A First-Hand Account of Kicking Fentanyl Addiction: Reversing Hebb's Law

https://mindmatters.ai/podcast/**ep186**/

Announcer:

Greetings and welcome to Mind Matters News. Before we get started today, I'd like to take a moment and let you know that this interview contains descriptions of surgery and opioid addiction that some may find disturbing. Listener discretion is advised.

Robert J. Marks:

Greetings. Welcome to Mind Matters News. I'm your blithesome host Robert J. Marks. In a previous podcast, we chatted with Dr. Richard Hurley about opioid addiction. Addiction is documented by the science of neuropsychology. Donald Hebb, who passed in 1985, is considered the father of neuropsychology because of the way he first effectively merged the psychological world and the world of neuroscience. He is known for Hebb's Law, and we study this in artificial intelligence and it's part of brain chemistry. Hebb's Law says that, summarized in a very short statement, it's that neurons that fire together, wire together. In terms of addiction, this roughly means that as you repeatedly perform into action that gives you pleasure, and by pleasure, we can also include the idea of relief. So it gives you pleasure of relief. Anyway, an action that gives you pleasure, as this happens, the neurons between the action and the pleasure in your brain simultaneously fire.

Robert J. Marks:

So the path between the neurons dedicated to the action and the neurons dedicated to the pleasure, they build up in strength. So the path becomes stronger and stronger. Triggers eventually push you towards performing the action to experience the pleasure. I think I mentioned in the previous podcast with Dr. Hurley that I used to smoke. I am old enough to remember when smoking was allowed on airplanes, commercial airplanes. There were smoking and nonsmoking sections. It was actually a big joke because after the plane took off, the whole cabin filled with smoke. But after the plane took off, it was okay to smoke. And there was this audible ding when the non-smoking light was turned off and all the smokers lit up. Both the smoking and non-smoking sections of the cabin were filled with tobacco smoke. Today, smoking on commercial aircraft seems intolerable. So the good news is I quit smoking, and my neural path between what the audible ding and having a cigarette began to lessen, but it never went away.

Robert J. Marks:

Today, when the fasten seatbelt lights goes off in an airplane, there's also a ding. It was like a ding when the no smoking light went off. And when this happens, I get an immediate urge to have a cigarette, even today. The urge is slight and the urge is mostly curious, I think, that's interesting. It isn't a compelling urge, but I quickly and easily dismiss it and just go on about things. But this reminds me, the little dinging that the neuropath talked about in Hebb's Law, it's still there. It's diminished, but it's still there. The neuropsychological science of addiction is more complicated than this, but Hebb's Law is one high level way to look at it. Now, opioids of course are more addictive than tobacco.

Robert J. Marks:

Our guest today was addicted to opioids, specifically the highly potent synthetic opioid, fentanyl. And we're not going to disclose his identity, but we'll simply call him Stretch. Is that okay?

Stretch:

That's fine, yeah.

Robert J. Marks:

Okay. Well Stretch, welcome.

Stretch:

Thank you. Thanks for having me, Mr. Marks.

Robert J. Marks:

You're very welcome. Well, first of all, let's get legality out of the way. You never purchased fentanyl off the street. I think all of the drugs that you became addicted to were prescribed by physicians. Is this right?

Stretch:

Yep.

Robert J. Marks:

And I do know that you suffered from a series of failed surgeries. And so let's talk about these and could you kind of go through the surgeries and the pain that was associated with each one of the surgeries, and then the corresponding opioid prescriptions you were given?

Stretch:

Sure. That's a long, long story. Essentially, I got diagnosed with inflammatory bowel disease, this was 1999. And it was after a long period of bleeding, basically bloody diarrhea continuously. And urgent. Urgent. But it was always lots of blood. And before I ended up at the gastroenterologist, as for a note, my general practitioner kept diagnosing me with hemorrhoids for all this blood. In all reality, the failings of the medical community started with the late diagnosis of this disease I was having symptoms of, for a long time, before my general practitioner walk through the insurance approved steps to get me a proper diagnosis. And initially, the inflammation was seen with the barium enema, which is a horrible experience. You don't want to be in front of a doctor who is standing behind a sheet of Plexiglas to assess you. That's never a good situation.

Robert J. Marks:

Wait, wait, there was a Plexiglas between you and the doctor.

Stretch:

Yes, because I had received a barium enema for the imaging. And when he came in, he wanted to protect himself in case the barium let loose.

