Oxycodone Intravenous for Adults

Who can administer

Administration RESTRICTED - see Appendix 1

Important information

- This monograph is for use in the setting of **ACUTE pain ONLY**
- Ensure **correct programme** is selected on PCA pump for Oxycodone (See "PCA" policy on QPulse, CLN-NM-047)

Dose equivalency

- There are significant differences of opinion as to the bioavailability of IV and oral oxycodone preparations
- In general, in the context of **acute pain management** use the following equivalency
  - Oral oxycodone 2mg is equivalent to 1mg parenteral oxycodone
  - Note: inter-patient variability requires that each patient is carefully titrated to the appropriate dose
- **Patients already on opioids**
  - Conversion is problematic and should require input from a consultant with a special interest in pain or palliative care

Available preparations

Oxycodone **10mg in 1ml** ampoules

Oxycodone **20mg in 2ml** ampoules

- **For IV use:** available for theatres, recovery and surgical wards only
- Used to prepare PCA bags in the event of commercially produced stock being unavailable

Oxycodone **50mg in 100mL PCA bags (commercially prepared)**

Oxycodone **50mg in 1ml** ampoules (not routinely supplied)

Reconstitution

- Not required
- **Already in solution**
- **Dilute further prior to administration**

Infusion fluids

Sodium chloride 0.9% or Glucose 5%

Methods of intravenous administration

PCA

- Administer via programmed PCA device - ensure correct programme is selected on PCA pump for Oxycodone
- If commercially prepared PCA bags are not available, it may be required to prepare an infusion using ampoules. Â Prepare an infusion containing 50mg per 100ml

Bolus Intravenous injection

- Dilute to 1mg per ml with infusion fluid or Water for Injections
- Administer slowly over one to two minutes

Intravenous infusion

- Dilute to 1mg per ml with infusion fluid or Water for Injections (unless PCA- see above for required strength for PCA)
- Administer at a starting rate of 2mg per hour

Dose in adults

Subcutaneous dosing (at ward level)

- Give 2.5 to 5mg given every 4 to 6 hours PRN (**maximum in older patients** 2.5mg/dose) [ref 1]
- Used in Continuous subcutaneous infusions- as per Palliative care

Intravenous bolus (Anaesthetist, Recovery theatre nurses, Specialist pain nurses ONLY) [ref 1]

- Give 0.5 to 1mg, repeated in 5 minutes if required (not to be given outside theatre/recovery unless on direct instruction of anaesthetist)

PCA

- Give according to hospital policy-see QPulse document CLN-NM-047

Continuous Subcutaneous Infusion (CSCI)

- Use as per Palliative care

Renal dosing

- Dose initiation should follow a conservative approach. Doses should be reduced by 50% and each patient should be titrated to adequate pain control according to their clinical situation

Monitoring

- Monitor blood pressure, heart rate, respiratory rate, oxygen saturation, pain and sedation scores
- As per GUH Early Warning Score chart
- Treatment of overdose: use naloxone

Further information

- **Toxicity** may be enhanced by **inhibitors of CYP3A4 , ultra-rapid metabolisers of CYP2D6** and in **renal impairment**

Storage

- Store below 25^{0}C
- Controlled drug cupboard

References

SPC Oxynorm 10mg/ml March 2025

1: Email communication with Dr Olivia Finnerty February 9th, 2023

Therapeutic classification

Opioid analgeisa