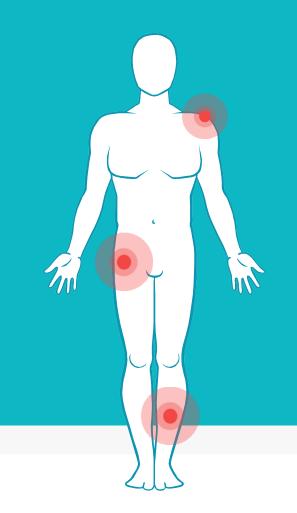
Pain in the challenging trauma patient.



Dr Ben Rippin F.R.C.A.
Consultant Anaesthetist L.G.I.

"The relief of suffering is a great good. The curing of illness and disease - these are great human goods.

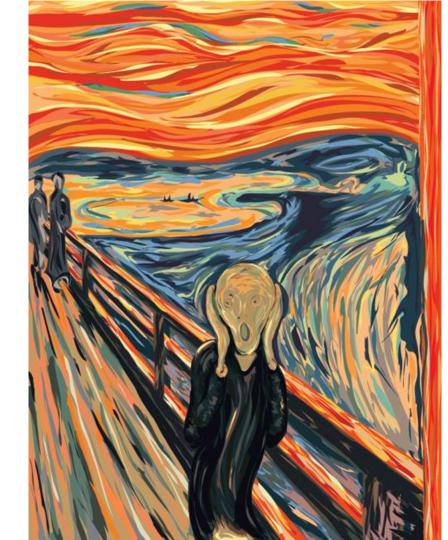
This is the mission of medicine"

Michael Sandel



The Drugs don't work.....

- ▶ Genetic subgroups
- ⊳Non-opiod Naive.
- ▶ Opiod Non-responders.



Genetic varience.

Genetics

- Weak opiods are PROdrugs.
- Require acetylsation.
- ⊳P450 sub groups.
- ⊳Non-responders.
- ⊳Some respond +++.



Non Opiod "Naive".

I.V.D.U.



Trainspotting

From the makers of

Shallow Grave

18

From: Molecular Mechanisms of Opioid Receptor-dependent Signaling and Behavior

Anesthesiology. 2011;115(6):1363-1381. doi:10.1097/ALN.0b013e318238bba6

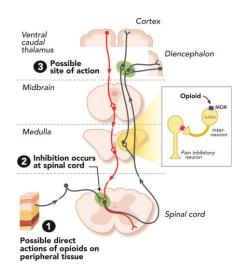


Figure Legend:

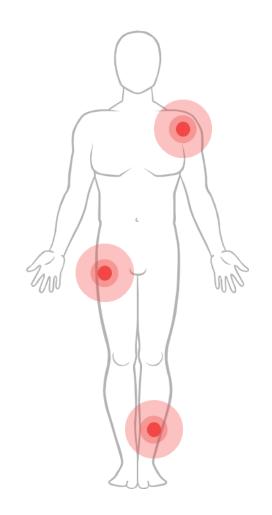
receptor.

Fig. 1. Sites of action of opioid analgesics. The gray pathway

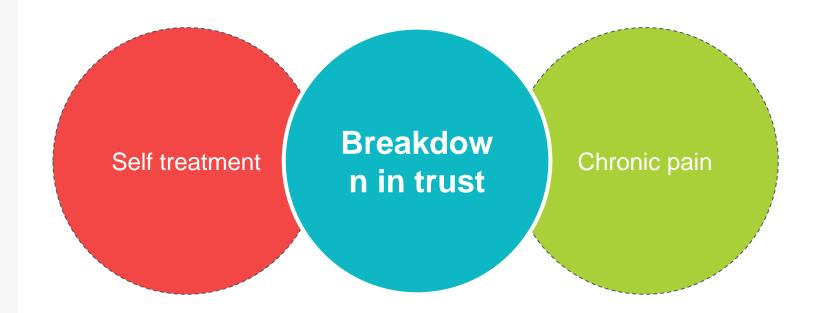
shows the sites of action on the pain transmission pathway from periphery to central nervous system. The red pathway shows the actions on pain-modulating neurons in the midbrain and medulla. GABA = γ -aminobutyric acid; MOR = μ opioid

"Myths" surrounding IVDUs

- They CAN benefit from opioid therapy for moderate/severe acute pain.
- Maintenance methadone or buprenorphine will NOT provide analgesia.
- HYPER algesia may be present.



