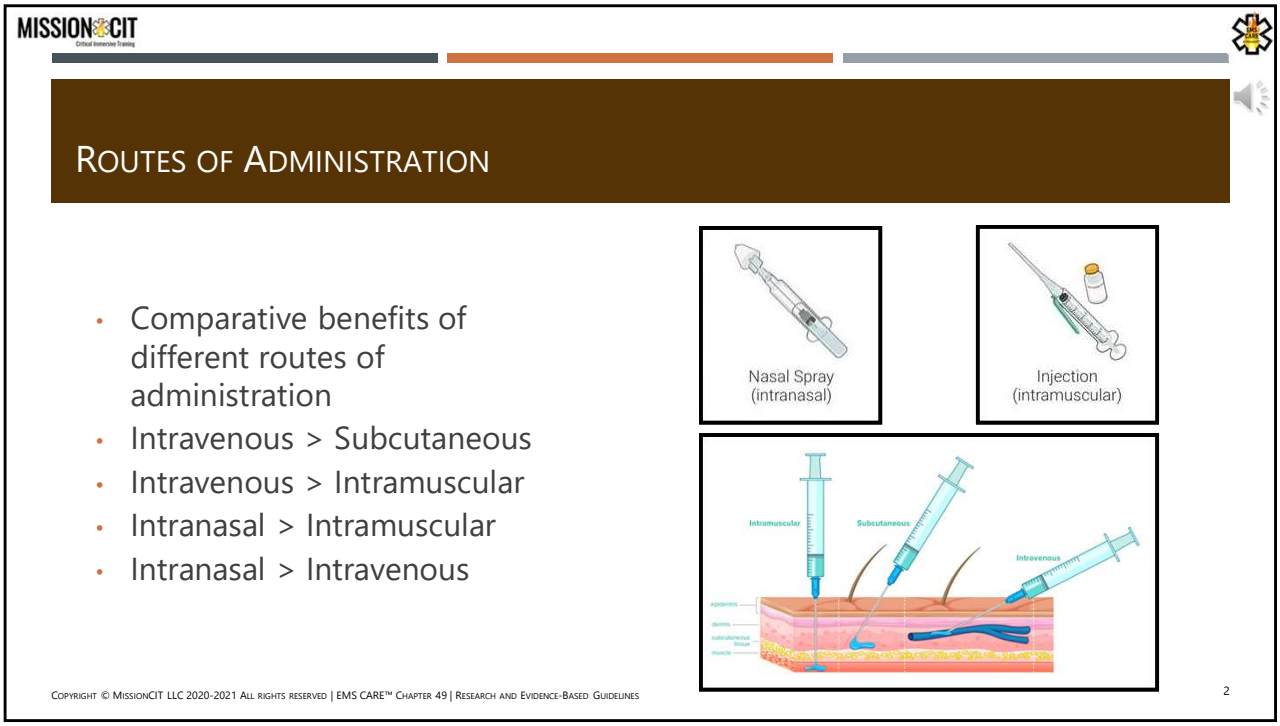


Thank you, Missah!

Welcome to this lesson where we will delve into the research happening in the administration of Naloxone and the evidence that has been gathered so far in this area.



This area of research aimed to answer the following question:

For patients with confirmed or suspected opioid overdose, what are the comparative benefits and harms related to out-of-hospital administration of naloxone by EMS personnel using intravenous, intramuscular, subcutaneous, and intranasal routes of administration?

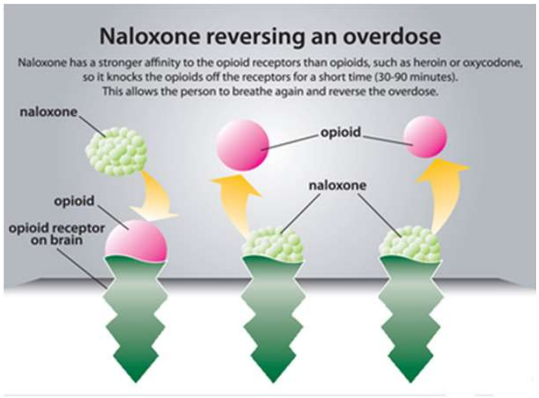
- First off, the panel compared intranasal vs intramuscular and found that intranasal was a better route because of ease of administration and practitioner safety, especially in the event of opioid

withdrawal symptoms. Also, needlestick injuries can be a cause of concern among EMTs who may have less experience with intramuscular dosing.

