Psychopharmacology

Part 3

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PART 3

- Pain Medications
- Polypharmacy
- Cannabis
- Hallucinogens
- Steroids
Two pathways originating in lower brain stem modulate transmission of pain.

- Physical component
  - Descending NE and 5HT which activate endorphin neurons. (antidepressants can effect too)

Affective component and emotional response to pain.

- Chronic pain treatment focuses on behavioral modification, CBT, biofeedback

Judicious opioid use is important
OPIOID PAIN MEDICATIONS

Controlled Substances Guidelines

The following should be documented in every chart when chronic controlled substances are being prescribed.

Guidelines per Kentucky Medical Board of Licensure

1. __________ Complete History and Physical to Include:
   (date completed)
   • Nature and intensity of the pain/condition
   • Current and past treatments for pain/condition
   • Underlying or coexisting disease or condition
   • Effect of the pain/condition on physical and psychological function
   • History of any substance abuse
   • Family History, esp. any 1st degree relative with chemical dependence problems

2. __________ Document 1 or more recognized medical indication(s) for the use of the
   (date completed) controlled substance

3. __________ Document through patient records or clinical trial that non-addictive
   (date completed) medication regimens have been inadequate or unacceptable for solid clinical
   reasons

4. __________ Kasper report initially and as needed to aid in documenting the patients
   (date completed) history of drug utilization (needs to be kept separate from chart)

5. __________ Signed Controlled Substances Contract on chart.
   (date completed) Controlled Substance Contract not applicable because:

6. __________ Documented Treatment Plan
   (date completed)

7. __________ Documented discussion of risk, benefits, and limitation of treatments
   (date completed)

8. __________ Documentation of Medication: Date, Type, Dosage, Quantity, and Refills
   (date completed)

9. __________ Document periodic review of effectiveness
   (date completed)

10. __________ Document diagnostic, therapeutic, laboratory results, and consultations or
    (date completed) evaluations
CONTROLLED SUBSTANCE AGREEMENT
UofL Family & Geriatric Medicine

Controlled substances have the potential to be addictive and must be taken exactly as prescribed. I __________________, understand that if I am prescribed a controlled substance I must adhere to the following restrictions.

PLEASE INITIAL EACH LINE

Failure to conform to any of the below listed restrictions may result in being dismissed as a patient of the Family and Geriatric practice sites and being reported to the Louisville Metro Police Prescription Drug Squad.

1. ______________ I will not use any alcohol or illegal drugs.

2. ______________ I will not take any other prescribed medications without first notifying Doctor ____________________.

3. ______________ I will notify Doctor ____________________ immediately of any other physician(s) currently prescribing me a controlled substance(s) or that has been prescribed to me in the past 30 days (including Emergency Rooms and Immediate Care Centers.) Failure to do so is a felony crime (KRS 218a.140 Obtaining or attempting to obtain drugs by fraud or deceit) and will be reported to the Louisville Metro Police Prescription Drug Squad.

4. ______________ I will submit to random urine and/or serum drug screens as ordered.

5. ______________ I will purchase all of my medication at ______________ Pharmacy and authorize Doctor ____________________ to communicate with my pharmacist. There must also be a signed pain contract in the patient’s chart or the patient will be brought in for a signed pain contract within 2 weeks.

6. ______________ I understand that it is illegal to share this medication.

7. ______________ I understand that drinking alcohol with this medication may be fatal.

8. ______________ I agree to keep my medication locked in order to prevent

9. ______________ I understand that failure to follow the restrictions will result in termination of the pain contract and other disciplinary actions.
• Opioid Receptors
  – Mu Receptors
  – Kappa Receptors
  – Delta Receptors

• Classification
  – Pure agonists
  – Pure antagonists
  – Mixed antagonists – antagonists
  – Partial agonists
• Effects
  – Analgesia
  – Bradycardia
  – Respiratory depression
  – Physical dependence
  – Euphoria
  – Can release histamine
  – Stimulates chemoreceptor trigger zone (nausea)
  – Suppress cough

