"Pain, Hidden in Plain Sight"

A Case-Based Approach to Assessing and Treating Pain in People Living With Dementia

Project ECHO - Dementia
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Objectives

- Review issues unique to People Living with Dementia (PLWD) when assessing and treating pain.
- Share screening tools for pain which can be used for PLWD.
- Review the evidence for assessing and treating pain in PLWD.
- Consider a stepwise approach when treating pain in PLWD.

Opening Case

An 84-year-old woman with moderate Alzheimer's dementia
living in with her attentive caregiver (daughter) at home and becomes increasingly agitated, resists care (unusual for her), took a swing at her daughter. Daughter calls PCP. Daughter asks for a UA "She always asks acts this way when she has a UTI". PCP orders a UA, it is negative"

She is started on an antipsychotic. Two weeks later, behaviors persist.

❓ What Was Missed?

POLL: When you see new-onset agitation in dementia, what's your first consideration?

Dehydration

Delirium

Constipation

Med change

Urinary Retention

Environment changes

Pain

Sleep Disruption

Infection

Journal of American Geriatric Society, 2013

Providence

Age-Friendly Health Systems Benefit Everyone

The 5Ms for Age-Friendly Health define how we care for older adults. At Providence, we believe this framework can apply to anyone, regardless if you're 65 or older. Age-Friendly Health is everyone's health.

Providence's **5Ms** for Age-Friendly Health:

WHAT MATTERS

Know your care preferences and set goals for your health. Establish Advance Directives and Trusted Decision Makers.

MEDICATION

Manage your medications and understand how they may impact your mobility and cognition.

MENTATION

Get the emotional and cognitive support you need. Understand, prevent, and seek treatment for dementia, delirium, and depression.

MOBILITY

Keep active and mobile, preventing injuries and falls. Learn how to safely mobilize as you age.

MALNUTRITION

Commit to proper nutrition and assess malnutrition risk regularly.

The Scope of the Problem

50–66%

of people with dementia experience pain

63.5% in U.S. community-based study
~58% in French nationwide study

24%

of nursing home residents with pain receive NO analgesics

People with dementia receive less pain medication than those without

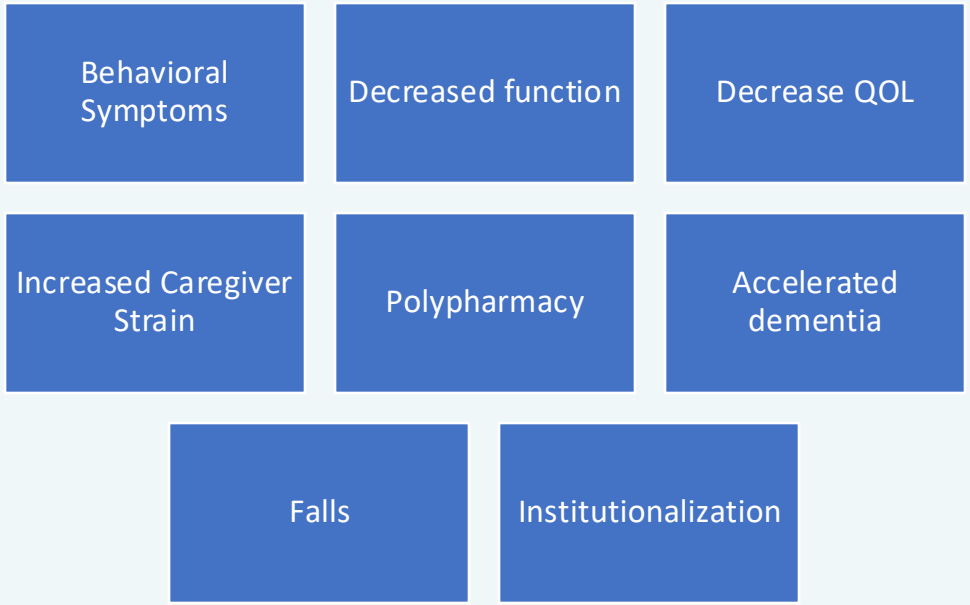
3.8×

more likely to exhibit aggression/agitation if pain is undertreated

OR 1.17 agitation, OR 2.11 depression (2025 meta-analysis)

Cochrane Database Syst Rev, 2022. J Clin Nurs, 2025

Why Is This So Important?



