



Perioperative Continuation of Chronic Opioids and Buprenorphine

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1

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2



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3

Objectives



- Explain the rationale for continuing or adjusting chronic opioid and buprenorphine therapy in patients undergoing surgical procedures, considering the risks of opioid withdrawal, inadequate analgesia, and potential drug interactions.
- Describe evidence-based protocols and strategies for managing patients on chronic opioid or buprenorphine therapy in the perioperative period, including pre-operative assessment, intraoperative adjustments, and post-operative pain management plans.
- Discuss the importance of interprofessional collaboration and communication in caring for patients on chronic opioid or buprenorphine therapy undergoing surgery, including coordination between anesthesia providers, surgeons, pain specialists, and addiction specialists.

4

Prevalence of Chronic Pain



- Nearly 25% of adults 18 years old and older in the United States experience chronic pain
- 25% of surgical patients are on chronic opioid therapy prior to surgery
- Including patients taking opioids prior to surgery, postoperative chronic opioid use ranges from 9.2%-13%



Lucas, J. W., & Sohi, I. (2024). *Chronic Pain and High-impact Chronic Pain Among U.S. Adults*, 2023. <https://doi.org/10.15620/cdc/169630>

Hah, J. M., Bateman, B. T., Ratliff, J., Curtin, C., & Sun, E. (2017). Chronic opioid use after surgery: Implications for perioperative management in the face of the opioid epidemic. *Anesthesia & Analgesia*, 125(5), 1733–1740. <https://doi.org/10.1213/ane.0000000000002458>

Sun EC, Darnall BD, Baker LC, Mackey S. Incidence of and Risk Factors for Chronic Opioid Use Among Opioid-Naïve Patients in the Postoperative Period. *JAMA Intern Med*. 2016;176(9):1286–1293. doi:10.1001/jamainternmed.2016.3298

5

Prevalence of Opioid Use Disorder



- Over 3 million people in the US are affected by Opioid Use Disorder (OUD)
- About 1.6% of the surgical population meet criteria for OUD
 - Of these, 27% are receiving MOUD treatment such as methadone or buprenorphine prior to surgery



Dydyk, A. M., Jain, N. K., & Gupta, M. (2024, January 17). *Opioid Use Disorder: Evaluation and management*. StatPearls – NCBI Bookshelf. <https://www.ncbi.nlm.nih.gov/books/NBK553166/#:~:text=%5B1%5D%20OUD%20affects%20over%201.6,epilepsy%20in%20the%20United%20States.re>

Li, Alicia & Huang, Yongmei & Martins, Silvia & Suzuki, Yukio & Ferris, Jennifer & xu, Xiao & Hershman, Dawn & Wright, Jason. (2025). Use and Outcomes of Medication for Opioid Use Disorder Among Patients With Opioid Use Disorder Undergoing Surgery. *Annals of Surgery Open*. 6. e598. 10.1097/AS9.0000000000000598.

6

Preop Opioid Use & Surgical Outcomes



- Patients on chronic opioid therapy prior to surgery have worse surgical outcomes including:
 - Increase in pain levels
 - Longer hospital admissions
 - Higher readmission rates
 - Increased risk of surgical complications such as infection, dislocation, and the need for subsequent surgeries
 - Increased post-operative ED visits



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7

Pre-operative Screening



Thorough patient history, including for substance use.

- Screening tools
 - Alcohol Use Disorders Identification Test (AUDIT)-C, AUDIT-C+2
 - Drug Abuse Screening Test (DAST)-10
 - ORT (opioid risk tool)
 - Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)



8

Pre-operative Considerations



- Assessing risk of withdrawal
- Anesthesia considerations
- Drug interactions – call your pharmacist
- Pain management plan – inadequate analgesia
- Coordination with pain and addiction specialists if needed



9

Pre-operative Planning



Talking to patients

COMPASS SHARP

WHAT WE DO INITIATIVES EDUCATION WHY COMPASS ICDRAIS CONTACT

100% recovery and short-term side effects are normal with surgery. There are things you can learn and do before and after surgery to set your journey. Explore the resources provided here.

PATIENT RESOURCES

- 1. Understanding Pain
- 2. Getting Ready For Surgery
- 3. Managing Pain After Surgery
- 4. Managing Pain After Surgery With Opioids
- 5. Treating Opioid Withdrawal

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10

Pre-operative Planning: Should we taper chronic opioid therapy?



