Introduction to fentanyl myths

Fentanyl is increasingly becoming a hot topic in today's society. We see an increasing number of overdoses from the drug itself, with heroin being mixed into fentanyol creating an even better high, often with deadly consequences.

However, there's a lot of myths surrounding fentanil itself. We've all seen YouTube videos and reels about law enforcement officers who, quote unquote, overdose on fentanyl, suddenly becoming incoherent, pass out, have seizures, all from incidental exposure.

So today's episode of the Jaffer Cast, we're going to dive into the world of fentanil, opiate use and overuse, and dispel some of myths around fentinil and heroin use in general.

Is fentynil a bad drug? The answer is it depends. If it's being used in a medical context, no, it is actually a very potent pain reliever that we often give in the hospital setting under, of course, very controlled circumstances.

To help dispel a lot of these myths and rumors, I'm going to be joined by Dr. Christopher Counts, a board-certified EM physician and toxicologist, where we're going go over what fentanyl is, what an overdose looks like, is what you're seeing on the internet even real?

And to top it all off, we are going do it and hopefully not have you fall asleep in meantime. This is the Jefford Cass, let's get going. All right. Hello, Dr.

Christopher Counts. Welcome to the show. Thank you so much for having me. Absolutely. All Right. So, you are an ER physician, just like moi, but you're more qualified.

Toxicology fellowship and poison center work

You are also a fellowship trained toxicologist. Is that correct? Correct. Tell me about that. First of all, emergency medicine specialty, three to four year residency program, then fellowship.

What is involved with this fellowship here? So my fellowship was two years long, all toxicology fellowships are, and there's a couple different components to it.

So the pace of it slows down a little bit from what we're used to in the ER. We have a lot fewer patients, a lots more time to think about them. Time to Think, what is this shit?

Yeah, you have to shift gears a lot when you're going from the ER to the poison center. But I was associated with the New Jersey Poison Center and we took calls from all across the state, healthcare facilities, as well as people calling in with potential toxic and poisonous exposures.

And then we also had a small inpatient service at a hospital in Newark as I remember when I was in medical school, I rotated at Lehigh Valley hospital and I actually did a one month toxicology rotation with them.

I, it was pretty interesting. It was very, very academic. Like there was a lot of didactics, but we did round on patients that were consulted on for toxicologist, both pediatric and adult.

And I remembered it, was on a salicylate, an aspirin overdose that was, that, in the ICU who unfortunately didn't survive. But I remember our attending got the call like late at night, like two in the morning.

And it was like, hey, you know, this patient's going to the ICU, aspirin overdose, suicide attempt. We're doing these

things, but he's breathing pretty quick and we're actually going put him on a ventilator.

I remembered my attending was, no, do not do that. It was a whole thing where he went into, and I was surprised that actually you don't want to put these patients on the ventilators.

Yeah, aspirin and salicylates in general are one of those, and there's many, but one the overdoses that scares me a lot. And I think even the most seasoned toxicologists get very nervous about those.

Yeah. Again, we're not going to talk about this. I should do one episode, at least on certain common overdosing too, especially in the wake of all this Tylenol.

bullshit going on, but I know the main point about your fellowship is basically just like researching a lot of these, not just poisons, I mean you're also looking at common medications, obviously Tylenol, aspirin and all that, it's a common medication, how to treat this, the ways effectively to treatment this and things like that.

And you are not talking to patients, you also talking us, like I'm calling into the poison control center, so you talking other providers as well. Exactly.

We interact with providers from the entire healthcare spectrum. One minute you might be on the phone with someone from a pediatric ICU and talking to an ER doctor.

It definitely gives you a chance to improve your communication skills and how to communicate recommendations over the phones. So do you get a lot of calls from patients about opiates?

We have overdoses, things like that, or is that mostly just handled by 911? So 911 will handle the majority of the calls for an acute overdose requiring an ambulance to go out there and administer naloxone.

We do get variety of call related to opioid use in general, you know, in unfortunate cases when A young child, for example, might be exposed to an opioid and ends up in the ICU.

The team will sometimes want to do some testing to find out what opioid it was or what other agents they might have been exposed too. So there's lots of different kind of opioid related issues that come up.

