Tolerance and Withdrawal From Prolonged Opioid Use in Critically Ill Children

abstract

OBJECTIVE: After prolonged opioid exposure, children develop opioid-induced hyperalgesia, tolerance, and withdrawal. Strategies for prevention and management should be based on the mechanisms of opioid tolerance and withdrawal.

PATIENTS AND METHODS: Relevant manuscripts published in the English language were searched in Medline by using search terms “opioid,” “opiate,” “sedation,” “analgesia,” “child,” “infant-newborn,” “tolerance,” “dependency,” “withdrawal,” “analgesic,” “receptor,” and “individual opioid drugs.” Clinical and preclinical studies were reviewed for data synthesis.

RESULTS: Mechanisms of opioid-induced hyperalgesia and tolerance suggest important drug- and patient-related risk factors that lead to tolerance and withdrawal. Opioid tolerance occurs earlier in the younger age groups, develops commonly during critical illness, and results more frequently from prolonged intravenous infusions of short-acting opioids. Treatment options include slowly tapering opioid doses, switching to longer-acting opioids, or specifically treating the symptoms of opioid withdrawal. Novel therapies may also include blocking the mechanisms of opioid tolerance, which would enhance the safety and effectiveness of opioid analgesia.


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KEY WORDS: tolerance, withdrawal, abstinence, opiate, opioid, narcotic, stress, critical illness

ABBREVIATIONS: AC—adenylate cyclase; cAMP—cyclic adenosine monophosphate; iNOS—inducible nitric oxide synthase; PKC—protein kinase C; NMDA—N-methyl-D-aspartate; COMT—catechol-O-methyltransferase; M6G—morphine-6-glucuronide; M3G—morphine-3-glucuronide; MNAS—Modified Narcotic Abstinence Scale; WAT-1—Withdrawal Assessment Tool 1

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Critically ill children and neonates routinely receive opioids for analgesia and sedation to reduce pain, anxiety, agitation, and stress responses; retain monitoring devices; facilitate ventilation; and avoid secondary complications.1–3 Prolonged opioid therapy often leads to tolerance, seen as diminishing pharmacologic effects, and is associated with opioid withdrawal when opioids are weaned or discontinued4–8 (Table 1). Opioid withdrawal can be treated or prevented by using a variety of therapeutic approaches,4,9 but it may be more desirable to block the mechanisms that lead to opioid tolerance.10–12 We review here the epidemiology of opioid tolerance and withdrawal, the underlying cellular mechanisms, and novel approaches to avoiding these complications in critically ill children.

**SCOPE OF THE PROBLEM**

Treatment of pain is a priority for all patients,13 especially for children because of their vulnerability and limited understanding.14 Appropriate analgesia reduces the stress responses and improves the clinical outcomes of pediatric patients,15–17 whereas inadequately treated pain may alter their subsequent development.18–20 Up to 74% of children recalled their painful experiences during PICU admission.21–23 Pain-induced agitation can endanger the stability of endotracheal tubes, vascular access devices, or other interventions that are necessary for intensive care. Unplanned extubations in children with a critical airway can be fatal.24,25 Overuse of these agents, however, may also have untoward consequences. Results of recent studies have suggested that critically ill patients are often oversedated, which prolongs their ventilator course and ICU stay.26 The need to wean sedatives or treat withdrawal symptoms can also delay ICU and hospital discharge.7

No consensus exists regarding the optimal choice, route, or dosing of analgesic/sedative drugs in children (Table 2). The Paediatric Intensive Care Society (of the United Kingdom) recently published 20 recommendations regarding analgesia/sedation, but none of these were based on randomized clinical trials or dealt with tolerance or withdrawal.27 The most commonly used drugs include morphine, fentanyl, midazolam, and lorazepam,28–30 but none of these drugs have been well studied in children. Given that opioids are often used for extended periods of time, in continuous infusions as opposed to their initially intended periodic administration, and in unstudied combinations, it is likely that most drug-related complications remain unreported.

Opioid tolerance was identified from a retrospective chart review in neonates,31 which showed fivefold increases in fentanyl infusions coupled with increases in plasma fentanyl concentrations to maintain the same clinical effect.31,32 Total fentanyl doses of more than 1.6 mg/kg or infusions that lasted longer than 5 days led to opioid withdrawal.31,32 Katz et al35 reported opioid withdrawal in 13 of 23 infants on fentanyl infusions and in all those who received fentanyl for more than 9 days. Results of subsequent reports4,31,34–38 suggested that opioid withdrawal occurs in up to 57% of PICU patients31 and in 60% of PICUs.39–42 Multiple studies have revealed complications39,40 and prolonged hospitalization that resulted from opioid tolerance after critical illness.2,41 Clearer understanding of opioid pharmacology may improve the management of opioid tolerance, dependence, and withdrawal in pediatric patients.

**CELLULAR CHANGES AFTER OPIOID THERAPY**

Six major categories of opioid receptors and their subtypes have been described: \( \mu, \kappa, \delta, \) nociceptin, \( \sigma, \) and \( \varepsilon \) (Table 3). Opioid agonists elicit

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**TABLE 1 Definition of Terms and Underlying Mechanisms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
<th>Primary Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tolerance</td>
<td>Decreasing clinical effects of a drug after prolonged exposure to it</td>
<td>Upregulation of the cAMP pathway; desensitization of opioid receptors; other mechanisms</td>
</tr>
<tr>
<td>Dependence</td>
<td>A physiologic and biochemical adaptation of neurons such that removing a drug precipitates withdrawal or an abstinence syndrome</td>
<td>Activation of second-messenger protein kinases; changes in neurotransmitter levels; changes in neuronal networks</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>A clinical syndrome that manifests after stopping or reversing a drug after prolonged exposure to that drug</td>
<td>Superactivation of AC; opioid receptor coupling to Gs protein; activation of excitatory amino acid receptors</td>
</tr>
<tr>
<td>Tachyphylaxis</td>
<td>Rapid loss of drug effects caused by compensatory neurophysiologic mechanisms</td>
<td>Exhaustion of synaptic neurotransmitters; activation of antagonist signaling systems; activation of NMDA receptors and iNOS</td>
</tr>
<tr>
<td>Addiction</td>
<td>A chronic, relapsing syndrome of psychological dependence and craving a drug for its psychedelic, sedative, or euphoric effects; characterized by compulsion, loss of control, and continued use of a substance despite harmful effects</td>
<td>Activation of dopaminergic reward systems in nucleus accumbens; mechanisms associated with tolerance and dependence</td>
</tr>
</tbody>
</table>
physiologic, pharmacologic, or adverse effects by activating single or multiple populations of these receptors on the basis of their specific binding properties. These receptors are also activated by endogenous opioid peptides or other mediators that regulate various physiologic functions.