Chronic opioid therapy for pain and surgery

- Continuation of opioid agent vs adjustment
 - Tapering opioids before surgery?
 - Patient-facing [handout here](#)
- Guidelines: CDC 2022 (recommend dose reduction when risks > benefits; avoid abrupt tapers), HHS 2019 taper guide (how to taper safely).
- Dose-response risk: Harms rise with higher daily MME; benefits plateau—supports aiming for the lowest effective dose.
- Interventional evidence: Motivational-interviewing-guided taper RCT (post-surgical) improved taper success; post-op taper associated with better PROs; individualized taper protocols reduce MMEs in arthroplasty.
- Preop course matters: Decreasing preop use linked with better long-term utilization and outcomes.
- Perioperative consensus & reviews: Recommend preop weaning to improve outcomes when feasible.

CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. Tapering when risks > benefits; avoid rapid tapers. HS Guide for Clinicians on Appropriate Dosage Reduction or Discontinuation of Long-Term Opioids (2019). Practical taper principles. Sullivan MD, et al. Motivational-interviewing + guided taper after surgery [EClinicalMedicine, 2020]. Goessling J, et al. Post-op tapering and PROs (Reg Anesth Pain Med, 2024). Individualized taper protocol in arthroplasty—lower discharge MME (J Arthroplasty, 2024). Ngai DS, et al. Preop utilization patterns and long-term postop outcomes (claims analysis). Editorials/reviews advocating preop weaning: BJA 2021; Perioperative Medicine 2017.



Tapering Opioids Before Surgery

Do you live with chronic pain?
Are you using opioid pain medications?
Do you plan to have surgery?



If you answered "yes" to these questions, experts recommend reducing or stopping your use of opioid pain medicine before surgery.

While it may be challenging, tapering your use of opioid medications before surgery can help:

- Improve your recovery time
- Reduce the number of short-term opioids you need after surgery
- Lower your risk of post-surgical complications
- Decrease your chances of needing hospitalization after surgery
- Lower medical costs
- Reduce the likelihood of developing or worsening chronic pain after surgery

Taper safely

Talk to your healthcare provider about your opioid use. They can help you taper your dosage slowly and safely over time and explore alternative strategies.

These illustrations focus on self-management that you do, supported by medical treatment.

11

MOUD



- Unique pharmacology on mu receptor
- Agonist vs partial vs antagonist
- Affinity



12

Pre-operative Planning: Should we stop or adjust their MOUD?



Medication for Opioid Use Disorder (MOUD)

- Literature supports continuation of MOUD in most cases
- Standardized hospital policy with decision support workflow, based on consideration of:
 - Type of surgery – anticipated pain and healing trajectory
 - Patient-specific factors – any contraindications to standard anesthesia, analgesia strategies
 - Current opioid regimen – agent, dose
- Balance with shared decision making with patient, prescriber of opioids

13

Perioperative Management of Patients on Opioids (Including MOUD)



Compass SHARP [Example Policy](#)

Patient populations:

- Patient with chronic pain on current home opioid dose high enough to make them opioid tolerant (MME>60)
- Patients with a history of opioid use disorder (OUD) currently being treated with methadone or buprenorphine
- Patients currently taking naltrexone for treatment of alcohol or OUD



Perioperative Management of Patients on Opioids (including MOUD)

Optimal pain management for surgical patients involving opioid therapy, including medications for opioid use disorder (MOUD), requires a multidisciplinary approach. Surgeons, anesthesiologists, pain specialists, addiction specialists, pharmacists, and primary care physicians must collaborate closely to ensure safe and effective care. This guideline provides evidence-based recommendations for perioperative opioid management. Institutions should integrate these recommendations with their established pre-operative screening, pain management, and addition consultation processes.

Categories of Patients Receiving Preoperative Opioid Medications

- Patients with complex chronic pain history, who are currently taking high enough doses of opioid pain medications daily to be considered opioid tolerant (≥ 80 MME daily)
- Patients with a history of opioid use disorder (OUD) are currently being treated with methadone or buprenorphine.
- Patients currently taking naltrexone for treatment of alcohol or OUD, or for weight loss.

Recommendations for the Perioperative Management of These Opioid Medications

For the patients listed above, providers should follow the recommendations below for perioperative management of home pain medications, and adjust opioids on the days that need to be taken, where appropriate.