I have some questions on that. So you talk about, you know, testing for an opiate. Now we're not CSI. I think a lot of patients come into the ER. They think that, oh, my child or I got something in my drink or they took a pill or, they have something and I don't know what it is.

Recognizing toxidromes and overdose presentations

Can you test it? And the answer is… Not really. The answer is no. You know, CSI was you get the chemical, you take the blood, and you do like PCR molecular analysis.

And you're like, oh, yeah, this is the dimerization of oxycodone. It's a very potent date rape drug. No, sorry. I don't know what your child or your teenager or college student took.

I feel like the teaching moment, I have a lot of these patients is we treat toxidromes. I don't know if you agree or disagree on that one. We see a patient who presents clinically a certain way and we treated the clinical presentation.

Yes. No, a, lot, of toxicology is about learning how to recognize those toxodroms and then how, to also get other people within the healthcare system to, recognize them in their patient.

For example. Yeah, go ahead. Yeah, so if there's, say someone took an overdose of an SSRI, which is a common antidepressant, it can present with some changes in mental status, but lots of things cause changes and mental studies.

And so helping, you know, guide folks through the differential diagnosis, both toxologically and the non-toxicologic diagnosis differential is very important.

Yeah. And you talk about someone who comes in, you know, acting, let's say bat shit crazy, right? Like, You know you, see people like in the street, for example, Acting a certain way and you think, Oh, they're crazy.

and they might be, there's a very good chance it could just be absolutely crazy off their psych medication, whatever. But then police get involved, 911 gets involved and You realize that, oh, this patient is suffering from a medical condition.

Somebody comes In SSRI poisoning, Let's Say they are altered. What does that look like? Yeah, so it will depend a little bit on how much they took, when they take it.

You know, in the most severe forms, patients can be sedated, sometimes they can even seize. And then the kind of constellation of serotonin toxicity are things like GI symptoms, a lot of vomiting and diarrhea.

I think, you know we as healthcare providers often forget that the serotonin we have in our body is actually kind in a gut. So if you have a seratonin excess, then you'll have lots of GI Yeah.

And it's interesting because one of the most common nausea medications, Zofran on Densitron, targets those types of receptors, especially in the gut too.

So all of a lot of stuff. People are probably listening to this and going, okay, when are they getting to the opiates? And the reason why I'm talking about the toxidrome, and toxodrome meaning that how is a patient presenting to you?

Are they sweaty? Or are the dry? are They confused? or Are They vomiting? Do they have constipation? Like all these clinical symptoms fit into a giant picture.

And so now we talk about opiates and these patients too have a clear clinical picture that people are very familiar with. You know, they're rolling in here and they are not breathing.

That's the main thing. It's, oh my God, are they not Usually they come around with Narcan, Naloxone. Other times they don't. They're getting it on ventilator, being put on, ventilators, so being intubated, breathing tube down their throat, getting bagged by the EMS response crew and you know, they're coming in and, you now, ideally they, eventually the body metabolizes this and they wake up and their fine, but it's all about getting to these people.

Yes, certainly. And the key thing that you said was the decreased respiration. They're not breathing. A lot of times, I think we as clinicians, maybe pre-hospital providers as well, want to give Naloxone or Narcan, which is the reversal agent.

Ideally, you would see the patient wake up and start breathing, but they could have something else intoxicating them on board. Bleeding in their brain.

There's a whole variety of reasons that they might not wake up, but you're still doing the right thing by Focusing on their breathing. Yeah, and I think people also get misconstrued because I you know, like pre-hospital Let's say police often are the first team to interact with a 911 call like this, right?

Mm-hmm. Yep. So now they also carry Narcan and they'll call, you, know the the EMS crew and say, hey, You know is unresponsive. I'm giving Nar can come over and then EMS group comes in and they say, okay, you know, how much did you give?

I gave two sprays, like one in each nostril kind of thing. They're not waking up. Okay, great. So what are we doing now? Okay. Well, I'm going to give more Narcan.

I want to get more in NarCan. And all of a sudden, it goes from like, one to two to five to eight milligrams of NarCAN, they're waking it up, It's like we got to figure this out here.

