## Narcotic Antagonists

Chronic opioid users/abusers have:

- More pain post-op
- Higher narcotic requirement
- Increased risk of respiratory depression
- Possible adrenal insufficiency

Antagonists:

- Naloxone (Narcan, Evzio, Rivive, Klaxxado) – IV, Intranasal
- Naltrexone – PO – Revia, Contrave (combo with Buspar for weight loss)
- Naltrexone also used to treat alcoholism in a sustained release IM form that lasts for a month (Vivitrol)

Buprenorphine (Buprenex, Butrans, Bridaxi, Belbuca, Sublocade) narcotic that has a very high affinity to opioid receptors, but only partially activates them (partial μ-agonist):

- Will displace full opioid agonists from opioid receptors
- Has a ceiling for analgesia and adverse effects
- The ceiling effect can hamper adequate surgical analgesia
- Available as SL, IM, IV

Buprenorphine + naltrexone (Suboxone, Zubsolv)

- Oral dissolving, but the naltrexone is poorly absorbed – it is added to discourage IV use
- Same considerations as buprenorphine

Options for patients on buprenorphine and/or naltrexone:

- Maintain them on their usual dose
  - This is the best option for minor procedures
- D/C oral meds at least 72 hours pre-op
  - This is the best option for major procedures
  - Monitor for possible withdrawal while awaiting surgery
  - Consider methadone for a bridge therapy
- For major urgent procedures, large doses of short-acting narcotics may need to be used
- Maximize multimodal analgesia

Peripheral PO antagonists:

- Entereg (alivmopan) does not cross the blood-brain barrier, so it can selectively block GI opioid receptors with no change to the analgesic effect of opioids and will not cause withdrawal. Avoid in hepatic disease and ESRD
- Relistor (methylnaltrexone) is similar, but is also available SQ
- Movantik (naloxegol) but could cross the BBB at higher doses