Title	Date	Major Peri-operative recommendations
Anderson et al	2017	1. Where moderate to severe pain is expected, cancel surgery such that buprenorphine is weaned off before surgery and short-acting opioids are used to replace it. 2. A plan for follow-up and reinstitution of therapy should be established 3. Anticipate patient's opioids requirements will be similar to an opioid-tolerant patient 4. Consider adjuncts – NSAIDs, membrane stabilizers, acetaminophen, local anaesthetics, regional anesthetic techniques 5. Ensure appropriate outpatient follow-up with buprenorphine provider
Sen et al	2016	1. Discontinue buprenorphine 72H before operative procedure, or replace buprenorphine with methadone 2. Expect additional opioid doses for acute pain control 3. Discharge on pure opioid induction protocol of buprenorphine in conjunction with primary provider
Jonan et al	2018	1. Utilize non-opioid adjuncts, regional Anesthesia, and local anesthetic infiltration by surgeon where possible. 2. Where low post operative pain is expected, continue buprenorphine perioperatively without taper 3. Where intermediate pain is expected, discontinue buprenorphine 3 days prior to procedure, consider high dose PCA, and consider ICU admission for respiratory monitoring 4. Where High pain is expected, discontinue buprenorphine 3-5 days prior to procedure, consider pure opioid agonist to manage withdrawal, and consider ICU for respiratory monitoring
Childers and Arnold	2012	1. Adjuvant analgesics and interventional procedures should be provided if available 2. Hold buprenorphine and start short acting opioid agonists if expecting moderate to severe pain 3. Re-initiate buprenorphine in the post-operative period with the buprenorphine provider 4. Where mild to moderate pain is expected, consider treating pain with buprenorphine alone, or use short-acting opioid agonists at higher doses 5. Consider replacing buprenorphine with methadone for opioid addiction where ongoing pain management is expected
Bryson	2014	1. Ideally, buprenorphine should be discontinued 72H before surgery, then restarted once patient no longer has acute pain requiring narcotic analgesics 2. If the plan is to continue buprenorphine, use short-acting opioid analgesics to achieve pain control, expecting higher than normal effective doses. Divide buprenorphine maintenance dose and administer every 6-8 hours 3. If the plan is to stop the buprenorphine, use standard opioids for analgesia, conduct a slow taper over 2 weeks or an abrupt taper over 3 days, remaining buprenorphine free for 72 hours before surgery 4. If the relapse rate is too high, replace maintenance dose of buprenorphine with methadone before surgery, and use another short-acting opioid and analgesic for breakthrough pain
Berry (Vermont Guidelines)	2015	1. Reduce buprenorphine dose to 8mg SL on the day of surgery 2. Use oxycodone or other full agonists to make up opiate debt + typical post operative course management 3. Expect longer than normal pain management regimen in the post operative period 4. Buprenorphine doses above 10mg daily will block opioid analgesics for pain
Lembke et al. (Editorial)	2018	1. Continue buprenorphine in the perioperative period for patients taking 12mg SL or less 2. Taper buprenorphine to 12 mg SL 2-3 days pre-op 3. Multimodal analgesia, Regional techniques where possible 4. Higher than normal doses of opioids to treat pain for 2-4 days post-op