MORPHINE – A POWERFUL NARCOTIC PAIN KILLER ABUSED AT A HIGH RATE LEADING TO DETERIORATION OF HUMAN QUALITY: A MINI REVIEW

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ABSTRACT

The present review details the impact of morphine in addict cases, its abuse and severe case studies. Morphine is a dangerously addictive drug and it presents the patient with a wide range of potential side effects, even when it is prescribed and the administration is monitored. The signs and symptoms of a morphine abuse overdose can include: Fluid in the lungs, Cold, clammy skin, Flaccid muscles, Stupor, Slow breathing, Slow heart rate, Coma etc. Cessation of dosing with morphine creates the prototypical opioid withdrawal syndrome, which, unlike that of barbiturates, benzodiazepines, alcohol, or sedative-hypnotics, is not fatal by itself in neurologically healthy patients without heart or lung problems. Morphine addiction treatment options that include holistic drug rehab, as well as private drug treatment geared toward corporate executives.

Morphine is a member of the opioid family of drugs which is prescribed by physicians to help manage moderate to severe pain in patients who are suffering from chronic illnesses like cancer. While most patients who are under supervised care use the drug as prescribed, when taking the medication at home or away from a hospital environment, morphine can be easily abused (Trescot et al. 2008). Then, of course, are those who use the drug purely on a recreational level. For these individuals, abuse develops rather quickly. Morphine is a dangerously addictive drug and it presents the patient with a wide range of potential side effects, even when it is prescribed and the administration is monitored. Of course, when morphine abuse is taking place, the following side effects may be more pronounced than what is normally experienced viz. Depression or irritability, Anxiety, Constipation or diarrhea, Trouble sleeping or insomnia, Abdominal pain including cramps, Memory loss, Tremors or seizures, Vision problems including involuntary movement of the eyeball, Rash, hives and/or itching, Headache, High or low blood pressure etc.

Continued use or abuse of opioids can result in physical dependence and addiction. The body adapts to the presence of the drug and withdrawal symptoms occur if use is reduced or stopped. These include restlessness, muscle and bone pain, insomnia, diarrhea, vomiting, and cold flushes with goose bumps (“cold turkey”). Tolerance can also occur, meaning that long-term users must increase their doses to achieve the same high.

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REAL UTILIZATION OF MORPHINE IN CLINICAL MEDICINE

In clinical medicine, morphine is regarded as the gold standard, or benchmark, of analgesics used to relieve intense pain and suffering. Like other opioids, such as oxycodone, hydromorphone, and diacetylmorphine (heroin), morphine acts directly on the central nervous system (CNS) to relieve pain (Klous et al. 2005). Morphine is primarily used to treat both acute and chronic severe pain. It is also used for pain due to myocardial infarction and for labor pains. There are however concerns that morphine may increase mortality in the setting of non ST elevation myocardial infarction. Morphine has also traditionally been used in the treatment of acute pulmonary edema (Kerr et al. 1991).

Immediate release morphine is beneficial in reducing the symptom of acute shortness of breath due to both cancer and non-cancer causes. In the setting of breathlessness at rest or on minimal exertion from conditions such as advanced cancer or end-stage cardio-respiratory diseases, regular, low-dose sustained release morphine significantly reduces breathlessness safely, with its benefits maintained over time. Hormonal role of morphine is also discovered (Stefano et al. 2004).

Its duration of analgesia is about 3–4 hours when administered via the intravenous, subcutaneous, or intramuscular route and
3–6 hours when given by mouth. Morphine is also used in slow release formulations for opiate substitution therapy (OST) in Austria, Bulgaria, and Slovenia, for addicts who cannot tolerate the side effects of using either methadone or buprenorphine, or for addicts who are “not held” by buprenorphine or methadone. It is used for OST in many parts of Europe although on a limited basis.

Morphine is known on the street and elsewhere as M, sister morphine, Vitamin M, morpho etc. MS Contain tablets are known as misties, and the 100 mg extended-release tablets as greys and blockbusters. The “speedball” can use morphine as the narcotic component, which is combined with cocaine, amphetamines, methylphenidate, or similar drugs. “Blue Velvet” is a combination of morphine with the antihistamine tripelemamine (Pyrabenzamine, PBZ, Pelamine) taken by injection (Meine et al. 2005), or less commonly the mixture when swallowed or used as a retention enema; the name is also known to refer to a combination of tripelemamine and dihydrocodeine or codeine tablets or syrups taken by mouth.

“Morphia” is an older official term for morphine also used as a slang term. “Driving Miss Emma” is intravenous administration of morphine. Multi-purpose tablets (readily soluble hypodermic tablets that can also be swallowed or dissolved under the tongue or betwixt the cheek and jaw) are known, as are some brands of hydromorphone, as Shake & Bake or Shake & Shoot.