Robert J. Marks:

Was there radioactivity in the barium? Is that the idea?

Stretch:

Yes, there was. But he was more concerned with the splashing onto him, the stuff that might come flying out of my bottom.

Robert J. Marks:

Oh my gosh.

Stretch:

So he stood behind like a Roman shield that he carried with him. It was Plexiglas that he could see through.

Robert J. Marks:

Did he carry it around like a shield?

Stretch:

I swear to goodness, yes. He came out of the office with the computers and grabbed the shield and walked up to me and.

Robert J. Marks:

Oh, that's terrible. That's a terrible experience. Okay, go ahead. Go ahead.

Stretch:

Anyhow, I finally saw a gastroenterologist. He did an endoscopy. Yes, there was evidence of ulcerative colitis, which is the swelling of only well, it's the ulceration of only the rectum and large bowel. If you've heard of Crohn's disease, Crohn's disease is basically the same inflammatory bowel disease, but it affects the whole digestive tract, where ulcerative colitis is strictly colon and rectum.

Stretch:

So I went on medication. That was difficult trying to hold an enema of medication when you go to bed every night. So I was glad that my disease went into remission, which at the time, I just thought had never having a life-threatening disease or a long term disease, I didn't understand the significance of the medication, and getting it into remission at the time. So after the medication worked, I stopped taking the medication, thinking, oh, goody, that's over with. Well, it came back with a vengeance and the medication never worked again, after that period. So I ended up in the hospital, local hospital, for a week. They couldn't bring the inflammation under control with prednisone. That was the place I received my first injection of opiates. First experience with opiates ever was in that hospital, about the fourth day I was in there.

Stretch:

The nurse was, she was let's say, she instigated the shot. I think she understood I was pretty miserable and offered me one where nobody else had. And of course I was kind of like, "I guess." And she's, "Okay I'm going to get you one." So she comes back with a shot and gives it to me. And I just remember, it

seemed like forever later, just sitting on the edge of the bed in the same exact spot that I was, after I sit up after she gave me the injection. So it really just kind of totally zoned me out.

Robert J. Marks:

It zoned you out.

Stretch:

It zoned me out, but it was like it was an escape from the reality of the situation at the time, even though I didn't understand it as such. I just zoned out. So it kind of gave me a mental and a physical respite that I probably didn't even recognize that I was getting at the time. But it wasn't a sense of, I want that again, or, oh, I need to have that. I just noticed it was like, man, there was something strange happening with the passing of time over this period. I realized I was loopy. But the notion that all this time had passed and I couldn't recall being miserable or whatever during that period was interesting. So I ended up going to the Cleveland Clinic. My gastroenterologist that I had basically said, "You're going to the Cleveland Clinic."

Robert J. Marks:

Now, the Cleveland Clinic has an incredible reputation.

Stretch:

Yes. At the time they were one of the best, probably next to Mayo Clinic, the next best place to go in the country for bowel surgery, colorectal surgery. And there was a gentleman there, started a program called Dr. Fazio, who had been there for years from Australia and had really developed a fine program there, that they were proud of and that drew a lot of support. So off I went, transferred at night in an ambulette, which don't pick the ambulette.

Robert J. Marks:

What's an ambulette.

Stretch:

An ambulette is a wheelchair delivery van that's made to deliver wheelchairs, not people.

Robert J. Marks:

I see. Okay.

Stretch:

So they put you in a wheelchair in the wheelchair van, and you're surrounded by 50 wheelchairs, banging and clanking, and banging and clanking for however long it takes to get you to the next hospital. So you've been in this nice calm environment. Next thing you know, you're in a 55 gallon drum with people banging on it with sticks for an hour. So it's really a traumatic experience. Don't do the ambulette unless you absolutely have to. Have a family member transfer you to the other hospital, if you can.

Robert J. Marks:

Okay. So you went to the Cleveland Clinic and you had an operation.

Stretch:

I ended up, yes, having an emergency colectomy, and it was kind of taken out of my hands. Surgeon said, "You got to do this, or it could rupture and you might die." This was their protocol. If it got so bad that it looked like could be at risk of the inflammation and the ulceration actually breaking through the boundary of the bowel, into the abdominal cavity. And then that's the risk factor that can set off, I guess, problems with sepsis and other things that can be deadly. So that was their line that they didn't want my bowel to cross that line. So they chose to cut me wide open and take out the whole large intestine. I take that back, they left my rectum. They left my rectum. And sowed me back up with the end ileostomy, the end of my small bowel protruded through my abdomen, and then used a regular ostomy appliance.