Why Is Pain Missed in Dementia?

🗣️ Communication breakdown

Difficulty self-reporting pain due to cognitive impairment — but self-report remains possible in mild–moderate dementia

🎭 Atypical presentation

Pain manifests as agitation, resistance to care, vocalizations, withdrawal — easily mistaken for BPSD

🧠 Clinician bias

Tendency to attribute behavioral changes to dementia itself rather than searching for a modifiable cause

Ties into Personhood

⚠️ Assessment gap

Lack of routine, structured pain assessment using validated observational tools in clinical practice

The Assessment of Pain in PLWD

- Must be **multidimensional** approach to pain assessment
  - Self-report assessments – should always include if possible
  - Pain history information
  - Considering coping, psychological, attitude, belief
  - Physical examination - focus on common conditions that are painful in adults
  - Understand type of pain
  - Informant-based ratings
  - Observation of pain behaviors

Recognizing Pain: Consider 6 Behavioral Domains

Facial Expressions

Frowning, grimacing, frightened look, rapid blinking

Verbalizations

Moaning, groaning, calling out, crying, sighing, "ouch"

Body Movements

Rigid posture, guarding, rocking, rubbing, bracing

Interpersonal Changes

Aggression, resistance to care, social withdrawal, disruptive behavior

Activity Changes

Refusing meals, altered sleep patterns, wandering, reduced mobility

Mental Status Changes

Increased confusion, delirium, crying or distress without clear cause

J Am Geriatr Soc, 2015

Pain Assessment: A Practical Approach

ASPMN Recommended Framework for Nonverbal Patients

1

Attempt Self-Report

Even in mild–moderate dementia. Numeric rating scales and verbal descriptors can be valid. Never assume a patient cannot report.

2

Search for Potential Causes

Arthritis, fractures, constipation, UTI, pressure injuries, contractures. Examine the patient systematically.

3

Observe Pain Behaviors - TOOL

Facial expressions, vocalizations, body movements, guarding, grimacing — especially during care tasks or movement.

4

Seek Proxy Input

Family members and direct care staff who know the patient's baseline are critical informants.

Herr 2011• AGS 6 Domains of Nonverbal Pain Behavior 2002

Observational Tools: Evidence for Impact

Validated Observational Tools

PAINAD

Most widely used in clinical practice & research. 5 items, 0–10 scale. Brief & practical for bedside use.

Abbey Pain Scale

Originally designed for end-stage dementia. 6 items. Common in Australian aged care.

DOLOPLUS-2

Multi-dimensional, 10 items. Well-validated in European settings.

PACSLAC

24-item checklist. Covers facial expressions, activity, body movements, physiological indicators.

Clinical Impact of Using Observational Tools

Compared to clinical judgment alone, observer-rated instruments like the PAINAD improved:

↑25%

Recognition of pain presence

↑42.5%

Classification of pain intensity above chance

Lancet Neurology, 2022

What TOOL to use to assess Pain in PLWD?

Clinical Psychology Review 124 (2026) 102704

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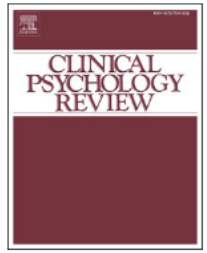
journal homepage: www.elsevier.com/locate/clinpsychrev



Check for updates

Pain in dementia: A systematic review of the measurement properties of observational assessment tools

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Pain Assessment in Advanced Dementia -**PAINAD**

Evidence-Based

- PAINAD is strongly recommended based on robust psychometric evidence from multiple independent studies and systematic reviews.

Concise and Practical Structure

- The scale uses five behavioral items enabling **quick** bedside administration ideal for frail or complex patients.

