Alfentanil

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What is it?

- Alfentanil is a potent synthetic opioid
- It is short acting than morphine and fentanyl
- It works on opiate receptors in the body
- We use vials of 25mg/50mls vials.
- As a member of the opioid family it has all the common side effects such as respiratory depression and slowing of gastro intestinal peristalsis.

Why do we use it?

- The respiratory depression and sedation provided by it assist other agents such as propofol to enable patient to tolerate ventilation.
- It has analgesic properties.
- Alfentanil has a rapid onset (1- 3 minutes) and a short half life compared to many other family members such as morphine
- It does not produce histamine or have any active metabolites like morphine

What are the problems with it?

- It is very potent 1mg (or 2mls/hr) of alfentanil can be the equivalent of 10 mg of morphine depending on how patient metabolised it.
- It has context sensitive half life so longer patients on it, longer it hangs around
- When patients are recovering the residual effects of the drug may contribute to delirium.

How do we give it?

- We tend to give it via a central line or peripheral cannula as an infusion at between 0-2mls/hr, occasionally upto 3-4ml/hr.
- Infusions rate over 4mls/hr should be reserved for patients who have large opiate tolerance such as those who take illicit drugs or methadone
- We can give a bolus of 1 to 2 ml of the drug to control pain, this may decrease blood pressure or depress breathing. *If we give a bolus we must record this on the observation chart.*
- We also commonly give a small bolus when first increasing the rate of infusion
- We normally use 50ml bottles via an infusion pump but it can be given in a 50ml syringe via a syringe pump.

What should we look out for?

- What is patients pain score?
- For bolus doses check breathing and blood pressure observations
- Everyday, check if dose and rate still patient appropriate
- If patient hasn’t open their bowels then try to reduce amount running in