FENTANYL

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WHAT IS FENTANYL?

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*Fentanyl is classified as a **Schedule II** opiate analgesic

*It is the most potent opiate used in clinical practice in the USA

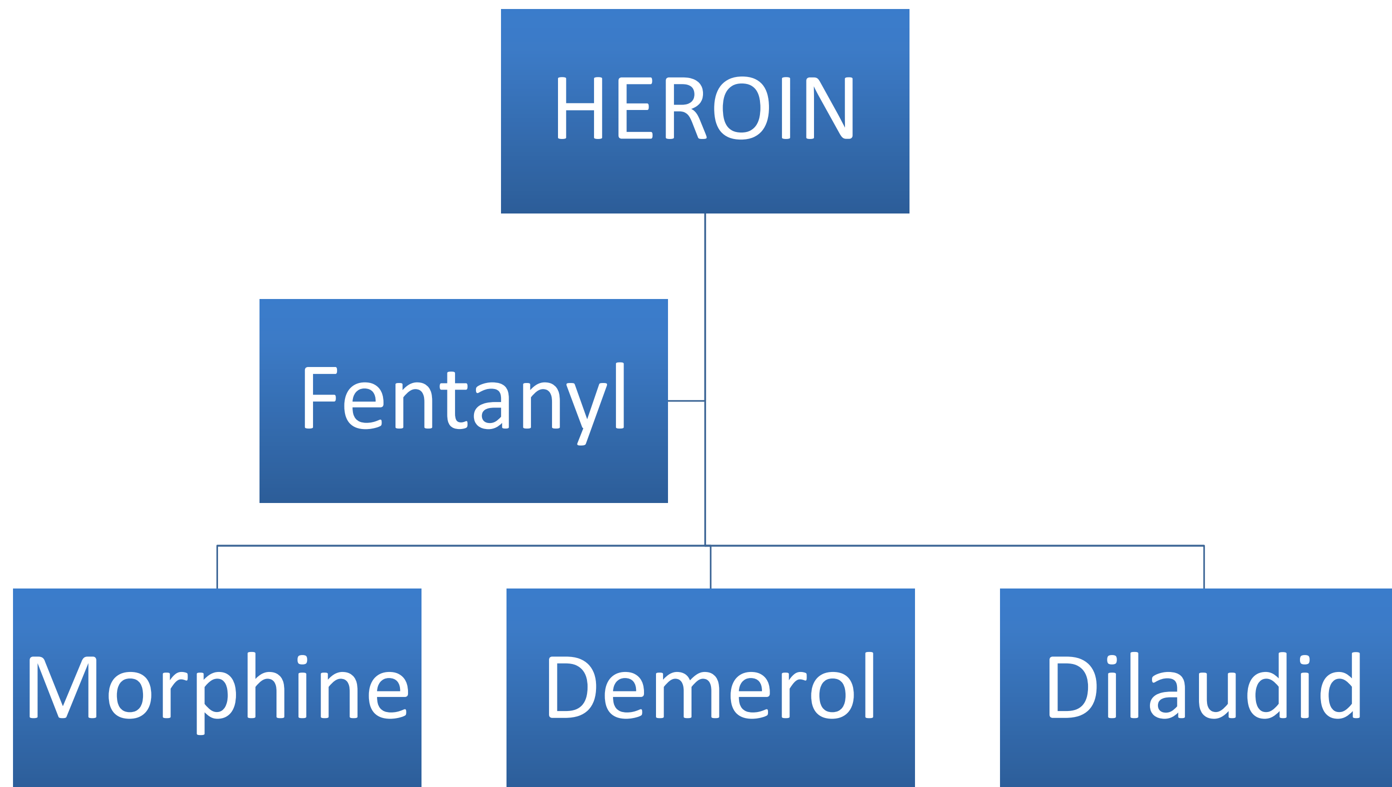
*Commonly used as an analgesic sedative for medical procedure sedation

*Rapid onset and metabolism allows for shorter duration of recovery after administration

D.E.A. Drug Schedules

- **Schedule I**
  - No currently accepted medical use and high potential for abuse
- **Schedule II**
  - High potential for abuse with use potentially leading to severe psychological or physical dependence
- **Schedule III**
  - Moderate to low potential for physical and psychological dependence
- **Schedule IV**
  - Low potential for abuse and low risk of dependence
- **Schedule V**
  - Lower potential for abuse than Schedule IV drugs

Relative Opiate Potencies



How is fentanyl supplied?

Fentanyl is mass produced as:

*powder

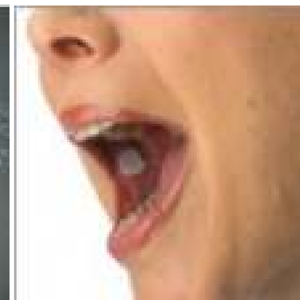
*liquid

*transdermal gel patch

*'lollipop'

*mucosal patch

*nasal spray



WHY IS FENTANYL UNIQUE?

*100x more potent than morphine

*20-50x more potent than heroin

*Good cardiovascular stability

*Rapid onset analgesia and sedation

*Well-tolerated with little documented true allergy

*Inexpensive

FENTANYL USES

*Intravenous anesthetic

*Cancer pain

*Skin patch pain reliever

*Oral/Nasal preparation for more rapid onset

*Sedative for medical procedures

*Illicit drug use

OPIATE SIDE EFFECTS

*Decreased respirations

*Sedation

*Urinary retention

*Nausea

*Dry mouth

*Constipation

*Decreased blood pressure and heart rate

*Drug-drug synergy

*Addiction / Rapid tolerance

THE FENTANYL ‘PROBLEM’

*Overuse of prescribed Fentanyl by patients

*Use of prescribed Fentanyl diverted by patients

*Illegal manufacturing and distribution of fentanyl

*Illicit drug use

-sole drug of abuse

-added to other drugs such as heroin or marijuana to increase potency

*Abuse by healthcare providers

*Prescription-writing abuse by physicians

*Poorly understood pharmacodynamics by non-anesthesiologists

CORRECTIVE ACTIONS

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1) Cap prescriptions to a maximum of 365 days/year
2) Point-of-service urinary drug screens
3) Encourage continuing medical education courses by medical boards for opiate prescribing
4) Make the Prescription Drug Monitoring Program ("PDMP") more thorough
   a) Allow access by first responders
   b) Enter results of urine drug testing into the PDMP
   c) Enter results of any previous hospitalizations for overdose
5) Review the PDMP data for highest volume opiate prescribers
6) Provide greater access to recovery programs and Vivitrol
7) Verify that there is no redundancy in a prescribed opiate regiment
   a) No reason for a patient to be on more than one long-acting and one short-acting opiate simultaneously

Fentanyl

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Questions?