14

Perioperative Management of Patients on Opioids Continued



Table 4. Recommendations of home medications for unanticipated acute pain and NPO

Medication	Recommendation
Morphine (intravenous or oral with a morphine or fentanyl)	- Convert oral daily morphine doses to IV (2:1 ratio) and divide into two to four equal doses a day. - It is important to note that the patient's regular dose of medication is not expected to treat any acute pain.
Hydrocodone	- Based on the timing of their last hydrocodone dose, patients may remain refractory to acetaminophen doses or more sensitive to opioids (greater than 24-72 hours last dose). - Contact anesthesia to inform that the patient is on hydrocodone PO or IV. - Optimize the use of nonopioid analgesics, such as acetaminophen, ketamine, regional anesthetic techniques, when indicated, and NSAIDs, unless contraindicated. - Do not restart hydrocodone sooner than 24 hours after the last oral dose. Reassess 24 hours to 7 days based on the patient's sensitivity, and post-operative wound characteristics. If long-acting opioid agents are used, consider waiting 3-7 days, consider the involvement of anesthesia or pain management specialists, if available, to guide the timing of hydrocodone reinitiation.
Buprenorphine	- Continue sublingual buprenorphine if the patient is able to take sublingual medications. - If daily buprenorphine dose 3.6 mg, use standard dose as needed (PRN) opioid for acute pain. Higher doses are sometimes, but not usually, needed. - If daily buprenorphine dose > 3.6 mg, will likely need higher dose as needed (PRN) opioid for acute pain. - May also consider additional buprenorphine 3.6 mg 16, TID for acute pain control.
Opioid therapy for chronic pain	Convert home dose of opioid (if known) by contacting prescriber or checking the PDMP) to a scheduled dose of IV opioid to assist withdrawal symptoms and ensure as needed (PRN) IV opioid is available for acute pain.

Additional Recommendations

- Initiation of initiation of buprenorphine while patients are on opioid agonists. Consider retro-cessing initiation of buprenorphine.
- All patients with a history of OUD should be discharged with a prescription for extended-release buprenorphine.

Compass SHARP Example Policy Recommendations:

- Perioperative management of home medications
 - Stop, adjust, continue
- Management of unanticipated acute pain and nothing by mouth (NPO) diet

15

Perioperative Management of Patients on Opioids Continued



Table 5. Perioperative Management of Home Buprenorphine Algorithm

For all patients, continue sublingual buprenorphine (Buprenex) or buprenorphine/naloxone (Suboxone, Zubsolv) throughout the perioperative period, by following these steps:

- Step 1: Determine the total 24-hour home dose of buprenorphine (regardless of any naloxone component):**
- If the home dose is 3.6 mg per day: Continue the home dose throughout the perioperative period. Do not discontinue prior to surgery, and at this step of algorithm.
 - If the home dose is > 3.6 mg per day, proceed to step 2 (includes additional patients).
- Step 2: Determine anticipated opioid requirements post-operative pain after surgery:**

Buprenorphine post-operative opioid requirements	Transition		
	Before surgery	On the day of surgery and throughout hospital stay	Preparing for discharge
Maintain or High-Dose Requirements	If home dose is 3.6 mg: - Continue buprenorphine dose based on that per the day before surgery. (Note: buprenorphine dose is 3.6 mg 16, BID or 7.2 mg 16, BID, PO, QD, or QID, as appropriate.) - Do not discontinue buprenorphine prior to surgery. - Continue buprenorphine dose through the perioperative period.	If home dose is 3.6 mg: - Continue buprenorphine dose based on that per the day before surgery. (Note: buprenorphine dose is 3.6 mg 16, BID or 7.2 mg 16, BID, PO, QD, or QID, as appropriate.) - Do not discontinue buprenorphine prior to surgery. - Continue buprenorphine dose through the perioperative period.	If home dose is 3.6 mg: - Continue buprenorphine dose based on that per the day before surgery. (Note: buprenorphine dose is 3.6 mg 16, BID or 7.2 mg 16, BID, PO, QD, or QID, as appropriate.) - Do not discontinue buprenorphine prior to surgery. - Continue buprenorphine dose through the perioperative period.
	If home dose is > 3.6 mg: Consider continuing home dose if patient continues regular activities. Continue on as needed or based on patient and provider preference.	If home dose is > 3.6 mg: - Continue buprenorphine dose based on that per the day before surgery. (Note: buprenorphine dose is 3.6 mg 16, BID or 7.2 mg 16, BID, PO, QD, or QID, as appropriate.) - Do not discontinue buprenorphine prior to surgery. - Continue buprenorphine dose through the perioperative period.	If home dose is > 3.6 mg: - Continue buprenorphine dose based on that per the day before surgery. (Note: buprenorphine dose is 3.6 mg 16, BID or 7.2 mg 16, BID, PO, QD, or QID, as appropriate.) - Do not discontinue buprenorphine prior to surgery. - Continue buprenorphine dose through the perioperative period.
Low-Dose Requirements	Continue home regimen. Do not discontinue prior to surgery or discharge home dose throughout the perioperative period.		