• Tolerance and Dependence
  – Molecular basis is thought to involve glutaminergic mechanism
  – Activation of NMDA receptors correlates to resistance
  – Glutaminergic receptors (NMDA) may regulate mRNA of mu receptors
  – Ketamine found to prevent late onset and long lasting enhancement in pain sensitivity after initial analgesic effect dissipated.
## Table 9.1: Acute effects of opioids and rebound withdrawal symptoms

<table>
<thead>
<tr>
<th>Acute action</th>
<th>Withdrawal sign</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesia</td>
<td>Pain and irritability</td>
</tr>
<tr>
<td>Respiratory depression</td>
<td>Hyperventilation</td>
</tr>
<tr>
<td>Euphoria</td>
<td>Dysphoria and depression</td>
</tr>
<tr>
<td>Relaxation and sleep</td>
<td>Restlessness and insomnia</td>
</tr>
<tr>
<td>Tranquilization</td>
<td>Fearfulness and hostility</td>
</tr>
<tr>
<td>Decreased blood pressure</td>
<td>Increased blood pressure</td>
</tr>
<tr>
<td>Constipation</td>
<td>Diarrhea</td>
</tr>
<tr>
<td>Pupillary constriction</td>
<td>Pupillary dilation</td>
</tr>
<tr>
<td>Hypothermia</td>
<td>Hyperthermia</td>
</tr>
<tr>
<td>Drying of secretions</td>
<td>Lacrimation, runny nose</td>
</tr>
<tr>
<td>Reduced sex drive</td>
<td>Spontaneous ejaculation</td>
</tr>
<tr>
<td>Peripheral vasodilation; flushed and warm skin</td>
<td>Chilliness and “gooseflesh”</td>
</tr>
</tbody>
</table>
Treatment of dependence:

Old theory: medically managed withdrawal to opioid free state.

Newer theory: lifelong opioid maintenance

Area of great debate.
Medical literature shows increased rate of mortality with use of opioids.
## OPIOIDS

### Table 1. Abuse-Deterrent Formulations

<table>
<thead>
<tr>
<th>Drug (Generic)</th>
<th>Dosage</th>
<th>Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aversion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxecta (oxycodone HCl)</td>
<td>5, 7.5 mg (tablets)</td>
<td>AVERSION technology impedes opioid extraction via dissolution of tablets using water or alcohol, which causes the tablet to form into a viscous gel, trapping the active ingredient</td>
</tr>
<tr>
<td><strong>Physical Barrier</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exalgo (hydromorphone HCl)</td>
<td>8, 12, 16, 32 mg (tablets)</td>
<td>Osmotic Extended-Release Oral Delivery System (OROS) technology uses an osmotically active bilayer core enclosed in a semipermeable tablet shell membrane that allows both a consistent 24-h delivery rate and provides a barrier to abuse</td>
</tr>
<tr>
<td>Opana ER (oxymorphone HCl)</td>
<td>5, 7.5, 10, 15, 20, 30, 40 mg (tablets)</td>
<td>INTAC is a tamper-resistant technology designed to prevent modification of the drug into a fine powder and provide resistance to dissolution via liquids, as the remnants of a broken tablet will form a viscous gel to trap the active ingredients</td>
</tr>
<tr>
<td>OxyContin (oxycodone HCl)</td>
<td>10, 15, 20, 30, 40, 60, 80, 160 mg (film-coated tablets)</td>
<td>Reformulated to form viscous hydrogel when mixed with aqueous liquid for dissolution</td>
</tr>
<tr>
<td><strong>Agonist-Antagonist Combination</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suboxone (buprenorphine/naloxone)</td>
<td>2 mg/0.5 mg, 4 mg/1 mg, 8 mg/2 mg, 12 mg/3 mg (sublingual film)</td>
<td>Combines buprenorphine, a partial opioid agonist-antagonist, and naloxone, an opioid antagonist. Buprenorphine provides analgesia while its combination with naloxone prevents IV abuse</td>
</tr>
</tbody>
</table>
• 4:1
• Sublingually, naloxone exerts no clinically significant effect leaving buprenorphine to predominate.
• IV, physically dependent patients will experience withdrawal effects of naloxone.
• Buprenorphine has ceiling effects which limits addiction risk.
OPIOIDS, COCAINE, OTHERS

