NAME OF THE MEDICINE

Morphine sulfate pentahydrate

Chemical Name: Di(7,8-didehydro-4,5α-epoxy-17-methylmorphinan-3,6α-diol) sulfate pentahydrate.

Structural Formula:

\[
\text{\includegraphics[width=0.6\textwidth]{chemical_formula}}
\]

Molecular formula: \( C_{34}H_{40}N_2O_{10}S \cdot 5H_2O \)

Molecular Weight: 759

CAS Number: 6211-15-0

DESCRIPTION

Morphine sulfate pentahydrate is a white, odourless, crystalline powder or needle-like crystals. It is soluble in water and ethanol. It is practically insoluble in ether or chloroform.

Each modified release tablet contains 10mg, 30mg, 60 mg or 100mg morphine sulfate pentahydrate as the active ingredient. In addition, each modified release tablet contains the following inactive ingredients: lactose (except the 100 mg), hyetellose, hypromellose, povidone, purified talc and magnesium stearate. The tablet coatings contain a different colourant for each strength, as follows:

- 10 mg – Opadry buff OY-3607
- 30 mg – Opadry violet OY-6708
- 60 mg – Opadry orange OY-3533
- 100 mg - Opadry grey OY-8238

Morphine sulfate pentahydrate 100 mg corresponds to 75 mg of morphine free base.
PHARMACOLOGY
Pharmacological Actions
Morphine sulfate pentahydrate is a narcotic analgesic.

Pharmacodynamics
Morphine is a phenanthrene alkaloid obtained from opium. Morphine and related compounds interact with specific receptors primarily found in the brain, spinal cord and the myenteric plexus of the gut wall. In humans, the principal pharmacological actions of morphine are in the central nervous system (analgesia, drowsiness, mood changes (including euphoria and dysphoria), mental clouding, respiratory depression, nausea or emesis, miosis) and on smooth muscle (increased gastrointestinal tone with a reduction in propulsive motion, increased biliary pressure and increased tone of the ureter and vesical sphincter).

Morphine induced analgesia is a result of increases in both the pain threshold and pain tolerance. Morphine alters the affective response to pain, in that patients remain aware of its existence but are less distressed. Morphine relieves most types of pain but is more effective against dull constant pain than sharp intermittent pain.

Pharmacokinetics:
Absorption:
Morphine is readily absorbed from the gastrointestinal tract, nasal mucosa and lung, and after subcutaneous or intramuscular injection. Due to first pass metabolism, the effect of an oral dose is less than that of the same dose given parenterally. The parenteral to oral morphine potency ratio has been reported to range from 1:6 to 1:2. In general, the greatest difference between parenteral and oral potency is seen in acute studies. With chronic dosing, oral morphine is about one-half to one-third as potent as when given by injection.

Distribution:
Following absorption, approximately 30 to 35% of morphine is reversibly bound to plasma proteins. Free morphine readily leaves the circulation and is concentrated in the liver, kidney, lung, spleen and, to a lesser extent, skeletal muscle. In adults, only small quantities of morphine pass the blood-brain barrier.

Metabolism:
Conjugation with glucuronic acid is the major metabolic pathway for morphine. The major metabolite is morphine-3-glucuronide. Other metabolites include normorphine, morphine-6-glucuronide, morphine-3,6-diglucuronide and morphine-3-ethereal sulfate. The mean elimination half-life of morphine is two to three hours, with great interpatient variability.
Excretion:
The major route of excretion is via the kidney. Approximately 7 to 10% is excreted in the faeces via the bile. Conjugated morphine excreted in the bile may be hydrolysed and reabsorbed from the large bowel.

At steady state, morphine sulfate SR tablets produce peak morphine concentrations approximately three to five hours postdose, and therapeutic levels tend to persist for a 12 hour period.

INDICATIONS
Treatment of opioid responsive, chronic severe pain.

CONTRAINDICATIONS
Hypersensitivity to opiate narcotics; acute asthma or other obstructive airways disease, acute respiratory depression; cor pulmonale; cardiac arrhythmias; acute alcoholism; delirium tremens; severe CNS depression; convulsive disorders; increased cerebrospinal or intracranial pressure; head injury; brain tumour; suspected surgical abdomen; paralytic ileus, severe liver disease, incipient hepatic encephalopathy; severe renal dysfunction; concurrent (or within 14 days of therapy) monoamine oxidase inhibitors (see Interactions); children under one year of age; pregnancy. Not recommended for preoperative use or for the first 24 hours postoperatively.