Home Buprenorphine Algorithm

Step 1: Identify strategies for managing unanticipated acute pain and NPO status:

- When moderate to severe post-operative pain is expected, optimize multimodal approach, regional blocks, or neuraxial anesthesia if indicated, along with a high efficacy IV opioid. Higher doses may be necessary to compete with buprenorphine for the modulation of neuropathic.
- Close post-operative monitoring will be required as daily doses of opioids must be reassessed frequently.
- The half-life of buprenorphine varies depending on the dose and route it was last given. As levels decrease, a lower dose of opioid may be required.
- Continuing sublingual buprenorphine may be appropriate for some patients who are NPO, if they can hold the

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- Sublingual buprenorphine under their tongue without swallowing, the dose will be absorbed.
- Different dosage forms of buprenorphine or buprenorphine/naloxone are NOT bioequivalent (see tables 1, 2)

Additional considerations:

- The plan for dose reduction should be a shared decision made between the patient, anesthesiologist, and primary buprenorphine prescriber.
- A patient-specific plan that is different from the above recommendations may be considered per patient and buprenorphine prescriber preference.
 - Patient is encouraged to have a consultation and discussion with a pain management provider.
 - This may include the continuation of buprenorphine at the existing dose throughout the perioperative period.
- For chronic patients, do NOT interrupt buprenorphine dosing in the perioperative period, regardless of dose.
- Low opioid requirements refer to low-dose post-operative pain or procedures where historically less than two-day courses of low-dose oxycodone or hydrocodone are prescribed.
- Prior to leaving the buprenorphine dose down, sublingual buprenorphine services should be normalized, if available, and team discussion should occur with all members of the care team. Upon discharge, care team will conduct patient's buprenorphine prescriber and provide a handoff of management course and post-discharge plan.

16

Intraoperative Considerations



- Tolerance to anesthetics and opioids
- Drug interactions (e.g., methadone, buprenorphine, naltrexone)
- Altered physiologic responses
- Anesthesia team coordination
- Multimodal analgesia
 - Compass SHARP [Guideline](#)
 - Compass SHARP Non-Opioid Medication [Dictionary](#)



17

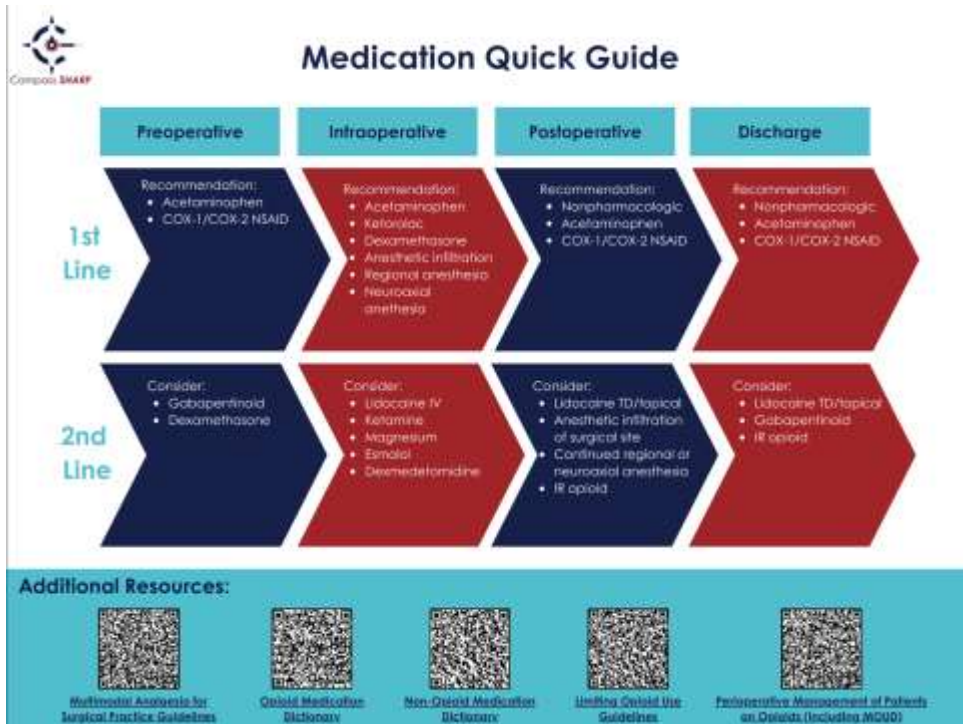
Post-operative Considerations



- Pain control: multimodal analgesia, continuation of anesthetic blocks
- Monitoring for withdrawal symptoms
- Avoiding opioid overuse and relapse
- Having a plan for unanticipated acute pain – refer to algorithm in policy
- Have an exit strategy for a safe discharge plan
- Involvement of pain and addiction specialists



