This guide is to aid medical staff in the conversion from sublingual buprenorphine (Temgesic) to appropriate dosing of oral route opioid analgesics as well as commonly used non- opioid adjuvant analgesics.

Is the patient complex? If not, proceed with COOLED.

If the patient is considered a complex patient, then the Acute Pain Service will manage their analgesic requirements. Please do not alter the pain management strategy.

Complex patients include those with:

- Pre-admission oMEDD> 60 (oMEDD is oral morphine equivalent daily dosage) History of chronic pain.
- **History of substance abuse.**
- **Significant patient concern.**
- Significant nursing or medical concern.
- Severe hepatic or renal impairment.

Checklist PRIOR to conversion from sublingual Buprenorphine.

- Patient is tolerating oral intake, including being able to swallow oral tablets.
- The patient does NOT have malabsorption (active vomiting, high ileostomy output particularly with non-absorbed tablets seen in the stoma bag, absence of flatus, development of post-op ileus)
- Pain is well controlled in relation to the functional activity score (FAS) AND patient has mobilised
- Plan has been communicated to nursing staff and the patient.
- Renal function checked prior to prescribing oral analgesics that may require dose adjustments.
- Patient's regular pre-admission medications are charted, available and have been confirmed
- If indicated, controlled release opioid (e.g. Targin) charted to be given at earliest 3 hours following the last dose of either regular or PRN sublingual buprenorphine. All new controlled release opioids require a weaning plan.
- PRN oral opioid analgesia and adjuncts (see below) are charted and available

Does the patient not meet COOLED criteria? If no, perform the following every day:

- Examine PRN doses of sublingual buprenorphine used in last 24 hours.
- If no PRN use has occurred, remove one of regular sublingual buprenorphine dose

until only BD regular dose is required.

- E.g., if on QID regular regime, change to TDS regular
- E.g., If on TDS regular, change to BD regular

- If only BD regular regime has been required, with no PRN doses used, remove BD regular regime altogether and only use buprenorphine on a PRN basis.

Any issues or concerns?

Any issues or concerns relating to the analgesia management, please contact the Pain Service on Ext # 94383 Ph *206 (CNC Acute Pain) or Ph *280 24/7 Anaesthetic Duty Registrar

Dosage considerations for oral analgesia:

- Reduce the dosage if: elderly; frail; OSA; renal and hepatic impairment Increase the dosage if: opioid tolerant.
- The analgesic requirement should reduce with each postoperative day but will be influenced by the patient's activity.
- Ensure that patient has mobilised and performed activities of daily living (e.g., toileting) before using the buprenorphine dose of the preceding 24hrs as basis for conversion to oral analgesia.
- Buprenorphine is not charted more frequently than QID (6hrly) due to duration of action (longer than oxycodone)

Buprenorphine use in the last 24hrs		Suggested oral oxycodone dose
REGULAR	**PRN (Total/24hrs)**	
O microg	**≤1200 microg**	Oxycodone 5-10 mg every 3 hours PRN
	1200-2000 microg	Targin 5/2.5 mg BD for 3 days AND, Oxycodone 5-10 mg every 3 hours PRN
	>2000 microg	**Do Not Convert: Contact Acute Pain Service**
200 microg TDS = 600 microg	**≤600 microg**	Oxycodone 5-10mg every 3 hours PRN
	600-1400 microg	Targin 5/2.5 mg BD for 3 days AND, Oxycodone 5-10 mg every 3 hours PRN
	>1400 microg	**Do Not Convert: Contact Acute Pain Service**
	≤600 microg	Targin 5/2.5 mg BD for 3 days AND, Oxycodone 5-10 mg every 3 hours PRN
400 microg TDS = 1200 microg	**600-800 microg**	Targin 10/5 mg BD for 3 days AND, Oxycodone 5-10 mg every 3 hours PRN
	>800 microg	**Do Not Convert: Contact Acute Pain Service**

Note: 200 microg sublingual buprenorphine is equivalent to 5 mg oral Oxycodone dosing without accounting for cross-tolerance.

The weaning period for controlled release agent depends on the surgery and may range from 3 days to more than 2 weeks. In general, a stop-date should be instituted for controlled release opioids.

***NB**: if the patient was taking a controlled release opioid pre-admission, it is likely that it will need to be continued postoperatively.*

***NB**: if the patient was using buprenorphine patch pre-admission, please do not start another controlled release opioid without discussing with the Acute Pain Services.*

Non-Opioid Adjuncts

- All patients should receive adjuvants.
- Usually these are used for 3 to 5 days.

Medication	Dose	Comment
Paracetamol	1 g qid	Consider dose reduction in severe hepatic impairment
Ibuprofen	200-400 mg tds with food prn	Caution in patients with renal impairment, age >75, concurrent ACE-Inhibitor use, Hx of haematemesis or gastritis
Tramadol	50-100 mg qid prn	Do not use if age >75yrs and caution in patients on other serotonergic medications e.g.: SSRIs, TCAs
Pregabalin	75-150 mg bd	Not typically used in the acute setting. **CAUTION** in the **ELDERLY** patients – can cause confusion. Dose reduce e.g., 25mg bd to start
Other agents may be used in consultation with the Acute Pain Services		

Issues or Concerns regarding Analgesia selection or dosing:

Contact the Pain Services on ***280.**