Patients with chronic pain not due to malignancy, who have a prior history of substance and alcohol abuse.

PRECAUTIONS
Morphine must be administered with caution in patients taking CNS depressants (see INTERACTIONS WITH OTHER MEDICINES).

Opioids, such as morphine sulfate pentahydrate, may influence the hypothalamic-pituitary-adrenal or -gonadal axes. Some changes that can be seen include an increase in serum prolactin, and decreases in plasma cortisol and testosterone. Clinical symptoms may manifest from these hormonal changes.

Head injury and increased intracranial pressure
The respiratory depressant effects of morphine and the capacity to elevate cerebrospinal fluid pressure, may be greatly increased in the presence of an already elevated intracranial pressure produced by trauma. Also, morphine may produce confusion, miosis, vomiting and other side effects which obscure
the clinical course of patients with head injury. In such patients, morphine must be used with extreme caution and only if it is judged essential.

**Respiratory depression**

The major risk of opioid excess is respiratory depression. Morphine should be used with extreme caution in patients with substantially decreased respiratory reserve, pre-existing respiratory depression, hypoxia or hypercapnia. Such patients are often less sensitive to the stimulatory effects of carbon dioxide on the respiratory centre, and the respiratory depressant effects of morphine may reduce respiratory drive to the point of apnoea.

**Hypotensive effect**

Morphine administration may result in severe hypotension in patients whose ability to maintain adequate blood pressure is compromised by reduced blood volume, or concurrent administration of such drugs as phenothiazines or certain anaesthetics.

**Abdominal conditions**

Morphine may obscure the diagnosis or clinical course of patients with acute abdominal conditions. Where there is a possibility of paralytic ileus occurring, morphine should not be used. Should paralytic ileus be suspected or occur during use, morphine should be discontinued immediately. As with all oral morphine preparations, MORPHINE MR APOTEX tablets should be used with caution post-operatively and following abdominal surgery, as morphine impairs intestinal motility and should not be used until the physician is assured of normal bowel function.

Decreased gastric emptying associated with morphine may be expected to increase the risks of aspiration either associated with morphine induced CNS depression/coma, or during or after general anaesthesia.

**Cordotomy**

Severe pain antagonises the subjective and respiratory depressant actions of morphine. Should pain suddenly subside, these effects may rapidly become manifest. Patients who are scheduled for cordotomy, other interruption of pain transmission pathways or other pain relieving surgical procedures should not receive MORPHINE MR APOTEX tablets within 24 hours of the procedure. Pain in the immediate preoperative period and any symptoms of opioid withdrawal should be managed with short acting analgesic agents. If further treatment with MORPHINE MR APOTEX tablets is indicated, the dosage should be adjusted to the new post-operative requirement.
**Biliary tract and sphincter of Oddi conditions**

Because of the spasmogenic properties of morphine in the biliary tract and sphincter of Oddi, it should be used only when necessary and with caution in biliary colic, operations on the biliary tract and acute pancreatitis.

**Acute ulcerative colitis**

Morphine may cause toxic dilatation in patients with acute ulcerative colitis.

**Hyperalgesia**

Hyperalgesia that will not respond to a further dose increase of morphine sulphate may occur in particular at high doses. A morphine sulphate dose reduction or change in opioid may be required.

Morphine-6-glucuronide may accumulate in patients with renal failure, leading to CNS and respiratory depression.

Morphine should be used with caution in patients with impaired respiratory function, convulsive disorders, inflammatory bowel disorders, prostatic hypertrophy, adrenocortical insufficiency, hypotension with hypovolaemia, diseases of the biliary tract, pancreatitis and opioid dependency.

Caution is needed when changing between different presentations of morphine, or other potent opioid analgesic preparations, and the patient should be re-titrated and clinically reassessed.

Morphine may lower the seizure threshold in patients with a history of epilepsy.

**Formulation**

The modified release tablets must be swallowed whole, and not broken, chewed or crushed. The administration of broken, chewed or crushed modified release morphine tablets leads to a rapid release and absorption of a potentially fatal dose of morphine.

It is not possible to ensure bioequivalence between different brands of modified release morphine products. Therefore, caution is needed when changing between different brands of sustained or modified release morphine, or other strong opioid analgesic preparations, and the patient should be re-titrated and clinically re-assessed.

