Opioids, Pain, and Substance Use Disorders - CASE RECOMMENDATION FORM

Presenter Credential:___DO_____

After review of the case presentation and discussion of this patient's case among the ECHO Community of Practice, the following suggestions have been made:

Summary:
65+ year old female with past medical history of hypertension and opioid use disorder (heroin, fentanyl, prescription opioids). Long history of knee pain that severely impacts quality of life. Determined will need right knee replacement. Scheduled for knee surgery in 2-months. Surgeon requested for her to come off Suboxone before surgery. Pt is very anxious about this since she is stable on her 12mg daily for the past 5 months. This is her longest period of sobriety in decades. Requested for PCP to talk to surgeon about current plan and pain management plan post-surgery. Medication adherence is good. Current medication includes Suboxone 4mg TID, Lisinopril 10mg, Ibuprofen 200mg PRN. Recently moved to Idaho due to stressful home environment and substance use. Wanted to "start new" and had friends/family in the area. Since moving, has been active member of community and church.

Treatment Question(s):
1. Should we continue to recommend current Suboxone dose of 12mg?
    - Would there be benefits in skipping her dose that day or lowering her w/o totally stopping Suboxone?
    - Would there be any benefit in switching her to a buprenorphine only medication for the week of surgery?
2. Pt is very anxious about her post-operative pain control. Do you have any recommendations to discuss with the surgeon?

Recommendations:
- **Continue buprenorphine throughout the procedure.**
    - Previously, the practice was to stop or reduce buprenorphine to free up receptors, but now it's becoming the standard of care to maintain the dose and add full opioid agonists as needed. This dynamic process allows some agonists to reach the receptors.
    - Any opioid agonist can be used, such as hydrocodone or oxycodone, but some prefer hydromorphone due to its higher receptor affinity, which may better penetrate buprenorphine's blockade.
    - Consider using non-opioid analgesics, such as an NSAID, when appropriate. Non-opioid medications can help manage pain alongside buprenorphine, depending on the procedure and the surgeon's preferences, though some may worry about the impact on healing (especially with orthopedic surgeries).
    - For procedures like knee surgery, which can be very painful, long-lasting nerve blocks (e.g., saphenous block) can manage pain for the first few days of pain. This option may not be available to the surgeon, so scheduling acetaminophen (e.g., Tylenol) after surgery can be important, but you'll need to keep an eye on the total dose.
- **Set up a pain contract with trusted individuals to manage post-op opioids.**
    - In cases where opioids are needed post-op, patients can have a trusted individual control the distribution of medications to avoid misuse and ensure they take the correct dose.
- **Educate surgeons about current standards of care.**
    - Some surgeons follow older practices of stopping buprenorphine. It may help shift their approach if you educate them about the benefits of continuing buprenorphine, such as better outcomes, less opioid use, and easier for them to deal with the patient's pain and withdrawal.
    - Suggestions may be accepted more readily by the surgeon if specific dosages are recommended.
- **Consider prescribing post-operative pain medications if the surgeon refuses.**
    - If a surgeon is unwilling to manage post-op pain in patients on buprenorphine, then a primary care provider could step in to prescribe the necessary medications, while following up with the surgical team.

Consider presenting a patient case at a future ECHO Idaho session.

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