It may be something else or it could be, yeah, we have a stroke now or something to that effect. Exactly. My kind of rule of thumb is once you get to about 8 to 10 milligrams of the nasal spray that's not working, you've got, it's Now, so the most common opiate that everybody kind of knows about is heroin, you know, heroin overdoses, things like that.

But we're seeing a lot of other stuff in the community right now, right? Can you talk about that? Yeah, of course. And I think the first thing probably to say about heroin is since about 2013 or so, there's been, much fewer or much less heroin actual heroin in, the heroin people are buying, over time, what is called heroin.

for those just listening, has actually become more and more of just fentanyl, as well as analogs of fentanil. So there's many different modifications that drug dealers and producers can make to try to skirt drug control laws.

It's a lot of Fentanylo and the heroin. Now, more recently, we're also seeing other types of sedatives that are not even opioids mixed into the Yeah. I mean, I'm seeing like, like veterinary drugs sneaking in here.

And, you know, the issue with these is obviously we don't have an antidote for them. At least to my knowledge, we won't an anecdote. Yeah, um, it depends on how we're defining antidotes.

Um, there is not a reversal. There's not reversal agent in terms of the, management or what they need, which is. Exactly. But they just need good supportive care.

You know people. A lot of VR doctors will joke that toxicology is just recommending benzos and supportive care, which… That's how we get through my day.

Exactly. It's a good tenant. But yeah, you're correct. There is no kind of reversal agent that acts like naloxone. So the two big veterinary sedatives that we've seen are xylazine and then metatomidine.

Naloxone, fentanyl, and mixed overdoses

And these are both tranquilizers for… Yeah. And metatomidine to me is a little bit scarier from, just from an emergency medicine perspective, because I'm seeing these patients coming in hypotensive.

I mean, their blood pressure is like 70 over 30. Their heart rates, I've seen normal heart rate of like, 70. And I'm looking at this and going, okay, give Narcan and they're waking up.

They're literally looking my face and saying, what are you doing to me, bro? And i'm like, I am trying to save your life, but clearly, i don't know if i am helping because your heart rate is still 20 and your blood pressure is 70 over 30 right now.

Yeah, it's very scary. less hemodynamic effects. And, you know, at the end of the day, we're just kind of guessing based on, trends like we've seen a decline now in xylazine and drug samples that are analyzed and an increase in metatomidine.

So we can kind surmise that, that's what they might have in front of you. But there's a history of all sorts of adulterants like malaria drugs like quinine Yeah, occasionally diabetes drugs will pop up and then some of these drugs and patients can remember that.

Yeah. I remember there's a rash of those years ago of like patients coming in with persistently like you can't get their blood sugar up. You have to put them on glucose strips.

I'd forgotten about that. I have no idea what the rationale on the drug dealer's side for that, like maybe it tastes bitter or you're making someone altered from hypoglycemia, which seems bad.

It seems counterintuitive. You want to increase your sales, but killing your clientele probably isn't the way to do it here. Now, I know that there's also a thought process that, you know, the drug dealer is going to put something into their product, cut it.

And like, so a little bit, terminology and lingo, when we're talking about cutting heroin, we don't mean physically cutting it, right? You know? But there is, there are ways to increase the amount of a drug that is currently available to you.

If you have two grams of heroin but you a bunch of buyers, they need eight grams heroin. You basically dilute it And then you're quote unquote cutting it with other of these chemicals.

So in fact, you can cut it up with metatomidine means that you could increase your supply and potentially increase the potency and people go, oh yeah, this guy gets a really good high.

But exactly. You're killing your clientele too. Yeah. And you can imagine the, you know, having full disclosure, not a drug dealer or having seen a dealer's operation.

But I presume it's not, the most scientific or rigorous regulated environment. And just, we're talking about minuscule amounts, physical amounts of drug to actually get you high.

How do you, equally distribute that across that eight grams that you're trying to make and then divvy up into smaller bags? Right. I mean, look, we've all seen Breaking Bad to some degree, I imagine, you know, like with meth and, the blue meth, and all that.

But, so let's talk about fentanyl now being mixed in with the heroin, because it's, if you get a patient who comes in, who snorted or injected or, whatever to their heroin and there's fentanil component in their fentynil, Narcan still works for fentinyl.