### TABLE 2 Equivalent Analgesic Doses of Opioids

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Total Adult Dose, mg</th>
<th>Pediatric Dose, mg/kg</th>
<th>Oral/Parenteral Potency Ratio</th>
<th>Duration of Analgesia, h</th>
<th>Maximum Efficacy</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opioid analgesics used frequently in PICU patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>10</td>
<td>0.05–0.1</td>
<td>Low</td>
<td>4–5</td>
<td>High</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>0.1</td>
<td>0.001–0.003</td>
<td>Low</td>
<td>1–1.5</td>
<td>High</td>
</tr>
<tr>
<td>Methadone</td>
<td>10</td>
<td>0.025–0.1</td>
<td>High</td>
<td>8–24</td>
<td>High</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5</td>
<td>0.002–0.005</td>
<td>Low</td>
<td>4–5</td>
<td>High</td>
</tr>
<tr>
<td>Meperidine</td>
<td>60–100</td>
<td>0.5–1.5</td>
<td>Medium</td>
<td>2–4</td>
<td>High</td>
</tr>
<tr>
<td><strong>Opioid analgesics used less frequently in PICU patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>0.5–1.5</td>
<td>Insufficient data</td>
<td>Low</td>
<td>3–4</td>
<td>High</td>
</tr>
<tr>
<td>Sufentanil</td>
<td>0.02</td>
<td>0.001–0.003</td>
<td>Parenteral only</td>
<td>1–1.5</td>
<td>High</td>
</tr>
<tr>
<td>Alfentanil</td>
<td>0.3</td>
<td>0.01–0.05</td>
<td>Parenteral only</td>
<td>0.25–0.75</td>
<td>High</td>
</tr>
<tr>
<td>Remifentanil</td>
<td>0.003a</td>
<td>0.001–0.003a</td>
<td>Parenteral only</td>
<td>0.05b</td>
<td>High</td>
</tr>
<tr>
<td>Levorphanol</td>
<td>2–3</td>
<td>Insufficient data</td>
<td>High</td>
<td>4–5</td>
<td>High</td>
</tr>
<tr>
<td>Nalbuphine</td>
<td>10</td>
<td>0.1–0.2</td>
<td>Parenteral only</td>
<td>3–6</td>
<td>High</td>
</tr>
<tr>
<td>Buprenorphine</td>
<td>0.3</td>
<td>0.002–0.006</td>
<td>Low</td>
<td>4–8</td>
<td>High</td>
</tr>
<tr>
<td>Butorphanol</td>
<td>0.2</td>
<td>0.01–0.025</td>
<td>Parenteral only</td>
<td>3–4</td>
<td>High</td>
</tr>
<tr>
<td>Tramadol1</td>
<td>50–100</td>
<td>0.5–1.5</td>
<td>High</td>
<td>4–6</td>
<td>Moderate</td>
</tr>
<tr>
<td>Codeine</td>
<td>30–60</td>
<td>0.5–1</td>
<td>High</td>
<td>3–4</td>
<td>High</td>
</tr>
<tr>
<td>Hydrocodonec</td>
<td>5–10</td>
<td>0.1–0.15</td>
<td>Medium</td>
<td>4–6</td>
<td>Moderate</td>
</tr>
<tr>
<td>Oxycodonec</td>
<td>4.5</td>
<td>0.1–0.2</td>
<td>Medium</td>
<td>3–4</td>
<td>Moderate</td>
</tr>
<tr>
<td>Propoxyphene</td>
<td>60–120d</td>
<td>Insufficient data</td>
<td>Oral only</td>
<td>4–5</td>
<td>Low</td>
</tr>
<tr>
<td>Pentazocinec</td>
<td>30–50d</td>
<td>0.5–1</td>
<td>Medium</td>
<td>3–4</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

| a Administered as a continuous infusion at 0.025–0.2 μg/kg per minute. |
| b Duration depends on a context-sensitive half-time of 3 to 4 minutes. |
| c Also available in sustained-release forms. |
| d Analgesic efficacy at this dose is not equivalent to 10 mg of morphine. |

