oxymorphone (ox-i-mor-fone)

Opioid agonist

Classification
Therapeutic: opioid analgesics
Pharmacologic: opioid agonists

Schedule II

Pregnancy Category C

Indications
Management of moderate to severe pain. Extended-release tablets should only be used in patients who require continuous, around-the-clock management of chronic pain. Supplement with analgesics.

Contraindications/Precautions
Contraindicated in: Hypersensitivity; Concurrent alcohol; Moderate/severe hepatic impairment; Significant respiratory depression (unless monitoring and resuscitative equipment are readily available); Acute or severe bronchial asthma (extended-release); Acute, mild, intermittent, or postoperative pain (extended-release); Paralytic ileus.

Use Cautiously in: Acute alcoholism or delirium tremens or other toxic psychosis; Mild hepatic impairment; Brain injury; Intracranial pressure (may obscure neurologic signs and further increase ICP); Volume depletion or drugs that may cause hypotension including diuretics and phenothiazines (4% risk of severe hypotension); Circulatory shock (may precipitate shock); Adrenal insufficiency; Seizure disorders; Hypothyroidism; Prostatic hypertrophy or ureteral stricture; Severe pulmonary or renal impairment; Biliary tract disease or pancreatitis; OB: Use only in pregnancy if maternal benefit outweighs fetal risk; Lactation: Lactation; Geri: Blood levels are increased; dose accordingly.

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, nausea, vomiting.
GU: Urinary retention.
Derm: Flushing, sweating.
Misc: Physical and psychological dependence, tolerance.

Interactions
Drug-Drug: Use with caution in patients receiving MAO inhibitors (may result in unpredictable reactions — initial dose of oxymorphone to 25% of usual dose); 4% risk of CNS depression; Nalbuphine, buprenorphine, or pentazocine may precipitate withdrawal in physically dependent patients.

TIME/ACTION PROFILE (analgesic effects)

<table>
<thead>
<tr>
<th>ROUTE</th>
<th>ONSET</th>
<th>PEAK</th>
<th>DURATION</th>
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</thead>
<tbody>
<tr>
<td>PO</td>
<td>variable</td>
<td>variable</td>
<td>4–6 hr</td>
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<tr>
<td>PO</td>
<td>unknown</td>
<td>unknown</td>
<td>12 hr</td>
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<tr>
<td>IM</td>
<td>10–15 min</td>
<td>30–90 min</td>
<td>3–6 hr</td>
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<tr>
<td>IV</td>
<td>5–10 min</td>
<td>15–30 min</td>
<td>3–6 hr</td>
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<tr>
<td>Subcut</td>
<td>10–20 min</td>
<td>variable</td>
<td>3–4 hr</td>
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</tbody>
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Concomitant use of oxymorphone and other CNS depressants or alcohol should be used with caution.

Partial Agonist Opioid Analgesics may precipitate withdrawal in physically dependent patients. Nalbuphine, buprenorphine, or pentazocine may precipitate withdrawal in physically dependent patients.

Opioids may precipitate withdrawal in physically dependent patients.

Drug-Delivery Devices: Use caution when administering IV infusion through a Y-site with other IV medications.

CNS: Sedation, confusion, drowsiness, dizziness, hallucinations.
GI: Constipation.
Resp: RESPIRATORY DEPRESSION.
CV: Hypotension, orthostatic hypotension.
Drug: Natural Products: Concomitant use of kava-kava, valerian, or chamomile can increase CNS depression.

Route/Dosage
Larger doses may be required during chronic therapy.

PO (Adults): Opioid-naive patients—10–20 mg every 4–6 hr, some patients may require initial dose of 5 mg, not to exceed 20 mg. Once optimal analgesia is obtained, chronic pain patients may be converted to an equivalent 24-hour dose given as extended-release tablets every 12 hr.

Subcut, IM (Adults): 0.5–1 mg q 3–6 hr as needed. Do not administer labor—(0.5–1 mg).

PO (Adults): 5 mg q 3–6 hr as needed.

NURSING IMPLICATIONS

Assessment
● Assess type, location, and intensity of pain prior to and 1 hr following IM and 15–30 min (peak) following IV administration. When titrating opioid doses, increases of 25–50% should be administered until there is either a 50% reduction in the patient’s pain rating on a numerical or visual analogue 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 ineffective and side effects are minimal.