Robert J. Marks:

That sounds terrible.

Stretch:

That was the first surgery of a series of three that was intended to get me a functional ileum pouch, I've heard it referred to. And essentially, it's a reservoir that they fashion out of your small intestine that serves as your rectum, as a place for your stool storage.

Robert J. Marks:

Okay. Now, when you did this, again, that was clearly a lot of pain, and there were probably more opioids.

Stretch:

Yes. And interestingly, at the time, of course I had pain medicine for the surgery and after. My pain was bad, but it wasn't excruciating. They gave me opiates until it was time to go home. They gave me a modest amount of opiates. I believe they actually had tapered me off the opiates before they let me leave the hospital.

Robert J. Marks:

Dr. Hurley, I was talking to him. He said that during surgery, he pumps enough fentanyl into a patient to kill them. Because if he didn't take over for the breathing, that they would just stop breathing. But they're in the operating room, and so, the breathing apparatus takes over. So you went through an experience like that, I suppose.

Stretch:

Yeah. And wake up in the recovery room and the nurse would assess your pain, if I recall. I'm awful groggy and they would administer more if you needed it, kind of assess based on your feedback.

Robert J. Marks:

Did they give you one of these little push buttons?

Stretch:

Eventually. From the recovery room, by the time you got back into your hospital room, I believe I had, even in that surgery, because that was in 2000. And some of the stuff, there has been differences, but I

do believe I had a pump with a button. So that's your solution, which is self-initiated, which is you learn that it's self-initiated, but it won't give you any more medication than the doctor has told it, it can give you.

Robert J. Marks:

But there's a maximum that you can give yourself?

Stretch:

Yeah. But the important thing there was, is when I checked out, they were very adamant to me about not using opiates, unless I absolutely has to. Percocet at the time, common just everyday Percocet. "Don't use this if you don't need to," just very direct. And I didn't feel like I needed to. And I headed the warning so I used ibuprofen. We're fine.

Robert J. Marks:

Not an opiate.

Stretch:

For the most part, I use ibuprofen. After I was home, there were a couple nights where I chose to take some of the opiates and I hated the way it made me feel. I mean, it bothered me. I couldn't sleep and things were irritating and it's just like, I don't like the way this stuff makes me feel. So I was deterred from taking it.

Robert J. Marks:

It's really constipating too. Right?

Stretch:

Well, that's an issue that eventually turns out to be a blessing and a curse for people that have had bowel surgeries because where a normal person ends up constipated and has extremely difficult time overcoming that after having been on a lot of opiates, a person who has chronic loose bowels, the slowing of your digestive system is a very beneficial thing.

Robert J. Marks:

That's interesting because it solidifies the waste.

Stretch:

It gives it time to yeah, draw out some water, which you need. You need your fluids and you need nutrition from your food. And typically, what's going on is it's just flying through your system. And for whatever reason, the calming effects of opiates is a calming effect on your bowels. It's different from Imodium type bowel slowers, in that the Imodium type bowel slowers, they will cause cramping, they will make it extremely difficult to actually use the bathroom to evacuate your bowels if you need to.

Stretch:

And it doesn't do anything for the pain. So it prolongs the pain that you're in while you're trying to evacuate your bowels because it's slowed things down, it's made things rock hard and it's just not conducive to helping you. So the opiates do the opposite. The opiates help you out with all that stuff. It's

a calm, you don't typically get like rocks formed in your system. And when you need to evacuate, you can do so without a huge amount of pain and it works better. Of course, you're using opiates. And there are bowel slowers that are designed... That are opiates that are prescribed as bowel slowers.

Robert J. Marks:

Wow. For that specific purpose.

Stretch:

For bowel slowing. Yes. But for the same reason, they're addictive.

Robert J. Marks:

So you had the surgery, you went home, you took some opioids.

Stretch:

Yes. Didn't like it and got through my recovery without them, for the most part.

Robert J. Marks:

Okay. Would you say you were in any way addicted? Did you have any-

Stretch:

Interestingly, I didn't know it at the time. But after having been on them in the hospital and come home, I was really having a hard time sleeping. I was fidgety and my arms would ache and it's like, what is going on? And after I ended up dependent and addicted, I understood what was happening at that time. And I actually ended up calling, I was so disturbed, I called one of the doctors at the Cleveland Clinics, "What's going on?" From the withdrawal effects that I didn't understand that I was experiencing, I was experiencing them as just like a panic psychological problem.

