



## The Current Opioid Crisis & Shortage, the Crisis Not to Waste Twenty-Five Years of Opioid Free Anesthesia

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### Editorial

For more than a half century, the use of opioids has been a ubiquitous part of anesthesia starting with morphine premedication to ameliorate Stage 2 excitement with ether induction. If opioids were so effective at blocking afferent nociceptive (pain) signals to the brain, why do patients continue for have postoperative pain? Why should opioids continue to be given for postoperative pain? Why is there a need for an Enhanced Recovery after Anesthesia (ERAS) program? (Figure 1). On March 26, 1992, this author began working in a plastic surgery office that had experienced a fentanyl related over medication death two years earlier. Avoiding opioids was simple in this setting. No opioids were available or permitted to be administered. Necessity became the mother of invention. In December 1991, this author heard plastic surgeon Charles Vinnik presents his diazepam ketamine technique and was interested enough in his use of ketamine to visit him on March 23, 1992 to observe his work [1]. While the author was convinced that large diazepam doses would block ketamine hallucinations, hypertension and tachycardia, it was unknown as to whether or not propofol would have the same negative side effects blocking effect. Titrating propofol gradually to a loss of lid reflex and loss of verbal response prior to administering 50 mg IV ketamine, independent of body weight, confirmed this author's suspicion that hypnosis from propofol would block ketamine negative side effects [2,3]. Although the clinical end point signs for ketamine protection were consistent, the paradigm did not become numerically reproducible until the addition of real time BIS/EMG

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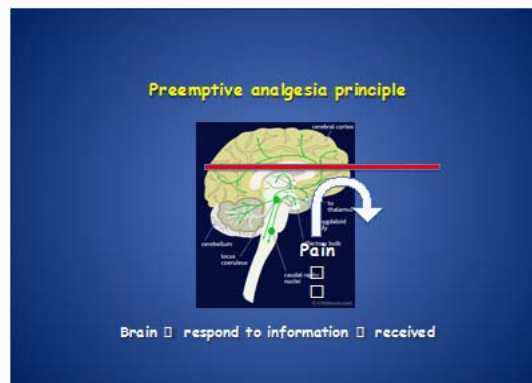


Figure 1: Brain cannot respond to information not received.

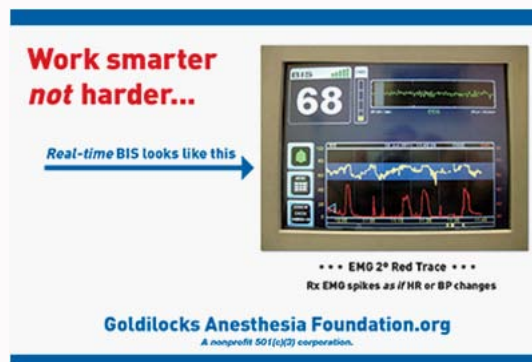


Figure 2: BIS with real time EMG signal (lower, red trend).

brain monitoring on December 26, 1998 (Figure 2). An incremental propofol induction provides a numerically reproducible level of propofol (i.e.  $60 < \text{BIS} < 75$  with baseline EMG). After which a 50 mg dissociative dose of ketamine will deny the brain the knowledge of the surgeon's incursion into the protected world of self (Figure 1) [4-8]. Preemptive ketamine gives dramatically better patient outcomes with virtually no need for postoperative opioids. The interval between the skin incision & the need for analgesia allows healing to take place. When postpone analgesia is needed, much less, if any opioids are needed. Over 25 years providing preemptive ketamine with opioid free, Goldilocks anesthesia for more than 6,000 patients resulted in not a single hospital admission for pain as well as no ketamine hallucinations. Avoiding opioids during surgery also resulted in the lowest published postoperative nausea & vomiting rate (0.6%) in high risk patients without using anti-emetics like Zofran or Emend! Avoiding opioids during surgery as well as the need for opioids after surgery is the key to avoiding postoperative opioid addiction [9].

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