Consequences of poor analgesia.



Non opiod Naive.

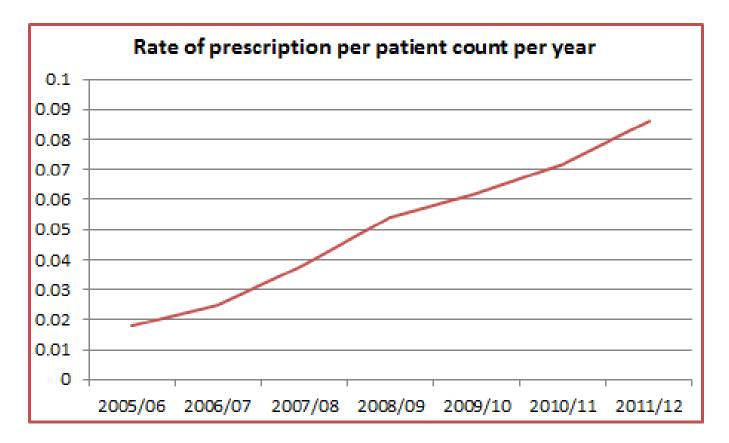
latrogenic opiod use.



13

GPs in Leeds and bradford.

Strong opioid prescriptions(Foy 2015)



£289.8 million 2013. Cost of optod personptions.

94,358 Perscriptions for non cancer pain

Lower SE class

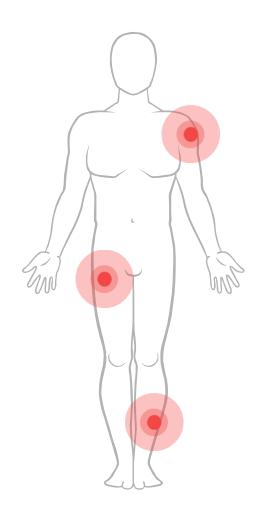
More prevelent.

Whose repsonsibilty?

- ▶10% Still on strong opiods 12 months.
- ▶ Rate of Dependency around 10%
- ▶ ERAS programmes/ Bed pressures
- MUST have plan in place for review on discharge

Opiod Non responders

"More is better right?"



Common problems

- ⊳nausea. (NNH: 4.2)
- constipation. (NNH: 4.2)
- ⊳drowsiness. (NNH: 6.2)

Escalating opiods

Non responders

▶ Neuropathic pain.

Cancer .

⊳Burns.

Consequences high doses

▶ High rate GI bleeds.

▶High rate MIs.

Immunosupression.

⊳Hyperalgesia.

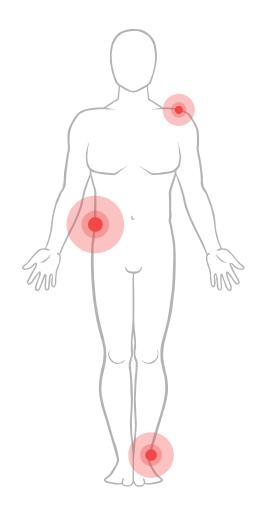
► The risk of harm increases with doses equivalent to 120mg Oral morphine day, but there is no increased benefit.

If the patient is using opiods but is still in pain, they should be discontinued even if no other treatment is available



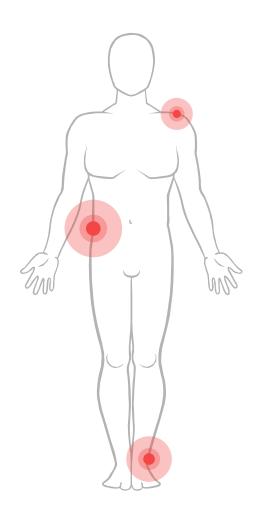
Opiod equivalency

	Relative Potency	Equivalent to 10mg oral morphine	Maximum dose
Dihydrocodeine	0.1	100mg	1.2G
Morphine	1	10mg	120mg
Oxycodone	2	5mg	60mg



