Uses of Some Opiates Limited in HIV Patients

BY ROBERT FINN
San Francisco Bureau

SAN FRANCISCO — Opiates are often the best choice when treating pain in patients with HIV, but some of the available drugs can have limitations, Dr. Robert V. Brody said at a meeting on HIV management sponsored by the University of California, San Francisco.

Meperidine (Demerol), for example, is an opiate whose time has come and gone. "If you know a physician who still uses intramuscular Demerol for the management of pain like we did 30 years ago, you're in the presence of Tyrannosaurus rex," said Dr. Robert V. Brody of San Francisco General Hospital.

In fact, this agent was removed from the San Francisco General Hospital formulary about 15 years ago. The problem is that although meperidine is a short-acting opiate, one of its metabolites accumulates. As patients continue to use the drug, they tend to get irritable, experience myoclonus, or, in some cases, develop seizures, he said.

Similarly, mixed agonist-antagonists like pentazocine or butorphanol (Stadol) have little use. They're difficult to titrate, and if a patient gets too high a dose, agitation and psychotomimetic effects can appear. Furthermore, since these drugs are part antagonist, it's difficult to simply discontinue them and give the patient something stronger, Dr. Brody said.

Tramadol, although not a bad drug, also has its limitations. Not chemically an opiate, tramadol occupies the μ opiate receptor and also has properties similar to SSRIs. It's prone to abuse and can be quite expensive, he said.

Buprenorphine is usually thought of in the context of opiate detox, but it's also mildly effective against pain. Its major limitation is that it binds so tightly, if the patient turns out to need something stronger, nothing is going to work very well. It's also quite expensive, Dr. Brody said.

Physicians often use fentanyl patches inappropriately. They should be used only for chronic, stable pain and never for postoperative or unpredictable pain. The onset of analgesia can take more than 12 hours, and fentanyl's effects can last more than 18 hours after the patch is removed. Adding another opiate to a fentanyl patch can easily result in an overdose, he noted. ■

Use of Intranasal Lidocaine May Relieve Migraine

SOUTH LAKE TAHOE, CALIF. — The next time you see a patient with a migraine headache, you might want to try intranasal lidocaine, Dr. John Richards said at an emergency medicine conference sponsored by the University of California, Davis.

"It's a very easy block, and it doesn't involve a needle," said Dr. Richards of the department of emergency medicine at the UC Davis Medical Center, Sacramento. "So it's worth a try."

The literature on lidocaine treatment for migraine is not extensive, and at least one study found it to be of no benefit. But in some studies, lidocaine successfully resolved the migraine in 30%-50% of patients, with a relapse rate of about 20%.

Dr. Richards said he has had good experience with lidocaine. "I've had success with it for migraines, cluster headaches, and just headaches in general," he said.

With cluster headaches, there usually is not complete relief, "but it does help them quite a bit," he said.

The technique for treatment is to apply 4% lidocaine jelly to a long cotton swab, then aim the swab straight down the nasal canal all the way until it stops, on the side of the headache, or bilaterally if the headache is bilateral. The target is the sphenopalatine ganglion, which is located in the pterygopalatine fossa, posterior to the middle turbinate and inferior to the maxillary nerve. "It is covered by a small amount of mucous membrane [1.5 mm thick], so it is actually pretty easy to get to," Dr. Richards said.

A second technique is to lay the patient back, with the head over the edge of the table at a 45-degree angle, and administer lidocaine drops, which will pool in the appropriate area. In one successful randomized trial, 10 drops were used, and the patients remained in their positions for 30 minutes, he said.

—Timothy F. Kirn