

Guidelines for the Perioperative Management of Buprenorphine

Surgical team/ PreOP Clinic identifies patient on buprenorphine :
(Butrans[®], Suboxone[®], Subutex[®], Zubsolv[®], Belbuca[®], Temgesic[®], Sublocade[®], Buprenex[®])

MINIMALLY PAINFUL SURGERY

NO or minimal need for postop opioid therapy expected

(such as endoscopy, cataracts, etc)

Continue home dose through procedure day and after discharge.

Avoid discontinuation or holding of buprenorphine doses.

PAINFUL SURGERY

Expected need for postoperative opioid therapy.

Patients on **HIGH** doses of buprenorphine/naloxone or buprenorphine monoproduct:

> 16 mg/day Suboxone, Subutex,
> 11.4 mg/day Zubsolv

Patients on **LOW** doses of buprenorphine:

Transdermal Buprenorphine (Butrans Patch) or Buccal Film (Belbuca), ANY DOSE
≤ 16 mg/day Suboxone, Subutex,
≤ 11.4 mg/day Zubsolv,

No preoperative dose adjustment

1. Continue home dose through procedure day and after discharge
2. Consult acute pain service, if available, if inpatient surgery (stay > 23 hours)

Operation **EMERGENT**

Operation **ELECTIVE**

Pre-operative dose adjustment not possible:

1. Two BUP management options (see text):
 - a. Continue BUP method (preferred), or
 - b. Discontinue BUP method
2. Anticipate need for high doses of opioids
3. Consult acute pain service
4. Consider postoperative ICU stay after surgery

SURGICAL TEAM

Contact buprenorphine prescriber to discuss dose continuation or gradual dose reduction in anticipation of elective surgery

Schedule PreOP Clinic appointment within 2-4 weeks, not later than one week before surgery

PreOp Clinic

Contact buprenorphine prescriber:

1. Discuss continuation of current dose of buprenorphine, dividing the dose for better pain coverage, or dose reduction to <16 mg/day Suboxone/Subutex, < 11.4mg/day Zubsolv, by time of surgery
2. Update and record prescriber name and contact information in PreOP

Submit consult for Pain Service (if available) IF expected inpatient

stay

DAY OF SURGERY

Perioperative plan per OR Anesthesia team / Acute Pain Team (if available)

- Use non-opioid analgesics (gabapentin, pregabalin, acetaminophen, NSAIDs) pre-operatively if not contraindicated
- Use continuous regional anesthesia techniques if possible (epidural and peripheral nerve catheters)
- Use IV ketamine, lidocaine intra-operatively if not contraindicated

AFTER SURGERY

The Pain Service will be following patients postoperatively if needed.
Pain management plan per Pain Service recommendations.

- Maintenance or placement of axial or peripheral nerve catheters, or short-term nerve blocks as necessary
- Focus on non-opioid medication (gabapentinoids, acetaminophen, NSAIDs, antidepressants, α₂ agonists etc.)
- Use full agonist opioid with high binding affinity (hydromorphone, fentanyl, or sufentanil) orally, IV, or by PCA
- Avoid use of long-acting opioids!
- Continuation of buprenorphine, at home dose, lower dose, or higher dose
- Consider Ketamine infusion protocol (1-5mcg/kg/min infusion) (if applicable)
- Use Non-medication/non-procedural adjuncts (acupuncture, pet therapy, PT and mechanical supports as appropriate)

Buprenorphine Re-Induction Planning should not be necessary if patients continued to take buprenorphine during their hospital stay or were on the buprenorphine formulations for pain management (transdermal patch or buccal film). If buprenorphine was discontinued, the pain service attending decides, in collaboration with the buprenorphine prescriber or X-waivered provider which re-induction strategy is appropriate.