

**SECTION: R-02**

**PROTOCOL TITLE: Opioid Overdose**

**REVISED: December 01, 2022**

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**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. The provider should always consider that there may be other causes for altered mentation.

The Opiate Toxidrome consists of:

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

**BLS SPECIFIC CARE: See Protocol M-1, PM-1, PM-9**

- Oxygenation: Initiate basic airway/oxygenation/ventilation maneuvers prior to opioid antagonists. Some opiate overdose patients will respond well to simple assisted ventilations.
- Narcan (naloxone)
  - **IM/IN:** 2-4 mg\*. Repeat as needed to a maximum of 10 mg if IV access is unavailable
  - \*Some IN preparations of naloxone are supplied in 4 or 8 mg applicator packages. These may be used if available.
  - If patient has obviously aspirated, consider bypassing Narcan and manage airway if required.
- Do not delay basic care (i.e. Airway positioning, ventilations, or CPR) waiting for Naloxone availability or for Naloxone to take effect.
- Physical restraints as necessary

**AEMT/O.M. Specific Care: See Protocol M-1, PM-1, PM-9**

- Narcan (naloxone)
  - **IV/IO:** 0.1-2 mg slowly. Repeat as needed every 1-2 minutes to a maximum of 10 mg via the IV route.
  - If patient has obviously aspirated, consider bypassing Narcan and manage airway to include advanced airways if required.

**ALS SPECIFIC CARE: See Protocol M-1, PM-1, PM-9**

- Attempt to identify co-morbid factors and other medical issues, including poly-pharmacy involvement.
  - Initiate EKG monitoring and obtain a rhythm strip.
- If patient has obviously aspirated, consider bypassing Narcan administration and intubate as required
- Naloxone Infusions: for recurrent somnolence or sedation
  - Re-administer bolus of 0.1-2mg naloxone and initiate infusion
  - IV/IO 0.1-10 mg/hour, titrated for effect.
  - To mix: 4 mg/250 cc.

# Protocol R-02

## OPIATE OVERDOSE

The physician medical directors direct that suspected opioid overdose patients who are contacted by ACCESS system providers, **even if the overdose has resolved**, should be strongly encouraged for transport for evaluation whenever possible.

### PHYSICIAN PEARLS:

**Need for Transport:** The physician medical directors direct that suspected opioid overdose patients who are contacted by ACCESS system providers, even if the overdose has resolved, should be strongly encouraged for transport for evaluation whenever possible. If the patient refuses, these cases should be documented thoroughly.

**Clinical Goal:** The goal of naloxone administration is to reverse respiratory depression and hypoxia while avoiding combativeness and agitation. Use the *lowest dose* possible to restore spontaneous respirations but avoid precipitating withdrawal

**PPE:** EMS Provider risk of accidental airborne exposure is negligible when basic BSI/PPE (i.e. Gloves, eye protection, mask) is worn.

**Route:** Low dose naloxone titrated carefully via the IV route is preferable over large boluses IM or IN. Consider focusing on airway and respiratory support while IV access is established.

**Naloxone infusions:** Not every patient will need a naloxone infusion. Naloxone infusions are an option for patients who are re-sedating after initial naloxone administration. Naloxone infusions should be preceded by a supplementary bolus of IV/IO Naloxone, and then initiated at a rate equivalent to the initial dose required to maintain respiratory effort. I.E. if 1 mg was initially required for restoration of respirations, the dose may be initially set at 1 mg/hour to maintain that state.

The lower dose ranges of Naloxone (0.1-0.4 mg) is intended to avoid the rapid reversal of a narcotic induced coma. Rapid Reversal may lead to vomiting, combativeness, seizures and rarely even cardiac arrest. These adverse events can be minimized with airway management, slow administration and small titrated doses of naloxone.

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

Certain opioids, such as Imodium, can cause EKG changes and QT prolongation. EKG monitoring is indicated.