**Lactose**

MORPHINE MR APOTEX tablets (10 mg, 30 mg and 60 mg tablets only) contain lactose. Patients with rare hereditary problems including galactose
intolerance, Lapp lactase deficiency or glucose-galactose malabsorption should not take these strengths of MORPHINE MR APOTEX tablets.

**Use in chronic nonmalignant pain:**
The use of MORPHINE MR APOTEX for the treatment of chronic pain which is not due to malignancy should be restricted to situations where:

- all other conservative methods of analgesia have been tried and have failed;
- the pain is having a significant impact on the patient's quality of life; and
- there is no psychological contraindication, drug seeking behaviour or history of drug misuse.

Prior to long-term prescription, a trial of MORPHINE MR APOTEX or shorter acting opioids should be undertaken. Long-term administration of MORPHINE MR APOTEX should only occur if this trial demonstrates that the pain is opioid sensitive. Opioid naive patients who require rapid dose escalation with no concomitant pain relief within the trial period should generally be considered inappropriate for long-term therapy.

A single doctor should be responsible for the prescription and monitoring of the patient's opioid use.

Doctors prescribing MORPHINE MR APOTEX should consult appropriate clinical guidelines on the use of opioid analgesics in such patients (e.g. Australian Pain Society publication in The Medical Journal of Australia 1997;167:30-34).

**Drug Dependence:**
As with other opioids, tolerance and physical dependence tend to develop upon repeated administration of morphine, and there is potential for abuse of the drug and for development of strong psychological dependence. MORPHINE MR APOTEX should therefore be prescribed and handled with the high degree of caution appropriate to the use of a drug with strong abuse potential.

Drug abuse is not, however, a problem in patients with severe pain in whom morphine is appropriately indicated. On the other hand, in the absence of a clear indication for a strong opioid analgesic, drug seeking behaviour must be suspected and resisted, particularly in individuals with a history of, or propensity for, drug abuse. Withdrawal symptoms may occur following abrupt discontinuation of morphine therapy or upon administration of an opioid antagonist. Therefore, patients on prolonged therapy should be withdrawn gradually from the drug if it is no longer required for pain control.

**Abuse of oral dosage forms**
Abuse of oral dosage forms by parenteral administration can be expected to result in serious adverse events, which may be fatal.
Special Risk Groups
Morphine should be administered with caution and in reduced dosages to elderly or debilitated patients, to patients with severely reduced hepatic or renal function, and in patients with Addison’s disease, hypothyroidism, prostatic hypertrophy or urethral stricture.

Patients should be cautioned about the combined effects of morphine with other CNS depressants, including other opioids, phenothiazines, sedative/hypnotics and alcohol.

Effect on ability to drive or operate machinery:
Morphine may impair the mental and/or physical abilities needed for certain potentially hazardous activities, such as driving a car or operating machinery. Patients should be cautioned accordingly.

Effects on fertility
Prolonged use of opioid drugs may result in impairment of reproductive function, including infertility and sexual dysfunction in both sexes and irregular menses in women.

Use in pregnancy
Australian Pregnancy Categorisation C. Drugs which, owing to their pharmacological effects, have caused or may be suspected of causing, harmful effects on the human foetus or neonate without causing malformations. These effects may be reversible.

Opioid analgesics may cause respiratory depression in the newborn infant. Morphine has been associated with foetal CNS defects in rodent studies.

In humans it is not known whether morphine can cause foetal harm when administered during pregnancy. Use of Morphine MR APOTEX tablets should be avoided to the extent possible in patients who are pregnant. Long-term use of opioids in pregnancy may result in a neonatal opioid withdrawal state.

Use during labour and delivery:
Morphine crosses the placental barrier and its administration during labour can produce respiratory depression in the neonate. These products should only be used during labour after weighing the needs of the mother against the risk to the fetus.
Use in lactation:
Morphine has been detected in human breast milk; caution should be exercised if morphine is administered to a breastfeeding woman and use of morphine sulfate should be avoided to the extent possible.

INTERACTIONS WITH OTHER MEDICINES

Acidifying or alkalisning agents
Generally, the effects of morphine may be antagonised by acidifying agents and potentiated by alkalinising agents. Concurrent administration of antacids may result in a more rapid release of morphine than otherwise expected; dosing should, therefore, be separated by a minimum of two hours.

