Morphine may impair mental and/or physical abilities required for the performance of potentially hazardous tasks

May be absorbed through intact or disrupted skin. Wear protective clothing. Washing hands before and after handling the product may reduce the risk of skin absorption

Morphine readily crosses the placental barrier and may cause fetal harm when administered to a pregnant woman. Morphine should be given to a pregnant woman only if it is deemed essential.

Morphine is administered to a nursing woman. This may result in severe hypotension in an individual whose ability to maintain his blood pressure has markedly diminished. Use in labor and delivery should be encouraged. Concomitant administration of a β-blocker (propranolol) or other antihypertensive drugs should be considered when the use of morphine is discontinued in pregnancy. The respiratory depressant effects of morphine and its metabolites are significantly increased in the presence of increased intracranial pressure or cerebral arteriovenous malformations. Morphine is contraindicated in patients with acute abdominal conditions. Morphine is not administered to prevent impaction.

The administration of morphine may result in severe hypotension in an individual whose ability to maintain his blood pressure has markedly diminished. Use in labor and delivery should be encouraged. Concomitant administration of a β-blocker (propranolol) or other antihypertensive drugs should be considered when the use of morphine is discontinued in pregnancy. The respiratory depressant effects of morphine and its metabolites are significantly increased in the presence of increased intracranial pressure or cerebral arteriovenous malformations. Morphine is contraindicated in patients with acute abdominal conditions. Morphine is not administered to prevent impaction.

Drug Interactions

Generally, effects of morphine may be potentiated by monoamine oxidase inhibitors (e.g., phenelzine), phenothiazines or certain anesthetics.

Central Nervous System:

Morphine may increase anticoagulant activity of coumarin and other anticoagulants. The administration of morphine may result in severe hypotension in an individual whose ability to maintain his blood pressure has markedly diminished. Use in labor and delivery should be encouraged. Concomitant administration of a β-blocker (propranolol) or other antihypertensive drugs should be considered when the use of morphine is discontinued in pregnancy. The respiratory depressant effects of morphine and its metabolites are significantly increased in the presence of increased intracranial pressure or cerebral arteriovenous malformations. Morphine is contraindicated in patients with acute abdominal conditions. Morphine is not administered to prevent impaction.

General

Respiratory depression is a common clinical finding in neonates of mothers dependent on opioids. Respiratory depression may be exacerbated by the administration of other sedatives, hypnotics, anesthetics, or narcotics. Respiratory depression may be averted or reversed by naloxone. Morphine may increase anticoagulant activity of desiccated thyroid, phenobarbital, phenytoin, and corticosteroids. The antihypertensive activity of guanethidine may be enhanced by the concurrent administration of morphine. The antihypertensive activity of clonidine may be potentiated by the concurrent administration of morphine. MORPHINE SULFATE should be used with caution and only if it is deemed essential in patients who are concurrently taking monoamine oxidase inhibitors.

Hypotensive Effect:

The most frequently observed adverse reactions are:

1. Physical dependence
2. Tolerance
3. Withdrawal

Physical dependence may develop after repeated therapeutic dosage over a period of several days. Morphinism in one individual does not necessarily imply that physical dependence will develop in all individuals. The development of physical dependence and the severity of withdrawal symptoms is related to the duration of therapy, the dose of the drug, and the individual's sensitivity to the drug. Abrupt discontinuation of narcotics after prolonged therapy may result in severe withdrawal reactions. In general, the higher the dose of the drug, the greater the likelihood of the development of physical dependence and the greater the severity of withdrawal symptoms. Physical dependence has been reported to occur with the administration of narcotics of varying potencies. The administration of morphine may result in severe hypotension in an individual whose ability to maintain his blood pressure has markedly diminished. Use in labor and delivery should be encouraged. Concomitant administration of a β-blocker (propranolol) or other antihypertensive drugs should be considered when the use of morphine is discontinued in pregnancy. The respiratory depressant effects of morphine and its metabolites are significantly increased in the presence of increased intracranial pressure or cerebral arteriovenous malformations. Morphine is contraindicated in patients with acute abdominal conditions. Morphine is not administered to prevent impaction.

NURSING MOTHERS

Morphine is detected in human milk. The effects of morphine on nursing infants have not been evaluated.

ADVERSE REACTIONS

The most frequent adverse reaction resulting from the administration of morphine is respiratory depression. Most commonly, respiratory depression in adults occurs at doses equal to or greater than 100 mg. Respiratory depression may be averted or reversed by naloxone. Respiratory depression may also be caused by concomitant administration of CNS depressants (including alcohol). Respiratory depression may also be caused by concomitant administration of CNS depressants (including alcohol), including hypnotics such as sedative-hypnotics, phenothiazines, and other tranquilizers. Morphine may increase anticoagulant activity of desiccated thyroid, phenobarbital, phenytoin, and corticosteroids. The antihypertensive activity of guanethidine may be enhanced by the concurrent administration of morphine. The antihypertensive activity of clonidine may be potentiated by the concurrent administration of morphine. MORPHINE SULFATE should be used with caution and only if it is deemed essential in patients who are concurrently taking monoamine oxidase inhibitors.

Additional information about this product can be found on the product’s website.
Once pain control is established, periodic attempts to reduce the narcotic dose should be made. If respiratory activity and other vital signs are adequate, the patient may be monitored and closely observed for at least three days before reduction is attempted. Dosing rather than the first sign of relief in a pain patient should be used when titrating the dosage to a level that just maintains a tolerable level of pain. The dose, therefore, should be titrated rather than the first sign of relief in patients who are already dependent on narcotics. The dose, therefore, should be maintained for at least three days before reduction is attempted. Dosing rather than the first sign of relief in patients who are already dependent on narcotics should be used.

During the first two to three days of effective pain control, periodic attempts to reduce the narcotic dose should be made. If respiratory activity and other vital signs are adequate, the patient may be monitored and closely observed for at least three days before reduction is attempted. Dosing rather than the first sign of relief in patients who are already dependent on narcotics should be used.

It may be possible for the analgesic to control severe pain in a patient who has been taking a large drug dose for an extended period of time. These patients may often tolerate the abrupt interruption of the analgesic with no unpleasant withdrawal symptoms. If the drug dependence is significant, it is possible to induce physical and emotional withdrawal symptoms by gradually withdrawal of the drug.

Morphine is a Schedule II controlled substance under the federal Controlled Substances Act. As with other narcotics, some patients may develop a physical and psychological dependence on the drug. In such cases, abrupt discontinuance may precipitate typical withdrawal symptoms, including convulsions. Therefore the drug must be withdrawn gradually over a period of days or weeks. For this reason, the patient should be kept under continued supervision and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.

If the patient is so exhausted that the patient becomes apathetic and unresponsive to supportive measures, a dose of naloxone HCl (0.4 mg) should be administered intravenously and simultaneously with oxygen, intravenous fluids, vasopressors and other supportive measures. The narcotic antagonist should not be administered in the terminal phase of cancer. The patient should be kept under continued supervision and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. Since the duration of action of morphine may exceed that of the antagonist, the patient should be kept under continued supervision and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. Since the duration of action of morphine may exceed that of the antagonist, the patient should be kept under continued supervision and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. Since the duration of action of morphine may exceed that of the antagonist, the patient should be kept under continued supervision and repeated doses of the antagonist should be administered as needed to maintain adequate respiration. Since the duration of action of morphine may exceed that of the antagonist, the patient should be kept under continued supervision and repeated doses of the antagonist should be administered as needed to maintain adequate respiration.