Managing Pain for Patients using Medication-Assisted Treatment for Opioid Use Disorder

Patients presenting for abortion may be using medication-assisted treatment for opioid use disorder. Clinics should be prepared to treat patients using buprenorphine, methadone, or naltrexone. While previous guidelines recommended stopping or decreasing medications prior to elective surgery, ***this practice is no longer recommended****. Stopping or decreasing medication results in severe withdrawal symptoms and cravings, increasing the risk of relapse and causing difficulty with pain management. This guide was developed to help providers manage peri-operative pain while MAINTAINING patients on their addiction treatment regimen.*

PRINCIPLES

1. **Important: Patients should be continued on their buprenorphine or methadone in order to prevent withdrawal and reduce the risk of relapse.** Patients in withdrawal have severe pain and anxiety which can be difficult to control during an abortion procedure. Reassure the patient of the value of medication-assisted treatment and let them know that they will receive additional medication for pain during the procedure. Support their continued treatment for opioid addiction.
2. **Methadone and buprenorphine when prescribed for opioid use disorder are not analgesics** during or after a procedure. Additional medications are required.
3. If possible, **oral naltrexone should be held for 72 hours** to allow opioids to work. Because IM naltrexone has a prolonged effect (30 days), patients should not have their procedure delayed.
4. **Higher opioid doses are often needed due to tolerance**. High-potency opioids used for analgesia and sedation like fentanyl and hydromorphone bind avidly to the opioid receptor and will work best for acute pain in the presence of buprenorphine. Let patients know that they will feel analgesia but may or may not feel euphoria and sedation. Acknowledge that opioids may be triggering.
5. **Benzodiazepine effectiveness will not be affected by buprenorphine.** Benzodiazepines may be more sedating for patients using methadone or buprenorphine. Monitor patients carefully.
6. **Reversal agents, including naloxone, should be present in the procedure and recovery room**. If naloxone is needed for reversal, start with a low dose and administer slowly.
7. **Consider supplemental analgesics:**
    a. ***Ketamine IV*** works well alone and in combination with midazolam and/or opioids and does not cause respiratory depression. Blood pressure may increase transiently immediately after administration. Rapid infusion or high doses may cause dysphoria or hallucinations; midazolam reduces this risk.
    b. ***Dexmedetomidine IV*** is an α_2-adrenergic agonist providing analgesia and anxiolysis without respiratory suppression. Transient bradycardia or hypotension can occur with rapid infusion.
    c. ***Gabapentin PO*** is a common addition to pre-operative oral medications and can help with pain and anxiety. Gabapentin can be used illicitly and, like opioids, may be triggering for some patients.
8. **When counseling on pregnancy options,** review that people using buprenorphine and methadone have healthy pregnancies and newborns. If requested, refer to prenatal providers who treat addiction, and reassure that neonatal abstinence syndrome is manageable without long-term sequelae.
9. **Offer and encourage communication with the medication-assisted treatment provider**. Encourage early follow-up with treatment provider.
10. **Practice trauma-informed care:** Patients with substance use disorder have a higher risk of physical, sexual, or emotional victimization. Use a trauma-informed approach with all patients.
11. **Need help?** The Substance Use Warmline offers free addiction specialist consultation: **(855) 300-3595,** 9 am to 8 pm Eastern time.

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Table: Managing pain in patients using medication-assisted treatment for opioid use disorder*

<table>
<tr><td>Managing medication-assisted treatment</td><td colspan="2">Buprenorphine: Continue home dose.
Methadone: continue dose on day of procedure.
Naltrexone (po): hold for 72 hours prior to procedure
Naltrexone (IM): do not delay procedure; opioids may be ineffective if <30days since last injection.</td></tr>
<tr><td>Pre-operative oral pain medication or oral pain management only</td><td colspan="2">Give NSAID (e.g., ketorolac or ibuprofen) and acetaminophen 1000 mg.
Any opioid may be given. May give twice the standard dose.
Opioids are less effective if the patient is on naltrexone.
Lorazepam 1-2 mg (avoid if also using IV midazolam intra-operatively).
Consider gabapentin 300 -600 mg (may cause sleepiness after procedure).</td></tr>
<tr><td rowspan="2">Intra-operative pain management for moderate sedation</td><td>Methadone or Buprenorphine</td><td>Naltrexone (po < 72 hours, IM < 30 days)</td></tr>
<tr><td>Cervical block.
Fentanyl 200 mcg IV (higher initial doses are often needed).
Midazolam 2 mg IV (may repeat 1-2 mg q 2-5 minutes). Can take 3-6 minutes before full effect.
Consider ketamine 0.3-1.0 mg/kg (25-50 mg, slow push IV.
Consider dexmedetomidine 25 mcg slow push IV (repeat q5-10 min as needed).</td><td>Cervical block.
Midazolam 2 mg IV (may repeat 1-2 mg q 2-5 minutes). Can take 3-6 minutes before full effect.
Consider ketamine 0.3-1.0 mg/kg (25-50 mg, slow push IV.
Consider dexmedetomidine 25 mcg slow push IV (repeat q5-10 min as needed).
Fentanyl is not effective at office-based doses.</td></tr>
<tr><td>Intra-operative pain management for deep sedation</td><td colspan="2">Cervical block
Propofol per facility protocol
Careful escalation of fentanyl with monitoring.</td></tr>
<tr><td>Post-operative pain management for home use</td><td colspan="2">Give NSAIDs (e.g., ibuprofen)
Give acetaminophen (maximum daily dose < 4000 mg)
Avoid opioids or mixed narcotic analgesics (e.g., Tylenol with codeine)</td></tr>
<tr><td>Medical abortion</td><td colspan="2">Continue regular dose of medication-assisted treatment
Give NSAIDs (e.g., ibuprofen)
Give acetaminophen (maximum daily dose < 4000 mg)
Avoid opioids or mixed narcotic analgesics (e.g., Tylenol with codeine)</td></tr>
</table>

*Research on pain management in patients on medication-assisted addiction treatment is limited. This table is based on expert opinion.

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