Amphetamines, chlorpromazine and methocarbamol
The analgesic effect of morphine is potentiated by amphetamines, chlorpromazine and methocarbamol.

CNS depressants
Morphine should be used with caution and in reduced dosage in patients who are concurrently receiving other CNS depressants which include, but are not limited to opioids, anaesthetics, sedatives (including benzodiazepines), anxiolytics, hypnotics, barbiturates, phenothiazines, antidepressants (including tricyclic antidepressants), chloral hydrate, antipsychotics, glutethimide, tranquillisers, muscle relaxants, antihypertensives, gabapentin and alcohol as they may enhance the depressant effects of morphine. Pyrazolidone antihistamines and beta-blockers may also enhance the depressant effect of morphine. Interactive effects resulting in respiratory depression, hypotension, profound sedation, coma or death may result if these drugs are taken in combination with the usual doses of morphine.

Monoamine oxidase inhibitors
Nonselective MAOIs intensify the effects of morphine and other opioid drugs which can cause anxiety, confusion and significant respiratory depression, sometimes leading to coma. Morphine should not be given to patients taking nonselective MAOIs or within 14 days of stopping such treatment. It is unknown whether there is an interaction between the newer selective MAOIs (e.g. moclobemide and selegiline) and morphine, therefore caution is advised with such drug combinations.

Zidovudine
Morphine may alter the metabolism of zidovudine by competitively inhibiting glucuronidation or directly inhibiting hepatic microsomal metabolism, therefore this combination should be used with caution.
**Cimetidine**
A potentially lethal interaction between morphine and cimetidine has been reported. The patient exhibited apnoea, a significantly reduced respiratory rate and suffered a grand mal seizure. Naloxone increased respiratory rate, however confusion, disorientation, generalised twitching and periods of apnoea persisted for 80 hours.

**Coumarin and other anticoagulants**
Morphine may increase the anticoagulant activity of coumarin and other anticoagulants.

**Mixed agonist/antagonist opioid analgesics**
Mixed agonist/antagonist opioid analgesics (e.g. buprenorphine, nalbuphine, pentazocine) should not be administered to a patient who has received a course of therapy with a pure opioid agonist analgesic.

**Ritonavir**
Available data indicate that ritonavir may increase the activity of glucuronyl transferases. Consequently, coadministration of ritonavir and morphine may result in decreased morphine serum concentrations with possible loss of analgesic effectiveness.

**Propranolol**
The combination of morphine and propranolol is potentially lethal. Propranolol increases the acute CNS toxicity of morphine.

**Anticholinergics**
Medicinal products that block the action of acetylcholine, for example antihistamines, antiparkinsonians and antiemetics, may interact with morphine to potentiate anticholinergic adverse events.

**Rifampicin**
Plasma concentrations of morphine may be reduced by rifampicin.

**ADVERSE EFFECTS**

The following frequencies are the basis for assessing adverse effects.

- **Very common** (≥ 1/10)
- **Common** (≥ 1/100 to < 1/10)
- **Uncommon** (≥ 1/1,000 to < 1/100)
- **Rare** (≥ 1/10,000 to < 1/1,000)
- **Very rare** (< 1/10,000)
- **Not known** (cannot be estimated from the available data)
The major hazards associated with morphine, as with other opioid analgesics, are respiratory depression and, to a lesser degree, circulatory depression. Respiratory arrest, shock and cardiac arrest have occurred following oral or parenteral use of morphine.

**Very common adverse effects requiring medical attention:**
The most frequently observed side effects of opioid analgesics such as morphine are sedation, nausea and vomiting, constipation and sweating.

*Sedation*
Most patients experience initial drowsiness, partly for pharmacokinetic reasons and partly because patients often recuperate from prolonged fatigue after the relief of persistent pain. Drowsiness usually clears in three to five days and is usually not a reason for concern providing that it is not excessive, or associated with unsteadiness or confusional symptoms. If excessive sedation persists, the reason for it must be sought. Some of these are:
- concomitant sedative medications,
- hepatic or renal failure,
- exacerbated respiratory failure,
- higher doses than tolerated in an older patient, or
- that the patient is actually more severely ill than realised.