Correct. Absolutely works through fentinil. So basically we're just giving more at this point? Yeah, it kind of depends. How much Naloxone or Narcan to give is really a kind-of a bedside call.

You see how they're responding after you give a dose. And then in terms of the amount that's needed, theoretically you shouldn't need more. Potentially you could need for one of more potent fentanyls like Carfentanil, which unfortunately we see now and again.

But regardless of if it's heroin or fentanol, Naloxone should still… Now, do you see, um, you have any data on the current regions that we're seeing some of these overdoses?

So like we both work in the Northeast, East coast area. Is there current, are you up to date on current trends like the West coast, central, the U. S., you know, Southeastern, whatever.

I don't know if you had any of that data offhand. Yeah, definitely not numbers. And I obviously have more experience here in kind of Northeast corridor.

The opioid epidemic really is. affected all parts of the country. There's not really any area that's been spared from speaking with other toxicologists that practice in the West Coast, like kind of Arizona, out to California.

Stimulants like methamphetamine, I think, are a little bit more common out there. And unfortunately, starting to see a lot of kind-of mixed overdoses where individuals are using both methanphetamines with fentanyl.

Um, and maybe that's intentional, but in some cases, you know, we also get reports of contamination of other drugs. Oh, do you mean the stuff isn't USDA approved and FDA regulated?

That's surprising to me. Yeah, believe it or not. So, okay. We have a patient who comes in now on methamphetamine cut with fentanyl or vice versa, like whatever, heroin, fentanil, cut-with-methamphetamines.

But methmphetamin makes you hyper alert and aware. What are these patients looking like at this bi-clinically? Yeah, it's a great question and it kind of changes throughout the course of their ED stay.

You know, the last patient I saw like this, he had a bit more of an opioid presentation, was a little bit sedate, definitely had some respiratory depression.

But then when they got naloxone, they didn't wake up to be a normal person. They kind woke up and were hyper agitated, you know. Very fast heart rate, kind getting up, walking around, which is what you'd expect from more a pure stimulant side.

And it's interesting because you probably treated them with a benzo, like something like a, you know, verset or something that. So, which is, You know like you just woke the patient up, they're half asleep, not breathing, and now, okay, I'm going to give you something to calm down now.

It's like, what are we doing right now? Yeah. Yeah, exactly. Makes it, it can be very, very difficult to manage. Patients can tolerate a little bit of decreased respiratory drive, decreased ventilation.

And those patients who want to think critically about, when is the point when I actually need to administer the Narcan. Probably when they're stripping their clothes off in front of children and grandmas, that's probably when we need to do something.

So here's a question then, this obviously, we're talking about ER specific patients, right? What's the judgment call for pre-hospital EMS providers? Can they make a judgment called or is it just, you know, do what you can, strap them down and roll them in?

And, um, you mean for the, more for an agitated patient or? Yeah, like it's like, let's say they get a call, the suspected overdose and they, get there and you know, they're drowsy.

So they give them Narcan, right? They wake up, but now they do exactly what you said. They're like agile. You're walking around heart rates like 160. Do they now give the Benzo if they are allowable or are they strapping them down?

Or are you now concerned that there could be something else? metabolic underlying these cases, you know, is it a methamphetamine or something else? Yeah, that last point is very critical.

It's incredibly hard to tell just in the pre-hospital setting what all is going on. If the patient is hyperactive but their mental status is pretty clear, they're able to show you what they took that maybe can push you in one way or the other.

Whatever it takes for them to be able safely transport the patients as well as protecting themselves while transporting the person to care is ideal. Generally, I think medications are better to control a situation rather than going right to restraints.

A patient who has some physical restrains, there's a lot of risk associated with that. Yeah, we talk about, actually spoke to a reporter a couple of years ago about agitator excited delirium.

And that was, you know, a hot button topic back in 2020, 2021. The idea that, police were restraining people who may have had some kind of drug injection or may be having a medical episode and suddenly now they're in restraints, they are not moving and they now can't breathe.

you know, and they're dying. What is the answer to this? Well, the answers is you get EMS involved and you have them at least monitor the patient. Now, if you can't, you need vital signs, need oxygen, things like that to figure out what's going on here.

