level of consciousness)

Administer naloxone 0.1 to 0.2 mg IV Q 2 to 3 minutes or naloxone 0.1 to 0.2 mg subcutaneously Q 5 to 10 minutes until respiratory rate is more than 10 per minute.

If no response in 2–10 minutes, repeat naloxone 0.2 to 0.4 mg Q 2 to 3 minutes.

Continue to monitor respiratory rate Q 15 minutes until no naloxone given for 1hr.

## Known or Suspected Overdoses

Administer naloxone 0.4 to 2 mg IV; if no response, repeat naloxone 2 to 4 mg Q 2 to 3 minutes.

In cases of large narcotic overdoses or methadone overdoses, higher doses may be required.

If no response after 10 mg of naloxone, reassess diagnosis.

## Nausea and vomiting

Consider switching to a different opioid

Due to central stimulation

- prochlorperazine 2.5 to 10 mg PO/PR/IV/subcutaneous QID prn
- metoclopramide 5 mg PO/IV/subcutaneous QID prn
- haloperidol 0.5 to 1 mg PO/subcutaneous BID-TID prn

Due to gastric stasis or delayed gastric emptying:

- metoclopramide 5 mg PO/IV/subcutaneous QID
- domperidone 5-20 mg PO TID-QID

Due to vestibular stimulation

- dimenhydrinate 25 to 50 mg PO/PR/IV/subcutaneous Q4-6H prn

## Constipation

Initiate bowel regimen when starting any opioids

- docusate and lactulose +/- senna glycosides

If no BM in 48–72 hours, check for impaction and manual removal

- Administer bisacodyl suppository +/- glycerin suppository
- Increase docusate, lactulose and senna glycosides as tolerated

## Hyperalgesia

Repeated opioid exposure may result in sensitization and worsening pain state despite high opioid doses. Optimal treatment options include decreasing opioid doses or rotating to different opioid, e.g. methadone.

## Naloxone

### Onset of effect

- within 1 to 2 minutes following IV
- within 2 to 5 minutes following IM or subcutaneous injection
- NOTE: onset of action for subcutaneous route is not as prompt as with IV and may be delayed in patients who are hypotensive or have impaired peripheral circulation

### Duration of effect

- 45 minutes to 3 to 4 hours
- Effective doses may be repeated every 30 to 60 minutes
- Since duration of action of opioid may exceed that of naloxone, especially in the case of methadone, repeated doses or IV infusion may be required

### IV administration

- IV direct may be administered by RN over 15 to 45 seconds
- IV infusion restricted in critical areas

### Caution

- in patients who have received potentially cardiotoxic drugs or who have pre-existing cardiac diseases
- Hypotension, hypertension, ventricular tachycardia or fibrillation and pulmonary edema have been reported
- May precipitate acute withdrawal symptoms in patients who are dependent on narcotics within 15 to 30 minutes after receiving naloxone
- Larger than necessary doses of naloxone may result in reversal of analgesia

Based on work previously done by PHC and FH renal programs