Robert J. Marks:

You did have withdrawal symptoms, but you really didn't identify them with the opioids.

Stretch:

Yeah, I didn't know that's what it was.

Robert J. Marks:

Lets go to the next stage. That surgery didn't work some way, right?

Stretch:

Like I said, this was the part one surgery of three that occurred. So July, 2000, I had the colectomy. December of the same year, I had another surgery where they opened me completely up again, went in and created what they call a J-pouch, the ileum pouch out of the small intestine and fashioned it to my rectal stump, planning to use my anus to evacuate this pouch. So it was a big surgery. And after that surgery-

Robert J. Marks:

So the previous surgery failed in some way?

Stretch:

The failure is happening... See when you're calling, saying the previous surgery, the first surgery that failed is really a three surgery process.

Robert J. Marks:

Oh, I see. Okay.

Stretch:

So this is the second part of that surgery where it was very difficult. It was like potentially not a long enough recovery between my first surgery and my second surgery. So it really wiped me out and I was sore, and I felt like I'd been beat up really bad after that surgery. So I started using the opiates more just because I was a wreck, basically. I think surgery was very invasive.

Robert J. Marks:

And the doctors were happy to prescribe you the opiates, right?

Stretch:

Yes, a modest amount of opiates. I think I had 20 Percocet or something. And like I said, I was struggling. And I used those and then I didn't have anymore. And it took me a while to come around after that, weeks before I was... Just to give you an idea, after I got home from the hospital, it was two weeks before I could walk up a flight of stairs to get to the shower. I'd go sit down at the table and somebody would have to scoot me up to the table to eat. That's the kind of condition I was in. So the second surgery was worse than that. My perception was I didn't have enough pain medication, but I got through it. And then the third surgery-

Robert J. Marks:

Well, before that, did you consider yourself in any way addicted after the second surgery?

Stretch:

No, no. I considered myself under medicated.

Robert J. Marks:

Under medicated.

Stretch:

Yes. Because of the intensity of the recovery from that second surgery. So after the third surgery, which was not nearly as invasive as the first two. But at the time, I didn't understand what the recovery was going to be like. And actually, it was very frightening because I was going to start using my anus and my bowels, like I hadn't done for a year at that point, because that was April of 2001. So it wasn't quite a year.

Robert J. Marks:

It was new style of life for you.

Stretch:

Yeah. But the recovery, as far as pain, wasn't that, I say that, but a whole different problem arose. But as far as recovery from the abdominal surgery, I expected it to be worse. I asked for more pain medication, which they gave me based on my experience the second time around. But then I didn't end up needing them. That's kind of the point I'm trying to make. I had most of a bottle pain medication left over after the recovery of that surgery.

Robert J. Marks:

Okay. But I do know that eventually from your stories that you did get addicted. What happens with the addiction?

Stretch:

The J-pouch never worked properly and it leaked into my abdominal cavity. I'll just say my J-pouch leaked stool, diarrhea, into my abdominal cavity for seven years. I carried an abdominal infection and the pouch itself was always ulcerated and red and infected. And the gastroenterologist I had at Cleveland Clinic was a dedicated man trying to come up with solutions for these post pouch surgery problems. And they called it a pouchitis, which is basically just an infection in a pouch that they didn't understand.

Stretch:

So the point I'm trying to make is we diddled around trying to fix the pouch longer than we should have. It should have been excised long before it was. We didn't do that. They didn't do the imagery that would've been necessary to see the abdominal infection because they were looking in my pouch, not in my abdominal cavity. And over this period of time, starting with the third surgery, directly after the third surgery, I would have frequent excruciatingly, painful bowel movements. I consider myself a pretty tough guy. I would come out of the bowel movements, shaking, eye watering, my knees quivering. That's the type of pain it was that I would need to recover from.

Robert J. Marks:

And this wasn't from the constipation, this was regular.

Stretch:

This was pain. It was like trying to evacuate razor blades, kind of thing. And it really did feel like somebody was jamming a knife up my rear end every time. But I would've to do this 14 times a day, 12, 14 times a day. And this went on for months and years in different varying amounts.

Robert J. Marks:

Years?