If it is necessary to reduce the dose, it can be carefully increased again after three or four days if it is obvious that the pain is not being well controlled. Dizziness and unsteadiness may be caused by postural hypotension, particularly in elderly or debilitated patients. It can be alleviated if the patient lies down. Because of the slower clearance in patients aged over 50 years, an appropriate dose in this age group may be as low as one-half or less the usual dose in the younger age group.

*Nausea and vomiting*
Nausea and vomiting occur frequently after single doses of opioids, or as an early unwanted effect of regular opioid therapy. When instituting prolonged therapy for chronic pain, the routine prescription of an antiemetic should be considered. Patients taking the equivalent of a single dose of morphine of 20 mg or more (MORPHINE MR APOTEX 60 mg every 12 hours) usually require an antiemetic during early therapy. Small doses of prochlorperazine or haloperidol are the most frequently prescribed antiemetics. Nausea and vomiting tend to lessen in a week or so, but may persist due to opioid induced gastric stasis. In such patients, metoclopramide is often useful.

*Constipation*
As with all opioid analgesics, constipation is very common. In some patients, particularly elderly or bedridden patients, faeces may become impacted. It is essential to caution patients in this regard and to institute an appropriate regimen of bowel management at the start of prolonged opioid therapy.
Softeners, laxatives and other appropriate measures should be used as required.

Other adverse effects include:

**Cardiac disorders**
Not known: bradycardia, palpitations, supra-ventricular tachycardia

**Ear and labyrinth disorders**
Uncommon: vertigo

**Endocrine disorders**
Uncommon: a syndrome of inappropriate antidiuretic hormone secretion characterised by hyponatremia secondary to decreased free-water excretion may be prominent (monitoring of electrolytes may be necessary)

**Eye disorders**
Uncommon: visual disturbance
Not known: miosis

**Gastrointestinal disorders**
Common: abdominal pain, anorexia, dry mouth
Uncommon: dyspepsia, ileus, taste perversion
Not known: cramps, gastrointestinal disorders

**General disorders and administration site conditions**
Common: asthenic conditions (fatigue, malaise), pruritus
Uncommon: peripheral oedema
Not known: drug tolerance, oedema, drug withdrawal syndrome, drug withdrawal syndrome neonatal

**Hepato-biliary disorders**
Uncommon: increased hepatic enzyme
Not known: biliary pain, biliary spasm, biliary tract cramps

**Immune system disorders**
Uncommon: hypersensitivity
Not known: anaphylactic reaction, anaphylactoid reaction

**Nervous system disorders**
Common: dizziness, headache, involuntary muscle contractions, somnolence
Uncommon: convulsions, hypertonia, paraesthesia, syncope, seizures
Not known: hyperalgesia, weakness

**Psychiatric disorders**
- Common: confusion, insomnia
- Uncommon: agitation, euphoria, hallucinations, malaise, mood altered
- Not known: drug dependence, dysphoria, thinking disturbances

**Renal and urinary disorders**
- Uncommon: ureteric spasm, urinary retention or hesitance

**Reproductive system and breast disorders**
- Not known: amenorrhoea, erectile dysfunction, reduced libido or potency

**Respiratory, thoracic and mediastinal disorders**
- Uncommon: bronchospasm, pulmonary oedema, respiratory depression
- Not known: cough decreased

**Skin and subcutaneous tissue disorders**
- Common: hyperhidrosis, other skin rashes including contact dermatitis
- Uncommon: urticaria

**Vascular disorders**
- Uncommon: facial flushing, hypotension
- Not known: faintness, postural hypotension

**Withdrawal (abstinence) syndrome**
Physical dependence with or without psychological dependence tends to occur on chronic administration. An abstinence syndrome may be precipitated when opioid administration is discontinued or opioid antagonists administered. Tolerance to the effects of morphine may develop.

The following withdrawal symptoms may be observed after opioids are discontinued: body aches, diarrhoea, gooseflesh, loss of appetite, nervousness or restlessness, runny nose, sneezing, chills, tremors or shivering, stomach cramps, nausea, trouble with sleeping, unusual increase in sweating and yawning, weakness, tachycardia and unexplained fever. With appropriate medical use of opioids and gradual withdrawal from the drug, these symptoms are usually mild.
DOSAGE AND ADMINISTRATION

Administration and dosing of morphine should be individualised, bearing in mind the properties of the drug. In addition, the nature and severity of the pain or pains experienced, and the total condition of the patient must be taken into account. Of special importance is other medication given previously or concurrently.

