**oxyCODONE** (ox-i-koe-done)

**Classification**
Therapeutic: opioid analgesics
Pharmacologic: opioid agonists, opioid agonists/nonopioid analgesic combinations

**Schedule II**
Pregnancy Category B

**Indications**
Moderate to severe pain; extended release product should be used for patients requiring around-the-clock management of chronic pain.

**Action**
Binds to opiate receptors in the CNS. Alters the perception of and response to painful stimuli, while producing generalized CNS depression.

**Therapeutic Effects:**
Decreased pain.

**Pharmacokinetics**

Absorption: Well absorbed from the GI tract.

Distribution: Widely distributed. Crosses the placenta; enters breast milk.

Protein Binding: 38–45%.

Metabolism and Excretion: Mostly metabolized by the liver by the CYP3A4 isoenzyme.

Half-life: 2–3 hr.

**TIME/ACTION PROFILE (analgesic effects)**

<table>
<thead>
<tr>
<th>ROUTE</th>
<th>ONSET</th>
<th>PEAK</th>
<th>DURATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>PO†</td>
<td>10–15 min</td>
<td>60–90 min</td>
<td>3–6 hr</td>
</tr>
<tr>
<td>PO</td>
<td>10–15 min</td>
<td>3 hr</td>
<td>12 hr</td>
</tr>
</tbody>
</table>

†Controlled release

**Contraindications/Precautions**

Contraindicated in: Hypersensitivity. Some products contain alcohol or benzyl alcohol and should be avoided in patients with known intolerance or hypersensitivity. Significant respiratory depression. Paralytic ileus; Acute or severe bronchial asthma; Acute, mild, intermittent, or postoperative pain (extended release).

Use Cautionally in: Head trauma; Paralytic ileus; Severe renal or hepatic disease; Hypothyroidism; Adrenocorticotropic hormone disorders; Severe uncontrolled ADH release. CYP3A4 inhibitors; Blacks; Asians; Non-English speaking patients; Elderly; CYP3A4, CYP2C19, CYP2C9.

Use with extreme caution in: Acute or severe bronchial asthma; Severe, uncontrolled ADH release.

**Adverse Reactions/Side Effects**

CNS:
- Confusion, sedation, dizziness, dysphoria, euphoria, floating feeling, hallucinations, headache, unusual dreams.

EENT:
- Blurred vision, diplopia, miosis.

Resp:
- RESPIRATORY DEPRESSION.

CV:
- Orthostatic hypotension.

GI:
- Constipation, dry mouth, choking, GI obstruction, nausea, vomiting.

GU:
- Urinary retention.

Derm:
- Flushing, sweating.

Misc:
- Physical dependence, psychological dependence, tolerance.

**Interactions**

**Drug-Drug:**
- Use with caution in patients receiving MAO inhibitors (may result in unpredictable reactions—initial dose of oxycodone to 25% of usual dose).
- Additive CNS depression with alcohol, antihistamines, and sedative/hypnotics.
- Administration of partial-antagonist opioid analgesics may precipitate withdrawal in physically dependent patients.
- Nalbuphine, buprenorphine, or pentazocine may antagonize analgesia. Potent CYP3A4 inhibitors including erythromycin, ketoconazole, itraconazole, voriconazole, or ritonavir may q levels. Potent CYP3A4 inducers including rifampin, carbamazepine, and phenobarbital may levels.

**Route/Dosage**

Larger doses may be required during chronic therapy.

| PO (Adults) | 50 kg: 5–10 mg q 3–4 hr initially, as needed. Controlled-release tablets (Oxycontin) may be given q 12 hr. |
| PO (Adults) | 50 kg: 0.2 mg/kg q 3–4 hr initially, as needed. |
| PO (Children) | 0.05–0.15 mg/kg q 4–6 hr as needed, as immediate-release product. |
| Rect (Adults) | 0.1–0.15 mg/g–q 3–4 times daily, as needed. |

**NURSING IMPLICATIONS**

**Assessment**
- Assess type, location, and intensity of pain prior to and 1 hr (peak) after administration. When initiating opioid doses, increments of 25–50% should be administrated. 

