Perioperative Management of Patients on Medications for Opioid Use Disorder

Introduction

Medications for opioid use disorder (MOUD) can complicate pain control during and after surgery. While there are no universally adopted protocols for managing MOUD in the perioperative period, there are nonetheless helpful guidelines to consider for your patients preparing for surgery.

General Principles

- Communicate and collaborate closely with the surgical and anesthesia teams
- Always optimize non-opioid medications for pain control
- Discuss whether regional anesthesia can be used for your patient's procedure
- Whenever possible, keep your patient in a controlled environment (ie, inpatient) for any period in which they are not on full-dose MOUD
- Patients not on MOUD may be particularly susceptible to pain and are at increased risk of returning to use in the postop period

Methadone

As a full agonist, methadone will not block the effects of other concurrently administered agonists during or after surgery and therefore does not need adjustment (Harrison TK et al, *Anesthesiology Clin* 2018;36(3):345–359).

- Continue home dose throughout the perioperative period; communicate and coordinate planning with methadone clinic
- Use short-acting opioids for additional pain control for ≤7 days after surgery
- Don't increase methadone for pain control since doses can "stack" due to methadone's long half-life
- If possible, split methadone to BID or TID for the immediate postop period
- Switch to IV if the patient can't take PO; reduce dose to one-half to two-thirds

Buprenorphine

Concerns that buprenorphine complicates pain management during the perioperative period are likely exaggerated (Kornfeld H and Manfredi L, *Am J Ther* 2010;17:523–528). Nonetheless, the tight receptor affinity and partial agonism of buprenorphine does mean it could theoretically interfere with other opioids used during and after surgery. We recommend adjusting the buprenorphine dose only in cases when severe postop pain is expected; the surgical and anesthesia teams can help you determine the level of expected pain for a given procedure if you aren't sure.

- If mild or moderate postop pain is expected, continue buprenorphine unchanged
- For major surgeries when severe postop pain is expected:
  - Give full buprenorphine dose the day before surgery
  - Give a small dose (4–8 mg) preoperatively
  - Restart full dose on the day after surgery
- Use short-acting opioids for additional pain control for ≤7 days after surgery

Naltrexone

As an opioid blocker, naltrexone can interfere with the function of opioid analgesic medications. Ideally, the medication should be stopped prior to surgery.

- Oral naltrexone should be stopped for two to three days before surgery
- Extended-release injectable naltrexone should be held for 30 days before surgery
- Patients on naltrexone do not have opioid tolerance, so they may be very sensitive to opioids
- Naltrexone can be restarted once patients are off opioid analgesics for seven to 10 days

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