● Patients taking controlled-release tablets should also be given supplemental short-acting opioid dose at breakthrough pain.

● An opioid analgesic chart (see Appendix E) should be used when changing routes or when changing from one opioid to another.

● Assess BP, pulse, and respirations before and periodically during administration. If respiratory rate is <10/min, assess level of sedation. Physical stimulation may be sufficient to prevent significant hypoventilation. Dose may need to be decreased by 25–50%. Initial dosages will diminish with continued use.

● Prolonged use may lead to physical and psychological dependence and tolerance. This should not prevent patient from receiving adequate analgesia. Most patients who receive oxymorphone for pain do not develop psychological dependence and addiction. Progressively higher doses may be required to relieve pain with long-term therapy.

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

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

● Excretion and Overdose: If an opioid antagonist is required to reverse respiratory depression or coma, naloxone is the antidote. Dilute the 0.4-mg ampule of naloxone in 10 mL of 0.9% NaCl and administer 0.5 mL (0.02 mg) by direct IV push every 2 min. For children and patients weighing <10 kg, dilute 0.1 mg of naloxone in 10 mL of 0.9% NaCl for a concentration of 10 mcg/mL and administer 0.5 mcg/kg every 2 min. Titrate dose to avoid withdrawal, seizures, and severe pain.

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, clarify all ambiguous orders; have second practitioner independently check original order, dose calculations, and infusion pump settings.

● Explain therapeutic value of medication prior to administration to enhance the analgesic effect.

● Regularly administered doses may be more effective than prn administration. Analgesic is more effective if given before pain becomes severe.

● Coadministration with nonopioid analgesics may have additive analgesic effects and may permit lower doses.

● Medication should be discontinued gradually after long-term use to prevent withdrawal symptoms.

● PO: Administer at least 1 hr prior to or 2 hr after eating.

● Extended Release: Swallow controlled-release tablets whole; do not break, crush, or chew. Titrate to addition to pain or regular use or no more than 2 doses of supplemental analgesia (rescue) per 24 hr. Dose should be based on 24-hr opioid requirement determined with short-acting opioids then converted to controlled-release form.

● If patient is opioid-naive, start with 5 mg every 12 hr, then titrate in increments of 5–10 mg every 12 hr for 5–7 days to a level that provides adequate analgesia with minimal side effects.

● If converting from Opana to Opana ER, administer half the patient’s total daily dose of Opana as Opana ER every 12 hr.

● If converting from parenteral oxymorphone, administer 10 times the patient’s total daily parenteral oxymorphone dose as Opana ER for two equally divided doses every 12 hr.

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CONTINUED
Continued

oxymorphone

- If converting from other opioids, 10 mg of oral oxymorphone is equianalgesic to hydrocodone 20 mg, oxycodone 20 mg, methadone 20 mg, and morphine 30 mg orally.

IV Administration

- Direct IV: Administer undiluted. Concentration: 1 mg/mL. Rate: Give over 2–3 min.

Patient/Family Teaching

- Instruct patient on how and when to ask for pain medication.
- Instruct patient to take oxymorphone as directed and not to adjust dose without consulting health care professional. Take missed doses as soon as possible if not chronic therapy. If almost time for next dose, skip dose and return to regular schedule. Do not double doses unless advised by health care professional. Discontinue gradually under supervision of health care professional. Caution patient to keep medication out of reach of children and pets.
- Advise patient that oxymorphone is a drug with known abuse potential. Protect it from theft, and never give to anyone other than the individual for whom it was prescribed.
- Caution patient not to share this medication, may cause harm or death and is against the law.
- Medication may cause drowsiness or dizziness. Advise patient to call for assistance when ambulating or smoking. Caution patient to avoid driving and other activities requiring alertness until response to medication is known.
- Advise patient to make position changes slowly to minimize orthostatic hypotension.
- Advise patient to avoid concurrent use of alcohol or other CNS depressants with this medication.
- Advise patient to notify health care professional of all Rx or OTC medications, vitamins, or herbal products being taken and to consult with health care professional before using other medications.

- Encourage patient to turn, cough, and breathe deeply every 2 hr to prevent atelectasis.
- Instruct patient taking Opana ER tablets that soft mass resembling tablets may appear in stool; active medication was already absorbed.
- 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?