



Compass SHARP in Practice

Podcast Series



Perioperative Pain Management for Patients on MOUD: Part 1

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Q&A Highlights

Q: Should methadone be continued around surgery?

A: Methadone should generally be continued through the perioperative period, including the day of surgery, to maintain baseline opioid coverage. This helps prevent withdrawal, uncontrolled pain, or return to illicit substance use.

Q: How does methadone affect perioperative pain management?

A: Patients on methadone often require higher perioperative opioid doses due to cross-tolerance, with more frequent dosing to manage pain effectively. Methadone's analgesic effect is shorter than its maintenance effect for withdrawal or craving, so dividing doses (e.g., from once daily to every 6–8 hours) around surgery can improve pain control. Close monitoring is essential for respiratory depression and heightened pain sensitivity from chronic opioid use.

Q: What if patients are NPO after surgery?

A: For NPO patients, IV methadone is an option. Dose conversion isn't one-to-one; starting at about 50% of the oral dose with careful monitoring is recommended, with repeated dosing every 6–8 hours. Close monitoring for respiratory depression and QT interval prolongation is important throughout the perioperative period.

Q: What other strategies support perioperative pain management?

A: Multimodal analgesia is key. Use acetaminophen, NSAIDs, or COX-2 inhibitors when appropriate, and consider regional or neuraxial anesthesia. Coordinate closely with the anesthesia team to implement these techniques. Patients will likely need additional opioid therapy beyond their baseline methadone—via IV PCA or scheduled oral opioids—to achieve effective pain control.

Q: How can transitions from inpatient to outpatient care be optimized?

A: Ensure continuity of care by coordinating closely with the outpatient team and, when possible, the patient's methadone clinic. Confirm current dosing, arrange timely follow-up—ideally the next day—and communicate clearly to prevent gaps that could lead to withdrawal or under-treatment.

Q: How common is QTc prolongation and what should we monitor?

A: About 34% of patients may have QTc prolongation. However, progression to torsades de pointes, a dangerous arrhythmia, is rare (~2%). Higher doses and other risk factors increase the risk.

Q: How can torsades be prevented in methadone patients?

A: Monitor QTc with baseline and periodic EKGs, especially at higher doses (>100 mg/day) or with added risk factors. Correct electrolyte abnormalities and review interacting medications. Consider postponing elective surgery if QTc >500 ms. Low starting doses (5–10 mg/day) generally remain safe.

Quick Takeaways

- Continue methadone perioperatively to avoid withdrawal or uncontrolled pain.
- Patients often require higher and more frequent opioid dosing due to tolerance.
- Consider splitting doses or using IV methadone if oral administration isn't possible.
- Multimodal analgesia improves pain control and safety.
- Coordinate closely with outpatient providers to maintain continuity.
- Monitor QTc and other risk factors for cardiac complications.

This episode covers perioperative management of patients on methadone, emphasizing continuation of therapy, dose adjustments, multimodal analgesia, IV options for NPO patients, coordination with outpatient care, and monitoring for QTc prolongation and cardiac risk.

Resources

Provider Resources:

- [Perioperative Management of Patients on Opioids](#)
- [Opioid Medication Dictionary](#)
- [Non Opioid Medication Dictionary](#)
- [Medication Quick Guide](#)
- [Multimodal Analgesia for Surgical Practice](#)
- [Guidelines on Limiting Opioid Use in the Perioperative Setting](#)