

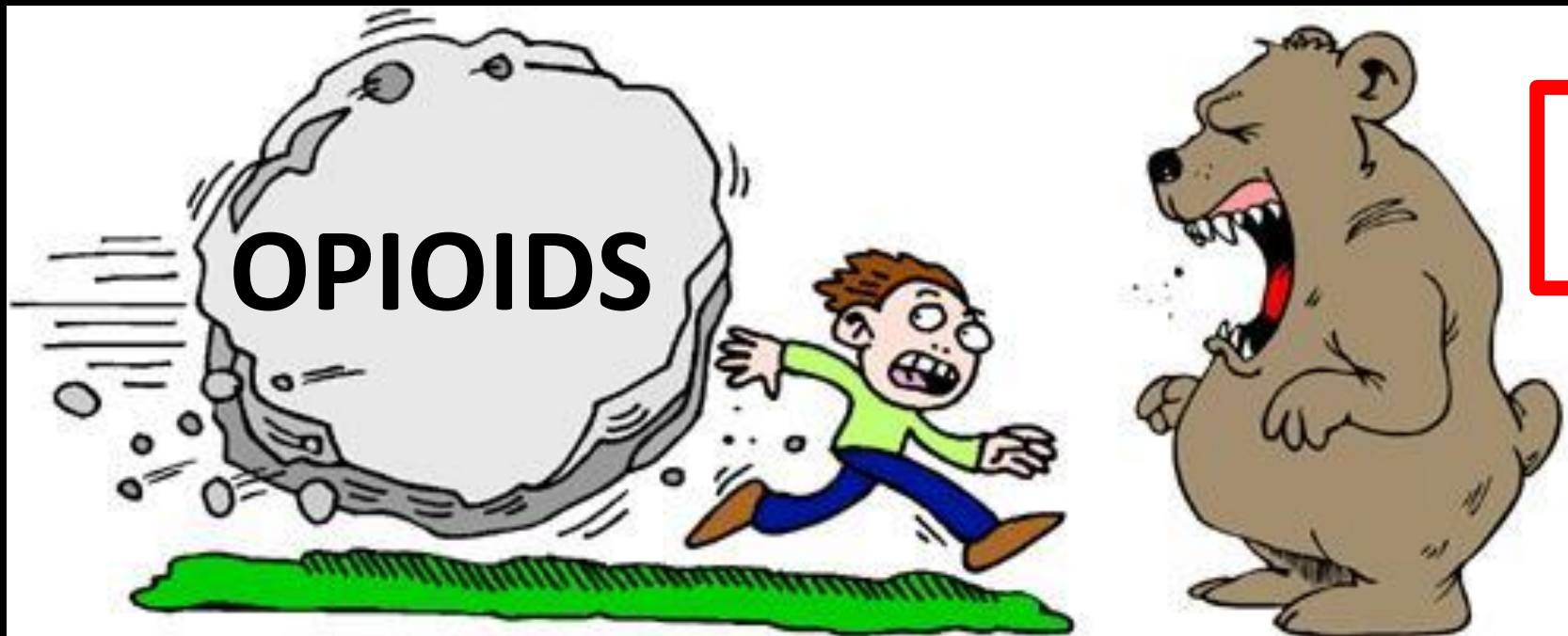
*Opioids, Buprenorphine,  
and your Toolbox*

