# Compass SHARP in Practice Podcast Series

Compass SHARP

COMPASS HEALTHCARE COLLABORATIVE
Sustainable Healthcare Transformation

## Perioperative Pain Management for Patients on MOUD: Part 2

Hosted By: Rachael Duncan, PharmD, BCPS, BCCP, with guest Dr. Jennifer Hah, MD (anesthesiologist, pain, and addiction medicine specialist)

## Q&A Highlights

**Q: Is buprenorphine a viable alternative for patients who must stop methadone due to QTc prolongation?**
**A:** Buprenorphine is a safe alternative to methadone for patients with QTc prolongation, lowering cardiac risk, easing withdrawal, and improving outpatient management while reducing relapse and overdose risk.

**Q: How do you transition patients from methadone to buprenorphine?**
**A:** Gradually taper methadone to around 30 mg/day to reduce withdrawal risk and make buprenorphine induction safer. Monitor daily for withdrawal symptoms and adjust as needed. If time is limited, microdosing or a buprenorphine bridge can allow a quicker transition, but individualized management and symptom rescue are essential.

**Q: How can we avoid precipitated withdrawal with buprenorphine?**
**A:** The main goal in switching from methadone to buprenorphine is avoiding precipitated withdrawal. Ideally, transitions occur well before surgery, with microinduction for sensitive patients, and close coordination with surgical and addiction teams.

**Q: How is perioperative buprenorphine managed?**
**A:** Perioperative buprenorphine management depends on dose and formulation. Low doses (≤8 mg/day), can use as-needed opioids; higher doses may need more opioids or extra buprenorphine. Extended-release or high doses may delay elective surgery. Careful planning and coordination are essential, especially in special populations like pregnant patients.

**Q: If you have time before elective surgery, should buprenorphine dosing be adjusted for perioperative pain management?**
**A:** Ideally, high-dose buprenorphine (>16 mg/day) can be gradually reduced to 16 mg/day or less to improve pain control with added opioid agonists. Emphasize multimodal analgesia, consider regional or neuraxial anesthesia, and plan for alternatives like IV lidocaine or ketamine if needed. Patient education and shared decision-making are key.

**Q: What are key strategies on the day of surgery?**
**A:** If no prior taper, high-dose buprenorphine (>16 mg/day) can be reduced to ~8 mg on the day of surgery, with acute pain managed using additional opioid agonists. For lower doses (≤16 mg/day), continue current dosing or split doses throughout the day. For NPO patients, IV buprenorphine is an option—about 3–4× more potent than sublingual, so use a conservative dose.

**Q: How should discharge and return to home buprenorphine dosing be handled?**
**A:** Coordinate with their prescriber, taper any extra opioids, and ideally return to their home buprenorphine dose, using multimodal analgesia to manage pain.

## Quick Takeaways

- Buprenorphine is a safe and effective alternative for patients with methadone-related QTc concerns.
- Methadone tapering and careful induction prevent precipitated withdrawal.
- Multimodal analgesia and opioid agonist supplementation help manage perioperative pain.
- Extended-release and high-dose buprenorphine may require dose adjustments or surgical timing considerations.
- Discharge planning and communication with outpatient providers are essential for smooth transitions.
- Obstetric patients require special consideration; do not stop buprenorphine.

This episode covers perioperative buprenorphine management, including transitioning from methadone, preventing precipitated withdrawal, dosing adjustments for surgery, multimodal pain strategies, and discharge planning to maintain continuity of care.

## 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