### TABLE 3 Major Classes of Opioid Receptors

<table>
<thead>
<tr>
<th>Opioid Receptor</th>
<th>Cellular Expression</th>
<th>Physiologic Effect</th>
<th>Endogenous Ligand</th>
</tr>
</thead>
<tbody>
<tr>
<td>μ₁, μ₂</td>
<td>Cortical layers III and IV, thalamic nuclei, striosomes within the striatum, periaqueductal gray, dorsal horn (lamina I and II) of the spinal cord</td>
<td>Supraspinal analgesia, euphoria, respiratory depression, sedation, miosis, reduced gastrointestinal motility, physical dependence</td>
<td>β-Endorphin, methionine- and leucine-enkephalins, endorphin-1, endorphin-2</td>
</tr>
<tr>
<td>κ₁, κ₂, κ₃</td>
<td>Hypothalamic nuclei, periaqueductal gray, claustrum, dorsal horn of the spinal cord</td>
<td>Spinal analgesia, sedation, miosis, respiratory depression, dysphoria, inhibition of anti-diuretic hormone release</td>
<td>β-Endorphin, dynorphin A₁₋₁₇</td>
</tr>
<tr>
<td>δ₁, δ₂, δ₃</td>
<td>Deep cortical layers, striatum, amygdalar nuclei, pontine nuclei, olfactory bulbs</td>
<td>Spinal and supraspinal analgesia, dysphoria, sedation, mild psychotomimetic effects, respiratory/vasomotor control</td>
<td>Methionine-enkephalin, β-Endorphin</td>
</tr>
<tr>
<td>Nociceptin/orphanin FQ (ORL)</td>
<td>Cortex, olfactory nuclei, lateral septum, central gray, hypothalamus, pontine and interpeduncular nuclei, hippocampus, amygdala, substantia nigra, raphe magnus, locus coeruleus, spinal cord</td>
<td>Spinal and supraspinal analgesia, appetite, anxiety, memory processing, autonomic regulation, cardiovascular and renal functions, locomotor activity, gastrointestinal motility tolerance to μ-agonists</td>
<td>Nociceptin</td>
</tr>
<tr>
<td>σ</td>
<td>Cortex, nucleus of tractus solitarius, raphe nuclei, pontine nuclei, rostral ventrolateral medulla</td>
<td>Dysphoria, psychotomimetic effects, mydriasis</td>
<td>Sigmaphin</td>
</tr>
<tr>
<td>ε</td>
<td>Nucleus accumbens, arcuate and preoptic hypothalamic nuclei, ventromedial periaqueductal gray, locus coeruleus, medullary nuclei</td>
<td>Supraspinal analgesia, sedation, maturation of sperm, other functions</td>
<td>β-Endorphin, cholecystokinin, endorphin₁₋₁₇</td>
</tr>
</tbody>
</table>
Opioid Analgesia

Binding of specific ligands to opioid receptors leads to conformational changes in the receptor protein that initiate signal transduction with the activation of inhibitory G proteins (G\(_{i}\)/G\(_{o}\)). Activation of G\(_{i}\) protein down-regulates adenylate cyclase (AC), thus reducing intracellular cyclic adenosine monophosphate (cAMP) levels, whereas G\(_{o}\) proteins regulate an internally rectifying K\(^+\) channel to cause hyperpolarization of the neuronal membrane. Signal transduction from activated opioid receptors lowers neuronal excitability, reduces action-potential duration, and decreases neurotransmitter release, which leads to opioid analgesia (Fig 1).

Opioid-Induced Hyperalgesia

Some opioid agonists elicit naloxone-reversible and dose-dependent excitatory effects at the opioid receptor. These effects result from opioid receptors coupling with stimulatory G proteins (G\(_{s}\)), which stimulate AC, increasing cAMP and activating protein kinase A and ultimately leading to neuronal activation. Neuraminidase increases these effects, whereas treatment with a neuraminidase inhibitor (eg, oseltamivir) blocks the “paradoxical” hyperalgesia caused by opioid therapy.

Opioid-induced hyperalgesia occurs even in the absence of opioid tolerance (Fig 2), as demonstrated in opioid addicts, normal adult volunteers, and those who receive opioid therapy with morphine, fentanyl, remifentanil, hydrocodone, oxycodone, or methadone. Finkel et al postulated its occurrence in children with intractable cancer pain and successfully treated them with low-dose infusions of ketamine. Proposed mechanisms include the sensitization of primary afferent neurons, enhanced production and release of excitatory neurotransmitters, decreased re-uptake of excitatory neurotransmitters, sensitization of second-order neurons, and descending facilitation from the rostral ventromedial medulla associated with upregulation of the central dynorphin and glutamatergic systems.
Mechanisms:
- Receptor desensitization

Therapeutic approaches:
- Opioid dose escalation
- Use longer-acting opioids
- Add nonopioid analgesics
- Add drugs that prevent or delay tolerance

Mechanisms:
- Sensitization of primary afferent neurons
- Activation of dynorphin and central glutamatergic systems

Therapeutic approaches:
- Tapering opioid doses
- Add NMDA antagonists
- Try longer-acting opioids
- Attempt rotation of opioids

Mechanisms:
- Disease progression
- Neuropathic pain mechanisms
- Enhanced opioid metabolism

Therapeutic approaches:
- Opioid dose escalation
- Add nonopioid analgesics
- Treat for neuropathic pain or other pain mechanisms

**FIGURE 2**
Algorithm showing that clinical signs of diminished opioid analgesia may result from developing opioid tolerance, a worsening pain state, or opioid-induced hyperalgesia. Although opioid dose escalation may overcome pharmacologic tolerance, it enhances opioid-induced hyperalgesia. Opioid-induced hyperalgesia has a generalized distribution as opposed to the localized distribution of preexisting pain, which may progress to a worsening pain state but usually responds to opioid dose escalation.

**Opioid Tolerance**

Although opioid-induced hyperalgesia and tolerance use similar mechanisms, (Fig 3) tolerance primarily results from receptor desensitization and upregulation of the cAMP pathway. Other mechanisms such as neuroimmune activation, production of antiopioid peptides, or activation of the spinal dynorphin system also contribute to opioid tolerance.

Opioid receptor desensitization can be caused by (1) downregulation of opioid receptors, (2) β-arrestin-mediated receptor internalization, (3) uncoupling of opioid receptors from inhibitory G proteins, (4) increased production of nitric oxide via inducible nitric oxide synthase (iNOS) activation, and (5) signaling via G_{i(2)} proteins. Upregulation of the cAMP pathway results from (1) supersensitization of AC, (2) coupling of opioid receptors with Gi proteins, and (3) upregulation of spinal glutocorticoid receptors via a cAMP response element-binding (CREB) protein-dependent pathway, which activates protein kinase Cγ (PKCγ) and N-methyl-D-aspartate (NMDA) receptors.