Stretch:

Yes. Yes. Because I would get it under control a little bit and it would go wacky. I wore out, I became resistant to one antibiotic, Flagyl. I had another antibiotic, Cipro, that I was using heavily that if I became antibiotic resistant to that medication, there was only one more antibiotic that was available for me.

And had I became resistant to that, then I would've been at severe risk of all the infections, hospital infections, the C. diff and the whatever else.

Stretch:

Anyhow, the point is we did great lengths to try to get that J-pouch working. And I stuck it out the best I could, and I used pain medication to do it. I was able to bridge off of the pain medication that I had leftover from the third surgery start taking it, realized that it was going to enable me to live a better life. And that's when I basically chose, I'm going to do this, I'm going to use these meds because I need to.

Stretch:

What I should have done was said, okay, let's cut this pouch out and do something different. But didn't have the wisdom to do that at the time. So I started medicating it with pain medication. And my gastroenterologist chose... After I decided to utilize the medication, he didn't want to be involved in prescribing the medication long term, which I understand. They were starting to get a lot of heat from the FDA, which was of course induced by the evil pharmaceutical companies. But they came down on the doctors. So the doctors chose to direct all their patients for chronic pain to actual chronic pain doctors at the Cleveland Clinic. So there was a pain management department.

Robert J. Marks:

Yeah. My understanding from Dr. Hurley, I think it was 2018 that there was guidelines put up for the prescription of things like fentanyl and Oxycontin.

Stretch:

Yeah. I don't know exactly what they were, but I know they really tightened up the ship as far as people's access to the medications.

Robert J. Marks:

Now, I think you mentioned to me that one of the ways that you took the medication was through lollypops. Is that right, fentanyl?

Stretch:

Yeah. Yes. I was in that whole... You may have heard the whole story about the company that developed those. I was prescribed those fentanyl lollipops after having been on large amounts of tablet prescription medication. And I had started taking Oxycontin, which is oxycodone in some continuous release form.

Robert J. Marks:

Right. Right, right.

Stretch:

Well, the continuous release mechanism doesn't work very well for a person that doesn't have a complete bowel system because it doesn't stay in your system long enough for all the medication to release from the pill. And the other thing that happens is the pill-

Robert J. Marks:

Oh, that's right. The Oxycontin is slow release.

Stretch:

Yeah. So you spit it out halfway through because you don't have anymore bowel.

Robert J. Marks:

Because it goes through your system. I see. Okay.

Stretch:

And for some reason this is very, very, very, very difficult for doctors to understand. I don't understand why. I don't understand if they insist that they don't want to go there because they don't want to have to adjust their thinking. But people do not absorb medication in the same way, but they prescribe medication as though everybody receives the doses into their body the same way doesn't happen.

Robert J. Marks:

Okay.

Stretch:

So they assume you are absorbing all the medication. There's no way for you to say no, I'm not. Well, I found out a way. These pills would swell up. So I would have to force them through my anus to evacuate them. And they would plop into the toilet and I fished one out. I dried it, I cut it in half. I took pictures and I took it to the doctor.

Robert J. Marks:

Oh, that's so terrible.

Stretch:

This is what you have to do with educated men. You have to fish stuff out of the toilet to make illustrations for these people that think that they know what they're doing.

Robert J. Marks:

We think about this as gross in a way of talking about it. But when you're experiencing pain, you go through all sorts of situation.

Stretch:

You have to. And it's amazing how resilient humans are. It's amazing how adaptable we are. And I've experienced that too. It's like, you just find a new normal. But when you're under the stress of constant pain, your body knows that you need to make a change, and it will basically force you to find some type of solution because your body won't tolerate the pain. It's basically a motivator, personal motivator, physical pain. You just can't ignore it.

Robert J. Marks:

So when did you know you were addicted?

Stretch:

Well, after I started taking it to just try to maintain some, and I was working full time, and over time and I was trying to travel. I mean, this was crazy. But I knew, based on the feeling when I didn't have it, that I was starting to become dependent on it because I would start to feel agitated. And I knew that this was because I didn't have the medication in my system. Of course, there would be more pain. But on top of the pain, there would be this kind of mental, just aggravation, unhappiness.

Robert J. Marks:

When you get addicted to opioids, such as fentanyl, you have to take it not to get that euphoria again, but to feel normal.

