Module 2: Chronic Opioid Therapy – Perioperative Planning

Welcome to Compass SHARP in Practice, a quick high-yield learning session made for busy healthcare professionals like you. In each episode, our Compass coaches will explore a real-world case, define a clinical goal, and walk through practical strategies to improve care. Whether you're tuning in via video, audio, or reading the summary, we hope to sharpen your skills and build knowledge that helps you better care for your patients.

A Patient Case

Jim is a 62-year-old man with a history of chronic low back pain. He takes a total of 120 morphine milligram equivalents (MME) of MS-Contin daily. He is scheduled for a total knee replacement. His surgeon assumes that because he is already taking opioids, a few extra tablets at discharge will not cause harm. After surgery, Jim asks for guidance on managing his medications. The surgeon recommends stopping his usual medications and instead taking the new prescription: 60 tablets of 10-milligram oxycodone, one to two tablets four times a day, with no coordination between the surgical team and his chronic pain provider.

Within days, Jim experiences uncontrolled pain and severe anxiety, ultimately requiring readmission for poor pain control and opioid withdrawal.

Scenarios like this remain far too common—not because care teams do not care, but because perioperative planning for patients on chronic opioid therapy is complex. Evidence shows that patients on long-term opioids often have higher pain scores, greater tolerance, and more complications. Many surgeons also feel uncomfortable matching a patient's baseline opioid requirements while adding additional opioids to ensure adequate pain control.

In a patient like Jim, pain management may require significantly more than 120 MME to maintain comfort. Ideally, patients on chronic opioids deserve a well-formulated multimodal pain strategy with proactive planning. This includes scheduled non-opioid medications, regional or local anesthesia where appropriate, and clear communication with existing prescribers. When done correctly, patients on chronic opioid therapy can recover safely, achieve good pain relief, and avoid both overexposure and withdrawal.

Goal

Our goal in this module is to apply opioid stewardship principles that ensure safe, coordinated care for patients on chronic opioid therapy before, during, and after surgery.

Goal (cont.)

First, build a multimodal plan that addresses tolerance and maximizes non-opioid therapies. Consult anesthesiology and optimize the use of regional analgesia or nerve blocks to reduce post-operative opioid requirements. Consider continuous blocks to bridge patients through the peak of post-operative pain. Scheduled acetaminophen and NSAIDs can provide effective multimodal pain control. The patient's baseline opioid regimen should be continued to prevent withdrawal, with short-acting opioids added for surgical pain as needed.

Second, educate and align the care team. Nursing staff play a critical role in assessing for sedation or withdrawal and reinforcing that the goal of therapy is tolerability and function, not complete elimination of pain. Proactively explaining that some pain is normal—and even useful—after surgery can help reduce anxiety and set appropriate expectations.

Third, ensure safe transitions and follow-up. Documentation should summarize perioperative opioid use, and naloxone should be co-prescribed for patients at risk of polypharmacy or overdose. Follow-up with chronic pain providers should be scheduled before discharge and occur within a week of surgery, rather than waiting for complications to arise.

Back to the Case

Let's revisit our knee replacement patient, Jim, to see what happens when we apply these strategies

This time, the care team plans ahead. His baseline MS-Contin is continued, and multimodal therapy along with a regional block are added. Nursing staff monitor for sedation and withdrawal, and the discharge summary includes close follow-up with his primary care provider and a new prescription for naloxone. His pain remains controlled, recovery proceeds smoothly, and no readmission is needed. A simple shift from reactive to proactive planning transforms the entire outcome.

Takeaways

- Develop a process to identify patients on chronic opioid therapy before surgery.
- Build standing order templates that include multimodal therapy and naloxone prompts.
- Encourage proactive communication among anesthesiologists, surgeons, and outpatient providers.

Thank You

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Thank you for all you do caring for your patients.