Exactly. As much as I think you or I would feel a little bit limited in what is available in an ambulance, our Ems

colleagues can really accomplish a lot with their monitoring equipment.

They've got several medications available to help them. Definitely a good place for them to be involved. What's your thought on ketamine for something like this?

I've heard of, you know, mixed research and data says, hey, don't give ketamines to patients who may be having psychiatric issues or on psychiatric medications.

But then you get the patient that's, agitated like, this for whatever reason, and maybe they have something in their system. Is the ketamin going to make it worse?

Is it going at least control them? What do you think? Yeah, ketamine can be a good option. As I'm sure you've experienced, it's a little hard to predict how an individual patient might respond to ketamines.

Some are fighting dragons, man. It's pretty impressive. Exactly. I think there's probably a reason that benzos are always a toxicologist's best friend.

I never hesitate to go with a little bit of Versed if I think that a ketamine might not be a good choice for that patient. Someone whose blood pressure is already very high is someone I would maybe also consider not giving it to.

Street drug adulterants and veterinary sedatives

But if that's all you have and it's what's more likely to keep the patient and the other healthcare personnel safe, then it is reasonable to try. So I want to switch gears.

We've talked about, you know, obviously the opiates, we're throwing ketamine out there, throwing fentanyl. And I think it's important because the general public, if you're listening to this, You've heard ketamine, and you've hear fentanil being used in very negative connotation at times.

you know, fentanyl overdoses, I didn't mean overdosed. I think Matthew Perry was the one who was, was he taking ketamine and then he ended up drowning in his hot tub.

But understand that these are, you, know good medications gotten illicitly. And I don't know if you agree with this. One of the things I've heard toxicologists say is it's the dose that matters.

You know? Like everything is, is toxic depending on the does here. Yeah, yeah, exactly. One of the key tenants is that the dose makes the poison, you know, anything can be, water, if you drink enough of it can.

Be harmful. So really anything, can, be it's just the amount and. You know it is the correct person receiving the, correct medication or agent at the.

Correct time and yeah I think. I think that there's a lot of kind of fear and anxiety about these things. I, you know, know when I mentioned to patients in the emergency department that we're going to give them some fentanyl or give him some ketamine.

It's not uncommon for folks to be like, You're doing what? Like, pump the brakes. But yeah, I mean, both of these were, really developed for legitimate medical uses.

And, you know, somebody who comes in, our EMS providers pre-hospital are giving fentanyl for pain control, and it's usually in the setting of trauma, right?

Like you have an obvious broken bone, your bleeding out, gun or whatever the case is, And they're like, Hey, I need ores for fentanil. I'm like yeah, cool.

Have fun with it. But, understand that we're giving these doses in micrograms, like really tiny amounts here. And

like my common go-to dose is like 50 micro grams of fentonyl.

which is a hell of a lot lower than one gram, you know, they snort like two grams of fentanyl or it's like, okay, yeah. But then we get into a situation where the misconceptions occur and yeah, the patients are refusing these pain medications, these good medications out of fear, out what they see in the news or whatever the case is.

How do you approach that with them? What's usually like the starter, how do get the conversation started? Yeah, I've really moved to just kind of leading with a question and asking like, what exactly is it that you're worried about with this medication?

And I think a very common response will be, you know, i don't want to become addicted to it. Like, You know I don t want be affected like I hear people on the news being affected.

And you at that point can explain that You're not likely to become addicted just from an isolated use of an appropriate or inappropriately dosed medication.

Sometimes people will get to other personal experiences they've had with the drugs or with family members who have overdosed, but really trying to ask and understand what the hesitation is.

And you mentioned about, you know, see on the news, and I remember seeing a lot of videos online, less recently, but definitely elsewhere about first responders reacting to exposure to fentanyl and especially fentanil in its powdered form, heroin, whatever the case is.

And then they, they don't present like a typical overdose would. So, you know, we go back to the toxidrome and, certainly these drugs have a clear defined clinical toxodrome, but they're not responding in that way.

You know the officer, whoever it is, handling the suspect all of a sudden gets powder on their hands or whatever and all sudden they. You know, they're like passing out or having like, you know seizure like activity or something like that.

