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
SNP—single-nucleotide polymorphism
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,4,8 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.27

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 al33 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 complications44,40 and prolonged hospitalization that resulted from opioid tolerance after critical illness.7,41 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: κ, µ, δ, nociceptin, σ, and ε (Table 3). Opioid agonists elicit...
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.
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\textsubscript{i} and G\textsubscript{o}). Activation of G\textsubscript{i} protein down-regulates adenylate cyclase (AC), thus reducing intracellular cyclic adenosine monophosphate (cAMP) levels, whereas G\textsubscript{o} proteins regulate an internally rectifying K\textsuperscript{+} channel to cause hyperpolarization of the neuronal membrane.\textsuperscript{42} 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.\textsuperscript{10,43} These effects result from opioid receptors coupling with stimulatory G proteins (G\textsubscript{s}), which stimulate AC, increasing cAMP and activating protein kinase A and ultimately leading to neuronal activation.\textsuperscript{44} Neuraminidase increases these effects, whereas treatment with a neuraminidase inhibitor (eg, oseltamivir) blocks the “paradoxical” hyperalgesia caused by opioid therapy.\textsuperscript{45}

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.\textsuperscript{46,47} Finkel et al\textsuperscript{47} 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.\textsuperscript{46,48,49}

![Diagrammatic representation of the neuronal mechanisms underlying opioid analgesia.](image-url)
Opioid-induced hyperalgesia

Worsening pain state

Mechanisms:
- Receptor desensitization
- Superactivation of cAMP pathway

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 pre-existing 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.50,51 Other mechanisms such as neuroimmune activation,52 production of antiopioid peptides, or activation of the spinal dynorphin system53,54 also contribute to opioid tolerance.

Opioid receptor desensitization can be caused by (1) downregulation of opioid receptors55 (2) β-arrestin-mediated receptor internalization56,57 (3) uncoupling of opioid receptors from inhibitory G proteins,58 (4) increased production of nitric oxide via inducible nitric oxide synthase (iNOS) activation,59 and (5) signaling via G(o) proteins.60 Upregulation of the cAMP pathway results from (1) supersensitization of AC,51 (2) coupling of opioid receptors with G(o) proteins,43 and (3) upregulation of spinal glucocorticoid receptors61 via a cAMP response element-binding (CREB) protein–dependent pathway,62 which activate protein kinase Cγ (PKCγ) and N-methyl-D-aspartate (NMDA) receptors.

Neuronal protein kinases play a major role in opioid tolerance,62 including (1) second messenger–dependent protein kinases (eg, PKC, calcium/calmodulin-dependent protein kinase II [CaMK-II] or protein kinase A [PKA]),62,63 (2) G protein–coupled receptor kinases (GRKs),54–66 (3) mitogen-activated protein kinases (MAPKs),50,67,68 (4) extracellular signal-regulated kinases (ERK1/2),69–72 (5) spinally expressed EphB receptor tyrosine kinases,73 (6) the c-Jun N-terminal kinases (JNK), via expression of TRPV1 receptors,56,74 and (7) cyclin-dependent kinase 5 (Cdk5), via regulation of mitogen-activated protein kinase kinase 1/2 (MEK1/2).75 Activation of these protein-kinase systems results in opioid receptor phosphorylation,78 altered function of the ion channels involved in nociception,77,78 increased expression of immediate early genes (eg, FosB),79 and iNOS.80,81 These protein-kinase systems are regulated by interactions between opioid receptors and the excitatory glutamate receptors,82 γ-aminobutyric acid (GABA) A receptors,83 α2-adrenergic receptors,84 and cholecystokinin-B receptors.79,85 The activation of PKC, increases in intracellular calcium ions,57,86 and availability of postsynaptic density protein 95 (PSD-95)87 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 > dihydromorphine).42,88 Changes in these protein-kinase systems and downstream receptor functions occur in supraspinal areas including the forebrain, striatum, thalamus, and brainstem,89–91 as well as in the spinal cord dorsal horn,73,74 dorsal root ganglia, and peripheral nociceptors.55,63,77,82,92,93 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.94–98

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.99–101 Genetic variants affect different aspects of nociception and responses to opioid analgesia.102–104 Altered pain perception and opioid analgesia occur from widely prevalent gene variants for (1) μ-opioid receptor (OPRM1),100,105,106 (2) catechol-O-methyltransferase (COMT),99,107,108 (3) guanosine triphosphate cyclohydrolase 1 (GCH1), (4) transient receptor potential cation channel, subfamily V, member 1 (TRPV1), and (5) the melanocortin-1 receptor (MC1R).109,110 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 (M158V < V158M < V158V). Pre-

FIGURE 3
Diagrammatic representation of neuronal mechanisms underlying opioid tolerance, which decreases resting membrane potential, increases the action-potential duration (APD), and increases neurotransmitter release. µ-OR indicates µ-opioid receptor; IEG, immediate early genes (c-fos, FosB); PKA, protein kinase A; CREB, cAMP response element-binding protein; APD, action-potential duration; pCREB, phosphorylated CREB protein; G_i/G_o, inhibitory G proteins; G_s, stimulatory G protein; CaMK-II, calcium/calmodulin-dependent protein kinase II; PLA_2, phospholipase A_2; δ-OR, δ opioid receptor; NO, nitric oxide; nNOS, neuronal nitric oxide synthetase; HPETE, hydroperoxyeicosatetraenoic acid.
liminary data have suggested that this SNP reduces the need for postoperative opioid analgesia in infants\textsuperscript{138} and adults.\textsuperscript{139}

## 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.\textsuperscript{31,140–143} Opioid tolerance rarely occurs after therapy for less than 72 hours.\textsuperscript{144,145} Although continuous infusions of opioids seem to induce tolerance more rapidly than intermittent therapy,\textsuperscript{146} 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.\textsuperscript{147}