Stretch:

Yeah, absolutely. The withdrawal becomes the motivator. The withdrawal is what you are mostly concerned about, and that is not being sick. Because after you become dependent, the withdrawal is more disturbing and painful and agitating, whatever than the pain that you were trying to overcome with the medication ever was. And you may end up with the pain that you were trying to overcome with the medication on top of horrible withdrawal symptoms. And then maybe on top of that, you've got actual disease that's making you sick. So you've basically compounded your problem dramatically when you take on an addiction, if you've already got a physical health problem. Because you've created another one for yourself, that's as bad or worse than the one that you have, from your point of view, from your wellbeing, quality of life point of view. I believe the addiction was the hardest and most urgent thing I needed to take care of in the context of all that sickness.

Stretch:

Of course, as urgent as it was, it took me a long, long time and two stints in rehab, and then years with a Suboxone product, which is a synthetic opiate, that's not supposed to be psychoactive, that basically eliminates your cravings for the actual opiates. It tricks your body into thinking you're on opiates without the withdrawal associated with not being on them, somehow. And it's basically how I experienced it, was it was like an easier let down the Suboxone was yes, addictive in its own right in some way. But coming off of Suboxone was stepping down with less pain and discomfort than it would've been having tried to just come straight... Or had it been previously coming off of opiates without the Suboxone.

Robert J. Marks:

You mentioned you went to something like, I don't know if it was called Narcotics Anonymous or something like that, but to support group. You've shared with me some of the incredible people that you met there.

Stretch:

Yeah. Alcoholics Anonymous, bond Narcotics Anonymous, other addiction, Gambling Anonymous, and it's all about applying the principles of Alcoholics Anonymous to the other addictions. So it's the same thing, basically. It's just the matter of the different people that are in the group. Alcoholics Anonymous is tailored towards alcoholics. Narcotics Anonymous is tailored towards people that take drugs.

Robert J. Marks:

Do you remember any of the people that you met in these groups?

Stretch:

I met so many people, so many different people. And I've been in treatment with anesthesiologist sand dentists.

Robert J. Marks:

Okay. You had anesthesiologists in the group recovering from-

Stretch:

Yes. Dentists, nurses, chiropractors, wealthy businessmen, executives, down to people that had been on death row. I'm serious, the whole gamut-

Robert J. Marks:

So you have an anesthesiologist with a death row inmate.

Stretch:

Not at the same time, but via the same system, Alcoholics Anonymous. Into those rooms, came all these different types of people.

Robert J. Marks:

And this was probably a mix of people that got addicted both through prescription and through street drugs.

Stretch:

Absolutely. And yeah, doctors self prescribing to manage either an injury that they think they can fix themselves, or managing their anxiety and problems with their family with medication. Nurses that have easy access to it, know how to game the emergency rooms and get a bunch of medication out of the system, that type of thing. Nurses' boyfriends, who come in with the nurses who are addicted because they've had access to the drugs through their girlfriend, who's a nurse. And when I say that through these rooms, not specifically through the rooms of Alcoholic Anonymous, but also in the hospitals, in the detox hospital. I'm reflecting on the whole gamut of people I've seen in both of these environments.

Robert J. Marks:

So I want to talk about your detox in a minute. But you did go through detox and it was kind of self imposed detox, right?

Stretch:

Oh, I tried many, many times.

Robert J. Marks:

Many times.

Stretch:

I tried cold turkey so many times and I would be so sick for a week or two, just trying, trying. Miserable, barely able to get out of bed, trying to do it myself. And I would dedicate all that time and misery for however long it was. And I couldn't do it. I couldn't do it. The sickness would not go away. It would not go away. So at some point, you become desperate and you become suicidal. How do I get rid of this? I am miserable. I don't want to live like this. I can't live like this. The only solution a person sees is more of the drug. And really, that's the problem. The only solution is more of the drug. That breeds the desperation that people go through to get it. They become very desperate to get money, resources, to get the drug because they feel like they're going to die without it.

Robert J. Marks:

My goodness. But you did finally kick it.

Stretch:

I did. I kicked it by going to two different rehab programs, one in Columbus. And I kicked it, but it was premature. I kicked it and I still needed it from medical standpoint. So I ended up, eventually months later, starting it again.

Robert J. Marks:

See, that's what I was going to ask you. If you go through detox and you still have the pain, I don't know, is it better to live with the addiction or live with the pain? It's a rough choice.