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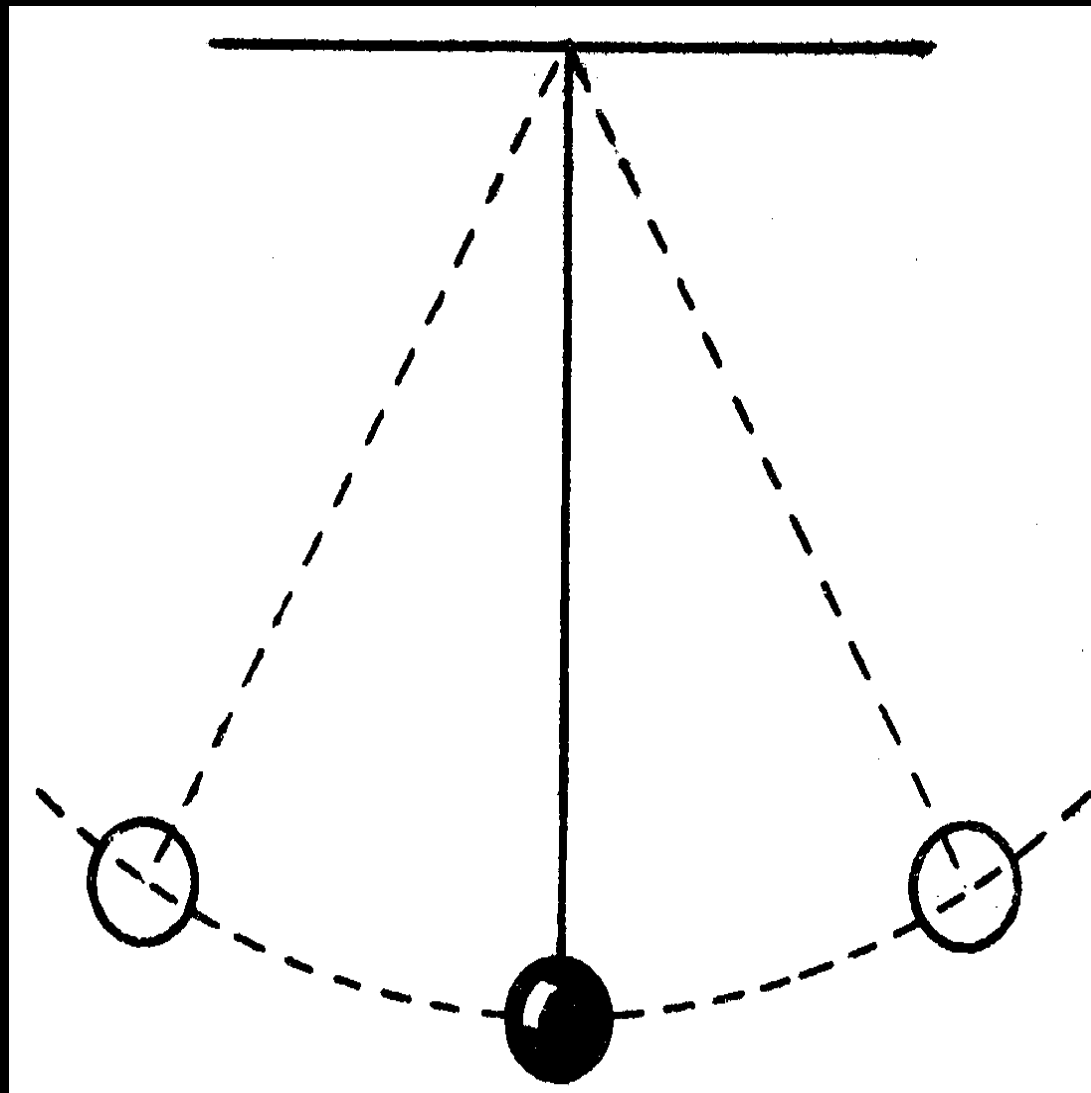
St. Joseph's Health