### Early Development

Infants at early developmental stages show greater vulnerability, because opioid therapy during critical brain development may produce long-term opioid tolerance.\textsuperscript{148,149} Indirect evidence has suggested that opioid tolerance develops earlier in preterm versus term newborns,\textsuperscript{144,150} supported by emerging animal data.\textsuperscript{145,148} The clinical signs of opioid withdrawal, however, are more prominent in term neonates.\textsuperscript{151} 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.\textsuperscript{152–155} M3G accumulation in preterm neonates antagonizes the effects of morphine and contributes to opioid tolerance. Developmental differences also explain why midazolam attenuates opioid tolerance in adult rats\textsuperscript{143} but not infant rats\textsuperscript{156} or why cotolerance to sedative and analgesic effects of fentanyl occurs in infant rats but not in adult rats.\textsuperscript{156} 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

### Table 4: SNPs That Affect Opioid Analgesia/Tolerance

<table>
<thead>
<tr>
<th>Gene</th>
<th>Variant\textsuperscript{a}</th>
<th>Frequency of Patients Affected, %\textsuperscript{c}</th>
<th>Affected Analgesics (Only Drugs With Positive Evidence Are Listed)</th>
<th>Multiply Standard Dose by This Factor, if SNP Is Present\textsuperscript{b}</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>IVS2–691C→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>0.67\textsuperscript{d}</td>
<td>105–107</td>
</tr>
<tr>
<td>MCTR (melanocortin-1 receptor)</td>
<td>29insA\textsuperscript{a}</td>
<td>2</td>
<td>Morphine</td>
<td></td>
<td></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>CYP206 (cytochrome P450 206)</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>
</tr>
<tr>
<td></td>
<td>Gene deletion</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>17OT→del</td>
<td>0.9</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2935A→C</td>
<td>0.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1758G→T</td>
<td>Rare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ABCB1 (P glycoprotein)</td>
<td>3435C→T exon 1</td>
<td>47.6</td>
<td>Morphine</td>
<td>&lt;$1 (dosing unknown)</td>
<td>117</td>
</tr>
<tr>
<td></td>
<td>2677 G→T/A exon 3</td>
<td>2</td>
<td></td>
<td>&lt;$1 (less nausea)</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>

\textsuperscript{a} The notation 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.

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

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

\textsuperscript{d} The factor of 0.67 /\textsubscript{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.157 No gender differences occurred in opioid withdrawal after exposure to morphine or fentanyl in infant rats,145,158 but gender differences occurred in morphine analgesia after fentanyl exposure in infancy.159 Human infants respond to aversive stimuli in a gender-specific manner,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.156,162 Infants who received fentanyl during extracorporeal membrane oxygenation required more supplemental analgesia, frequently developed opioid withdrawal, and required longer durations of opioid weaning compared with morphine-treated infants.7 Drugs that cause opioid receptor internalization, decreased receptor phosphorylation by G protein–coupled receptor kinases, and downregulation of opioid receptors are associated with less tolerance.42 The NMDA-antagonist effects and δ-opioid receptor desensitization caused by methadone explain its lower tolerance potential compared with morphine.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 al33 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.165 The neonatal abstinence syndrome has been well defined, but many of its clinical findings cannot be applied to children.166 In older children, common neurologic signs include anxiety, agitation, grimacing, insomnia, increased muscle tone, abnormal tremors, and choreoathetoid movements. Gastrointestinal symptoms include vomiting, diarrhea, and poor appetite, whereas autonomic signs include tachypnea, tachycardia, fever, sweating, and hypertension.167 Previous studies of opioid withdrawal in children used the Modified Narcotic Abstinence Scale (MNAS),7,33,34,36,41 which was originally developed for newborns of heroin-addicted mothers.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 size169 and responses to handling170) were not included. Another method, the Sedation Withdrawal Score developed by Cunliffe et al,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.165,167 These methods seem clinically useful, and psychometric evaluations of their sensitivity, specificity, validity, and reliability are currently underway.

Franck et al41 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.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 agents52 or subcutaneous infusions,36,173,174 which have the advantages of ease of use, decreased 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.175,176 It has a prolonged half-life,177,178 inhibits tolerance by multiple mechanisms,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 for 24 h</td>
<td>Day 7: reduce OD 20%, give PO every 12 h for 48 h</td>
</tr>
<tr>
<td>Day 6: discontinue methadone</td>
<td>Day 9: reduce OD 20%, give PO every 24 h for 48 h</td>
</tr>
<tr>
<td></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.

pediatric patients\(^{231-235}\) 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.\(^{228}\) Similar nurse-managed sedation protocols developed by Curley et al\(^{236,237}\) and Sury et al\(^{238}\) 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.\(^{232,239}\)

**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.\(^{28}\)

**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.\(^{227}\) 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.

**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,\(^{48,240-242}\) which supports similar findings from animal models.\(^{243,244}\)

**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.\(^{255}\) 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.\(^{28,256}\) 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 (MNAS, Sedation Withdrawal Score, Sophia 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 3), 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.

Critically ill children routinely receive opioids for pain management; this treatment often leads to opioid tolerance and withdrawal, both of which occur more commonly in infants and children because of developmental changes in metabolism, excretion, or dose/response curves, receptor subtypes, signal transduction, receptor induction, and regulatory pathways. Advances in opioid pharmacology cannot be applied to critically ill children, because the incidence and risk factors for opioid tolerance in PICU patients remain unknown. We need prospective observational studies to define the current incidence and risk factors for opioid tolerance in critically ill children, as well as randomized trials to compare the various therapies available for prevention and treatment of opioid withdrawal.

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