18



19

Managing Withdrawal Symptoms



- Common symptoms: discomfort, nausea, diarrhea, pain, dilated pupils
- Use of medications: opioids, clonidine, antiemetics, antidiarrheals, methadone, buprenorphine
- Importance of scheduled assessments, initiation of standard protocols



20

Pain Management Strategies



- Balanced analgesia: Nonsteroidal anti-inflammatory (NSAIDs), acetaminophen (APAP), regional anesthesia
- Nonpharmacologic methods
- Communication about expectations, healing trajectory, and care plans

PATIENT RESOURCES

1. Making Sense of Pain
2. Managing Pain After Surgery
3. Preparing For Surgery

PROCEDURE SPECIFIC POST-OP INSTRUCTION RESOURCES

Laparoscopic Cholecystectomy Joint Replacement Surgery Orthopedic and Sports Medicine
 Sinus Surgery Hernia Repair General Abdominal Surgery

PATIENT RESOURCE VIDEO SERIES



21

Interdisciplinary Team Approach



- Role of nurses, anesthesiologists, surgeons, pharmacists, social workers
- Discharge planning and linkage back to pain and addiction services



22

Discharge Considerations



- Continue multimodal analgesia
 - APAP + NSAID
 - Lidocaine topical/patches
- Tailor discharge opioid prescription (RX) to patient-specific needs
 - Balance risk/benefit
 - Shared decision making
 - Safe storage and disposal
 - Prescribe/dispense naloxone
- Follow up appointments with pain and addiction specialists



23

Policy, Protocol, Process



- Adopt example policy
- Develop multimodal pathways and protocol
- Implement automatic consult/referral
- Require pre-surgical planning meetings
- Build out order sets to support clinical care
- Communicate clear discharge planning that includes conversation with outpatient prescribers

24

Case Study 1



52-year-old female on long-term Suboxone for OUD presents for pre-op appointment

- Elective right total knee replacement (TKR) next week

Worried about pain control:

- Do I keep taking my Suboxone?
- I don't want any opioids - I'm scared I'll relapse.
- Will you be able to control my pain without opioids?

What are your next steps?



25

Case Study 1 Continued



Does your hospital have a guideline or clinical pathway?

Phone a friend

- Consult pain/addiction medicine
- Consult clinical pharmacist
- Consult behavioral specialist

Clarify her Suboxone dose

- Suboxone 8mg-2mg sublingual (SL) twice a day (BID)

Talk to the patient about options

Table 6. Perioperative Management of Home Buprenorphine Algorithm

For all patients, continue sublingual buprenorphine (Suboxone) or buprenorphine/naloxone (Suboxone, Zubsolv) throughout the perioperative period, by following these steps:

- Step 1: Determine the total 24-hour home dose of buprenorphine (regardless of any naloxone component)
- If the home dose is ≤ 8 mg per day, continue the home dose throughout the perioperative period. Do not discontinue prior to surgery, and at the day of surgery.
 - If the home dose is > 8 mg per day, proceed to step 2 (see table below for details).

Step 2: Determine sublingual opioid replacement prior to surgery:

Buprenorphine dose (mg)	Transition	
	Before surgery	On the day of surgery and throughout recovery stay
8 mg or less	Continue taking 8 mg or less of buprenorphine (Suboxone) or buprenorphine/naloxone (Suboxone, Zubsolv) throughout the perioperative period.	Continue taking 8 mg or less of buprenorphine (Suboxone) or buprenorphine/naloxone (Suboxone, Zubsolv) throughout the perioperative period.
More than 8 mg	On the day of surgery, replace the home dose of buprenorphine with an equivalent dose of a short-acting opioid (e.g., morphine, hydromorphone, fentanyl, etc.). On the day of surgery, replace the home dose of buprenorphine with an equivalent dose of a short-acting opioid (e.g., morphine, hydromorphone, fentanyl, etc.). On the day of surgery, replace the home dose of buprenorphine with an equivalent dose of a short-acting opioid (e.g., morphine, hydromorphone, fentanyl, etc.).	On the day of surgery, replace the home dose of buprenorphine with an equivalent dose of a short-acting opioid (e.g., morphine, hydromorphone, fentanyl, etc.). On the day of surgery, replace the home dose of buprenorphine with an equivalent dose of a short-acting opioid (e.g., morphine, hydromorphone, fentanyl, etc.). On the day of surgery, replace the home dose of buprenorphine with an equivalent dose of a short-acting opioid (e.g., morphine, hydromorphone, fentanyl, etc.).