# The Pain Management Dilemma



**PAIN**

**OPIOIDS FOR  
EVERYTHING**

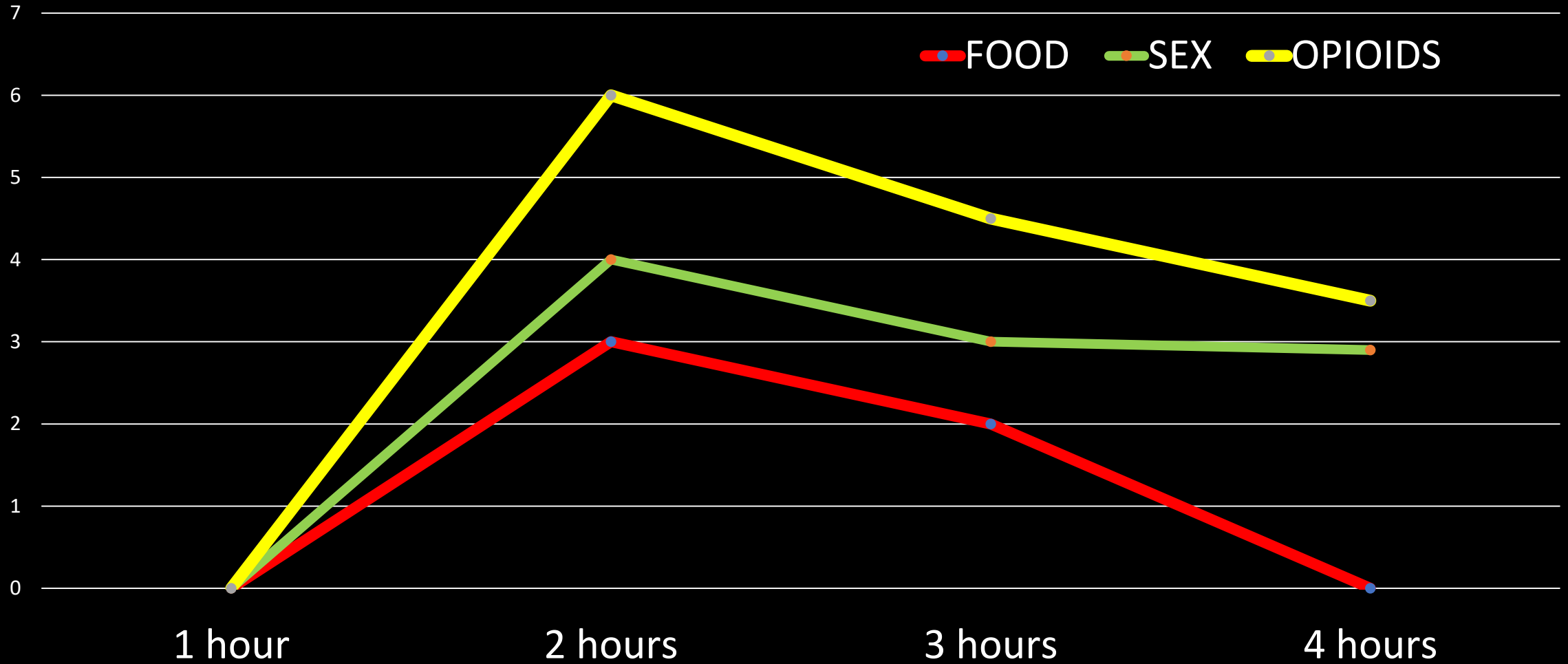


**OPIOIDS FOR  
NOTHING**



**KEEP  
CALM  
AND  
RESPECT  
OPIOIDS**

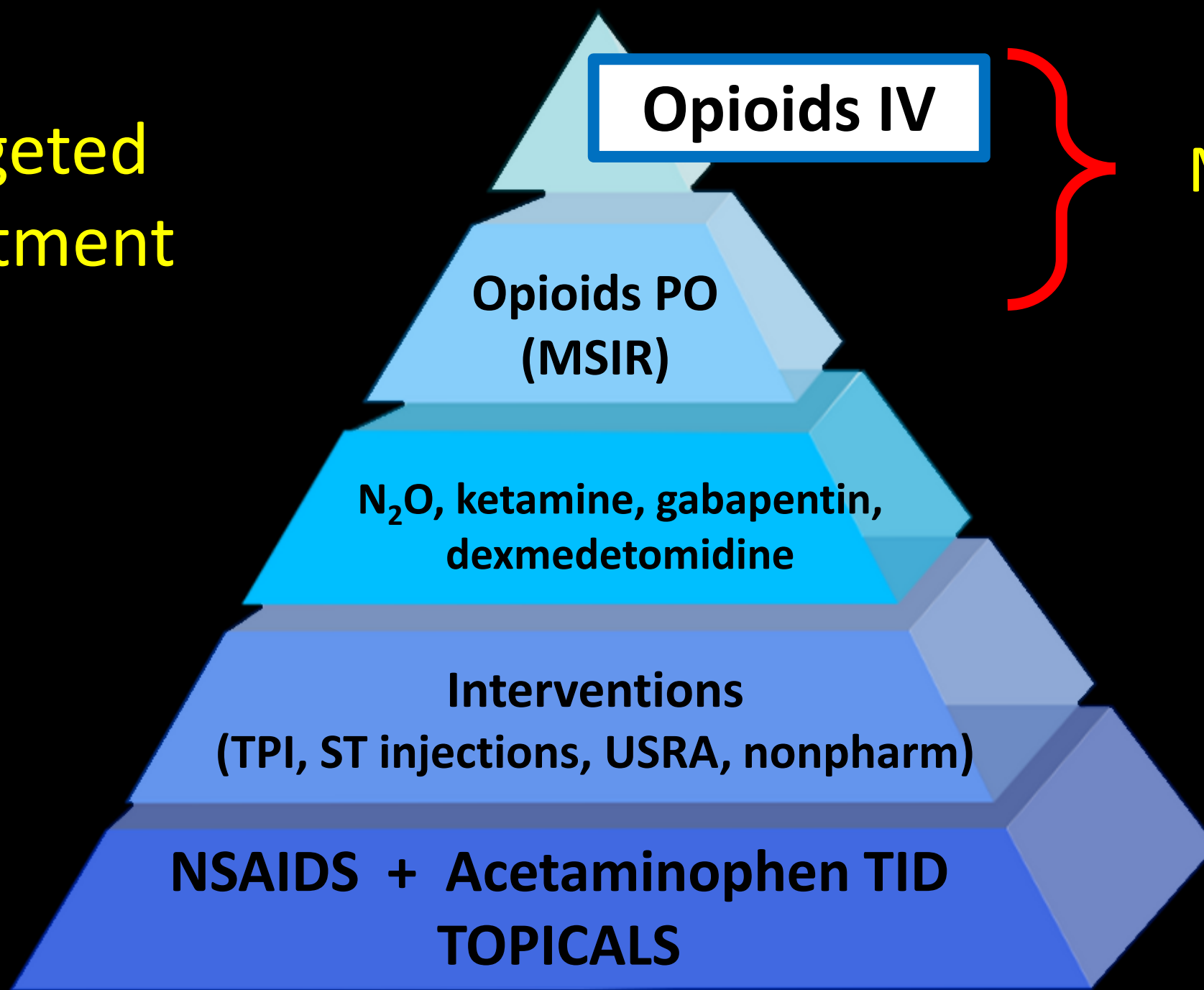
# Dopamine Spike





**ALTO**

**Targeted  
Treatment**



**Opioids IV**

**MASKING**

**Opioids PO  
(MSIR)**

**N<sub>2</sub>O, ketamine, gabapentin,  
dexmedetomidine**

**Interventions  
(TPI, ST injections, USRA, nonpharm)**

**NSAIDS + Acetaminophen TID  
TOPICALS**

# Abuse Potential

- Oxycodone
  - Most commonly abused (most desirable)
- Hydromorphone
  - IVP formulation extremely euphoric
- Morphine Sulfate Immediate Release
  - Less euphoric just as effective



# Tramadol

- **DO NOT USE IT**
- It is an opioid with ALL the same opioid harms we hate **PLUS additional adverse** effects



# The literature re: Efficacy

- Tramadol = APAP for abdominal pain
- Tramadol < NSAIDs for biliary pain
- Tramadol 100 mg < hydrocodone/APAP for MSK pain
- Tramadol/APAP < Ibuprofen 400 mg post op pain
- 5 RCTs Tramadol 75 mg + APAP < Ibuprofen 400 mg

# HARMS

- SEIZURE/Alzheimers + Parkinson's (chronic use)
- Serotonin Syndrome (SNRI effects)
- Varying metabolism
- Dose dependent respiratory depression
- CYP2D6 inh = Multiple drug:drug interaction
  - Can lead to withdrawal
- 50% of DM1 will get hypoglycemia
- Increased chance of admission 2/2 low Na<sup>+</sup>
- Long term increased mortality risk compared to NSAIDs

**Unknown amount of  
codeine  
+  
unknown amount of  
venlafaxine**



# Tramadol HARMS

- Major addiction potential
- As euphoric as heroin
- Activates addiction areas of the brain on fMRI
- Withdrawal is worse than with full agonists because it is mixed with SNRI
- SEIZURES!!!!