Neuronal protein kinases play a major role in opioid tolerance, including second messenger-dependent protein kinases (eg, PKC, calcium/calmodulin-dependent protein kinase II [CaMK-II] or protein kinase A [PKA]), G protein-coupled receptor kinases (GRKs), mitogen-activated protein kinases (MAPKs), extracellular signal-regulated kinases (ERK1/2), and cyclin-dependent kinase 5 (Cdk5), via regulation of mitogen-activated protein kinase kinase 1/2 (MEK1/2). Activation of these protein-kinase systems results in opioid receptor phosphorylation, altered function of the ion channels involved in nociception, increased expression of immediate early genes (eg, FosB), and iNOS. These protein-kinase systems are regulated by interactions between opioid receptors and the excitatory glutamate receptors.

γ-aminobutyric acid (GABA) A receptors, α₂-adrenergic receptors, and cholecystokinin-B receptors. The activation of PKC, increases in intracellular calcium ions, and availability of postsynaptic density protein 95 (PSD-95) are critical factors in the receptor interactions that lead to opioid tolerance (Fig 3).

Different opioids produce differential effects on these mechanisms, which contribute to their variable potential for producing opioid tolerance (eg, fentanyl > morphine > methadone > dihydroetorphine). Changes in these protein-kinase systems and downstream receptor functions occur in supraspinal areas including the forebrain, striatum, thalamus, and brainstem, as well as in the spinal cord dorsal horn, dorsal root ganglia, and peripheral nociceptors. Prolonged opioid exposure also activates the expression of antiopioid peptides including vasopressin, oxytocin, neuropeptide FF, cholecystokinin, or nociceptin, and mainly occurs in the spinal cord and brainstem.

**PHARMACOGENETICS OF OPIOID ANALGESIA AND TOLERANCE**

Information on the genetic mechanisms that regulate these cellular changes is emerging, but their clinical importance remains to be defined. Genetic variants affect different aspects of nociception and responses to opioid analgesia. Altered pain perception and opioid analgesia occur from widely prevalent gene variants for (1) μ-opioid receptor (OPRM1), (2) catechol-O-methyltransferase (COMT), (3) guanosine triphosphate cyclohydrolase 1 (GCH1), (4) transient receptor potential cation channel, subfamily V, member 1 (TRPV1), and (5) the melanocortin-1 receptor (MC1R). Metabolism and transport of opioids are
also affected by the genetic variants of cytochrome P450 2D6 (CYP2D6),111–117 P glycoprotein (ABCB1),118 and uridine diphosphate-glucuronosyltransferase 2B7 (UGT2B7).119–121 With the explosion of genetic information from the Human Genome Project, thousands of single-nucleotide polymorphisms (SNPs) have been identified in opioid receptors, transport proteins, intracellular signaling proteins, and metabolic enzymes that may affect opioid analgesia and tolerance. This complexity, coupled with the difficulties in studying pediatric development,122–126 limits the clinical utility of our knowledge. The SNPs currently known to modulate the clinical effects of analgesic drugs are listed in Table 4.

This genetic variability may explain some of the interindividual differences in analgesic requirements noted among critically ill children.127,128 In the μ-opioid receptor gene, a nucleotide substitution at position 118 (A118G) predicts an amino acid change at codon 40, from asparagine to aspartate, which binds μ-endorphin 3 times more potently than the wild-type receptor129 and significantly reduces the potency of morphine-6-glucuronide (M6G) in humans.130,131 It is unlikely that this SNP plays a role in opioid addiction,132,133 but its role in opioid tolerance has not been investigated.

Opioid doses for analgesia are also reduced by an SNP of the COMT gene encoding the substitution of valine by methionine at codon 158,134–137 which reduces COMT enzyme activity by three- to fourfold and is associated with greater activation of the endogenous μ-opioid system in response to pain (M158M < V158M < V158V). Pre-
liminary data have suggested that this SNP reduces the need for postoperative opioid analgesia in infants and adults.

**FACTORS THAT AFFECT DEVELOPMENT OF OPIOID TOLERANCE**

Clinical and experimental data have suggested that development of opioid tolerance and dependence can be modulated by various factors. Except for duration of therapy, most of these factors have not been investigated in children.

**Duration of Therapy**

Duration of opioid receptor occupancy is clearly important for the development of tolerance. Opioid tolerance rarely occurs after therapy for less than 72 hours. Although continuous infusions of opioids seem to induce tolerance more rapidly than intermittent therapy, a randomized trial demonstrated no significant differences between 0- to 3-year-old children who were randomly assigned to continuous versus intermittent morphine for postoperative analgesia.

**Early Development**

Infants at early developmental stages show greater vulnerability, because opioid therapy during critical brain development may produce long-term opioid tolerance. Indirect evidence has suggested that opioid tolerance develops earlier in preterm versus term newborns, supported by emerging animal data. The clinical signs of opioid withdrawal, however, are more prominent in term neonates. Preterm neonates metabolize morphine to morphine-3-glucuronide (M3G) with antiopioid effects, whereas older age groups form M6G with potent analgesic effects, and both metabolites have longer half-lives than that of morphine. Age-related differences among children in the development of opioid tolerance have not been investigated.