That's not typical. Like what's going on there? Yeah, correct. These videos do pop up now and again and they are a little concerning especially the way that they reported in the news.

You now headlines can be a bit misleading and even suggest that someone overdosed from seeing or touching or being around fentanyl which just can't happen.

In terms of what is actually going I think You know, these are people in very stressful situations. They're seeing something that they know to be very deadly.

And you know that kind of physical reactions that their having are very real in the moment, but they're definitely not intoxication by a drug. You can't inhale powdered fentanyl.

It's just sitting there or absorb too much through your skin. I was going to say, can it be absorbed in the skin, you know, powdered or liquid for that matter?

Cause I mean, our nurses are handling liquid fentanyl and sometimes, splashes or whatever. Like, is that something that they have to be aware of? Yeah.

So I, mean going back to, kind of basics for all of us, we should all be wearing appropriate PPE gloves, things like that when doing patient care. so, if you're doing that and there is a spill, just removing those gloves throwing them away.

If anything got on your skin just washing it with soap. and water is more than sufficient. Fentanyl can be absorbed through the skin, but really only in unique circumstances.

So, fentanyle patches are used for chronic pain patients, end-of-life care, and those are specially designed occlusive patches to facilitate delivery through this skin.

It's actually an interesting toxicology conceptual study out there. How long would it take for you to be in contact with those to become intoxicated and you'd have to basically cover your palms with them and leave them on for more than 10 minutes for You to even get an amount in your bloodstream that could potentially sedate you the the patches or the powder or The liquid patches patches interesting and then the power itself is very, you know unlikely to dissolve and You know if any of this gets exposed to broken skin, it's a little more of a concern, but really really not enough to make you sick Yeah, I say in general, you know, even like in inhalation, like, and, we're talking people who snort like large quantities of, powdered fentanyl and powdered heroin that get a high.

Agitation, ketamine, and prehospital management

So here's a question for you, a pharmacological question, if you knew about, is snording going to be the same efficacy as injecting? And my context to that is we basically, so we as humans have something called a first pass metabolism.

If you're a pharmacist, provider, whatever you know about this, but the idea is you ingest something. You eat it, you swallow it. Your body metabolized it first through the liver.

And then whatever is left over, now you have the remnant of the drug circulating and then it becomes affected. But obviously if you doing IV insertion, that you kind of bypass all that stuff.

So is it the same as snorting it? Yeah, so snorting or kind of insufflating something through your nose also will avoid any first pass, kind those first-pass effects, and it's actually a very quick delivery mechanism.

There is some thought that we're actually seeing less IV or injection use of fentanyl these days compared to heroin because fentanil itself is what we call lipophilic, which basically just means that it can crossed into fatty tissue very easily.

So if you snort something, it can easily cross into your brain. And it turns out that's a very effective way, you know, for people to get high using fentanyl.

It's interesting because in a way you can hide your use easier because you no longer have track marks going up your arms. But obviously there's risk to play something like that, corrosive or anything into you nose.

You have to be getting something going on in your nasal septum and inside your nose after that. Right? Yeah, I don't know if that's been looked at long term.

It's definitely an issue with cocaine and, you know, stimulants that can cause, basal constriction, narrowing of the blood vessels. But yeah, it certainly is kind of like caustic to the inside of your nose.

I remember in residency, I had a case where, um, this patient came with a bad nosebleed and turns out they had no septum. You know, the nasal septim, you know the middle part of the nose there, it was completely chewed away.

And it turns it out, It was from long-term cocaine use from, decades ago at this point, but it so eaten away that the, nose bleed came from higher up in the notes.

It wasn't actually a part, of nasal artery. And I remember, so, you know, we obviously have to put the whole, like, bilateral packing in and this and that, but there is nothing to actually push together.

There's no septum there. So this kept bleeding and bleeding. And, I'm, throwing in these like huge, and we're talking like yay big, what we call rhino rockets.

It was just not pushing against anything, ideally kind of get all the way up there and push against the artery. But she's still, this patient still had issues.

This was one of my first ambulance rides down. I was at Metropolitan and went down to Bellevue. And for those who don't know New York City, you go from, the Upper East Side down, to basically, lower, I think it was in the 30s or something like that.