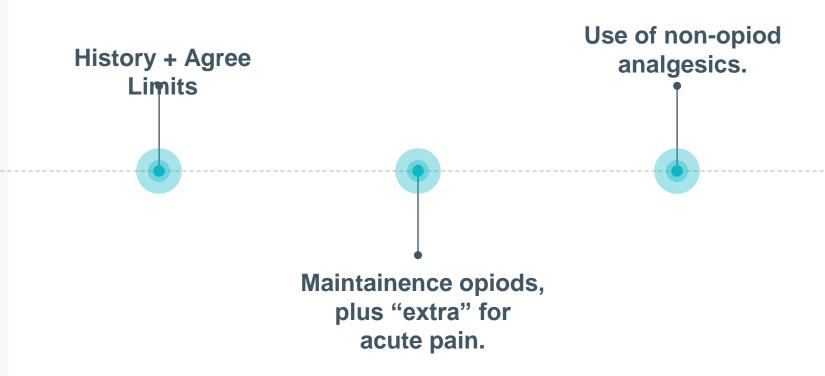
Opiod equivalency

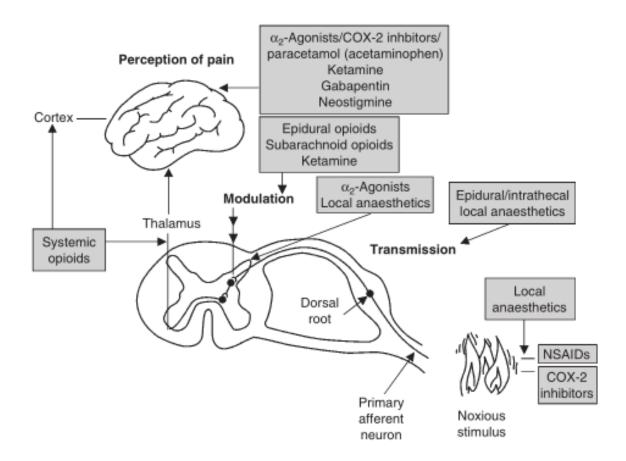
	Oral Morphine 24hrs
Buprenorphine (52mcg/hr)	126 mg
Fentanyl (50mcg/hr)	180 mg



Management options.

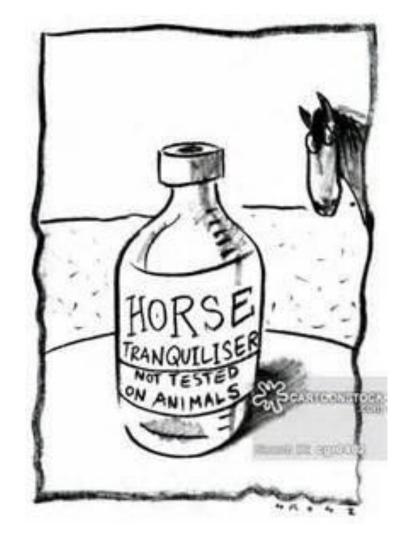
Non-opiod naïve.





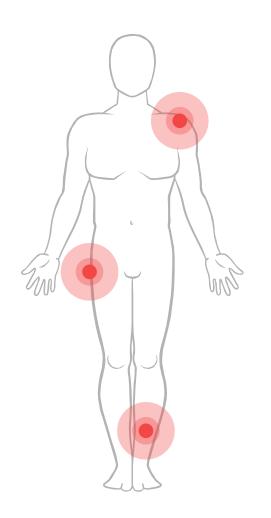
Ketamine.

- ▶Low dose = Analgesic.
- NMDA and opiod receptors.
- ▶ Hallucinations, anaesthesia.
- ▶Infusions / PCA (H.D.U.)
- ▶0.25mg/kg QDS orally.



Clonidine

- Alpha 2 agonist.
- Sedation and analgesia.
- Excellent in withdrawl.
- ▶ Can be given as IV Infusions (HDU)
- ▶Oral dose 25 mcg TDS
- ▶ Hypotension, Bradycardia.



NICE recommendations for Neuropathic pain

Т	C	A
		_

- Amitriptyline
- ▶10-150mg

Antiepileptics

- ▶Gabapentin 300mg TDS
- ▶Pregabalin50mg TDS

⊳Capsacin cream.

▶LA infusions

Summary

Weak opiods unpredictable
Opiod use not just IVDUs
Pain pathway is plastic.
High dose opiods not the answer
Hx and rapport key.
Alternate agents



THANK YOU!

Any questions?

You can find me at

- ▶ B.rippin@nhs.net