

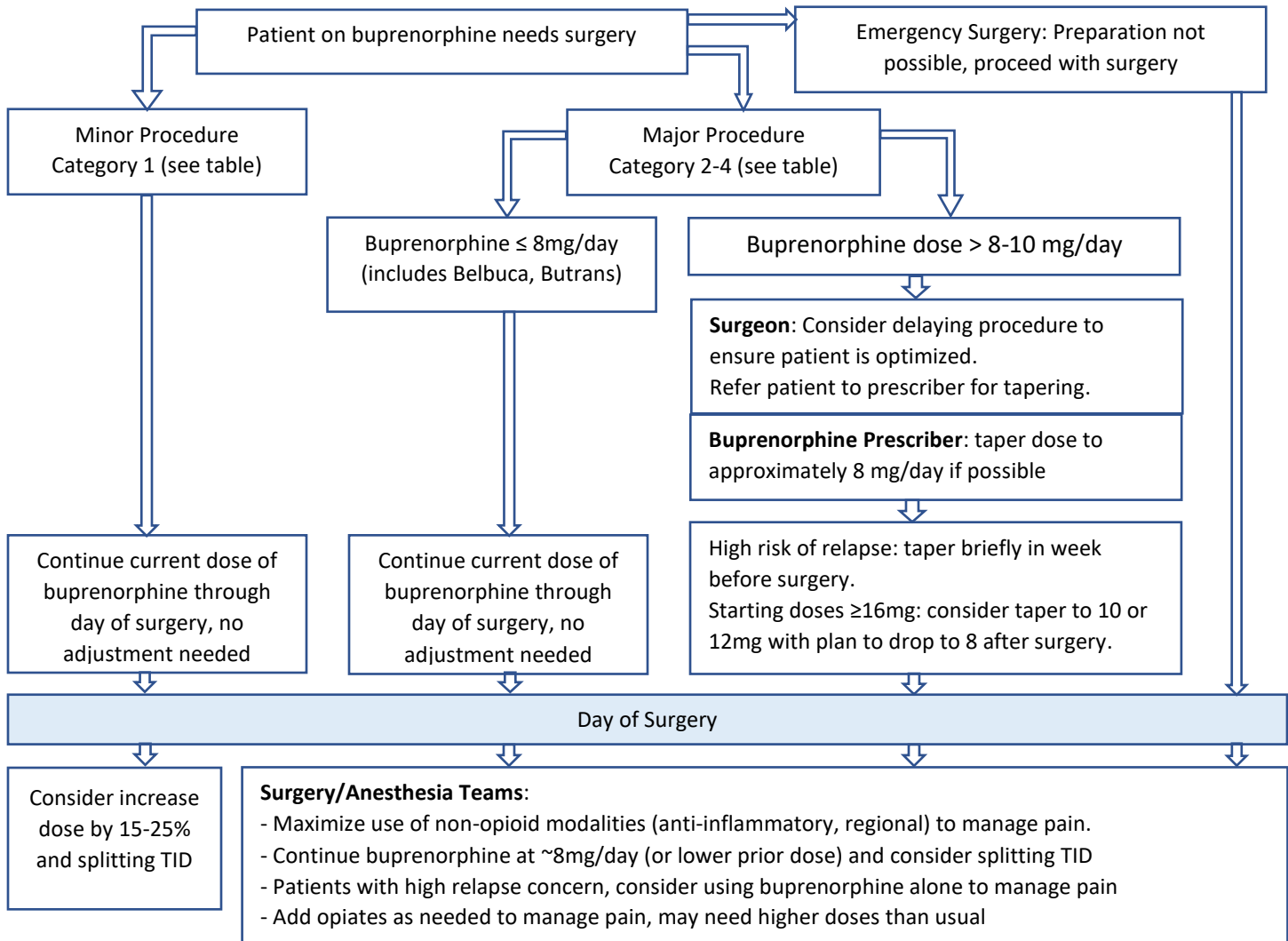


Periprocedural Buprenorphine Management Clinical Collaboration Guide

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Background/Considerations:

- Buprenorphine can be continued through procedures and is not a contraindication to acute pain management. When available, multimodal analgesia with anti-inflammatories, anxiety management (music, relaxation, medications), and regional techniques should be utilized.
- All patients should be screened for substance use disorder as part of the surgical H&P, and concerns about opioid use addressed.
- Hospitalized surgical patients with active substance use and not in current treatment should be considered for referral to Substance Use Disorder Service (SUDS) when available.
- Buprenorphine is a unique opioid that binds more tightly to opiate receptors than other opioids. Adding opioids to existing buprenorphine will not cause withdrawal. However, when Buprenorphine is started in patients who are already on opioids, it can displace other opioids from the mu receptor and result in severe, "precipitated withdrawal."
- Buprenorphine given on an outpatient basis for managing opioid withdrawal symptoms can be dosed once a day. The analgesic effect for managing pain is shorter (6-8 hours) and may require converting to BID-QID dosing for acute pain management.
- Doses in this guide should be used as an approximation, they are not exact targets. Some protocols even suggest continuing buprenorphine at any dose is a reasonable approach.
- Coordinated planning between the surgical team, anesthesiology provider, and the outpatient prescriber is essential to avoid complications, including relapse for patients with an opiate use disorder.