+ or - BBB crossing

In vivo Immunoconjugate Degradation

Her-KLH → 6AM-KLH → Mor-KLH

Heroin → 6AM → Morphine
Hepatic (liver) toxicity
• Reversibly blocks effects of opioids.
• Low dose naltrexone:
  – Inhibiting opioid receptors cause body to increase production of endorphins or encephalins to compensate for blocked receptors.
  – Persist after naltrexone has been eliminated from body.
  – Use in pain, fibromyalgia, fatigue thought to be due to effect on microglia which can modulate body’s response to inflammation. (anti-inflammatory)
• Combination with opioids (oxycodone) with ultra low dose naltrexone to block paradoxical hyperalgesia of long-term use opioid withdrawal.

• Methylnatrexone (Relistor®): μ-opioid antagonist (peripherally acting) which effects constipation, itching, without effecting analgesia or precipitating withdrawals.
Synthetic opioid used for maintenance therapy, blocks euphoric effects seen with opiates.

- Popularity increasing among physicians for chronic pain treatment.
- Has NMDA receptor activity and helps neuropathic pain better than many opiates. Decreased anti-nociceptive (reduced sensitivity to painful stimuli) effect of opioids.  
  - (+ μ opioid receptor activity)
- Tolerance may be lesser than other opioids.
- Inexpensive.
- Q-T prolongation and sudden cardiac death risk requires EKG monitoring.
HALLUCINOGENS, CANNABIS, AND STEROIDS

• Cannabis
  – Cannabinoid Receptor/therapeutic uses:
    • Weight loss drug (antagonist, pulled by EU after a few years)
    • Analgesia by modulating sensory input from tissue injury and reducing release of nociceptive neurotransmitters like substance P and glutamic acid.
    • Chronic pain syndrome use
  – Effects:
    • Memory impairment
    • Increased appetite
    • Impairment to focus attention and filter out irrelevant information
  – Side Effects:
    • Increased HR, BP, dry mouth, dizziness, slight nausea.

• Tolerance and Dependence:
  • Tolerance does develop
Anticholinergic psychedelics:
- Scopolamine
- Delirium
- Drowsiness
- Euphoria
- Tachycardia, blurred vision, HTN, increased body temp.

Catechololamine Like psychedelics:
- Mescaline
- Synthetic Amphetamine Derivatives
• Serotonin like psychedelic drugs:
  – LSD
  – DMT
  – Psilocybin and Psilocin (mushrooms)
  – Ololiuqui
  – Phencyclidine (PCP- Ketamine related)

• Toxicity
  – Psychotic states
  – Recurrent major affective disorder (or persistent)
  – “burnout” disruption of personality or chronic brain syndrome.
• **Anabolic-androgenic steroids**
  – Chemicals related to male hormone testosterone

• **Mechanism of action**
  – DHEA and androstenedione (precursor to testosterone)
  – Negative feedback on hypothalamus inhibits further stimulation of testosterone release

