Special Populations: MAT & C-Sections

Medication Assisted Treatment is a safe and effective treatment option during pregnancy. But how do you manage pain for patients that will deliver by C-section?

Most older protocols for anesthesia/surgery recommend stopping buprenorphine prior to the procedure. For Dr. Kaylin Klie, an addiction medicine specialist and Assistant Professor with the University of Colorado Department of Family Medicine, this makes sense if patient is in pain prior to procedure and the surgery is for the indication of the pain. For a C-section, most women are not suffering with severe pain prior to surgery.

What is being done for C-section (and other elective, not done for indication of pain procedures) is now to continue buprenorphine and just treat the pain on top of it. This not only avoids opioid-debt and having to cover both patient's withdrawal as well as their post-op pain, but also prevents the need for re-induction onto buprenorphine after the procedure.

The recommendation at this time is to continue patient's buprenorphine as scheduled without interruption for C-section. The patient will require higher doses of full-agonist opioids for adequate pain control post-partum, when compared to typical doses for opioid-naïve post-partum patients. If they are unable to get adequate pain control pp with PO opioids, fentanyl PCA can be done successfully while continuing buprenorphine with adequate pain control.

Sample MAT for C-Section

- 300mg gabapentin pre-op, then 100-300mg TID post-op for a couple of days
- Ask anesthesia to continue spinal anesthesia vs TAP block vs incisional block
- Scheduled APAP and ibuprofen post-op
- Toradol if patient can tolerate it and no other contraindication (pp hemorrhage, etc)