26

Case Study 1 Continued



Continue her Suboxone 8mg-2mg SL BID

- Split dosing to 0.5 film (4mg-1mg) SL four times a day (QID)

Use femoral and adductor canal blocks

- Explain how these work to block pain
- Consider use of a longer acting local anesthetic

Use non-opioid agents

- APAP + NSAID
- Intravenous (IV) ketamine, lidocaine patches

What is the plan if she has unanticipated acute pain?

- Increase Suboxone dose (give additional 2mg SL doses as needed (prn))
- Use high-affinity opioid. Close monitoring.
- Goal to not be discharged with opioid rx.

Discuss healing timeline expectations afterward and physical therapy/occupational therapy (PT/OT)

27

Case Study 2



61-year-old male admitted through the Emergency Department (ED) for laparoscopic cholecystectomy.

Patient is on naltrexone for treatment of alcohol use disorder.

What are next steps?

- AUDIT-C
- Notify anesthesia team
- Stop additional naltrexone doses
- Optimize anesthetic blocks, nonopioid agents

Medication	Recommendation
Naltrexone	• Coordinate management with naltrexone prescriber before and after surgery. • Ensure a plan is in place for additional support prior to surgery to prevent a recurrence of the condition naltrexone is being used to treat. For patients with a history of opioid use disorder, discuss with an addiction treatment provider (if applicable) or addiction specialist (if available) in advance of planned surgery. • Oral naltrexone: hold 72 hours prior to surgery. • Extended-release injectable naltrexone: for elective surgery, allow 21 days between the last injection and surgery date (may need oral "bridge" pending surgical date).
Naltrexone	• Based on the timing of their last naltrexone dose, patients may remain refractory to opioids (recent dose) or more sensitive to opioids (greater than 24-72h since last dose). • Contact anesthesia to inform that the patient is on naltrexone PO or IR. • Optimize the use of nonopioid analgesics, such as acetaminophen, ketamine, regional anesthetic techniques, when indicated, and NSAIDs, unless contraindicated. • Do not restart naltrexone sooner than 24 hours after the last opioid dose. Recommend 24 hours to 7 days based on the patient, comorbidities, and post-surgical opioid doses/ranges. If long-acting opioid agents are used, consider waiting 3-7 days; consider the involvement of addiction or pain management specialists, if available, to guide the timing of naltrexone re-initiation.

28

Case Study 2 Continued



- Maximize non opioid pain management strategies
- Monitor closely for when to restart naltrexone
- Weigh risk/benefit of a discharge opioid Rx → naloxone!
- Rely on APAP + NSAID + lidocaine patch on discharge



29

Summary & Key Takeaways



- Effective perioperative management in a patient with chronic pain or OUD requires preparation, compassion, and coordination
- Understand withdrawal, pain, and drug interactions
- Interprofessional collaboration and communication.



30

Resources and References



- Multi Organizational consensus to define guiding principles for perioperative pain management in patients with chronic pain, preoperative opioid tolerance, or substance use disorder [here](#)
- Support for Hospital Opioid Use Treatment (SHOUT) guidelines (OUD specific) [here](#)
- Institutional protocols, policies, and order sets
- Compass SHARP Provider Resource [page here](#)



31

Questions & Discussion



- Have you had a recent patient case you'd like to share?
- What challenges do you face at your institution in caring for perioperative patients on chronic opioid therapy? On MOUD?



32

Upcoming Events



Compass SHARP Lunch and Learns:

- **Chronic Pain: When to Refer?**
 - October 8th, 12:10 - 12:50 pm CT
- **Motivational Interviewing: Inspiring Behavior Change**
 - November 12th, 12:10 - 12:50 pm CT

Keeping you SHARP Office Hours:

- 4th Wednesday of the month, 12:00 – 1:00 pm CT
- [LINK](#) to register

33

Resources



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34

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37



Thank you



38