

SECTION: R-2

PROTOCOL TITLE: Opiate Overdose

REVISED: January 27, 2010

GENERAL COMMENTS: The goal in treating an opioid overdose patient is generally not to wake the patient, but to maintain breathing and the airway. While difficult, this is especially important as opiates are often mixed with hyperdynamic substances and other drugs at the street level, and the opioid may be masking or suppressing other toxic effects.

BLS SPECIFIC CARE: *See adult General Toxicological Care Protocol R-1*

- Oxygenation: some opiate overdose patients will respond well to simple assisted ventilations. See physician pearls
- Physical restraints as necessary
- If pediatric patient, determine patient's color category on length based resuscitation tape (Broselow Tape)
- In addition to obtaining standard medical history attempt to obtain:
 - Name of ingested substance(s)
 - Quantity ingested
 - Time of ingestion
 - Has vomiting occurred?

ILS SPECIFIC CARE: *See adult General Toxicological Care Protocol R-1*

ALS SPECIFIC CARE: *See adult General Toxicological Care Protocol R-1*

- Attempt to identify co-morbid factors and other medical issues, including poly-pharmacy involvement.
- If patient has obviously aspirated, consider bypassing Narcan administration and intubate as required

Opiate Antagonist:

- Rapid reversal of a narcotic induced coma may lead to vomiting and, possibly, seizures. Administer Narcan slowly and be prepared to address both
- Narcan (naloxone)
 - Adult
 - IV/IO/SL: 0.1-2 mg slowly. Repeat as needed every 1-2 minutes to a maximum of 10 mg.
 - IM/IN: 2 mg (1 mg in each nare if given IN.) Repeat as needed to a maximum of 10 mg. If IV access is unavailable. Use nasal atomizer

PHYSICIAN PEARLS:

The Opiate Toxidrome consists of:

- Altered mental status
- Miosis
- Unresponsiveness
- Shallow respirations
- Slow respiratory rate
- Decreased bowel sounds
- Hypothermia
- Hypotension

Osterwalder, et al notes that *“In 1000 clinically diagnosed intoxications with heroin or heroin mixtures, from 4 to 30 serious complications can be expected. Such a high incidence of complications is unacceptable and could theoretically be reduced by artificial respiration with a bag valve device (hyperventilation) as well as by administering naloxone in minimal divided doses, injected slowly.”*

This is supported by other studies and case reports as well. It is recommended that a couple of minutes of careful ventilation with a BVM (with Sellick’s maneuver) be performed prior to Narcan administration to decrease the incidence of (uncommon but serious) complications.

Many Opiates have a longer bioavailability than Narcan, therefore assess for re-sedation. Re-administer Narcan as needed.