**Gender Differences**

Gender differences suggest greater development of opioid tolerance in males than in females. After 2 weeks of

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**TABLE 4 SNPs That Affect Opioid Analgesia/Tolerance**

<table>
<thead>
<tr>
<th>Gene</th>
<th>Varianta</th>
<th>Frequency of Patients Affected, %c</th>
<th>Affected Analgesics (Only Drugs With Positive Evidence Are Listed)</th>
<th>Multiply Standard Dose by This Factor, if SNP Is Presentb</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPRM1 (μ-opioid receptor)</td>
<td>118A→G exon 1</td>
<td>11.5</td>
<td>Alfentanil, morphine, M6G, methadone</td>
<td>2.2</td>
<td>102–104</td>
</tr>
<tr>
<td></td>
<td>C→T intron 1</td>
<td>6</td>
<td>Morphine</td>
<td>&gt;1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>IVS2–31G→A intron 2</td>
<td>8.9</td>
<td>Morphine, M6G</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IVS2–61C→G intron 2</td>
<td>44.5</td>
<td>No effect</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COMT (catechol-0-methyl transferase)</td>
<td>472G→A exon 4</td>
<td>46.2</td>
<td>Morphine, M6G, fentanyl</td>
<td>0.674</td>
<td>105–107</td>
</tr>
<tr>
<td>MC1R (melanocortin-1 receptor)</td>
<td>29insAa</td>
<td>2</td>
<td>Morphine</td>
<td></td>
<td>108, 109</td>
</tr>
<tr>
<td></td>
<td>451C→T</td>
<td>4.5</td>
<td>M6G</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>478C→T</td>
<td>4.3</td>
<td>Pentazocine (only in females)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>880G→C</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CYP2D6 (cytochrome P450 2D6)</td>
<td>2549A→del</td>
<td>2</td>
<td>Codeine</td>
<td>Drug is ineffective</td>
<td>110–115</td>
</tr>
<tr>
<td></td>
<td>1846G→A</td>
<td>20.7</td>
<td>Tramadol</td>
<td>1.3</td>
<td></td>
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<tr>
<td></td>
<td>Gene deletion</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1707T→del</td>
<td>0.9</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2935A→C</td>
<td>0.1</td>
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<tr>
<td></td>
<td>1758G→T</td>
<td>Rare</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Gene amplification</td>
<td>2</td>
<td>Codeine</td>
<td>&lt;1 (dosing unknown)</td>
<td>117</td>
</tr>
<tr>
<td>ABCB1 (P glycoprotein)</td>
<td>3435C→T exon 1</td>
<td>47.6</td>
<td>Morphine</td>
<td>&lt;8&lt; (less nausea)</td>
<td>118–120</td>
</tr>
<tr>
<td></td>
<td>2677 G→T/A exon 3</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UGT2B7 (uridine diphosphate-glucuronosyltransferase 2B7)</td>
<td>211G→T exon 1</td>
<td>14.8</td>
<td>Morphine/M6G</td>
<td>Dosing unknown</td>
<td>118–120</td>
</tr>
<tr>
<td></td>
<td>802 C→T exon 2</td>
<td>53.7</td>
<td>Morphine/M3G</td>
<td>Dosing unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1059 C→G exon 4</td>
<td>2.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1062C→T exon 4</td>
<td>Rare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1192G→A exon 5</td>
<td>&lt;1</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*a Thenotation of the SNP is as follows: The number (eg, 118) denotes the complementary DNA position of the variant. The first letter (A, T, G, or C) denotes the most commonly found nucleotide (ie, the wild type), and the second letter denotes the nucleotide for variant alleles at this position. In case of MC1R 29insA, the variant is an insertion of an additional adenine after the nucleotide at complementary DNA position 29.

*b A rough and preliminary estimate of dosing in carriers of this particular variant is based on a limited amount of quantitative data.

*c Frequencies according to the dbSNP database (www.ncbi.nlm.nih.gov/SNP) were available and if not otherwise indicated.

*d The factor of 0.67/1.5 comes from the 1.5 times higher doses in wild-type patients as compared to carriers of the variant.
twice-daily morphine, the analgesic effective dose for 50% of subjects increased 6.9-fold in male rats versus 3.7-fold in female rats; subsequent naloxone treatment produced greater opioid withdrawal in males than in females.\(^\text{157}\) No gender differences occurred in opioid withdrawal after exposure to morphine or fentanyl in infant rats,\(^\text{145,158}\) but gender differences occurred in morphine analgesia after fentanyl exposure in infancy.\(^\text{159}\) Human infants respond to aversive stimuli in a gender-specific manner,\(^\text{160,161}\) but gender differences in opioid analgesia and tolerance have not been studied.

**Drug-Related Factors**

Greater tolerance occurs with the use of synthetic or short-acting opioids.\(^\text{156,162}\) Infants who received fentanyl during extracorporeal membrane oxygenation required more supplemental analgesia, frequently treated infants.\(^\text{7}\) Drugs that cause opioid receptor internalization, decreased receptor phosphorylation by G protein–coupled receptor kinases, and lower downregulation of opioid receptors are associated with less tolerance.\(^\text{42}\) The NMDA-antagonist effects and \(\delta\)-opioid receptor desensitization caused by methadone explain its lower tolerance potential compared with morphine.\(^\text{76,89,163,164}\) Differences in opioid tolerance induced by different opioids have not been investigated systematically in infants and children.

**CLINICAL MANAGEMENT OF OPIOID TOLERANCE AND WITHDRAWAL**

Bedside clinicians know that the duration of opioid exposure predicts opioid tolerance. Katz et al\(^\text{35}\) found that opioid withdrawal occurred in 100% of the patients who received fentanyl infusions for 9 days or more. Genetic and other factors are undoubtedly operative but have not been studied (see previous discussion). Opioid withdrawal must be treated aggressively by using combined pharmacologic, environmental, and nursing care approaches to decrease clinical complications and intense suffering. Therapeutic goals include reducing withdrawal symptoms, allowing regular sleep cycles, and reducing the agitation caused by medical interventions or nursing care.