• **Effects**
  – Muscle building effects, masculinizing
  – Enhanced physical strength
  – Endurance
<table>
<thead>
<tr>
<th>Name</th>
<th>Route</th>
<th>Brand name</th>
</tr>
</thead>
<tbody>
<tr>
<td>APPROVED IN UNITED STATES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testosterone cypionate</td>
<td>im</td>
<td>Depo-Testosterone, Virilon</td>
</tr>
<tr>
<td>Nandrolone phenpropionate</td>
<td>im</td>
<td>Durabolin</td>
</tr>
<tr>
<td>Nandrolone decanoate</td>
<td>im</td>
<td>Deca-Durabolin</td>
</tr>
<tr>
<td>Danazol</td>
<td>po</td>
<td>Danocrine</td>
</tr>
<tr>
<td>Fluoxymesterone</td>
<td>po</td>
<td>Halotestin</td>
</tr>
<tr>
<td>Methyltestosterone</td>
<td>po</td>
<td>Android, Metandren,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Testred, Virilon</td>
</tr>
<tr>
<td>Oxymetholone</td>
<td>po</td>
<td>Anadrol-50</td>
</tr>
<tr>
<td>Slanzolol</td>
<td>po</td>
<td>Winstrol</td>
</tr>
<tr>
<td>APPROVED OUTSIDE UNITED STATES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Testosterone enanthate</td>
<td>im</td>
<td>Delatestryl</td>
</tr>
<tr>
<td>Testosterone propionate</td>
<td>im</td>
<td>Testex, Oreton propionate</td>
</tr>
<tr>
<td>Methenolone enanthate</td>
<td>im</td>
<td>Primobolan Depot</td>
</tr>
<tr>
<td>Ethylestrenol</td>
<td>po</td>
<td>Maxibolan</td>
</tr>
<tr>
<td>Mesterolone</td>
<td>po</td>
<td></td>
</tr>
<tr>
<td>Methandrostenedolone</td>
<td>po</td>
<td>Dianabol</td>
</tr>
<tr>
<td>Methenolone</td>
<td>po</td>
<td>Primobolan</td>
</tr>
<tr>
<td>Norethandrolone</td>
<td>po</td>
<td></td>
</tr>
<tr>
<td>Oxandrolone</td>
<td>po</td>
<td>Anavar</td>
</tr>
<tr>
<td>Oxymesterone</td>
<td>po</td>
<td>Oranabol</td>
</tr>
<tr>
<td>APPROVED FOR VETERINARY USE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bolasterone</td>
<td>im</td>
<td>Finiject 30</td>
</tr>
<tr>
<td>Boldenone undecylenate</td>
<td>im</td>
<td>Equipoise</td>
</tr>
<tr>
<td>Stanozolol</td>
<td>im</td>
<td>Winstrol</td>
</tr>
<tr>
<td>Mibolerone</td>
<td>po</td>
<td></td>
</tr>
</tbody>
</table>
• Toxicity
  – Endocrine
  – Cardiovascular
  – Liver
  – Psychological
  – Aggressive behavior

• Dependence
  – Withdrawal symptoms when removed
  – Psychological depression, fatigue, restlessness, insomnia, loss of appetite, decreased libido.
<table>
<thead>
<tr>
<th>TABLE 14.2</th>
<th>Effects of anabolic-androgenic steroids</th>
</tr>
</thead>
</table>

**POSITIVE EFFECTS**
- Transient increase in muscular size and strength
- Treatment of catabolic states
- Trauma
- Surgery

**ADVERSE EFFECTS**

**Cardiovascular**
- Increase in cardiac risk factors
  - Hypertension
  - Altered lipoprotein fractions
  - Increase in LDL/HDL ratio
  - Reported strokes/myocardial infarctions

**Hepatic effects associated with oral compounds**
- Elevated liver enzymes
- Peliosis hepatis (greater than 6 months' use)
- Liver tumors
  - Benign
  - Malignant (greater than 24 months' use)

**Reproductive system effects**

**In males**
- Decreased testosterone production
  - Abnormal spermatogenesis
  - Transient infertility
  - Testicular atrophy

**In females**
- Altered menstruation

**Endocrine effects**
- Decreased thyroid function

**Immunologic effects**
- Decreased immunoglobulins IgM/IgA/IgG

**Musculoskeletal effects**
- Premature closure of bony growth centers
- Tendon degeneration
  - Increased risk of tendon tears

**Cosmetic**

**In males**
- Gynecomastia
  - Testicular atrophy
  - Acne
  - Acceleration of male pattern baldness

**In females**
- Clitoral enlargement
  - Acne
  - Increased facial/body hair
  - Coarsening of the skin
  - Male pattern baldness