Validity and Responsiveness

- PAINAD shows strong correlation with other pain tools and reliably tracks changes following interventions. Without variance in the use of the measure across racial groups

Limitations and Clinical Use

- PAINAD measures observable behavior and is best as a decision-support tool, not a standalone diagnostic test.

Clinical Psychological Review, 2026

The PAINAD Scale

Domain	Score 0	Score 1	Score 2
Breathing (non-vocal)	Normal	Occ. labored breathing; short period of hyperventilation	Noisy labored breathing; long periods of hyperventilation
Negative Vocalizations	None	Occasional moan/groan; low-level speech with negative quality	Repeated troubled calling out; loud moaning/groaning; crying
Facial Expression	Smiling or inexpressive	Sad; frightened; frown	Facial grimacing
Body Language	Relaxed	Tense; distressed pacing; fidgeting	Rigid; fists clenched; knees pulled up; pulling/pushing away
Consolability	No need to console	Distracted or reassured by voice/touch	Unable to console, distract, or reassure

Total Score: 0–10 • Score ≥3 suggests clinically significant pain • Most widely used and validated in LTC settings [Ref 8–10]

🎯 Interactive: Score the Patient

Clinical Scenario

During repositioning, the patient grimaces and pulls her leg away. She is moaning softly. Her breathing is normal. She is tense but briefly calms when daughter speaks to her.

Breathing	Vocalizations	Facial Expr.	Body Language	Consolability
?	?	?	?	?

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Breathing	Vocalizations	Facial Expr.	Body Language	Consolability
?	?	?	?	?

Back to the Case: Now What?

PAINAD score is 5/10 during repositioning. History of osteoarthritis. Recent fall. On no analgesics.

Non-Pharmacological (First-Line!)

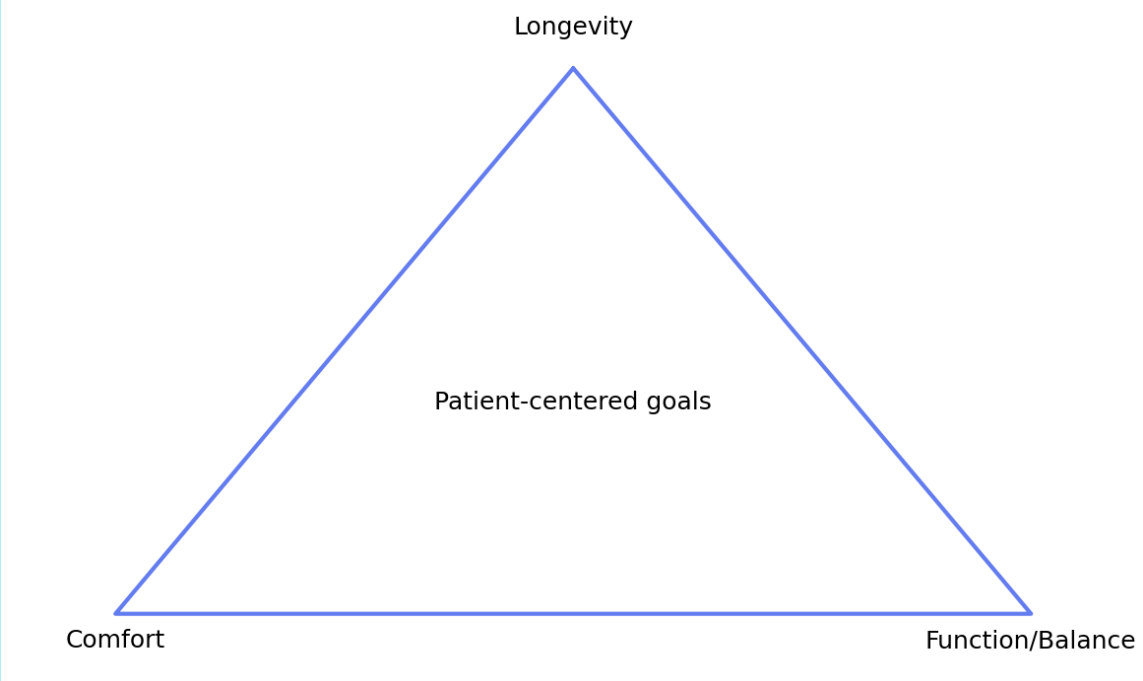
- Therapeutic massage / touch
- Music therapy (esp. during care tasks)
- Exercise / movement programs
- Distraction techniques
- Personally tailored interventions

Front Pain Res. 2026

What Matters Most?