# Best Practice

- Lowest effective dose of opioids WITH COUNSELING
- Shortest course
- Close follow up
- USE analgesic dosing of acetaminophen and an NSAID to the opioid. DO NOT USE combo products
- DO NOT USE TRAMADOL
  
- MSIR *may* be a better opioid (as it is less likable)
  - Issues: stocking at the pharmacy (let your local pharmacies know)



# Which is better for MSK pain?

- Ibuprofen 400 mg + APAP 1000 mg
- Ibuprofen 800 mg + APAP 1000 mg
- Codeine 30 mg + APAP 300 mg
- Hydrocodone 5 mg + APAP 300 mg
- Oxycodone 5 mg + APAP 325 mg



# To Start With

Acetaminophen 1000 mg TID

+

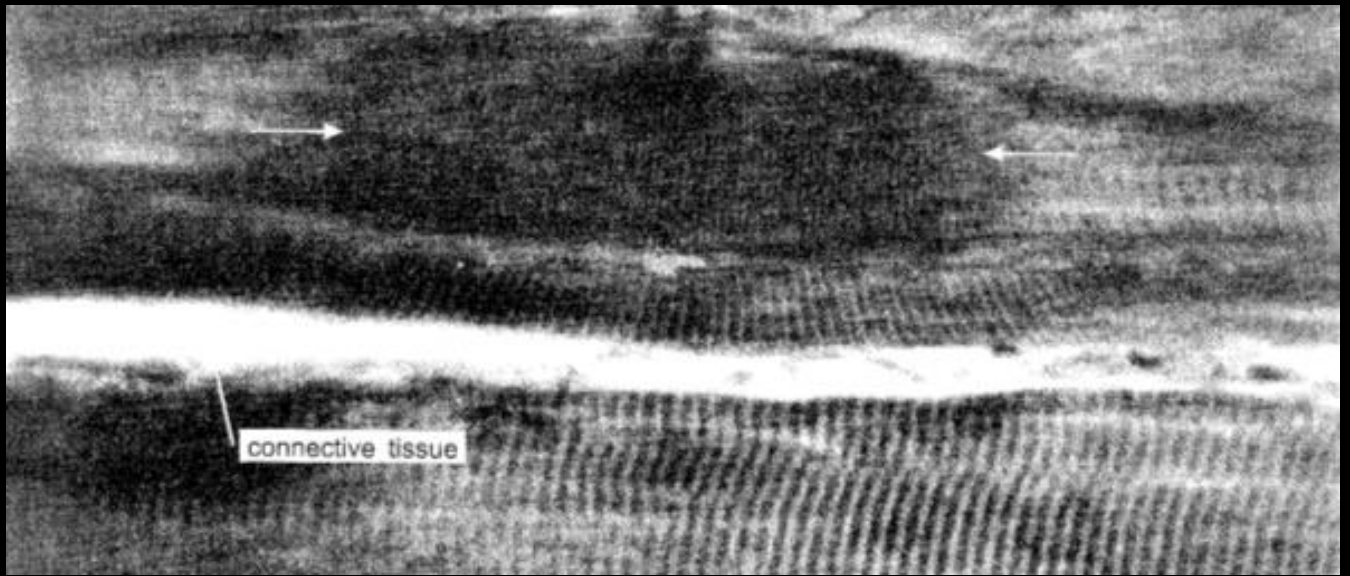
Ibuprofen 400 mg TID

Diclofenac 1% gel TID

+

Lidocaine 5 %  
(ointment/patch)

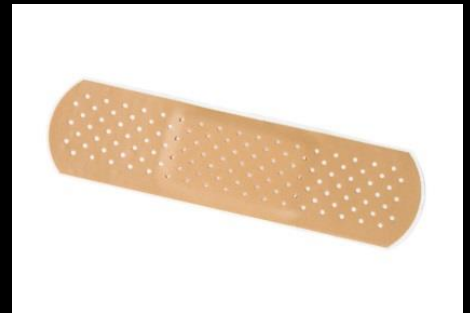
Physical Therapy



**21-25  
gauge**



**1-2 mL**



# Opioid Tolerant Patients Break The Crisis

- NSAIDs + Acetaminophen
- Dexamethasone
- Magnesium (NMDA receptor antagonist)- no adverse effects!
  - 2 grams IVPB or 400 mg PO

# Chronic Pain

- Be reluctant to start chronic non-cancer pain patients on opioids
  - Once they are on opioids they may never get off them
  - Remember alternatives
    - OMT
    - Acupuncture
    - Physical Therapy
    - Cognitive Behavioral Therapy
    - Massage
    - SSRIs, SNRIs, TCAs
    - Interventional Techniques (eg: ESI)