As with other strong opioid analgesics, use of morphine for the management of persistent pain should be preceded by a thorough assessment of the patient and diagnosis of the specific pain or pains and their causes. Use of opioids for the relief of chronic pain, including cancer pain, important as it is, should be only one part of a comprehensive approach.

MORPHINE MR APOTEX should be used for the long-term treatment of chronic severe pain only after the pain has been proven to be alleviated by opioids (with a trial of shorter acting opioids or MORPHINE MR APOTEX itself).

**Initial dose in adults:**
Individual dosing requirements vary considerably based on each patient's age, weight, severity of pain, and medical and analgesic history. The most frequent initial dose is 30 mg every 12 hours.

Patients aged over 50 years tend to require much lower doses of morphine than the younger age group. In elderly and debilitated patients and those with impaired respiratory function or significantly decreased renal function, the initial dose should be one-half the usual recommended dose.

**Initial dose in children:**

*Over 25 kg.*
The initial dose will depend upon the degree of morphine tolerance and should be titrated in accordance with the patient's needs (see Dose titration).

*25 kg or less.*
There are no controlled trials of the use of morphine sulfate in children weighing 25 kg or less, nor in children with chronic severe nonmalignant pain.

Patients currently receiving other oral morphine formulations may be transferred to MORPHINE MR APOTEX at the same total daily morphine dosage, equally divided into two MORPHINE MR APOTEX doses given every 12 hours.

For patients who are receiving an alternate opioid, the oral morphine sulfate equivalent of the analgesic presently being used should be determined. Having determined the total daily dosage of the present analgesic, the following equivalence table can be used to calculate the approximate daily oral morphine sulfate dosage that should provide equivalent analgesia. The total daily oral
Morphine dosage should then be equally divided into two MORPHINE MR APOTEX doses given every 12 hours.

### Table 1  Opioids: approximate analgesic equivalence

<table>
<thead>
<tr>
<th>Drug</th>
<th>Equivalent dose (mg)</th>
<th>Intramuscular</th>
<th>Oral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine sulfate</td>
<td></td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Oxycodone</td>
<td></td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>Dextromoramide</td>
<td></td>
<td>-</td>
<td>15</td>
</tr>
<tr>
<td>Papaveretum</td>
<td></td>
<td>-</td>
<td>45</td>
</tr>
</tbody>
</table>

Dose titration:
Dose titration is the key to success with morphine therapy. Proper optimisation of doses scaled to the relief of the individual's pain should aim at the regular administration of the lowest dose of morphine which will maintain the patient free of pain at all times. Dose adjustments should be based on the patient's clinical response. Higher doses may be justified in some patients to cover periods of physical activity.

Because of the modified release properties of MORPHINE MR APOTEX, dosage adjustments should generally be separated by 48 hours. If dose increments are required, they should be proportionately greater at the lower dose level (in terms of percentage of previous dose), than when adjusting a higher dose.

The usual recommended dose (every 12 hours) increments are 5, 10, 15, 20, 30, 40, 60, 90, 120, 150, 180, 200 mg. Above the 200 mg/dose (400 mg/day) increments should be by 30 to 60 mg.

MORPHINE MR APOTEX tablets are designed to allow dosing every 12 hours. If breakthrough pain repeatedly occurs at the end of a dose interval, it is generally an indication for a dosage increase, not more frequent administration. However, where judged necessary for optimisation of drug effects, MORPHINE MR APOTEX may be administered every eight hours. More frequent (than every eight hours) administration of MORPHINE MR APOTEX is neither rational nor recommended.

**Dosage adjustment or reduction:**
During the first two or three days of effective pain relief, the patient may exhibit drowsiness or sleep for prolonged periods. This can be misinterpreted as the effect of excessive analgesic dosing rather than the first sign of relief in a pain exhausted patient. The dose, therefore, should be maintained for at least three days before reduction, provided the sedation is not excessive or associated with unsteadiness and confusional symptoms, and respiratory activity and other vital signs are adequate. If excessive sedation persists, the reason(s) for such an effect must be sought (see Adverse Reactions, Sedation).
Following successful relief of severe pain, periodic attempts to reduce the opioid dose should be made. Smaller doses or complete discontinuation of the opioid analgesic may become feasible due to a change in the patient's condition or improved mental state.