Need to understand:

- prolong survival
- maintain function
- minimize symptoms/burden



Prescribing Principles for PLWD

- Treat to improve function and quality of life
- High risk of adverse effects due to age related changes should lead to cautious prescribing but not limit consideration
- Use the least invasive and reliable method
- Start low and go slow – especially in a brain that may be more prone to delirium
- De-prescribe when appropriate

Changing Pharmacokinetics and Pharmacodynamics

Table 1—Age-Associated Changes in Pharmacokinetics and Pharmacodynamics

Parameter	Age effect	Disease factor effect	Prescribing implications
Absorption	Rate and extent are usually unaffected	Achlorhydria, concurrent medications, tube feedings	Drug-drug and drug-food interactions are more likely to alter absorption
Distribution	Increase in fat:water ratio; decreased plasma protein, particularly albumin	Heart failure, ascites, and other conditions increase body water	Fat-soluble drugs have a larger volume of distribution; highly protein-bound drugs have a greater (active) free concentration
Metabolism	Decrease in liver mass and liver blood flow decrease drug clearance; may be age-related changes in CYP2C19, while CYP3A4 and 2D6 are not affected	Smoking, genotype, other medications, alcohol, and caffeine have more effect than aging on metabolism	Lower dosages may be therapeutic
Elimination	Primarily renal; age-related decrease in glomerular filtration rate	Acute and/or chronic kidney impairment, decreased muscle mass can result in worse kidney function than serum creatinine (Cr) levels might suggest	Serum Cr not a reliable measure of kidney function; best to estimate Cr clearance using formula
Pharmacodynamics	Less predictable and often altered drug response at usual or lower concentrations	Drug-drug and drug-disease interactions may alter responses	Prolonged pain relief with opioids at lower dosages; more sedation and postural instability from benzodiazepines; altered sensitivity to β-blockers

What about acetaminophen?

- Mixed evidence!
  - One study -authors concluded that paracetamol improved social interaction
  - Another found no significant difference in discomfort between the placebo and paracetamol groups
- But…"No average effect" ≠ "no one benefits"

BMC Med, 2020

How about NSAIDS?

- Choose when other safer therapies have failed in those with relatively lower risk
- Ongoing assessments of risks and therapeutic benefits
- Use at low effective dosage for shortest period of time
- Consider TOPICALs first

Diclofenac gel - 5–20% of the systemic exposure of oral diclofenac, which is why it tends to be much **safer for the stomach, kidneys, and heart**

Table 2. Topical Prescription Options for Chronic Pain

Generic	Brand	Dosing	Indication
Diclofenac sodium 1.5% w/w topical solution	Pennsaid	40 drops 4 times daily	Osteoarthritis of the knee
Diclofenac sodium 2% w/w topical solution	Pennsaid	2 pumps (40 mg) 2 times daily	Osteoarthritis of the knee
Diclofenac sodium 1% gel	Voltaren Gel	2-4 g 4 times daily	Osteoarthritis
Diclofenac epolamine 1.3% patch	Flector Patch	1 patch (180 mg) 2 times daily	Acute pain due to minor strains, sprains, contusion
Lidocaine 5% patch	Lidoderm Patch	1-3 patches applied once daily, removed after 12 h	Postherpetic neuralgia

w/w: weight-in-weight. Source: References 10-12, 14, 15.