# Know where to send them

- Find out who the pain physicians are within an hour of your office
  - Call them
  - Find out what insurance they take
- Find out who performs interventional procedures near you
  - Interventional radiology
  - Ortho/spine
  - Outpatient Pain Management

**Respect Opioids (consider MSIR)**

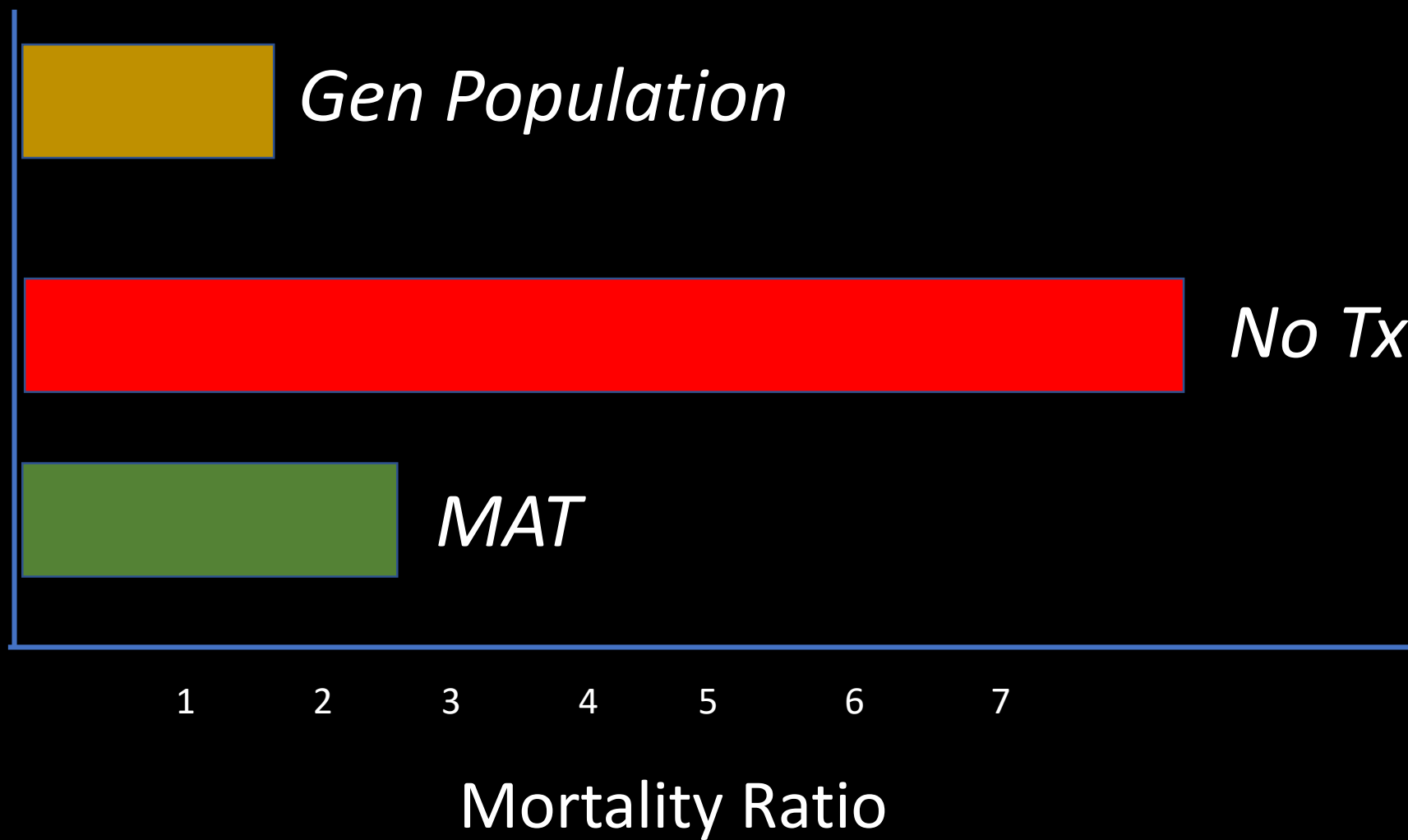
**Peruse your tool box and dig deep**

**Use TPI, OMT, and all alternatives FIRST**

**Be