Guidelines for Surgery in Patients Taking Buprenorphine/Suboxone

Buprenorphine is a partial opioid agonist that is used for several indications. In low doses—less than 1 mg/day—buprenorphine is used to treat pain (e.g. Butrans transdermal buprenorphine). In higher doses i.e. 4 – 24 mg per day, buprenorphine is used as a long-term treatment for opioid dependence and less often for pain management. At those higher doses, Buprenorphine has a unique ‘ceiling effect’ that reduces cravings and prevents dose escalation. Patients taking higher dose of buprenorphine, trade name Suboxone or Subutex, become tolerant to the effects of opioids, and require special consideration during surgical procedures or when treated for painful medical conditions.

There are two hurdles to providing effective analgesia for patients taking buprenorphine: 1. the high opioid tolerance of these individuals, and 2. the opioid-blocking actions of buprenorphine. The first can be overcome by using a sufficient dose of opioid agonist, on the order of 60 mg per day of oxycodone-equivalents or more. The second can be handled by either stopping the buprenorphine a couple weeks before agonists are required—something that most patients on the medication find very difficult or impossible to do—or by reducing the dose of buprenorphine to 4-8 mg per day, starting the day before surgery and continuing through the post-op period. Given the long half-life of buprenorphine, it is difficult to know exactly how much remains in the body after ‘holding’ the medication. That fact, along with the difficulty patients have in stopping the medication, leads some physicians (including myself) to use the latter approach—i.e. to continue 4 mg of buprenorphine per day throughout the postoperative period. People taking 4-8 mg of daily buprenorphine say that opioid agonists relieve pain if taken in sufficient dosage, but the subjective experience is different, in that there is less ‘euphoria.’

- Patients on daily maintenance doses of buprenorphine do NOT receive surgical analgesia from buprenorphine alone, as they are tolerant to the mu-opioid effects of buprenorphine.
- The naloxone in Suboxone does not reach the bloodstream in significant amounts, and has no relevance to the issue of post-operative pain and Suboxone/buprenorphine.
- Discontinuation of high dose buprenorphine/Suboxone results in opioid withdrawal symptoms within 24-48 hours, similar to the discontinuation of methadone 40 mg/day.
- Normal amounts of opioid pain medication are NOT sufficient for treating pain in people on buprenorphine maintenance.
- Opioid agonists will NOT cause withdrawal in people taking buprenorphine. Initiating buprenorphine WILL precipitate withdrawal in someone tolerant to opioid agonists, unless the person is in opioid withdrawal before initiating buprenorphine.
- Non-narcotic pain relievers CAN and should be used for pain whenever possible in people on buprenorphine to reduce need for opioids. Note that Ultram has opioid and non-opioid effects; the opioid effects are blocked by buprenorphine.
- I have had success in people taking 4 mg of buprenorphine/day, using oxycodone, 15-30 mg every 4 hours. Some patients can control their own intake of oxycodone while on buprenorphine, but some patients CAN'T. Overdose IS possible, if patients take excessive amounts of the opioid agonist. Consider providing multiple prescriptions with 'fill after' dates, each for a very short period of time (e.g. 2 days each) to that patients do not have access to large amounts of opioids at one time.

- For longer post-operative periods I have used combinations of long and short-duration agonists, e.g. Oxycontin 20 mg BID plus oxycodone, 15 mg q4 hours PRN.

- The risk of death is significant for opioid addicts not on buprenorphine. Buprenorphine/Suboxone has opioid-blocking effects that reduce risk of overdose and death. Asking a person to stop or ‘hold’ their Suboxone is introducing significant risk of injury. Opioid addicts are NOT generally able to stop Suboxone without replacing it with illicit opioids.

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In regard to IV sedation (e.g. dental procedures):

- Patients are tolerant to their current opioid—buprenorphine—and therefore are receiving NO analgesia from their regular medication.

- Benzodiazepines may be used in doses/frequencies similar to use in any patient NOT on opioids.

- Nitrous Oxide, Propofol, or other non-opioid medications are NOT affected by buprenorphine or Suboxone.

- Typical procedure in people on Suboxone/buprenorphine is to use the local anesthetic to control pain (i.e. a block), and benzodiazepines for sedation/amnesia.

- Holding Suboxone/buprenorphine does little or nothing beyond causing the patient significant anxiety and discomfort; the long half-life of buprenorphine keeps the medication active for several weeks, and even if it could be removed, patients would still have a high tolerance to opioids.

- Opioids CAN be used, especially if pulse-oximetry is present. Expect patients to require 3-4 times larger doses of opioid, because of the tolerance and blocking effects of buprenorphine.