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Pharmacist's Letter
Hospital

Acute Pain Management in Patients on MOUD: A Clinical Guide

Top Takeaways

- *Start with multimodal non-opioid strategies before escalating to opioids in patients taking MOUD therapy.*
- *Plan on continuing verified MOUD therapy during acute pain treatment whenever possible.*
- *Support patient safety at discharge by ensuring access to naloxone or nalmefene and providing education on its use, as well as opioid disposal.*

Treating acute pain can be challenging in patients taking meds for opioid use disorder (MOUD)...buprenorphine, methadone, and naltrexone.

You already know that adding opioids to MOUD can increase the risk of side effects, overdose, or relapse. But undertreated pain can also worsen outcomes...including returning to opioid misuse.

Navigate the balance between pain management and patient safety.

For mild to moderate pain, suggest multimodal non-opioid analgesia first...such as acetaminophen, ketorolac, or nerve blocks.

Expect home gabapentinoids and SNRIs (duloxetine, etc) to continue when appropriate to help reduce opioid use. Keep in mind that perioperative gabapentinoids also may lower inpatient opioid requirements.

If non-opioids aren't enough, expect to add a short-acting full opioid agonist (hydromorphone, fentanyl, morphine, etc). Anticipate higher initial doses to overcome receptor blockade and tolerance from MOUD.

Flag med orders for mixed agonist-antagonist opioids (nalbuphine, butorphanol, etc), since they can precipitate withdrawal.

Plan on methadone and buprenorphine to be continued as MOUD. Verify home doses directly with the patient or treatment program, since the prescription drug monitoring program may not reflect current dosing.

MOUD regimens may be adjusted to perform double-duty as analgesia, particularly when prescribers prefer to avoid adding opioids.

For example, daily methadone doses can be split every 8 hrs and buprenorphine every 6 to 8 hrs to leverage their shorter analgesic windows.

Watch for naltrexone use, which blocks opioid effects. Oral formulation washout may take several days...and injectable about 28 days.

If pain management is needed before washout is complete, consider IV ketamine first. If opioids are required, expect reduced responsiveness and carefully titrate IV opioids with close monitoring.

At discharge, ensure supplemental opioids are tapered, confirm MOUD doses are back at baseline, coordinate with the patient's outpatient MOUD provider, and check for a naloxone or nalmefene discharge Rx.

See our resources, Treatment of Acute Pain in Opioid Use Disorder, and Opioid Stewardship in the Hospital Setting CE course, for more on med options, typical doses, and side effects.

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Key References:

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