oxaprozin (ox-a-proe-zin)

**Drug**

**Classification**
Therapeutic: antirheumatics, nonsteroidal anti-inflammatory agents

**Pregnancy Category**
C (first and second trimester), D (third trimester)

**Indications**

**Action**
Inhibits prostaglandin synthesis. Therapeutic Effects: Suppression of pain and inflammation.

**Pharmacokinetics**

| Absorption: | Well absorbed following oral administration (80%); 35% is rapidly converted to an active metabolite. |
| Distribution: | Unknown. |
| Protein Binding: | 99.9%. |
| Metabolism and Excretion: | The active metabolite is metabolized by the liver to inactive compounds. |
| Half-life: | 42–50 hr. |

**TIME/ACTION PROFILE (antirheumatic action)**

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<thead>
<tr>
<th>ROUTE</th>
<th>ONSET</th>
<th>PEAK</th>
<th>DURATION</th>
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<tr>
<td>PO</td>
<td>unknown</td>
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**Contraindications/Precautions**

**Contraindicated in:** Hypersensitivity. Cross-sensitivity may exist with other NSAIDs, including aspirin. Active GI bleeding or ulcer disease. Peri-operative pain from coronary artery bypass graft (CABG) surgery. Lactation.

**Use Cautiously in:** Cardiovascular disease or risk factors for cardiovascular disease. Severe hepatic disease. Renal impairment. Use with caution in pregnancy. Use during lactation. Use cautiously in children 6 yr of age (safety not established). Geri: appears on Beers list; at risk of GI bleeding; may require adjustments in dosing due to age-related decrease in renal function.

**Adverse Reactions/Side Effects**

**CNS:** agitation, anxiety, confusion, depression, dizziness, drowsiness, headache, insomnia, malaise, weakness.

**EENT:** abnormal vision, tinnitus.

**Resp:** dyspnea, hypersensitivity pneumonitis.

**CV:** edema, vasculitis.

**GI:** GI BLEEDING, abdominal pain, diarrhea, dyspepsia, elevated liver enzymes, anorexia, cholestatic jaundice, constipation, dry mouth, duodenal ulcer, flatulence, gastritis, increased appetite, nausea, stomatitis, vomiting.

**GU:** albuminuria, azotemia, interstitial nephritis.

**Derm:** exfoliative dermatitis, Stevens-Johnson syndrome, toxic epidermal necrolysis, fever, flushing, sweating, photosensitivity, pruritus, rash.

**Hemat:** prolonged bleeding time.

**Metab:** weight gain.

**Neuro:** paresthesia, tremor.

**Misc:** allergic reactions including ANAPHYLAXIS, ANGIONEUROTIC EDEMA.

**Interactions**

**Drug-Drug:** Risk of GI effects and toxicity with aspirin, other NSAIDs, potassium supplements, corticosteroids, or alcohol. Chronic use with acetaminophen may increase risk of adverse renal reactions. May increase effects of anticoagulants, corticosteroids, or oral hypoglycemic agents. Risk of toxicity from methotrexate. Risk of bleeding with colchicine, corticosteroids, thrombolytic agents, anticoagulants, ticlopidine, clopidogrel, eptifibatide, or tirofiban. Risk of adverse hematologic reactions with antineoplastic or radiation therapy.

**Drug-Natural Products:** Anti-coagulant effect and bleeding risk with arnica, chamomile, clove, feverfew, garlic, ginger, ginkgo, Panax ginseng, and others.

**Route/Dosage**

**Osteoarthritis or Rheumatoid Arthritis**

PO (Adults): 1200 mg once daily; may be increased to an initial 1800-mg dose. Patients with low body weight, mild disease, or renal impairment may be started at 600 mg/day (not to exceed 1800 mg/day or 26 mg/kg/day). Daily doses >1200 mg should be given in 2–3 divided doses. Consideration should be given to decreasing dose to lowest effective amount.
Juvenile Rheumatoid Arthritis

PO (Children 6–16 yr):
- ≤ 55 kg — 1200 mg once daily;
- 32–54 kg — 900 mg once daily;
- 22–31 kg — 600 mg once daily.

NURSING IMPLICATIONS

Assessment
- Patients who have asthma, aspirin-induced allergy, and nasal polyps are at increased risk for developing hypersensitivity reactions. Monitor for rhinitis, asthma, and urticaria.
- Assess pain and range of motion prior to and periodically during therapy.
- Lab Test Considerations: May cause prolonged bleeding time, which may persist for up to 2 wk following discontinuation of therapy.
- Evaluate BUN, serum creatinine, GFR, and liver function tests periodically in patients receiving prolonged therapy. Serum potassium, BUN, serum creatinine, alkaline phosphatase, LDH, and ALT tests may show q levels. Blood glucose, hematocrit, and hematocrit concentration, leukocyte and platelet counts, and CCr may be p.

Potential Nursing Diagnoses

Acute pain (Indications)

Implementation
- Administration in higher than recommended doses does not provide increased effectiveness but may cause increased side effects. Use lowest effective dose for shortest period of time.

PO: Administer with food or antacids to decrease GI irritation.

Patient/Family Teaching
- Advise patient to take oxaprozin with a full glass of water and to remain in an upright position for 15–30 min after administration.
- Instruct patient to take medication as directed. Take missed doses as soon as remembered but not if almost time for the next dose. Do not double doses.
- May cause drowsiness and dizziness. Advise patient to avoid driving or other activities requiring alertness until response to the medication is known.
- Advise patient to avoid the concurrent use of diuretics, aspirin, antacids, and other OTC or herbal products without consulting health care professional.

Evaluation/Desired Outcomes
- Decreased pain and improved joint mobility. Maximum effectiveness may require 2 wk or more of continuous therapy. Patients who do not respond to one NSAID may respond to another.
- Advise patient to notify health care professional of medication regimen prior to treatment or surgery. Oxaprozin should be discontinued 2 wk prior to surgery.
- Advise patient to consult health care professional if rash, itching, visual disturbance, tinnitus, weight gain, edema, black stools, persistent headache, or influenza-like syndrome (chills, fever, muscle aches, cough) occurs.

Why was this drug prescribed for your patient?