Stretch:

You can't do the pain, it'll just destroy you. And actually there was another solution we tried, and this was through the pain management clinic at the Cleveland Clinic. The doctor was a doctor who had been involved in the early days of the neurostimulator development. So he'd been doing that for a long, long time. And he thought he could place a lead along my spine that would electrically scramble the pain signals coming from that area.

Robert J. Marks:

Oh my goodness. You had an operation on your spine.

Stretch:

I had two or three trials with that system that were temporary, where the wires came out of my back.

Robert J. Marks:

Oh my goodness. That's terrible.

Stretch:

And it was amazing how it worked.

Robert J. Marks:

It worked?

Stretch:

It really was. It would work, but the problem was it had to be located just right along your spine. And I would have the trial and be in the car, and by the time I would get home bouncing in the car, it would've shifted enough where it had stopped becoming effective.

Robert J. Marks:

Oh, geez.

Stretch:

And it may start working somewhere else, that you didn't want the electric stuff going to.

Robert J. Marks:

And what happens when it works somewhere else? Do you go numb?

Stretch:

Well, if you don't like the feeling of electricity boiling through your lower member, it's not comfortable,. And actually that happened during one of the surgeries. He was trying to place it and they're sending a charge to, and it electrifies my genital area essentially. And I start hollering out in the operating room that's what's happening. And he and the other people that were in there are laughing out loud at me, but it is kind of a shock.

Robert J. Marks:

Well, you want a doctor with a good sense of humor, I suppose. That's very interesting.

Stretch:

I don't know how much money they spent on that, but it was a serious effort. I didn't keep track with the insurance or whatever. But in the end, he decided, okay, he basically had to apply for the coverage and they determined through these trials that this was to work for these guys, this guy, we just got to get it implanted and sewn up in them. And then there's a remote you used to control it.

Robert J. Marks:

Oh really? So you have a little wireless remote, or is it plugged in?

Stretch:

No, there was no wire when it was done, however they did that.

Robert J. Marks:

Isn't that interesting?

Stretch:

So they did the implant. This was the surgery I was just describing where they were having a hard time locating it. And in the end, they stopped trying. I didn't exactly know what had gone on because I wasn't completely under, but they'd sedated me for relaxation kind of thing. And he came to my bedside and he said, "I have been doing this for, I don't know, 20 years or something," and he said, "You are the second person that I could not get this lead located in." He suspected, and this makes sense, he

suspected that it was the scar tissue that had developed from the other, the tests. And in my bowel troubles, there was lots of speculation about my body's maybe excessive production of scar tissue causing some problems. So that kind of related to that. I don't know, there's no proof, but it was interesting that he suspected it could be scar tissue.

Robert J. Marks:

Now, just to clarify, first of all, you were awake during the surgery for the spinal implant.

Stretch:

Yeah. And it wasn't painful. They had the sheet up and my head was on the other side, and I don't remember being in pain. It must have been a local anesthetic type thing.

Robert J. Marks:

Now was the purpose of it or the effect of it to reduce your pain from the operations or to counteract the opioid addiction?

Stretch:

Oh no, it was the pain that was a result of the dysfunctional J-pouch.

Robert J. Marks:

I see.

Stretch:

That was a result of the surgery. That's what it was all about.

Robert J. Marks:

Wow.

Stretch:

But at the time, had that been a solution, I still would've had to withdraw from opiates because I was taking large amounts of opiates at the time. So had that worked and in retrospect, I still would've had to have dealt with the opiate dependence problem.

Robert J. Marks:

Understood. So how long have you been free of opiates?

Stretch:

Seven years.

Robert J. Marks:

Seven years.

Stretch:

I think seven years

Robert J. Marks:

Will you ever take pain medication again, opioids?

Stretch:

I have. I've had to be in the hospital for bowel obstructions and I used what they gave me in the hospital. And I came home with a very small amount and used it, didn't have a problem.

Robert J. Marks:

Really?

Stretch:

Really.

Robert J. Marks:

So what was the problem the first time, you overdid it?

Stretch:

Yeah, I think just way too much in my system, my body truly became dependent. It needed the drug to function properly. And the way they describe what the drug does to you, it changes your brain chemistry. Your brain chemistry takes a very long time to readjust.

Robert J. Marks:

That's what I talked about in the monologue, in the introduction, this idea that neurons that fire together, wire together. So it takes a long time for that path to diminish and to go away.

