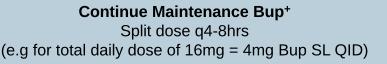


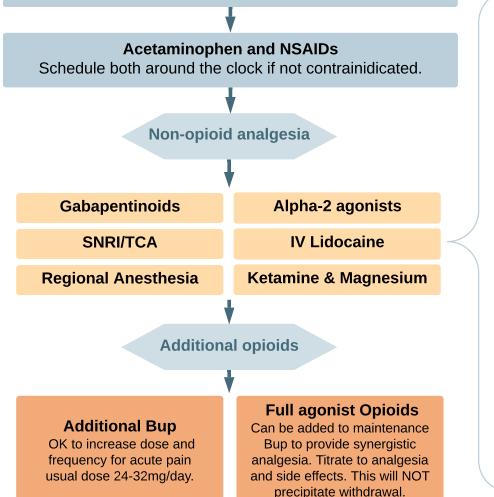
Acute Pain Management in Patients on Buprenorphine (Bup)* Treatment for Opioid Use Disorder Medical/Surgical Units

James Gasper, PharmD, Andrew Herring, MD, Kyle Harrison, MD, Sky Lee, MD, Hannah Snyder, MD



Promote calm and comfort

Anxiety, fear, depression are common: Instill sense of control, provide education on self-management techniques such as mindful meditation. Reduce noise, uncertainty, confusion. Positioning, splinting, and physical comfort should be maximized. Minimize unnecessary NPO status. Use adjunctive meds to treat symptoms (ie. diphenhydramine, ondansetron, melatonin, baclofen, etc).



*Guidelines are for patients on maintenance Bup, however if patient is on maintenance Methadone or Naltrexone:

- Methadone: Confirm maintenance dose. Continue full dose, can split dosing to aid pain control. Use multimodal analgesia. Do NOT use Bup.
- Naltrexone: If injectable, stop 1 mo prior to elective surgery and switch to PO. Stop PO 72 hours prior to elective surgery for full opioid agonists to be effective.

Gabapentinoids

Calcium channel inhibitors, gabapentin and pregabalin reduce postoperative pain and opioid consumption.

SNRI/TCA

Can help with neuropathic pain as well as anxiety/depression.

Regional Anesthesia

Peripheral nerve blocks

• Spinal or Epidural anesthesia

Alpha-2 agonists

Clonidine and Dexmedetomidine are anxiolytic and analgesic with significant opioid sparing affects.

IV Lidocaine (Na channel antagonist) Opioid sparing analgesic.

Ketamine & Magnesium (NMDA antagonists)

Ketamine is a potent non-opioid analgesic for opioid tolerant patients. Magnesium also has analgesic and opioid sparing effects.

Guidelines are options for multimodal analgesic therapy. Use clinical judgement and avoid use if contraindicated.

The CA Bridge Program disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

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PROVIDER RESOURCES

California Substance Use Line CA Only (24/7) 1-844-326-2626

UCSF Substance Use Warmline National (M-F 6am-5pm; Voicemail 24/7) 1-855-300-3595



REFERENCES

Alford D, Compton P, Samet J. Acute pain management for patients receiving maintenance methadone or buprenorphine therapy. *Ann Int Med.* 2006; 144(2):127-134.

Aurora Naa-Afoley Quaye, Yi Zhang, Perioperative Management of Buprenorphine: Solving the Conundrum, *Pain Medicine. 2019;* 20,(7):1395–1408.

Buvanendran A, Kroin JS. Multimodal analgesia for controlling acute postoperative pain. Curr Opin Anaesthesiol. 2009; 22(5):588-93.

Elvir-Lazo OL, White PF. The role of multimodal analgesia in pain management after ambulatory surgery. *Curr Opin Anaesthesiol.* 2010;23(6):697-703.

Fabrício T M, Mariana C R, Jordana A A, Luíse A C. Systemic Lidocaine for Perioperative Analgesia: A Literature Review. J Anest & Inten Care Med. 2015;1(1): 555551.

Fitzpatrick BM, Mullins ME. Intravenous lidocaine for acute pain: an evidence-based clinical update. Clin Exp Emerg Med. 2016; 3(2): 105–108.

Goel A, Azargive S, Weissman JS, et al. Perioperative pain and addiction interdisciplinary network (PAIN) clinical practice advisory for perioperative management of buprenorphine: results of a modified Delphi process. *Br J Anaesth*. 2019;123(2):e333-e342.

Hansen LE, Stone GL, Matson CA. Total joint arthroplasty in patients taking methadone or buprenorphine/naloxone preoperatively for prior heroin addiction: a prospective matched cohort study. J Arthroplasty. 2016;31(8):1698-701.

Harrison TK, Kornfeld H, Aggarwal AK, et al. Perioperative considerations for the patient with opioid use disorder on buprenorphine, methadone or naltrexone maintenance therapy. *Anesthesia Clin.* 2018;36(3):345-359

Kranke P. Jokinen J, Pace NL, et al. Continuous intravenous perioperative lidocaine infusion for postoperative pain and recovery. Cochrane Database Syst Rev. 2015;(7):CD009642.

Lawrence A Haber, MD, Triveni DeFries, MD, MPH, Marlene Martin, MD, Things We Do for No Reason[™]: Discontinuing Buprenorphine When Treating Acute Pain. *J. Hosp. Med* 2019;10;633-635. Published online first August 21, 2019.

Lembke A, Ottestad E, Schmiesing C. Patients Maintained on Buprenorphine for Opioid Use Disorder Should Continue Buprenorphine Through the Perioperative Period. *Pain Medicine*. 2019 Mar 1;20(3):425-428.

Macintyre PE, Russell RA, Usher KA, et al. Pain relief and opioid requirements in the first 24 hour after surgery in patients taking buprenorphine and methadone opioid substitution therapy. *Anaesth Intensive Care*. 2013; 41(2):222-30.

Oifa S, Sydoruk T, White I, et al. Effects of intravenous patient-controlled analgesia with buprenorphine and morphine alone and in combination during the first 12 postoperative hours: a randomized, double-blind, four-arm trial in adults undergoing abdominal surgery. *Clin Ther.* 2009;31(3):527-41.

Radvansky BM, Shah K, Parikh A, Sifonios AN, Le V, Eloy JD. Role of ketamine in acute postoperative pain management: A narrative review. *BioMed Research International*, 2015; 1-10.

Vilkins Al, Bagley SM, Hahn KA, et al. Comparison of post-cesarean section opioid analgesic requirements in women with opioid use disorder treated with methadone or buprenorphine. *J Addict Med.* 2017;11(5):397-401.

Wick EC, Grant MC, Wu CL. Postoperative multimodal analgesia pain management with nonopioid analgesics and techniques, A review. *JAMA Surg.* 2017;152(7):691-697.