November 22, 2004

«Prof_First_Name» «Prof_Last_Name»
«Prof_Address»
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Ref / PAI2137 Pain Management in Patients taking buprenorphine

Dear Dr. «Prof_Last_Name»,

This letter is in response to your inquiry regarding pain management in patients maintained on Suboxone® (buprenorphine and naloxone) and/or Subutex® (buprenorphine). The information presented here is intended to aid in your assessment of the appropriate use of Suboxone® or Subutex® in your specific patient. It should not be used to replace sound medical judgement.

Pain Management in Buprenorphine-maintenance Patients

Pain management is perceived as a potential issue in patients who are maintained on buprenorphine-containing medications such as Subutex® or Suboxone®. This need not be the case when the issue is addressed pragmatically. There is a paucity of reported formal trials of clinical practice in this area. However, the following guidance is a practical recommendation based on current generally accepted clinical practice. It contains general principles in the management of chronic and acute pain in buprenorphine-maintained patients as well as recommendations on possible strategies for analgesia in these patients.

General principles

Chronic pain

Management of chronic pain in the Subutex®/Suboxone®-maintained patient includes consultation with a specialist in pain medicine when possible and appropriate. Patients with chronic pain disorders and physical dependence are best managed by multidisciplinary teams that include pain and addiction medicine specialists. The site of such treatment will depend on patient need and the best utilization of available resources.

Acute pain

Management of acute pain in the Subutex®/Suboxone®-maintained patient entails:
a. Continuation of the regularly scheduled Subutex®/Suboxone® dose.
b. Additionally prescribing adequate doses of appropriate medications.

Strategies

The basic issue with analgesia in the buprenorphine-maintained patient is that while buprenorphine has analgesic properties, it is a partial agonist. This means that not only will it block the cravings associated with opioid dependence, but because of the high affinity of buprenorphine for opioid receptors it may also block the analgesic effect of other opioids. Current practice circumvents this problem in a number of ways:

1. In an emergency situation, the patient's pain may be managed by regional anesthesia, conscious sedation with a benzodiazepine, use of non-opioid analgesics, or general anesthesia (excluding halothane).

2. If a patient is experiencing pain but it is not an emergency situation, the recommended first course of action is for the physician to treat the pain with a non-opiate medication, such as ketorolac, NSAIDs or COX-II inhibitors.

3. If this is not adequate it may be possible for the limited period of time that the pain situation exists, depending on the dose of buprenorphine, to increase the dose of buprenorphine to obtain an analgesic effect.

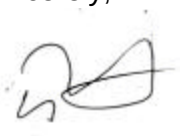
4. In a situation requiring additional opioid analgesia, the dose of the full opioid agonist required may be greater than usual. It is known that, depending on the effect measured, using higher doses of a full agonist opioid may overcome the blockade caused by buprenorphine. While there is little literature on this phenomenon in relation to the analgesic effects of opioids, anecdotal evidence suggests that this strategy may be effective in some patients. A rapidly acting opioid analgesic, which minimizes the duration of respiratory depression should be used. The dose of opioid medication should be titrated against the patient's analgesic, physiological (especially respiratory) responses, with close monitoring by trained staff.

5. In the case of elective surgery, the physician may titrate the buprenorphine dose down or transfer the patient to a full opioid agonist prior to surgery. Afterward, the buprenorphine level may be titrated back up to the therapeutic level. The transition back to buprenorphine should be easier if a short-acting full opioid agonist is used.

6. Use of regional anesthesia such as epidural blockade may also be considered in non-emergency situations.

7. Alternative methods of pain control, such as TENS, may be suitable for some patients.

Sincerely,



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