NSAID considerations
(also remember What Matters Most)

Risk Profile	Preferred Oral NSAID	Additional Measures
High GI risk, low CV risk	Celecoxib or traditional NSAID + PPI	Gastroprotection with PPI or misoprostol
Low GI risk, high CV risk	Naproxen + PPI	Naproxen may have a modest CV advantage (though PRECISION did not confirm superiority)
High GI + high CV risk	Avoid NSAIDs if possible; if unavoidable, celecoxib + PPI or naproxen + PPI depending on dominant risk	Consider non-NSAID alternatives
CKD (CrCl 50 mL/min)	Avoid all oral NSAIDs	Topical NSAID may be considered with monitoring

N Engl J Med. 2016

Non-opioid Meds and Starting Doses

Acetaminophen 325–500 mg every 4 h or 500–1,000 mg every 8 h	Maximum dose usually 3 g daily. Reduce maximum dose 50% to 75% in patients with hepatic insufficiency or history of heavy alcohol use.
Naproxen 220 mg twice daily Celecoxib 100 QD - BID	Consider issues on previous slide
Ibuprofen 200 mg three times a day	Food and Drug Administration indicates concurrent use with aspirin inhibits aspirin's antiplatelet effect

What about Opoids in PLWD?

- Opioids can have a role in people living with dementia—but they should be used **thoughtfully, at low doses, and for clearly identified pain**."
- This is a population at high risk for **delirium, sedation, falls, and constipation**, so we need to start low, titrate slowly, and monitor closely.
- At the same time, we shouldn't undertreat—**untreated pain also causes harm**, including agitation and functional decline.
- So it's always a balance: **treat pain when needed, but with careful goal-setting, close follow-up, and ongoing reassessment**.

Beers Criteria, JAGS, 2023

Starting Doses of Short Acting Opioids

Oxycodone 2.5–5 mg every 4–6 h

- Daily immediate-release dose limited by fixed-dose combinations with acetaminophen or NSAIDs. Immediate-release oxycodone is available without added co-analgesics

Morphine Immediate release 2.5–10 mg every 4 h

- Available in tablet form and as concentrated oral solution, commonly used for episodic or breakthrough pain and for patients unable to swallow tablets.

Hydromorphone 1–2 mg every 3–4 h

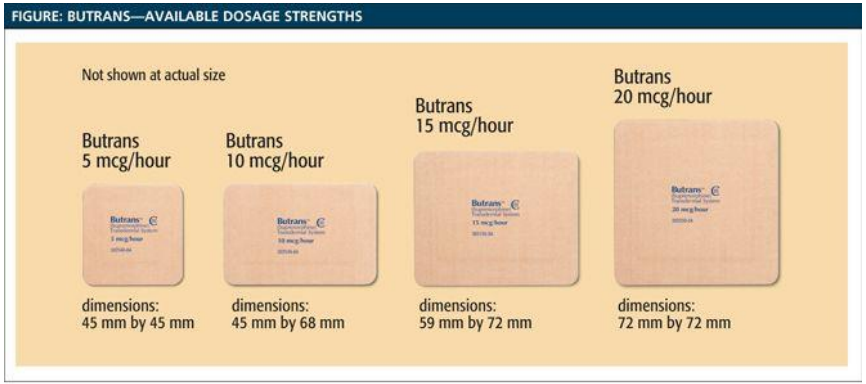
- For breakthrough pain or for around-the-clock dosing.

Hydrocodone 2.5–5 mg every 4–6 h

- Daily dose limited by fixed-dose combinations with acetaminophen or NSAIDs. Prescribers need to consider the amount of nonopioid agent in each of these preparations

Beers Criteria, JAGS, 2023

Buprenorphine Transdermal Patch



- Favorable pharmacodynamics/kinetics
- Does not require renal/hepatic dosing changes
- Led to reduced daytime activity in one study of nursing home patients
- Butrans 5mcg/hour is equivalent to 5-10mg oxycodone a day
- Can be started in opioid naïve people
- Other forms of buprenorphine may be considered

Adjuvant Therapies

All patients with neuropathic pain are candidates for adjuvant analgesics, can be considered in all undertreated pain

TCAs – generally avoid in older adults, especially those with dementia

Gabapentin (100mg) and Pregabalin (50mg)– need renal dosing if GFR<60 (cautions with prescribing cascade)

