HORMONE REPLACEMENT FOLLOWING OPIOID SUPPRESSION

Just about everyone who receives this Bulletin is aware that opioids suppress hormone levels. After all, we’ve known about opioid suppression for over 30 years. 1-6 Given this fact, the big question is—however—why isn’t every practitioner who prescribes opioids testing for and treating with hormones?

We propose 2 main reasons:

1. Not sure how to go about it.
2. Rotten attitude—lets ignore the issue and maybe it will go away.

Here are some BOLD-FACE facts about opioids and hormones—as unpleasant as they may be.

1. Hormone deficiencies in a pain patient worsen and prolong the pain. You can’t heal without hormones! 7-12
2. Opioids don’t work well and provide much relief without normal hormone levels. 7-10
3. Low hormone levels in opioid-maintained patients may cause all sorts of problems: depression, anergy, mental impairments, amenorrhea, loss of libido, erectile dysfunction, hyperalgesia, weakness, weight loss, osteoporosis. 13-22

WHICH OPIOIDS ARE THE WORST OFFENDERS?

Intrathecal and long-acting opioids including transdermal fentanyl are the worst offenders. 18-26 Intrathecal opioids cause the hypothalamus to be constantly bathed in opioids. Long-acting opioid administered orally or by patch produce a constant blood level which not only coats the hormone producing centers in the brain, but also the adrenals, and gonads.

One thing is clear. Intrathecal and long-acting opioids due to their almost universal proclivity to suppress hormones (about 85% of the time), should only be used as a last resort when short-acting opioids fail to control pain. 15,16
WHICH HORMONES ARE SUPPRESSED BY OPIOIDS?

Testosterone has gotten the most press, but pregnenolone, DHEA, and estrogen are commonly suppressed.\textsuperscript{15,16} Cortisol, progesterone, and oxytocin may even be lowered by opioids.\textsuperscript{16} Estrogen suppression results in amenorrhea in females.\textsuperscript{10,12} Opioids like to preferentially suppress gonadal releasing hormone in the hypothalamus but they may also directly affect hormone production in the pituitary, adrenals, and gonads.

WHAT HORMONES SHOULD BE TESTED AND TREATED?

Due to today’s easy access to commercial laboratories, we recommend a hormone profile in pain patients consisting of:

1. Cortisol
2. Pregnenolone
3. Testosterone
4. Dehydroepiandrosterone (DHEA)
5. Progesterone
6. Corticotropin (ACTH)

In a pain patient maintained on intrathecal or long-acting opioids, hormone testing should be done at least twice a year and whenever any of the complications (fatigue, hyperalgesia, etc.) occur. Replacement of deficient hormones should be done and the patient followed with repeat tests.\textsuperscript{27}

MAIN MESSAGE: Isn’t it time that hormone testing and replacement in patients on intrathecal and long-acting opioids be standard care? Given the serious complications of hormonal deficiencies, there is no longer any good excuse to avoid this clinical issue. Put another way, if you feel you are qualified and willing to prescribe intrathecal and other long-acting opioids, shouldn’t you be prepared to deal with their complications?

Dr. Hormone says,

\textit{Isn’t it time that hormone testing and replacement be standard of care in patients on intrathecal and long-acting opioids?}

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