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Buprenorphine for Postoperative Pain Following General Surgery in a Buprenorphine-Maintained Patient

TO THE EDITOR: Office-based, long-term buprenorphine is a growing treatment for opioid dependence (1). Patients with opioid dependence may require treatment for pain during their opioid therapy, and such treatment can be complicated. Recently suggested recommendations for the treatment of acute pain in a buprenorphine-maintained individual include the following four options: using concomitant short-term opioid analgesics, dividing the daily buprenorphine dose, replacing the buprenorphine with another opioid analgesic, or replacing the buprenorphine with methadone and then adding an opioid analgesic (2). We present a case of postoperative pain control in a buprenorphine-maintained patient, using supplemental doses of sublingual buprenorphine for pain management.

The patient was a 32-year-old woman with opioid dependence who had been successfully maintained on sublingual buprenorphine/naloxone 24/6 mg daily for 6 months, up to and including the day she underwent surgical removal of breast implants under general anesthesia. The patient was seen in an outpatient addiction treatment clinic (by Dr. Book) and prescribed buprenorphine/naloxone 2/0.5 mg tablets for postoperative pain control, with instructions to take one to two sublingual tablets every 4 to 6 hours for pain. On her first and second postoperative days at home, she reported taking 12/3 mg every 6 hours to relieve pain, in addition to her 24/6 mg per day baseline dose, for a total daily dose of 72/18 mg of buprenorphine/naloxone. She was able to successfully and comfortably taper her dose by postoperative day 11 to her baseline dose of 24/6 mg. The patient did not report taking other analgesics, including nonsteroidals.

Although this individual case was limited by self-report, self-titration, and lack of control, the off-label use of supplemental doses of sublingual buprenorphine for acute postoperative pain in a buprenorphine-maintained individual is a novel approach. Buprenorphine is a partial μ agonist shown to have a ceiling to analgesic effects in preclinical studies. Indeed, the bell-shaped dose-response curve of buprenorphine suggests that high doses may produce diminishing analgesic effects (3, 4). However, this was not the case for our patient, who had adequate pain control, with total daily doses of up to 72/18 mg following surgery that typically may require 60 mg per day of oxycodone. Furthermore, because no other respiratory depressants were used, this high dose of buprenorphine could safely be used as an outpatient dose. These findings suggest that the time-limited, off-label use of supplemental doses of sublingual buprenorphine may be an effective fifth option for management of acute pain in selected buprenorphine-maintained patients.

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Abacavir Sulfate and Mania in HIV

TO THE EDITOR: Case reports of manic episodes have implicated non-nucleoside reverse transcriptase inhibitors such as zidovudine, didanosine, lamivudine, and stavudine (1). We describe the case of a patient with mania that was associated with abacavir sulfate, another non-nucleoside reverse transcriptase inhibitor.

The patient was a 47-year-old man infected with human immunodeficiency virus (HIV) for 9 years prior to a manic episode. He had a long history of alcohol and substance abuse, but had been abstinent for the past 10 years. Hepatitis C was confirmed at the time of his HIV diagnosis. Over time, transaminases remained below two times the normal values, and the patient was never treated for this infection. No personal psychiatric history was reported, but he had one sibling who had a diagnosis of schizophrenia. Soon after his HIV diagnosis, first-line therapy with zidovudine, lamivudine, and delavirdine was initiated. The patient remained with the same therapy for 9 years. His plasmatic viral load was at a level of detection (<50 copies/ml), and he had a CD4-cell count of approximately 200 cells/mm^3. He never suffered from any opportunistic infection, which is an indication of good immunity. His antiretroviral regimen was changed to abacavir, lamivudine, and lopinavir/ritonavir in an attempt to increase his CD4-cell count. During this period, his CD4-cell count dropped to 159 cells/mm^3, despite a viral load that remained be-