ST VINCENT'S HEALTH AUSTRALIA

MATOD and the Management of Acute Pain

Victorian Opioid Management ECHO
Department of Addiction Medicine
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UNDER THE STEWARDSHIP OF MARY AIKENHEAD MINISTRIES

Methadone

- high vs low dose
- High dose- may be effectively providing opioid blockade

Buprenorphine/Buprenorphine/Suboxone

- high vs low dose
- High dose will effectively block effect of opioids

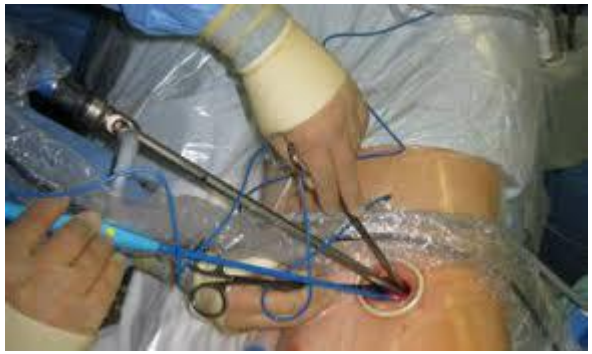
Hyperalgesia

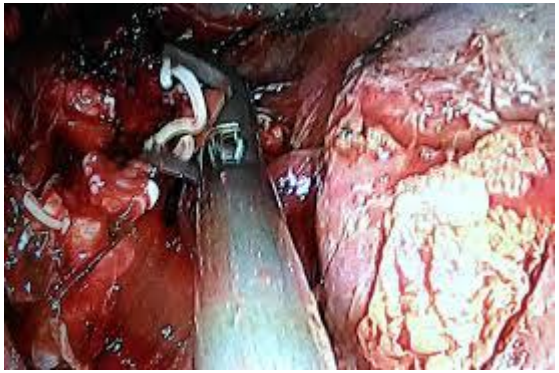
ivdu

Role of other agents

Acute pain

pathophysiology





Remember

Pharmacodynamic Drug Interactions = what the drug does to the body

Most methadone-related deaths occur in conjunction with other CNS depressants

opioids

benzodiazepines

alcohol (combination of non-fatal doses of both may lead to fatal effect)

tricyclic antidepressants (TCAs) – respiratory depression, pulmonary oedema, QTc

Methadone Toxicity

Usual triad of opioid toxicity (respiratory depression, pinpoint pupils, coma) may be preceded by:

Drowsiness

Slurred speech

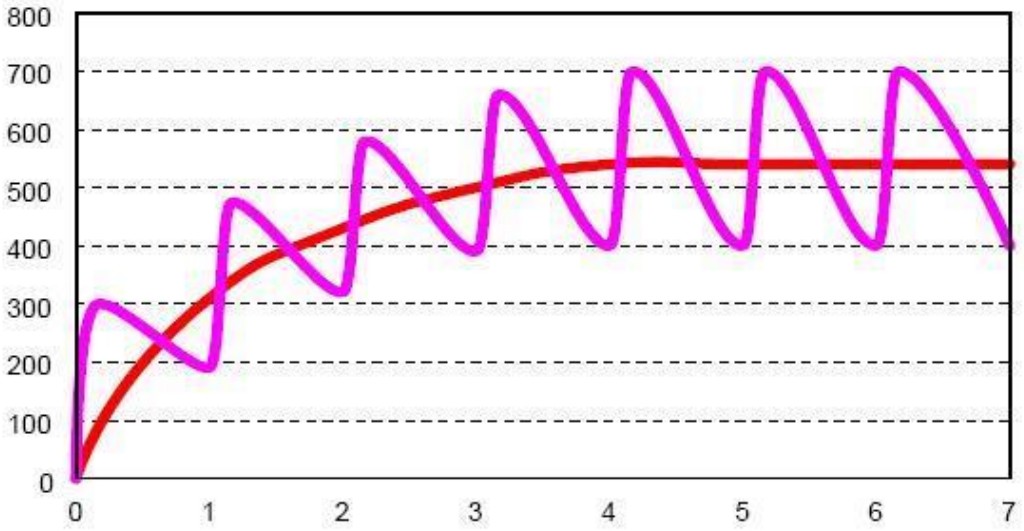
Poor balance (unsteady gait)

Note: additive effects of other sedatives

Due to methadone's unique pharmacokinetics – long time between ingestion and maximum effect, and t½ (leading to accumulation in tissues)

Steady State Simulation - Methadone Maintenance

Steady State attained after 4-5 half-lives -1 dose every half-life



Time in days (24 hrs.= methadone half-life)
Dose remains same - Effect increases

In the graph above the wavy line represents the blood levels of methadone as well as the "effect" it has on the individual patient.

Managing pain in pt on methadone

Low dose

Can add in any appropriate SHORT-ACTING analgesic(s)

Consider splitting dose

Monitor for sedation etc.

Aim to wean back to usual dose and treatment quickly

High dose

More complicated

Can split dose

Add non-opioid analgesia

Consider frequent doses of SHORT-ACTING opioids as well as non-opioid treatments

May need to up-titrate methadone to enable weaning of other opioids

Severe pain

Consider admission for pain management

Involving APS early

NSAIDs- Ketoralac (10-30mg deep imi q4-6 hrs, max 90mg/day)

Regional blocks

Local blocks

Intravenous ketamine

Tramadol

Tapentadol

USE SHORT-ACTING OPIOIDS ONLY (AVOID SR/LA PREPARATIONS)

buprenorphine

Inclusion of naloxone is irrelevant

Need to consider cause of pain, severity, likely duration in determining management

Always consider non-opioid options- local/regional anaesthesia, NSAIDs, ketamine

Options:

- **if low dose continue buprenorphine and add in pure opioid agonist**
- **increase buprenorphine, split dosing**
- **transfer to pure opioid agonist**
- **stop buprenorphine and use other opioid**
- **ketamine**
- **general anaesthesia**

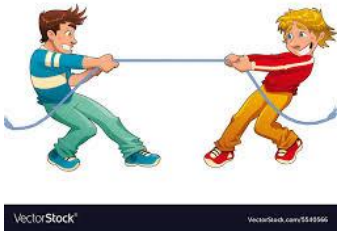
buprenorphine

When weaning additional opioids may need to increase buprenorphine dose

If buprenorphine ceased then will need to allow washout period before recommencing

May have to transfer to methadone

Sometimes challenging to get patients to accept going back onto ORT (MATOD)




any
questions?