

**From the Chief Medical Officer
Prof Sir Michael McBride**



Department of
Health

An Roinn Sláinte

Máinnstríe O Poustie

www.health-ni.gov.uk

HSS(MD) 60/2021

FOR ACTION

Chief Executives, Public Health Agency/Health and Social Care Board/HSC Trusts/ NIAS
GP Medical Advisers, Health and Social Care Board
All General Practitioners and GP Locums
(for onward distribution to practice staff)
OOHs Medical Managers (for onward distribution to staff)

PLEASE SEE ATTACHED FULL CIRCULATION LIST

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Our Ref: HSS(MD) 60/2021

Date: 24 August 2021

Actions to be completed as soon as possible.

Dear Colleague

POTENT SYNTHETIC OPIOIDS IMPLICATED IN INCREASE IN DRUG OVERDOSES

In the past 10-14 days there have been an unprecedented number of overdoses (with some deaths) in people who use drugs, primarily heroin, in some parts of England (5 London boroughs, Hampshire, Essex, West Sussex, Dorset, Thames Valley). There has also been reports within Belfast, that there is uncut heroin currently in circulation that seems to be resulting in overdose within a number of people. This risk is further increased with poly drug use, where a few service users have been found unresponsive and one person is currently seriously ill in hospital.

Testing in two areas (of 3 cases) has found isotonitazene, a potent synthetic opioid. Isotonitazene has been identified previously in the UK but its use has been more common in the USA. It was notified as a subject of concern in Europe in 2019. Its potency and toxicity are uncertain but perhaps similar to, or more than fentanyl, which is about 100x morphine.

The adulterated heroin used may be paler in colour than usual and may become darker than usual when dissolved for injection (“cooked up”). However, reports vary considerably. There is good evidence from reports that naloxone, the ‘antidote’ to opioid overdoses, works in these cases. The treatment required for an overdose that may be related to isotonitazene is the same as for other opioid overdoses, but

delivering it rapidly and completely is even more critical, as progression to respiratory arrest, and recurrence of respiratory arrest, are more likely. Those in contact with heroin users should be alert to the increased possibility of overdose arising from 'heroin' containing synthetic opioids, be able to recognise possible symptoms of overdose and respond appropriately.

Actions to be completed as soon as possible.

1. All organisations where staff may encounter people who use drugs should ensure those staff are:
 - made aware of the risk of severe toxicity resulting from adulteration of heroin with potent synthetic opioids such as isotonitazene;
 - made aware that the potency and toxicity of isotonitazene is perhaps similar to, or more than, fentanyl, which is about 100x morphine;
 - alert to the symptoms of opioid overdose in known and suspected heroin users;
 - communicate these risks to heroin users during any contacts; and
 - ensure people who use heroin and others who might encounter an opioid overdose have naloxone available (widening the availability of naloxone).
2. All organisations that provide emergency care for opioid overdose should ensure staff are supported to:
 - treat suspected cases as for any opioid overdose, using naloxone and appropriate supportive care; and
 - recognise the duration of action of naloxone is shorter than that of many opioids and appropriate monitoring and further doses of naloxone may be required. In the community this could include injectable or intranasal naloxone, administering a single dose and waiting for no response before administering more.

In specialist medical settings only:

- treatment may involve the intravenous naloxone titration regimen recommended by the National Poisons Information Service.
- intramuscular naloxone can be used as an alternative in the event that IV access is not possible or is delayed.

Naloxone dosing in acute medical care

The standard naloxone dosing regimen where potent opioid overdose is suspected (for adults and children > 12 years) for use in acute hospitals, subject to clinical assessment of the individual case, is:

- Give an initial dose of 400 micrograms (0.4 mg) intravenously.
- If there is no response after 60 seconds, give a further 800 micrograms (0.8 mg)
- If there is still no response after another 60 seconds, give another 800 micrograms (0.8 mg).
- If there is still no response give a further 2 mg dose. Large doses (4 mg) may be required in a seriously poisoned patient.
- Aim for reversal of respiratory depression, not full reversal of consciousness.

This regimen provides the appropriate doses needed in severe toxicity, while minimising the risk that excessive naloxone doses might precipitate acute opioid withdrawal. For further advice, medical professionals can use the National Poisons Information Service 24-hour telephone service on 0344 892 0111 or its online database, TOXBASE.

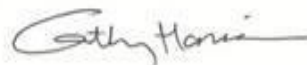
Further advice and reporting

- To report any additional intelligence about the use of and harm from synthetic opioids please email drug.alerts@phe.gov.uk. This will enable suitable information to be shared with relevant agencies, and help in assessment of the need for any further action.
- Up to date information for people considering using drugs, including advice on reducing risk, is available from www.talktofrank.com or from the FRANK helpline on 0800 77 66 00.
- Advice on responding in the community to an opioid overdose with naloxone is available from <http://www.prenoxadinjection.com/> (for injectable Prenoxad®) and <https://www.nyxoid.com/uk> (for nasal Nyxoid®)
- EMCDDA initial report on the new psychoactive substance N,N-diethyl-2-[[4-(1-methylethoxy)phenyl]methyl]-5-nitro-1H-benzimidazole-1-ethanamine (isotonitazene) | www.emcdda.europa.eu

Yours sincerely



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Chief Medical Officer



MRS CATHY HARRISON
Chief Pharmaceutical Officer