- Next, intranasal was compared with intravenous. The panel favored both equally but preferred intranasal among EMTs with little experience in intravenous injection.
- While comparing intravenous and subcutaneous, the panel favored intravenous as the chances for complications to both patients and providers were lesser.
- Finally, when intramuscular and intravenous were compared, the panel favored intravenous because of its ability to titrate the drug and reduce the chances for patient agitation.

Dosage and Timing

- Dose must restore and maintain respiratory function
- Not result in the return of full patient consciousness
- Wait for 2-3 minutes
- Administer dosage again only if needed
- Follow FDA guidelines and local protocols



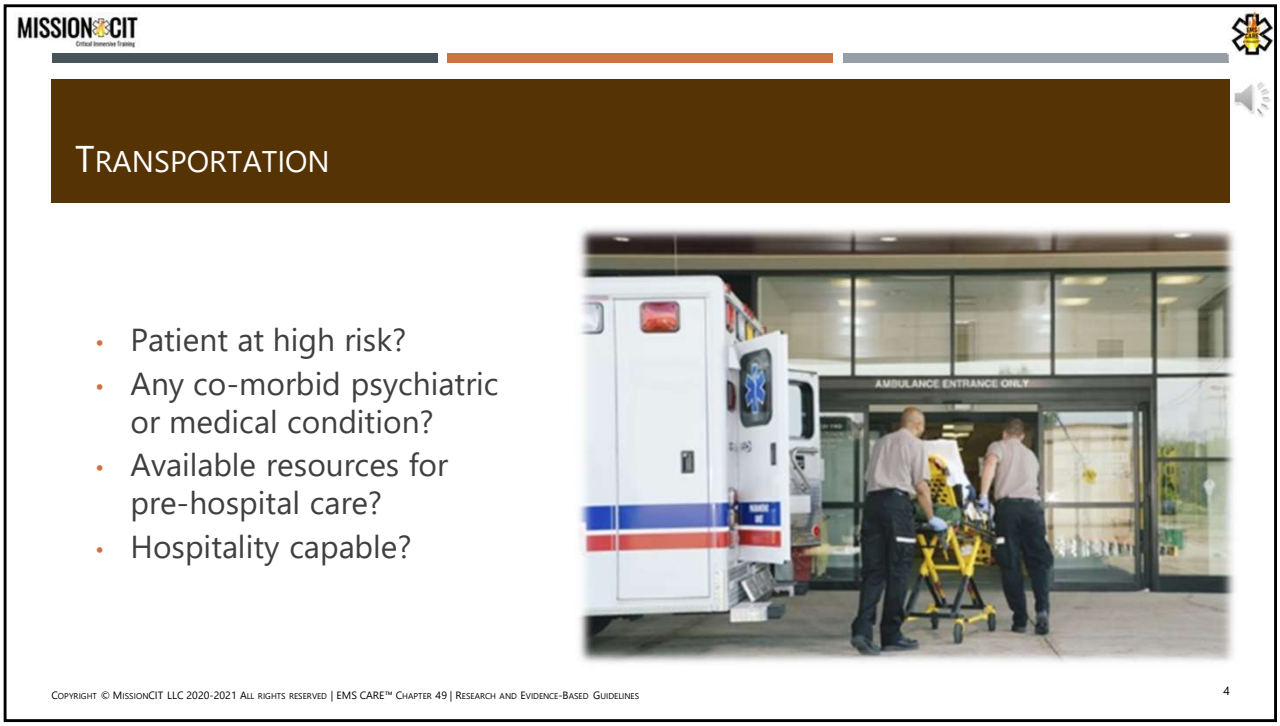
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Based on the existing evidence, the appropriate dose restores and maintains respiratory function and does not result in the return of full patient consciousness as the latter is not needed for patient safety. Also, restoring full consciousness may increase withdrawal and agitation, so just the right amount to provide respiratory function are enough.

After the dosage, EMTs must monitor the patient closely for the restoration of adequate ventilation. The dosage must be repeated only in case of inadequate response. Since the onset of action varies with the administration

route, it’s best to follow the FDA guidelines that recommend about 2-3 minutes. If you don’t see any improvement within this time, administer a second dosage.



While making transportation decisions, the following aspects must be considered:

- Is the patient at high risk of experiencing re-occurrence of overdose due to substances ingested?
- Are there any co-morbid psychiatric or medical conditions that would be better addressed in a hospital setting?
- Is there a lack of resources to refer the overdose patient to while in the field?
- Does the hospital have the resources to handle this patient?

The answers to these questions should shape your decision to transport a patient.

This brings us to the end of this lesson, and in the next one, Missah will talk about the evidence-based guidelines for fatigue risk management.