Legacy Health System Surgical Risk Classification Guideline

Use this list as a reference for implementation of the PAS & PSCC Appointment Guidelines and Pre-Anesthesia Testing Guidelines.

	Surgical Class 1	Surgical Class 2	Surgical Class 3	Surgical Class 4
General Description	<ol style="list-style-type: none"> 1) Minimal risk to the patient independent of anesthesia 2) Minimally invasive procedure with little or no blood loss 3) Often in office setting 	<ol style="list-style-type: none"> 1) Minimal to moderately invasive procedure 2) Blood loss < 500 ml expected 3) Mild risk to patient independent of anesthesia 	<ol style="list-style-type: none"> 1) Significantly invasive procedures 2) Blood loss potential > 500 ml 3) Moderate to major risk to patient independent of anesthesia 	<ol style="list-style-type: none"> 1) Highly invasive procedure 2) Blood loss potential >1,500 ml 3) Critical risk to the patient independent of anesthesia 4) Usual postoperative ICU stay with invasive monitoring
Includes	<ul style="list-style-type: none"> • Breast biopsy • Cataract extraction with lens insertion • Circumcision • Cystoscopy • Dental restoration • Dilatation and curettage • Endoscopy, routine procedures (EGD, colonoscopy) • Excision of minor skin or subcutaneous lesions • Fiberoptic bronchoscopy • Hysteroscopy • Ilizarov/ex-fix frame adjustment/removal • Imaging, non-invasive (MRI, CT, PET) • Minor hand and foot surgery (generally finger and toe surgeries) • Myringotomy tubes • Radiation oncology (brachytherapy, etc.) • Vasectomy 	<ul style="list-style-type: none"> • Minimally invasive surgery (e.g. lap cholecystectomy, lysis of adhesions, salpingo-oophorectomy, urologic procedures, ESWL, vasovasotomy) • Endoscopy, special procedures (e.g. ERCP, EUS with biopsy, esophageal banding, emergencies) • ENT/OMFS, routine (e.g. thyroid, parathyroid, tonsils/adenoids, endoscopic sinus/laryngeal) • Extraperitoneal general surgery (e.g. umbilical hernia repair, lymph node excision, breast surgery without reconstruction) • Imaging, invasive (e.g. coronary angiography, arteriogram, venogram) • Ophthalmology, invasive (e.g. vitrectomy, scleral buckle, corneal transplant, strabismus surgery) • Orthopedic surgery with tourniquet (e.g. arthroscopy, primary total knee or elbow arthroplasty, hand or ankle surgery, amputation below ankle) • Spinal surgery 1-3 levels • Wound procedures, deeper than dermis (e.g. sacral or ischial ulcer excision, flap procedures) 	<ul style="list-style-type: none"> • AICD or pacemaker insertion • Electrophysiology, supraventricular • ENT, complex (e.g. thyroid with airway/thoracic involvement, LaForte/midface, airway resection without node dissection or reconstruction) • Intracranial, min. invasive (e.g. VP shunt) • Imaging, highly invasive (biopsy of major organ, coronary laser, cerebral angio) • Major surgery, laparoscopic or open, involving internal organs (e.g. cystectomy, hysterectomy, myomectomy, colectomy, open cholecystectomy, liver resection, 1° or 2° cesarean delivery, prostatectomy, TURP) • Major plastic or breast surgery (e.g. mastectomy with reconstruction, abdominoplasty, full face lift) • Major vascular surgery w/o planned ICU stay (e.g. Fem-Pop bypass, BKA, AKA) • Nephrectomy (includes partial) • Orthopedic surgery, complex (e.g. bilateral or revision/re-do) or without tourniquet (total hip, total shoulder) • Spinal surgery >3 levels or abdominal approach • Thoracic surgery, min. invasive (e.g. pectus, pericardial window) 	<ul style="list-style-type: none"> • Cardiac Surgery • All Surgeries with planned ICU stay, which usually includes: <ul style="list-style-type: none"> o CEA o OMFS/ENT neck dissection and flap o Intrathoracic surgery o Intracranial surgery o Spinal corpectomy o AAA or TAA repair (endovascular or open) o TIPS (Transjugular intrahepatic portosystemic shunt) o EKOS or pulmonary artery thrombolytic catheter o Open intracardiac device implantation or lead extraction o Electrophysiology, ventricular o High-risk cesarean delivery (e.g. tertiary or greater, with planned hysterectomy, with known placenta accreta)

Based on: Blitz et. al. Anesthesiology 2016; 125:280-94. Revised by LHS Anesthesiology Steering Committee 8/2018.