**Risks/Complications**
- Monitor respiratory status; be alert for respiratory depression. Patients with a history of chronic lung disease or COPD, should be closely monitored. Assess bowel function; monitor for constipation and bowel obstruction.
tered until there is either a 50% reduction in the patient's pain rating on a numeri-
cal or visual analog scale or the patient reports satisfactory pain relief. A repeat
dose can be safely administered at the time of the peak if previous dose is ineffec-
tive and side effects are minimal.

● Patients taking controlled-release tablets may also be given supplemental short-
acting opioid doses for breakthrough pain.

● An oxydiazepam chart (see Appendix E) should be used when changing routes or
administering repeated doses.

● Assess BP, pulse, and respirations before and periodically during ad-
ministration. If respiratory rate is ≥15/min, assess level of sedation.

Physical stimulation may be sufficient to prevent significant hyperventila-
tion. Dose may need to be decreased by 25–50%. Initial drowsiness will
usually diminish with continued use.

An equianalgesic chart (see Appendix B) should be used when changing routes or
when changing from one opioid to another.

● Assess bowel function routinely. Prevention of constipation should be instituted
with increased intake of fluids and bulk, and laxatives to minimize constipating ef-
facts. Stimulant laxatives should be administered routinely if opioid use exceeds
2–3 days, unless contraindicated.

● Lab Test Considerations: May
determine plasma amylase and lipase levels.

● Toxicity and Overdose: If an opioid antagonist is required to reverse respira-
tory depression or coma, naloxone should be administered. Should
be administered only if opiate use exceeds 2–3 days, unless contraindicated.

High Alert:
Accidental overdose of opioid analgesics has resulted in fatalities.

Before administering, clarify all ambiguous orders; have second practitioner in-
dependently check original order and dose calculations.

Potential Nursing Diagnoses

Acute pain (Indications)
Chronic pain (Indications)
Risk for injury (Side effects)

Implementation

● High alert: Accidental overdose of opioid analgesics has resulted in fatalities.

Before administering, check all ambiguous orders; have second practitioner in-
dependently check original order and dose calculations.

Do not confuse short-acting oxycodone with long-acting Oxycontin.

Do not confuse oxycodone with hydrocodone. Do not confuse Oxycontin
with MS Contin.

● Explain therapeutic value of medication prior to administration to enhance the an-
algus effect.

● Regularly administered doses may be more effective than on-demand administra-
tion. Anecdotes in more effective if given before pain becomes severe.

● Controlled Release: Take 1 tablet at a time. Swallow controlled-release tablet
whole; do not crush, break, or chew. Taking broken, chewed, crushed or
dissolved controlled-release tablets leads to rapid release and absorp-
tion of a potentially fatal dose of oxycodone. Advise patients not to swallow
a crushed or dissolved controlled-release tablet prior to taking the needed
dose. Take each tab-

let with enough water to ensure complete swallowing immediately after placing in
mouth. Dose should be based on 24-hr opioid requirement determined with
short-acting opioid doses converted to controlled-release forms.

Do not use Fentanyl for administration via nasogastric, gastric or other feeding
tubes as errors cause obtundation of feeding tubes.

Patient/Family Teaching

● Instruct patient on how and when to ask for and take pain medication.

● Advise patient that oxycodone is a drug with known abuse potential. Protect it from
theft, and never give to anyone other than the individual for whom it was pre-
scribed.

● Medication may cause drowsiness or dizziness. Advise patient to take calcium carbonate
when antacids or acidophilic precipitate. Caution patient to avoid driving and other activities
requiring alertness until response to medication is known.

● Advise patients taking OxyContin tablets that empty matrix tablets may appear in
stool.

● Advise patient to make position changes slowly to minimize orthostatic hypoten-
sion.

● Advise patient to avoid concurrent use of alcohol or other CNS depressants with
this medication.
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- Instruct patient to notify health care professional of all Rx or OTC medications, vitamins, or herbal products being taken and consult health care professional before taking any new medications.
- Encourage patient to turn, cough, and breathe deeply every 2 hr to prevent atelectasis.
- Advise patient to notify health care professional if pregnancy is planned or suspected, or if breast feeding.

Evaluation/Desired Outcomes

- Decrease in severity of pain without a significant alteration in level of consciousness or respiratory status.

Why was this drug prescribed for your patient?