**Assessment of Opioid Withdrawal**

Authors of a recent systematic review noted the paucity of empirically developed and validated methods for assessment of opioid withdrawal in children.\(^\text{165}\) The neonatal abstinence syndrome has been well defined, but many of its clinical findings cannot be applied to children.\(^\text{166}\) In older children, common neurologic signs include anxiety, agitation, grimacing, insomnia, increased muscle tone, abnormal tremors, and choreothetoid movements. Gastrointestinal symptoms include vomiting, diarrhea, and poor appetite, whereas autonomic signs include tachypnea, tachycardia, fever, sweating, and hypertension.\(^\text{167}\) Previous studies of opioid withdrawal in children used the Modified Narcotic Abstinence Scale (MNAS),\(^\text{7,52,54,56,41}\) which was originally developed for newborns of heroin-addicted mothers.\(^\text{168}\) The MNAS was criticized for being subjective, clinically biased, and time-consuming. It included items that do not apply to children or ventilated patients, whereas other signs of the sedation-agitation spectrum (such as pupillary size\(^\text{169}\)) and responses to handling\(^\text{170}\) were not included. Another method, the Sedation Withdrawal Score developed by Cunliffe et al,\(^\text{171}\) included 12 symptoms of withdrawal, each scored subjectively on a 3-point scale. The Sophia Observation Withdrawal Symptoms Scale was designed for measuring opioid and/or benzodiazepine withdrawal in ventilated patients aged 0 to 18 years.\(^\text{165,167}\) These methods seem clinically useful, and psychometric evaluations of their sensitivity, specificity, validity, and reliability are currently underway.

Franck et al\(^\text{172}\) developed the Opioid and Benzodiazepine Withdrawal Scale as a 21-item checklist to evaluate the frequency and severity of withdrawal symptoms. This tool was later refined to develop the 12-item Withdrawal Assessment Tool 1 (WAT-1), which was tested in 83 PICU patients. Opioid withdrawal occurred in patients with WAT-1 scores of >3, with high sensitivity (0.87) and specificity (0.88) and excellent convergent and construct validity.\(^\text{172}\) Given its empirical development, ease of use at the patient’s bedside, and psychometric properties, this method has shown the greatest promise for the assessment of opioid withdrawal in children.

**Strategies for Treatment of Opioid Withdrawal**

The mainstay of pharmacologic management is gradual opioid weaning. In the acute situation, most opioids are given as continuous intravenous infusions. These infusions can be substituted with long-acting enterally administered agents\(^\text{52}\) or subcutaneous infusions,\(^\text{36,173,174}\) which have the advantages of ease of use, increased need for intravenous access, and early PICU discharge. Therapy must be directed by regular assessments for signs of opioid withdrawal. Pharmacologic agents commonly used to treat or prevent opiate withdrawal include the following.

1. Methadone is an effective analgesic for pediatric patients.\(^\text{75,176}\) It has a prolonged half-life,\(^\text{177,178}\) inhibits tolerance by multiple mechanisms,\(^\text{89,164,179}\) and is used increas-
TABLE 5  Methadone-Weaning Protocols After Opioid Therapy for 7 to 14 or >14 Days

<table>
<thead>
<tr>
<th>Short-term Therapy Protocol (7–14 d)</th>
<th>Long-term Therapy Protocol (&gt;14 d)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use 1-h dose to convert to methadone (OD)</td>
<td>Use 1-h dose to convert to methadone (OD)</td>
</tr>
<tr>
<td>Day 1: give OD PO every 6 h for 24 h</td>
<td>Day 1: give OD PO every 6 h for 24 h</td>
</tr>
<tr>
<td>Day 2: reduce OD 20%, give PO every 8 h for 24 h</td>
<td>Day 2: give OD, change to PO every 6 h for 24 h</td>
</tr>
<tr>
<td>Day 3: reduce OD 20%, give PO every 8 h for 24 h</td>
<td>Day 3: reduce OD 20%, give PO every 8 h for 48 h</td>
</tr>
<tr>
<td>Day 4: reduce OD 20%, give PO every 12 h for 24 h</td>
<td>Day 5: reduce OD 20%, give PO every 8 h for 48 h</td>
</tr>
<tr>
<td>Day 5: reduce OD 20%, give PO every 24 h</td>
<td>Day 6: reduce OD 20%, give PO every 24 h for 48 h</td>
</tr>
<tr>
<td>Day 6: discontinue methadone</td>
<td>Day 11: discontinue methadone</td>
</tr>
</tbody>
</table>

Those who are converting from other opioids to methadone should take into account the relative potency (see Table 2) and duration of action of the other opioids. OD indicates original dose; PO, by mouth.


ingly for opioid withdrawal in children. A methadone dose equivalent to 2.5 times the total daily fentanyl dose was effective for preventing opioid withdrawal in children. A methadone-weaning protocol, such as that depicted in Table 5, also prevented opioid withdrawal and reduced hospital stay.

4. Gabapentin was developed as an anticonvulsant but reduces neuropathic pain via effects on α2-D calcium channels. In adults who were undergoing rapid opioid detoxification, gabapentin effectively attenuated the severe back pain, limb thrashing, and restless-leg syndrome associated with opioid withdrawal and also changed their somatosensory evoked potentials and increased their tolerance to painful stimulation. Additional studies corroborated the efficacy of gabapentin for opioid withdrawal in adults, but it has not been tested in children.

5. Propofol can be used for preventing benzodiazepine and opioid withdrawal, as suggested by the results of preclinical and clinical studies. In 11 children who required mechanical ventilation, propofol infusions facilitated the rapid weaning of opioid and benzodiazepine infusions, which led to successful extubation, but no other studies have replicated these observations.

7. Previous case reports have suggested the utility of propoxyphene for treating morphine-induced opioid tolerance; few signs and symptoms of withdrawal and decreased respiratory depression were seen, which enabled these PICU patients to be weaned off the ventilator. There is little cross-tolerance between morphine and propoxyphene, although further evidence is required before it can be used clinically.

Other experimental agents such as memantine (a clinically available NMDA receptor antagonist or glycyl-L-glutamine (a naturally occurring dipeptide, produced by posttranslational processing of β-endorphin) have been suggested as therapies for opioid withdrawal but have not been tested in pediatric patients.

**Strategies for the Prevention of Opioid Tolerance**

Strategies to prevent or delay opioid tolerance have the advantage of avoiding dependency and withdrawal, thereby reducing the costs and complications of prolonged opioid weaning. The true incidence of opioid tolerance and the exact strategies for preventing it remain understudied in children.