Morphine can be smoked, especially diacetylmorphine (heroin), the most common method being the “Chasing The Dragon” method. To perform a relatively crude acetylation to turn the morphine into heroin and related drugs immediately prior to use is known as AAing (for Acetic Anhydride) or home-bake, and the output of the procedure also known as home-bake or, Blue Heroin (not to be confused with Blue Magic heroin, or the linctus known as Blue Morphine or Blue Morphone, or the Blue Velvet mixture described above).

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Acute morphine along with any other opioid withdrawal proceeds through a number of stages (Friswell et al. 2008). Other opioids differ in the intensity and length of each, and weak opioids and mixed agonist-antagonists may have acute withdrawal syndromes that do not reach the highest level (Naqvi et al. 2009).

Stage I: Six to fourteen hours after last dose: Drug craving, anxiety, irritability, perspiration, and mild to moderate dysphoria.

Stage II: Fourteen to eighteen hours after last dose: Yawning, heavy perspiration, mild depression, lacrimation, crying, running nose, dysphoria, also intensification of the above symptoms. “yen sleep” (a waking trance-like state)

Stage III: Sixteen to twenty-four hours after last dose: Rhinorrhea (runny nose) and increase in other of the above, dilated pupils, piloerection (goose bumps - giving the name ‘cold turkey’), muscle twitches, hot flashes, cold flashes, aching bones and muscles, loss of appetite and the beginning of intestinal cramping.

Stage IV: Twenty-four to thirty-six hours after last dose: Increase in all of the above including severe cramping and involuntary leg movements (“kicking the habit” also called restless leg syndrome), loose stool, insomnia, elevation of blood pressure, moderate elevation in body temperature, increase in frequency of breathing and tidal volume, tachycardia (elevated pulse), restlessness, nausea.

Stage V: Thirty-six to seventy-two hours after last dose: Increase in the above, fetal position, vomiting, free and frequent liquid diarrhea, which sometimes can accelerate the time of passage of food from mouth to out of system to an hour or less, weight loss of two to five kilos per 24 hours, increased white cell count and other blood changes.

Stage VI: After completion of above: Recovery of appetite and normal bowel function, beginning of transition to post-acute and chronic symptoms that are mainly psychological but that may also include increased sensitivity to pain, hypertension, colitis or other gastrointestinal afflictions related to motility, and problems with weight control in either direction.

In advanced stages of withdrawal, ultrasonographic evidence of pancreatitis has been demonstrated in some patients and is presumably attributed to spasm of the pancreatic sphincter of Oddi (Thompson 2001). However, human WBC synthesize morphine (Zhu et al. 2005). Drugs banning is more needed by governments of all countries to reduce human deterioration (Donald 2007).
TREATMENT OF MORPHINE ABUSE PATIENTS

Morphine addiction is a serious addiction that needs the prompt treatment of a rehab center to overcome. It’s time to come clean, admit to your addiction, and take the steps to get clean. With help from one of our high-quality substance abuse treatment centers, morphine addiction can indeed be overcome. Treatment Solutions offers clients a wide variety of morphine addiction treatment options that include holistic drug rehab, as well as private drug treatment geared toward corporate executives. The de-addiction program on the 12-step model for addiction and abstinence which works towards ensuring that lasting sobriety is attained. The de-addiction program works closely with trained physicians to include medication – but only for the length of time of need.

A very thorough physiological and psychological evaluation is made to create a treatment plan that is based around the patients’ needs. Each person who comes to us has a unique plan of care for their stay.

The entire treatment approach is based around meeting – and exceeding the needs to help heal the whole person – mind, body, and spirit.

Cognitive-behavioral therapy (CBT) is a very trusted form of therapy that seeks to correct the negative thoughts and behaviors and replace them with more positive and constructive ways to view the world. This can, in turn, change behavior for the better.

Rational emotive behavioral therapy (REBT) is an action-driven form of therapy that focuses upon resolving behavioral and emotional issues to lead a more productive and happier life.

Group therapy is a common form of therapy used to help individuals recover from addiction to morphine and other substances. Through group therapy sessions, frank and supportive environment is provided with others who share similar struggles. Group therapy topics may range from addiction, co-occurring disorders, relapse prevention, coping skills, and stress management.

Family therapy is a very important part of recovery journey as patients come from a larger family unit.

Individual therapy is used to address problems and concerns outside of a group setting allowing to open up and share parts of patients inner self with the therapist, like to discuss the roots of morphine addiction, discuss coping strategies, co-occurring disorders, and relapse prevention.

REFERENCES