reluctant to start opioids for chronic pain**

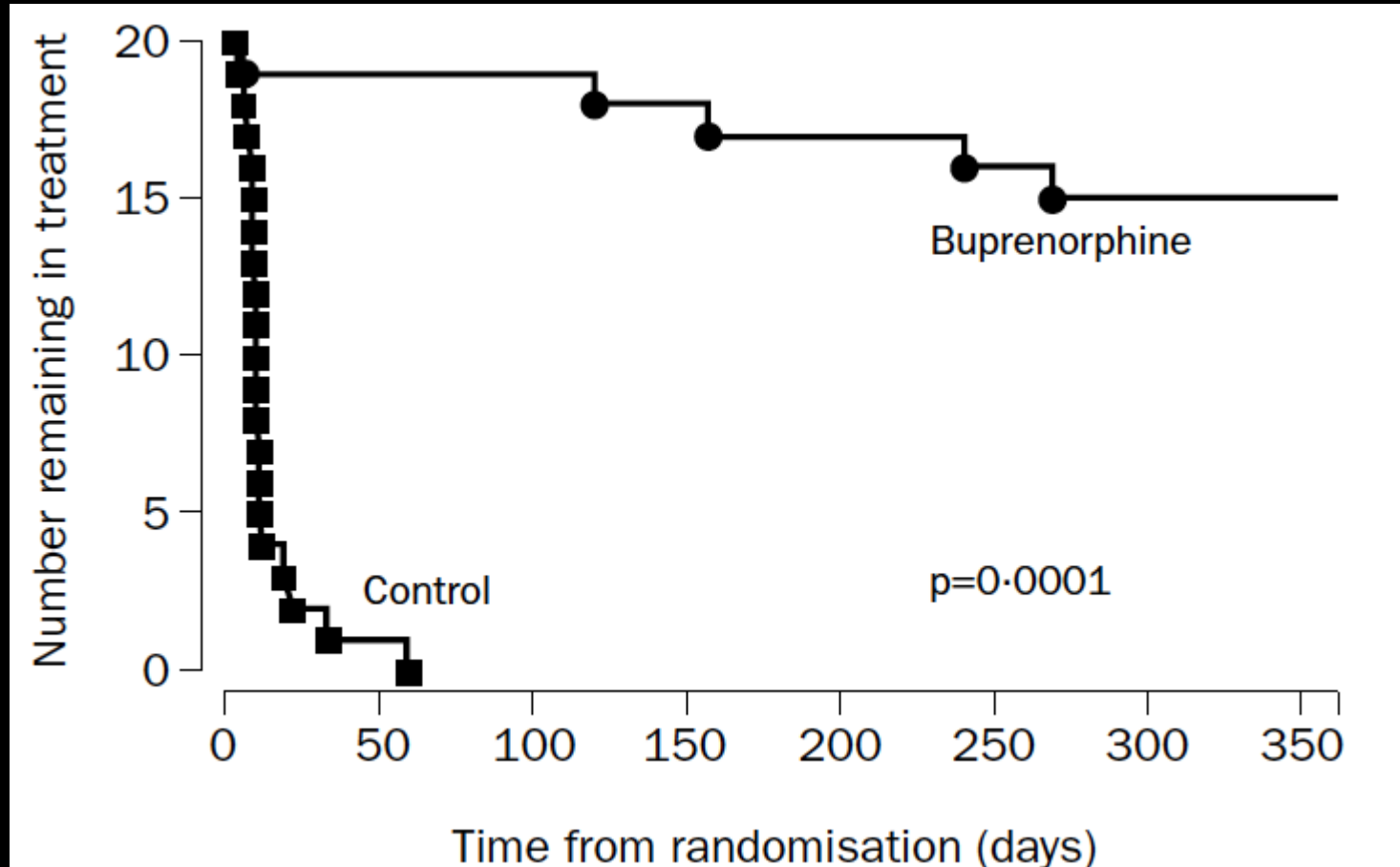
# Management of Opioid Withdrawal

# Death Rate





# Bup Taper vs Ongoing Tx



**Deaths: Taper –  
4/20**

**Buprenorphine –  
0/20**

You will SAVE LIVES

Starting MAT has a similar mortality reduction as treating a STEMI patient with a cath as opposed to thrombolytics

<https://www.njacep.org/MAT-Waiver>

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