**Practical Approaches**

Procedural changes such as the daily interruption of sedatives, nurse-controlled sedation, sequential rotation of analgesics (although associated with some concerns), or the use of epidural/intrathecal opioids in
pediatric patients\(^2^{31–235}\) may decrease the incidence of opioid tolerance and withdrawal.

**Nursing-Controlled Sedation Management Protocols**

Adult patients who were randomly assigned to a nurse-managed sedation protocol compared with nonprotocol sedation required shorter durations of mechanical ventilation and ICU and hospital stays and less frequent tracheostomy.\(^2^{28}\) Similar nurse-managed sedation protocols developed by Curley et al\(^2^{26,237}\) and Sury et al\(^2^{238}\) are currently under investigation in a cluster-randomized trial in ventilated children (Martha A. Q. Curley, personal communication, December 2008).

**Use of Epidural or Other Forms of Neuraxial Analgesia**

Effective analgesic doses for children are significantly reduced by epidural opioids compared with intravenous opioids. Given that the total opioid dose is a strong predictor for the occurrence of opioid withdrawal, greater use of neuraxial opioids may also reduce opioid tolerance.\(^2^{232,239}\)

**Sequential Rotation of Analgesic/Sedative Agents**

The sequential use of different classes of drugs (opioids, benzodiazepines, barbiturates, butyrophenones, halogenated hydrocarbons) is recommended for analgesia and sedation in adult ICU patients to reduce the incidence of tolerance and withdrawal.\(^4\) Although such an approach is not practical for all pediatric patients, it may be an option for PICU patients at high risk who are receiving opioid therapy for longer than 7 days.\(^2^{28}\)

**Daily Interruption of Sedative Infusions**

A scheduled daily interruption of all sedative infusions in adult ICU patients (until the patients were fully awake) resulted in a shorter duration of mechanical ventilation and ICU stay.\(^2^{27}\) This approach must be used with caution in infants and children, because awakening may cause more acute changes in their respiratory and hemodynamic variables and children are much more likely to pull out catheters and tubes than adult ICU patients.

**Promising but Experimental Therapies**

On the basis of the mechanisms of opioid tolerance, novel approaches for reducing or delaying its occurrence may be proposed, although the safety and efficacy of these approaches have not been investigated for critically ill children.

**Concomitant Infusion of Opioid Agonists and NMDA Antagonists**

NMDA receptors play multiple roles in the mechanisms that lead to opioid tolerance. Clinicians using combined intravenous infusions of morphine and low-dose ketamine (0.25–0.5 mg/kg) have noted significant opioid-sparing effects in patients with postoperative or cancer pain,\(^4^{8,240–242}\) which supports similar findings from animal models.\(^2^{43,244}\)

**Continuous Infusions of Opioid Agonists and Low-Dose Naloxone**

Low concentrations of opioid antagonists selectively block opioid receptors coupled with stimulatory \(G_{\alpha}\) proteins, thus blocking mechanisms for superactivation of the cAMP pathway.\(^10\) Three clinical trials in adults revealed that low-dose naloxone improves the efficacy of opioid analgesia and reduces tolerance.\(^1^{2,187,240}\) although 1 trial revealed opposite effects.\(^2^{46}\) All these studies were limited to 24 hours after surgery, a period during which the effects of opioid tolerance may not occur.\(^1^{41,146}\) Results of a retrospective case-control study in children suggested that low-dose naloxone infusions may reduce opioid requirements,\(^2^{47}\) but a clinical trial that was terminated early on the grounds of futility revealed no differences.\(^2^{48}\)

**Use of Noncompetitive NMDA Antagonists**

Opioids such as ketobemidone\(^2^{49,250}\) and methadone\(^6^{8,163,250}\) block NMDA receptors and also produce less tolerance than morphine or fentanyl. Combined exposure to methadone and morphine reverses the opioid tolerance caused by morphine via a desensitization of \(\delta\)-opioid receptors\(^1^{64}\) and uncoupling of these receptors from G proteins.\(^1^{79}\)

**Use of Nitric Oxide Synthase Inhibitors**

Inhibition of iNOS induction was noted to decrease the neuroadaptive changes associated with opioid dependence,\(^2^{51,252}\) which suggests the investigation of an iNOS inhibitor, 7-nitroindazole, in clinical trials for opioid addiction.\(^2^{53,254}\)

**Use of Selective Serotonin-Reuptake Inhibitors**

Preliminary data have suggested that fluoxetine may suppress the development of tolerance to morphine analgesia, which is further accentuated by l-arginine and nitro-l-arginine methyl ester treatment.\(^2^{55}\) These results suggest a role for the nitric oxide–cyclic guanosine monophosphate–serotonin signaling system in the development of opioid tolerance and withdrawal.

Despite the availability of multiple therapies for opioid withdrawal, or practical approaches and promising experimental therapies for preventing opioid tolerance, a high incidence of opioid withdrawal still occurs in the PICU.\(^2^{28,256}\) Randomized trials comparing these therapeutic options are needed to define their relative value for particular groups of PICU patients, thus enhancing the ability of clinicians to treat these complications of prolonged opioid exposure.
Opioid tolerance occurs in 35% to 57% of PICU patients and often results in a prolonged hospital stay or other complications. The effects of pharmacogenetic/genomic, drug-related, or patient-related factors (age, gender, diagnosis) on the development of opioid tolerance and withdrawal are currently unknown. A long-term goal is to develop therapeutic approaches that provide safe and effective opioid analgesia without inducing tolerance or withdrawal. By preventing or delaying opioid tolerance in critically ill infants and children, we can improve analgesic efficacy, avoid secondary complications, expedite recovery from critical illness, and reduce the need for prolonged intensive care support. Specific recommendations to achieve these goals include the following.

