
# Reduce Your Reliance on Opioids for Pain

## Non-opioid arsenals are as effective — without the unwanted side effects.

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Opioids aren't the end-all, be-all of pain management. In fact, they're one of the least effective tools available, and it's time to reduce or eliminate our reliance on opioids in acute pain management. Based on the combination of safety and effectiveness, the better choice is to routinely use around-the-clock acetaminophen and selective or non-selective NSAIDs for your post-surgical patients.

### Benefits and drawbacks of opioids

It's true, opioids are potent analgesics that can be titrated within a wide range. So we've been trained to titrate opioids until we achieve comfort in the patient. But the more I do this, the more I think opioids don't have limitless titration. Most patients would rather have pain than nausea and vomiting. And nausea and vomiting are very common in patients receiving opioids, occurring about 40% of the time. Respiratory depression is also a very common side effect, posing a big risk in patients with (often undiagnosed) sleep apnea. Other issues associated with opioids:

- GI side effects (constipation);
- sedation, confusion, mental status changes and intracranial pressure concerns; and
- hemodynamic effects.

Although the United States contributes about 4% of the world's population, it uses about 90% of the world's opioids. (See page 8 for the latest on Vicodin, the most prescribed drug overall in America.) Because of that demand, abuse and diversion should be real concerns for you.

### Your non-opioid arsenal

Opioids are great for nociceptive pain, but pain is multifactorial, with nociceptive, visceral, neuropathic, inflammatory and spasmodic components. A multimodal regimen that targets each of these factors (or just the relevant ones) can eliminate opioids or render them to supplemental treatment.

Multimodal means starting with 1 intervention (for example, acetaminophen), and adding medications or interventions subsequently in response to increased pain intensity. Employ different medications — including steroids and local anesthetics — with varied mechanisms of action to create synergistic pain relief with fewer side effects. The goal is to use at least 2 non-opioid agents, using opioids only as adjunctive agents, as much as possible. Minimizing opioids will result in a reduction of opioid-related side effects, fewer analgesic gaps, less dynamic pain, improved long-term outcomes, better functional post-op recovery and improved patient satisfaction. Your non-opioid arsenal:

- **NSAIDs.** NSAIDs are very safe, except in a few

cases (patients with significant renal disease or known GI bleeding). NSAIDs block the effects of the enzymes Cox-1 and Cox-2, effectively keeping down swelling (inflammatory pain) and relieving nociceptive pain at rest and during movement. Compared to opioids, NSAIDs are much more effective at reducing pain. Opioids result in spikes in pain, whereas NSAIDs provide longer-lasting relief of rest and movement pain. NSAIDs rank at the top of the scale for achieving at least 50% of maximum pain relief, while codeine sits at the bottom.

- **Acetaminophen.** This is one of the safest drugs we have (even in patients with hepatic issues), not to mention amazingly potent, with one of the broadest activities of any analgesic. No one's entirely sure precisely how acetaminophen works, but it's effective in neurological and nociceptive pain. A maximum dose of 4g a day is well-tolerated, although the FDA recommends 3g per day over the counter, just to be on the safe side. Giving 1g pre-operatively helps to get ahead of the pain. Post-op IV acetaminophen, which provides more rapid absorption in the central compartment, delayed the need for an opioid dose by 3 hours in 1 study. Further, the efficacy of Percocet has been shown to be similar to the efficacy of acetaminophen, without the oxycodone. **OSM**

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LOCAL ANESTHETIC

## Non-Opioid Injection to Control Pain at the Surgical Site

Local anesthetic injections may be the answer to getting your patients back to functionality post-op, according to a study presented in April during the Premier Global Hot Topics Session at the Aesthetic Meeting 2013 in New York City. The study found that patients treated with a new, injectable, non-opioid analgesic for dual abdominoplasty and breast procedure (either reduction or augmentation) reported low pain scores in the 3 days post-op, used 33% less narcotics for pain control and had a high satisfaction with pain management.

**AT THE SITE** Liposome injection of bupivacaine can quell pain for 3 days.

Stephan Finical, MD, FACS, a plastic surgeon, and Michael C. Edwards, MD, FACS, president-elect of the American Society of Aesthetic Plastic Surgery, presented the findings. The prospective, observational study of 49 patients at 10 sites assessed patient-reported outcomes and ease of use of a liposome injection of bupivacaine as an adjunctive pain therapy in soft-tissue aesthetic surgical procedures.

The non-opioid analgesic Exparel is indicated for administration into the surgical site and is said to deliver therapeutic levels of bupivacaine over the important first 72 post-op hours. The study's findings bear this out; its outcomes measures included the following parameters.

- **Pain.** As measured by NRS scores through post-op day 3, pain scores averaged less than 4.0.
- **Opioid consumption.** Through post-op day 3, narcotic use was 33% of expected, with patients provided 30 tablets for use during the study.
- **Quality-of-life impact and opioid-related symptom distress.** Measured using the Overall Benefit of Analgesic Score (OBAS), which has a scale of 0 to 24, patients reported an average <4.0, indicating a high overall benefit.
- **Patient satisfaction.** All patients reported >3 on the 0 to 4 Likert scale, indicating high satisfaction.

"Exparel lets surgeons treat pain directly at the surgical site with a single-dose injection for up to 72 hours, when post-op pain is at its worst," says Dr. Finical. "Using non-opioid adjunctive therapies for pain control lets us reserve opioids for rescue situations where breakthrough pain cannot otherwise be controlled. This means we can minimize use of pain medicines that can be addictive or come with other unwanted side effects."

***— Stephanie Wasek***

**For the Management of Postsurgical Pain**

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# Patient-Focused Pain Control That Lasts For Up To 72 Hours

## The only single-dose local analgesic to

- **Reduce or eliminate** opioids with pain control for up to 3 days
- **Without** the need for catheters or pumps

Pivotal studies have demonstrated the safety and efficacy of EXPAREL in patients undergoing bunionectomy and hemorrhoidectomy procedures.

The clinical benefit of the attendant decrease in opioid consumption was not demonstrated.

EXPAREL is a liposome formulation of bupivacaine indicated for administration into the surgical site to produce postsurgical analgesia.

**Important Safety Information:**

EXPAREL is contraindicated in obstetrical paracervical block anesthesia. EXPAREL has not been studied for use in patients younger than 18 years of age. Non-bupivacaine-based local anesthetics, including lidocaine, may cause an immediate release of bupivacaine from EXPAREL if administered together locally. The administration of EXPAREL may follow the administration of lidocaine after a delay of 20 minutes or more. Other formulations of bupivacaine should not be administered within 96 hours following administration of EXPAREL. Monitoring of cardiovascular and neurological status, as well as vital signs should be performed during and after injection of EXPAREL as with other local anesthetic products. Because amide-type local anesthetics, such as bupivacaine, are metabolized by the liver, EXPAREL should be used cautiously in patients with hepatic disease. Patients with severe hepatic disease, because of their inability to metabolize local anesthetics normally, are at a greater risk of developing toxic plasma concentrations. In clinical trials, the most common adverse reactions (incidence ≥10%) following EXPAREL administration were nausea, constipation, and vomiting.

**Reference:** Gorfine SR, et al. *Dis Colon Rectum.* Dec 2011;54(12):1552-1559.

***Please see brief summary of Prescribing Information on reverse side.***

**For more information, visit www.EXPAREL.com**



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