**Psychologic**
- Risk of habituation
  - Severe mood swings
  - Aggressive tendencies
  - Psychotic episodes
  - Depression
  - Reports of suicide

**Legislation**
- Classified as Schedule III controlled substance
POLYPHARMACY
What is Polypharmacy?

- 5 or more medications taken simultaneously
- More medications used than are clinically warranted.
- A Random Uncontrolled Experiment

Types of Polypharmacy
- Too many drugs
- Inappropriate choices
- Inappropriate combinations
- Administration errors
- Way off label use
- Inappropriate dosing
- Inappropriate prescriber
Silent Epidemic

A side effect of modern medical care

- 15 minute office visit/Hospital visit
- New drugs added annually
- Multiple specialists
- Over the counter products and supplements
Total drug burden is important

Average of 2.8 drugs discontinued per patient

1 year mortality rate
- 45% in control
- 21% in study group

Annual referral rate to acute care
- 30% in control group
- 11.8% in study group

The U.S. consumes 80 percent of the world's opioids and 99 percent of its hydrocodone.

PBS News Hour June 2011
"If you remember, I did mention possible side-effects."
Signs of Medication Related Problems: ???

• mental status changes
  – Agitation
  – Manic behavior
  – Any change in affect
  – confusion

• Not eating
• Not sleeping
• Somnolence
• Falls

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SIDE EFFECTS MAY INCLUDE:
NAUSEA, HEART BURN,
UPSET STOMACH, CRAMPS, RASH,
BLOATING, DIARRHEA,
HEADACHE,
CONSTIPATION,
FUNGAL INFECTION,
HIGH TEMPERATURE...

SKIN CANCER,
MEASLES, NODULES,
CHICKEN POX,
BIRD FLU, LOW
SPERM COUNT,
THE PLAGUE,
LEPROSY,
HIGH BLOOD
PRESSURE,
AND LAST BUT
NOT LEAST,
BLURRED VISION.

WELL... IF IT GETS
RID OF YOUR
EAR ACHES, I GUESS
IT'S WORTH IT.

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By: Sadie & the DREG
Akathesia and Agitation
Is it the drug or the disease?

Signs and Symptoms (multiple & nonspecific)

New Treatment Added

Diagnosis or Drug Side Effect?

How often are symptoms attributed to medication side effects?
All substances are poisons, what differentiates a poison from a remedy is dose

Sheer Numbers

JC, 22 year old father of two and boyfriend
Typical weekend binge: 40-50 pills and a quart of Jack Daniels
Several periods of staying clean
Prescribed Xanax to help his anxiety and drug withdrawal....
Toxicology report upon death: 134mg of Xanax (67 pills)
Seems Innocent Enough

OTC

Strongly anticholinergic
Lots of Tylenol

Look different; but are alike

Can alter other drug kinetics!

Sometimes anticholinergic, changes stomach pH
Heath Ledger
1979-2008

OTC stuff
• Doxylamine
  – NyQuil
  – Unisom
  – And who knows what else!

Prescription stuff
• Oxycodone
• Hydrocodone
• Diazepam
• Temazepam
• Alprazolam

Chief Complaints:
insomnia, anxiety, depression, pain and common cold per friends and family from the investigation

Two physicians (one in LA, one in Houston) were exonerated because “they had prescribed other medications, not the pills that killed him”
What if?

You took hands full of random non controlled Rx and OTC pills at a pharm party?

*Gabapentin
+Fluoxetine
-Digoxin
*Furosemide
-Nifedipine
*Celecoxib

How many?  Of which?  Your physiology
What’s in this bag?

Methadone X 5
Viagra X 3
Oxycodone X 2

**Respiratory depression**
**Sedation confusion**

**Neurotoxic**
Cardiac sudden death, inability to respond to Viagra induced bp drop, and oxycodone induced respiratory depression

**Drops bp, raises ht rate**

**PERFECT**
To Crush or not To Crush?
END OF PART 3

• Questions?

• Comments?

• Share Ideas?