Yeah, high 20s, low 30's I And the reason why I had to go was because fire department of New York doesn't really staff medics on its ambulances, at least regularly.

So if there's any like a highly critical patient that you'd have to transport, you're either getting a nurse or you were getting it doc to. And I drew the short straw.

I went down there with this patient because I'm like, I don't know if this person is going to need to be intubated on the way down. If they're constantly bleeding, they are getting blood, choking on blood.

I have to integrate this person. I'm like, I don't want to do that. They're crazy. That's so scary. Yeah. Thankfully, you know, it didn't happen. Actually, by the time we arrived at Bellevue, the bleeding stopped.

Classic. So, so of course, like I walk into the ER, this, You know I am a resident and all the other like you are residents are like the hell is this?

Why is, why is it even here? You I promise it was really bad at one point. I did a good job. This is a sign that. It's right. When I didn't work. Well, that can be discharged, you know, like, okay.

Oh yeah. Outpatient followed. So, the idea behind, obviously, incidental contact with these types of drugs, You're not really going to get sick from it.

You know? It is not going be something that you're going all of a sudden collapse and convulse over. we call it vasovagal etiology where suddenly people, I think, like you kind of said, it's a high stress environment.

They freak out a little bit and I thing something triggers in their brain, blood vessels dilate, they lose their blood pressure and all of a sudden they're passing out.

You know, but then they come back to within a couple of minutes without Narcan, without anything else. It's like, no, if you really ingested this drug, you wouldn't be just waking up after a minute or two.

Like you would be out for the count. Exactly. Yeah. And that gets back to the toxidromes that we were talking about before. So these patients, they don't have the opioid toxodrome there.

You know, if you look even while they're passed out or breathing in some of these videos, there's no respiratory depression. In some cases, people are actually breathing quite fast, which is just not what an opioid would do.

Yeah. What message would you give to patients when you're talking about drugs like ketamine, drugs, like fentanyl, even benzos?

Fentanyl exposure myths and skin absorption

Because all of these are in the street. You know, you talk about people who are highly dependent on benzo's, for example, the Xanax. You know, like they're going through withdrawal from these drugs and there's concerns for seizures and this and that, but what message you have if you're sending them home on like a Percocet or a Xanax or you doing outpatient ketamine infusions for psychiatric reasons, whatever, what is the message as far as addiction goes, if even know?

Yeah, it's a great question. The ketamine infusion one is a little, I think, harder to answer, and we're just starting to,

see and learn more about ketamine abuse and misuse.

In terms of opioids, medical community has prescribed a ton of Oxycontin and really spurred a lot of opioid use in patients, sending people with month supplies of these things.

There's been, a think a a of increased awareness on the part of the medical community in terms of limiting the amount of time someone actually needs an opioid, as well as actual restrictions and what we're able to prescribe.

My message to patients if they're getting a short course of opioids would be to just follow the instructions on their pills, use them only if you need them.

All of these patients I will also send with Naloxone or Narcan, and I think You know, even if you're not someone who's prescribed an opioid, I think everyone, all of us should carry Naloxone or Narcan because it's not uncommon where you could come across someone whose opioid overdose just in your day-to-day life.

I have a question for you. This is probably going to get me in trouble. Do you feel that sending somebody home with NALOXONE, it was a known drug addict for example, is enabling behavior?

That's an interesting question. So for context, right? So there's a lot of social media stuff out there. And, you know, as I started this podcast, I've become more, enmeshed in social, media and different points of view.

I don't recommend it. It's actually bad for your psyche. But I seen comments from people. And usually it's individuals who hold a very specific viewpoint, an outlook on life and outlook, on these types of people, people who are addicted to drugs and opiates and things like that, that well, you're just enabling them.

You know, well it just an excuse. Well, oftentimes they're missing the context. of their dependency, you know, and, we're not psychiatrists. I'm not going to get into the reasons for dependency.

You know right now, obviously it's a lot, but, my argument to them was, well, how are you going fix somebody if they're dead? Like the idea behind this is you want to eventually get them to a point where they can live and be productive members of society.