Stretch:

Absolutely. I had another factor that was important. I did do the Alcoholics Anonymous thing through the Suboxone program, which is required. Suboxone was the medication they used to wean me off of opiates, and that took five years I was on that stuff and gradually tapered down on that dose of that stuff.

Robert J. Marks:

Yeah.

Stretch:

So it was a very long and deliberate process to get off of it. And I basically, after twice in rehab, I was still addicted, dependent. I had got to the point while I was in rehab the second time at the Cleveland Clinic that I could go a day and not be miserable. But as soon as I went home, it was starting all over again. I think that's a testament to the people, places and things you hear of them say. You got to change your people, places and things.

Robert J. Marks:

For addictions.

Stretch:

And that's easy to do when you go to a hospital. But then they release you from the hospital and you're back to your same old people, places and things, which may be a daily routine of dealing with medical problems, which you don't get away from. The thing that saved me, I believe, was I did have that pouch removed. That was taken away and they gave me another solution, another pouch, that works a different way, that actually is now problematic, but isn't causing the pain that the other pouch caused. So I didn't feel it necessary to continue with the alcoholic Narcotic Anonymous system because my addiction was rooted in the medical aspect.

Robert J. Marks:

Yes.

Stretch:

And I didn't have the same triggers that the people that were there taking, say heroin and cocaine and other stuff. If I didn't have the medical problem, there was no pressing need for me to want to take that medication. Now, if it was laying around in front of my face, if it was down at the corner store, like alcohol, I may have not been able to have kicked it. But it was too hard to get and too risky to try to get. And I never wanted to take that step outside the relative legality of... I say relative because there was more scripts than I was supposed to have just on account of being in and out of the hospital so frequently.

Robert J. Marks:

Gotcha.

Stretch:

And they would write me scripts every time I left the hospital. So I ended up with an abundance of scripts that offered me more medication than I really should have been taking. So it wasn't done legitimately, but it wasn't done on the street, I guess, the support of my addiction.

Robert J. Marks:

Well, let me ask you one final question. What advice would you give to, I guess number one, people who are undergoing operations, who will need pain medication, such as fentanyl, the lollipop, the patches? Did you use the patches, the fentanyl patches?

Stretch:

I did patches, pills and lollipops at the same time.

Robert J. Marks:

Really? Oh gosh. What advice would you give them, or maybe some youngster who's considering going out and getting some fentanyl on the street?

Stretch:

Maybe you would be better off playing chicken with your friends in your fast cars or something than playing around with fentanyl. Maybe you'd want to like try some skydiving without a parachute or do the cliff climbing thing without any ropes and stuff. It's kind of the same thing. You're likely you're going

to die if you don't have a real good understanding of the risk that you're taking. And nobody does because nobody looks at it from the addiction point of view.

Robert J. Marks:

They're looking for that high.

Stretch:

Unless they're being advised. Yeah, right, you're taking it to alter your mind.

Robert J. Marks:

So what would you say to people that are undergoing operation, that know that they have to use this pain relieving medication after they're done? You basically didn't have a choice.

Stretch:

Well, I did, just because of the circumstances. The first surgery, the doctor says, "Don't use it if you don't have to." And then I did use it a couple nights that were bad, but it was like, I don't even like taking it. So I stopped, I had no interest in using it. I had an alternative, I had ibuprofen, which interestingly down the road, becomes a problem for people with bowel problems because you can't take lots of ibuprofen, it causes bleeding in your bowels. So as a bowel patient, you have no pain option choices other than acetaminophen which doesn't work, Tylenol, or opiates. That's your choice.

Robert J. Marks:

Yeah. Well this has been great. Thank you. We've been talking to somebody anonymous we're calling Stretch. Thank you, Stretch.

Stretch:

No problem.

Robert J. Marks:

Stretch is not his real name.

Stretch:

I hope I scared those kids enough to stay away from that stuff. It'll kill you, it really will. And you don't understand how it will kill you until it's too late, and then you will be on your way to the grave.

Robert J. Marks:

We can talk about the theory of brain chemistry and neuropsychology, but getting down to somebody who has experienced and walked through it is really eye-opening and really educational. So thank you very much. We really, really appreciate it. So that's it for this episode of Mind Matters News. Until next time, be of good cheer.

Announcer:

This has been Mind Matters News with your host, Robert J. Marks. Explore more at mindmatters.ai. That's mindmatters.ai. Mind Matters News is directed and edited by Austin Egbert. The opinions