1. Opioid doses should match the intensity and frequency of pain experienced by PICU patients, be titrated initially to achieve adequate analgesia, and be adjusted to find the minimum effective dose for each patient. Increased opioid requirements may be dictated by opioid tolerance or opioid-induced hyperalgesia or worsening pain states, each of which are treated differently (see Fig 2).

2. Short-acting opioids can be used for procedural or breakthrough pain, whereas longer-acting opioids can be used for established, prolonged, or chronic pain. Avoid using opioids if only sedation or motion control are required. Scheduled intermittent doses of longer-acting opioids may substitute for opioid infusions (see Table 2) to reduce tolerance.

3. Opioid withdrawal can be assessed by using various methods (MAS, Sedation Withdrawal Score, Brief Observation Withdrawal Symptoms Scale, Opioid and Benzodiazepine Withdrawal Scale). Currently, however, the WAT-1 scale seems to show the greatest promise for efficient assessment of opioid withdrawal in PICU patients.

4. Management of opioid withdrawal includes gradual opioid weaning (see Table 5), environmental and nursing supportive measures, and treatment with methadone, clonidine, or both or alternative therapies such as buprenorphine, dexmedetomidine, propofol, or gabapentin.

5. Prevention of opioid tolerance may include practical approaches such as nurse-controlled sedation or sequential rotation of analgesics, although promising experimental therapies include opioids combined with low-dose ketamine or naloxone or other classes of drugs.

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16. Barker DP, Rutter N. Stress, severity of ill-


19. Holsti L, Weinberg J, Whitfield MF, Grunau RE. Relationships between adrenocorti-
tropic hormone and cortisol are altered during clustered nursing care in preterm infants born at extremely low gestational age. Early Hum Dev. 2007;83(3):341–348

20. Whitfield MF, Grunau RV, Holsti L. Ex-
tremely premature (< 28 or = 800 g) schoolchildren: multiple areas of hidden disability. Arch Dis Child Fetal Neonatal Ed. 1997;77(2):F85–F90

21. Karande S, Kelkar A, Kulkarni M. Recollec-


23. Playfor S, Thomas D, Choonara I. Recollec-


27. Playfor S, Jenkins I, Byles C, et al. Consen-


29. Long D, Horn D, Keogh S. A survey of seda-
tion assessment and management in Aus-
tralian and New Zealand paediatric inten-

30. Sarkar S, Schumacher RE, Baumgart S, Donn SM. Are newborns receiving premed-
ication before elective intubation? J Peri-
notal. 2006;26(5):286–289

31. Arnold JH, Truog RD, Grav EJ, Scavone JM, Herschenson MB. Tolerance and depend-
ence in neonates sedated with fentanyl during extracorporeal membrane oxygen-
ation. Anesthesiology. 1990;73(6):1136–1140

32. Arnold JH, Truog RD, Scavone JM, Fenton T. Changes in the pharmacodynamic re-
response to fentanyl in neonates during con-

33. Katz R, Kelly HW, Hsi A. Prospective study on the occurrence of withdrawal in criti-


35. Tobias JD, Deshpande JK, Gregory DF. Out-
patient therapy of iatrogenic drug depen-

36. Tobias JD. Subcutaneous administration of fentanyl and midazolam to prevent with-
drawal after prolonged sedation in chil-


38. Fonsmark L, Rasmussen YH, Carl P. Occur-

39. Bergman I, Steeves M, Burckart G, Thomp-
son A. Reversible neurologic abnor-
malities associated with prolonged intrave-
rous midazolam and fentanyl administra-

40. Lane JC, Tennon MB, Lawless ST, Green-
wood RS, Zaritsky AL. Movement disorder after withdrawal of fentanyl infusion. J Pe-
diatr. 1991;119(4):644–651


42. Liu JG, Anand KJS. Protein kinases modu-

43. Crain SM, Shen KF. Modulation of opioid analgesia, tolerance and dependence by Gs-coupled, GM1 ganglioside-regulated opioid receptor functions. Trends Phar-

44. Crain SM, Shen KF. Ultra-low concentra-
tions of naloxone selectively antagonize exci-
taxatory effects of morphine on sensory neurons, thereby increasing its antinoci-
ceptive potency and attenuating tolerance/dependence during chronic co-

45. Crain SM, Shen KF. Neurominidase inhibi-
tor, oseltamivir blocks GM1 ganglioside-
regulated excitatory opioid receptor-

46. Chu LF, Angst MS, Clark D. Opioid-induced hyperalgesia in humans: molecular mech-

47. Finkel JC, Pestieau SR, Quezado ZM. Ket-
tamine as an adjuvant for treatment of can-

48. Lugj übi H, Gerber A, Schneider TW, Petersen-Felix S, Arendt-Nielsen L, Curato-
to M. Modulation of remifentanil-
induced analgesia, hyperalgesia, and tol-
erance by small-dose ketamine in


REVIEW ARTICLES


119. Mehlotra RK, Bockarie MJ, Zimmermann PA. Prevalence of UGT1A9 and UGT2B7 nonsynonymous single nucleotide polymor-


134. Ross JR, Riley J, Taegtmeyer AB, et al. Genetic variation and response to morphine in cancer patients: catechol-0-


140. Dewey WL. Various factors which affect the rate of development of tolerance and physical dependence to abused drugs. NIDA Res Monogr. 1984;59:39–49


159. Thornton SR, Smith FL. Long-term alterations in opiate antinociception resulting from infant fentanyl tolerance and depen-


208. Tobias JD. Dexmedetomidine to treat opioid withdrawal in infants following prolonged sedation in the pediatric ICU. *J Opioid Manag*. 2006;2(4):201–205


234. McCrory C, Diviney D, Moriarty J, Luke D, Fitzgerald D. Comparison between repeat bolus intrathecal morphine and an epidurally delivered bupivacaine and fentanyl combination in the management of post-thoracotomy pain with or without cyclo-


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