But in order to do that, they have to make sure they are alive. I think that's a great response. And then, you know, I as a medical community, we're starting to recognize more that addiction, the correct term in this case would be like opioid use disorder is a disease.

It's like a relapsing and remitting illness. You know the number of people in the US that have it is similar to the numbers that has diabetes and people who need insulin for their diabetes.

We don't call them insulin addicts and you're just enabling their diabetes by treating them with insulin. And some people are doing that in higher in government agencies.

I'm just gonna leave it at that. Yeah, that'll be the next episode of topics. We'll leave that for later. But yeah, I think it's important when you interact with people who have these questions.

And I also kind of ask people if they know anyone who has been affected by opioids. More often than not though, most people out there know someone who's overdosed or been impacted by an overdose in some way.

And I think it's important too, that there has to be some level of compassion for these individuals. And, I say that because one of my close colleagues has overcome opiate and drug dependence and is currently leading a very successful career as a physician.

You know, actually, I know of two people that I think about, two who I overcame it to be physicians and actually really effective physicians too. And I that has to kind of understated that, yes, there are people who are very far gone down the rabbit hole, who will absolutely need intensive therapy and the people recovered tend to have a lot

of support around them.

Uh, the people that don't, you know, it's, its, hit or miss. But this is not something that you can just decide to stop. I mean, an alcoholic can't just decided to start drinking.

You know they can, but then they're going to feel terrible. And there's this, I feel like no good amount of resources to help these people who do really want help and get better and stay healthy too.

Cause I think I like what your description is, is a relapsing and remitting condition. It's like a mess. it is like this requires constant monitoring.

constant care and for these people, constant validation. It's easy to say, oh, you're fixed. Congratulations. See you when we see you. And no. Yeah. A key part of this for a lot of people will be what we call medication assisted treatment or MAT.

Addiction, naloxone access, and closing thoughts

There's other comments that you'll run into when someone might hear that someone's taking a drug like or medication like methadone or buprenorphine, aren't you just replacing one addiction for another?

And that kind of gets back to what you were just saying about it being a chronic condition that needs managed. Yeah. And I think, first of all, people don't just kind of decide to become heroin addicts or, you know, alcoholics or something like that.

You know? There is something underlying all of this here that there's, are we replacing, one drug for another? No, You're taking drugs to replace something in your life.

I, think that's really missing out here. But like I said, that a discussion for a psychiatrist. If you're interested in, if you have a past interest in psychiatry, want to be on the show, please feel free to email me.

I'd be a great guest. Zero buddy. It's awesome. Dr. Christopher Counts, emergency medicine physician and toxicologist. Again, smarter than me, more academic than.

Um, thanks for coming on to talk about this stuff. That was really good. Thanks so much for having me. This was great. My thanks again to Dr. Christopher Counts, Board Certified E. M.

Physician, and Toxicologist for coming on the show to discuss all things fentanyl overdose and addiction. Again, fentanil by itself is not a terrible drug.

It is a potent pain reliever that we give in the clinical setting to help with severe pain. However, we are seeing an increasing amount of fentonyl overdoses with deadly consequences.

From the somnolent to the highly erratic, these drugs are mixed with other drugs too to create a varying level of toxidrome that, as clinicians, have a hard time treating in an acute care setting.

One thing to keep in mind with fentanyl, though, is that it is not something that you can incidentally overdose from. The reaction videos that see on the internet are actually just not true.

Sometimes there are a vasovagal episode, a stress response, but they are not due to overdoses of the drug themselves. Obviously, use proper protection when handling any kind of chemical, especially if they're narcotic or rather you do not know the composition of.

Protect yourself, but don't be afraid that you're going to instantly inhale something and cause an overdose just by being in the general vicinity. If you or somebody you know has addiction problems, please seek support.

There is help available to you. And unfortunately, there is no one-stop shop for a lot of these types of issues. But check with your local state, precincts, hospitals.

They all have resources to help you get the help and treatment that you need. Unless you have an allergy to fentanyl itself or other opiates or narcotics, Please don't be alarmed when a doctor or a nurse or even EMS come at you with a dose of fentanil to alleviate your pain.

That's it for this episode of the Jaffer Cast. Make good choices and we'll see you next time.