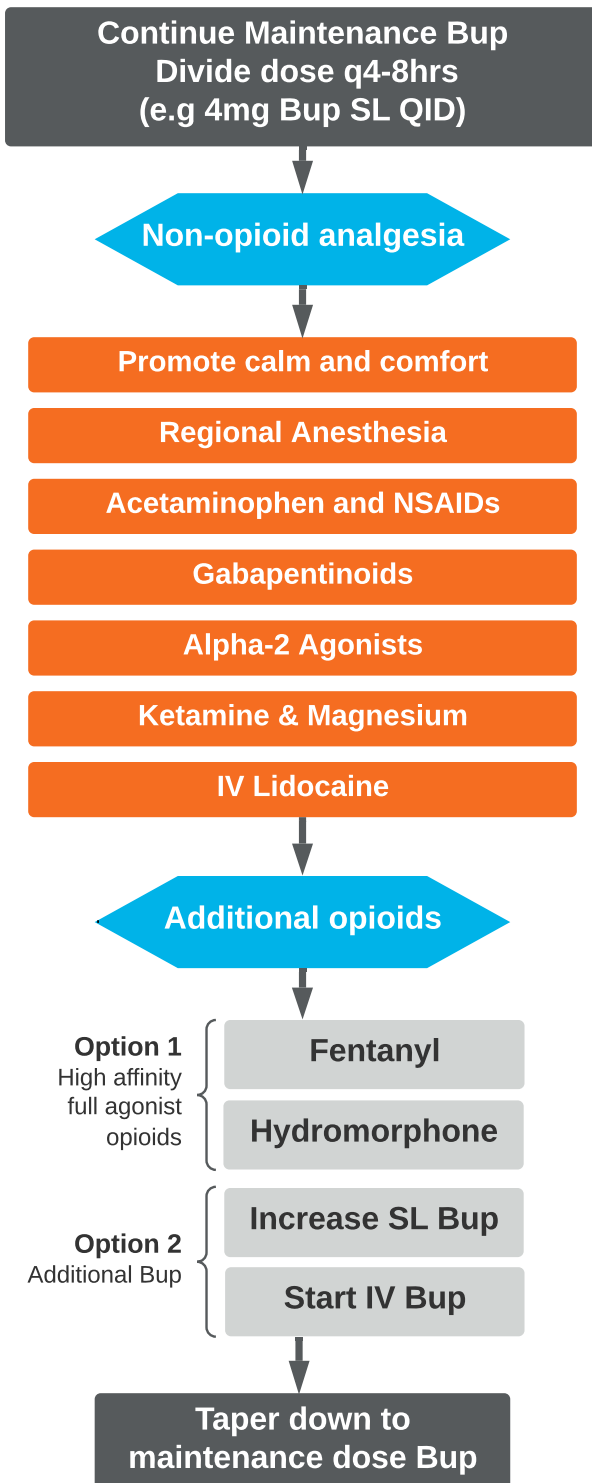


# Acute Pain Management in Patients on Buprenorphine (Bup) Treatment for Opioid Use Disorder

## Emergency Department / Critical Care



### Promote calm and comfort

**Anxiety, fear, depression are common:** Instill sense of control, provide education on self-management techniques such as mindfulness meditation. Reduce noise, uncertainty, confusion. Positioning, splinting, and physical comfort should be maximized. Minimize unnecessary NPO status.

### TREAT UNPLEASANT SYMPTOMS:

**Diphenhydramine** 25-50mg PO q8h prn insomnia/anxiety

**Tizanidine** 2-4mg q6h prn muscle spasms

**Ondansetron** 4mg PO q6h prn nausea

**Trazadone** 50mg PO qhs prn insomnia

**Melatonin** 3mg PO qhs prn insomnia

**Lorazepam** 0.5-1mg PO prn anxiety

**Antipsychotics** prn psychotic disorder symptom control

**Nicotine replacement** prn tobacco dependence

### Regional Anesthesia

**Peripheral nerve blocks:** superficial cervical plexus, brachial plexus, radial/median/ulnar, PECS, erratus plane, TAP, femoral, sciatic, posterior tibial.

**Spinal and Epidural anesthesia**

### Acetaminophen and NSAIDs

**Acetaminophen and NSAIDs**, when not contraindicated, should be the foundation of a multimodal analgesic strategy.

### Gabapentinoids

In opioid dependent patients, the calcium channel inhibitors, gabapentin and pregabalin reduce postoperative pain and reduce opioid consumption. Gabapentin 300-600mg PO TID.

### Alpha-2 agonists

Clonidine and Dexmedetomidine are anxiolytic and analgesic with significant opioid sparing effects. e.g. **Clonidine** 0.1-0.3mg PO q6-8h prn pain or anxiety (NTE 1.2mg/day, hold if BP <100/70).

### Ketamine & Magnesium (NMDAR antagonists)

**Ketamine** is the most potent non-opioid analgesic for opioid tolerant patients. A brief infusion of 0.3mg/kg IV over 15min is followed by 0.3-1mg/kg/hr as needed.

**Magnesium** is also an NMDAR with analgesic and opioid sparing effect. eg. 30-50mg/kg bolus followed by 10-mg/kg/hr.

### IV Lidocaine (Na channel antagonist)

Opioid sparing analgesic. A bolus of 1-1.5mg/kg is followed by 1.5-3 mg/kg/h. Contraindications include cardiac dysrhythmias. Must monitor serum levels after 24hrs.

### High Affinity Full agonist Opioids

Hydromorphone, fentanyl, and sufentanil can be added to maintenance Bup to provide synergistic analgesia. Titrate to analgesia and side effects. This will NOT cause withdrawal.

### Additional Bup

There is no clinical ceiling on Bup analgesia. SL Bup can be given as frequently as q2h. IV Bup is a potent analgesic start at 0.3mg IV and titrate as needed. At higher doses respiratory depression does occur.

Guidelines are options for multimodal analgesic therapy. Use clinical judgement and avoid use if contraindicated.

The CA Bridge Program disseminates resources developed by an interdisciplinary team based on published evidence and medical expertise. These resources are not a substitute for clinical judgment or medical advice. Adherence to the guidance in these resources will not ensure successful patient treatments. Current best practices may change. Providers are responsible for assessing the care and needs of individual patients.

SEPTEMBER 2021

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# Acute Pain Management in Patients on Buprenorphine (Bup) Treatment for OUD



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