**Note:** MORPHINE MR APOTEX tablets should be swallowed intact, not chewed, crushed or broken.

**OVERDOSAGE**

**Symptoms:**
Serious morphine overdosage is characterised by respiratory depression (reduced respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, flaccidity of skeletal muscle, miotic pupils; cold or clammy skin, and sometimes hypotension and bradycardia. Severe overdosage may result in apnoea, pulmonary oedema, circulatory collapse, cardiac arrest and death.

**Treatment:**
Primary attention should be given to the establishment of adequate respiratory exchange through the provision of a patent airway and controlled or assisted ventilation. The opioid antagonist naloxone hydrochloride (Section 20a) is a specific antidote against respiratory depression due to overdosage or as a result of unusual sensitivity to morphine. An appropriate dose of one of the antagonists should therefore be administered, preferably by the intravenous route. The usual initial intravenous adult dose of naloxone is 0.4 mg or higher. Concomitant efforts at respiratory resuscitation should be carried out. Since the duration of action of morphine, particularly modified release formulations, may exceed that of the antagonist, the patient should be under continued surveillance and doses of the antagonist should be repeated as needed to maintain adequate respiration. An antagonist should not be administered in the absence of clinically significant respiratory or cardiovascular depression. Oxygen, intravenous fluids, vasopressors and other supportive measures should be used as indicated.

In an individual physically dependent on opioids, the administration of the usual dose of opioid antagonist will precipitate an acute withdrawal syndrome. The severity of this syndrome will depend on the degree of physical dependence and the dose of antagonist administered. The use of opioid antagonists in such individuals should be avoided if possible. If an opioid antagonist must be used to treat serious respiratory depression in the physically dependent patient, the antagonist should be administered with extreme care by using dosage titration, commencing with 10 to 20% of the usual recommended initial dose.

Gastric lavage with a wide bore tube followed by administration of an activated charcoal suspension will aid the removal of morphine. A saline cathartic or sorbitol added to the first dose of activated charcoal may speed gastrointestinal passage of the product.
Toxicity:
Morphine toxicity may result from overdosage, but because of the great interindividual variation in sensitivity to opioids, it is difficult to determine an exact dose of any opioid that is toxic or lethal. Crushing and taking the contents of a modified release dosage form leads to the release of morphine in an immediate fashion; this might result in a fatal overdose.

The presence of pain or tolerance tends to diminish the toxic effects of morphine. Published data suggest that in a morphine naive, pain free individual, the lethal dose would be in excess of 120 mg. Patients on chronic oral morphine therapy have been known to take in excess of 3,000 mg/day with no apparent toxicity.

PRESENTATION AND STORAGE CONDITIONS
Morphine MR APOTEX modified release tablets are intended for oral administration.

Each modified release table contains 10mg, 30mg, 60mg or 100mg of morphine sulfate pentahydrate as the active ingredient.

10mg Tablet
Buff coloured, biconvex, smooth, round, film coated modified release tablets with 10 on one face.
Blister Pack (PVC/Aluminium in cartons) of 20, 28 or 60 tablets AUST R 132251

30mg Tablet
Violet coloured, biconvex, smooth, round, film coated modified release tablets with 30 on one face.
Blister Pack (PVC/Aluminium in cartons) of 20, 28 or 60 tablets AUST R 132254

60mg Tablet
Orange coloured, biconvex, smooth, round, film coated modified release tablets with 60 on one face.
Blister Pack (PVC/Aluminium in cartons) of 20, 28 or 60 tablets AUST R 132256

100mg Tablet
Grey coloured, biconvex, smooth, round, film coated modified release tablets with 100 on one face.
Blister Pack (PVC/Aluminium in cartons) of 20, 28 or 60 tablets AUST R 132258

Storage
Store below 25°C.
NAME AND ADDRESS OF THE SPONSOR
Southern Cross Pharma Pty Ltd
Suite 5/118 Church St
Hawthorn VIC 3122

NAME AND ADDRESS OF THE DISTRIBUTOR
Apotex Pty Ltd
16 Giffnock Avenue
Macquarie Park NSW 2113

APO and APOTEX are registered trade marks of Apotex Inc.

POISON SCHEDULE OF THE MEDICINE
S8.

Date of first inclusion in the Australian Register of Therapeutic Goods (the ARTG):
22-04-2009

Date of most recent amendment
6th March 2018