The effects of these medications are enhanced when used in combination with other pain analgesics and non-drug strategies

⚠ What to Avoid: AGS Beers Criteria

✕ **Skeletal muscle relaxants (cyclobenzaprine, methocarbamol)**	Poorly tolerated in older adults: sedation, fall risk, anticholinergic effects.
✕ **Tricyclic antidepressants (amitriptyline, nortriptyline)**	Highly anticholinergic; urinary retention, constipation, confusion, orthostatsis.
✕ **Chronic oral NSAIDs**	GI bleeding, renal injury, cardiovascular risk — unless alternatives inadequate + GI protection added.
✕ **Gabapentinoids + opioids or + benzodiazepines**	CNS depression synergy: risk of respiratory depression, fall, sedation. Renal toxicity

American Geriatrics Society 2023 Beers Criteria

Received: 17 November 2021 | Revised: 10 March 2022 | Accepted: 25 March 2022
DOI: 10.1111/jgs.17910

CLINICAL INVESTIGATION

Journal of the American Geriatrics Society

Elderspeak communication and pain severity as modifiable factors to rejection of care in hospital dementia care

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Sweetie/buddy

You are ready for breakfast, aren't you?

High-pitched sing song voices

It's ok to go poo-poo

Would you take this medicine for me?

Just relax, OK?

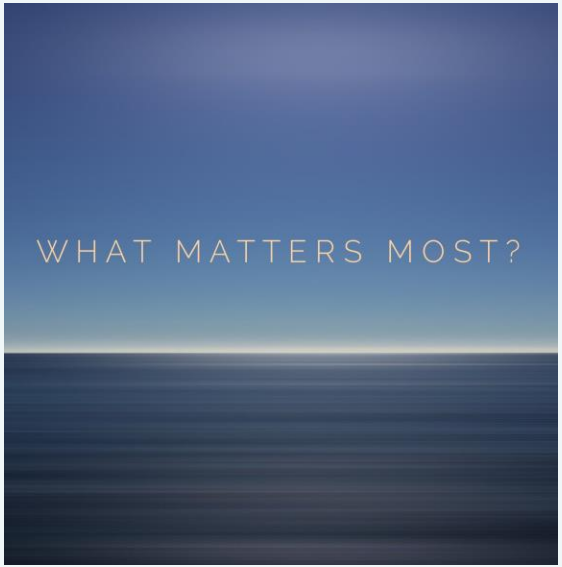
Key points

- Rejection of care when Elderspeak was used was more likely and more severe when patients were experiencing greater pain.

JAGS, 2022

Back to the Case: Now What?

PAINAD score is 5/10 during repositioning. History of osteoarthritis. Recent fall. On no analgesics.



Note: Despite guidelines, practice remains predominantly pharmacological with inconsistent non-pharm use (Dutch study, 2026 [Ref 12])

Pharmacological Stepwise Approach

Step 1

Acetaminophen

Max 3g/day if older and more frail; no cognitive effects

Step 2

Topical NSAIDs

e.g., diclofenac gel; avoid chronic oral NSAIDs (Beers)

Step 3

Low-dose opioids

Start low/titrate slowly; watch for delirium, constipation

Step 4

Neuropathic agents

Consider topicals or pregabalin at low doses if neuropathic component

What Would You Do?

Scenario A

Patient already on acetaminophen 3g/day. PAINAD still 5. No delirium. Has knee OA.

- A) Add topical diclofenac
- B) Add low-dose opioid
- C) Add pregabalin
- D) Reassess for other cause

Scenario B

No better, increased moaning in pain. Patient started on opioid – oxycodone 2.5mg; pain improved but now constipated and more confused. What do you do?

- A) Reduce dose + add bowel regimen
- B) Stop opioid entirely
- C) Add stimulant laxative only
- D) Switch to pregabalin

Case Resolution – 2 weeks later

Antipsychotic tapered and discontinued

Scheduled acetaminophen 1g TID cont'd, oxycodone 2.5mg PRN (used 3 times over last 2 weeks)

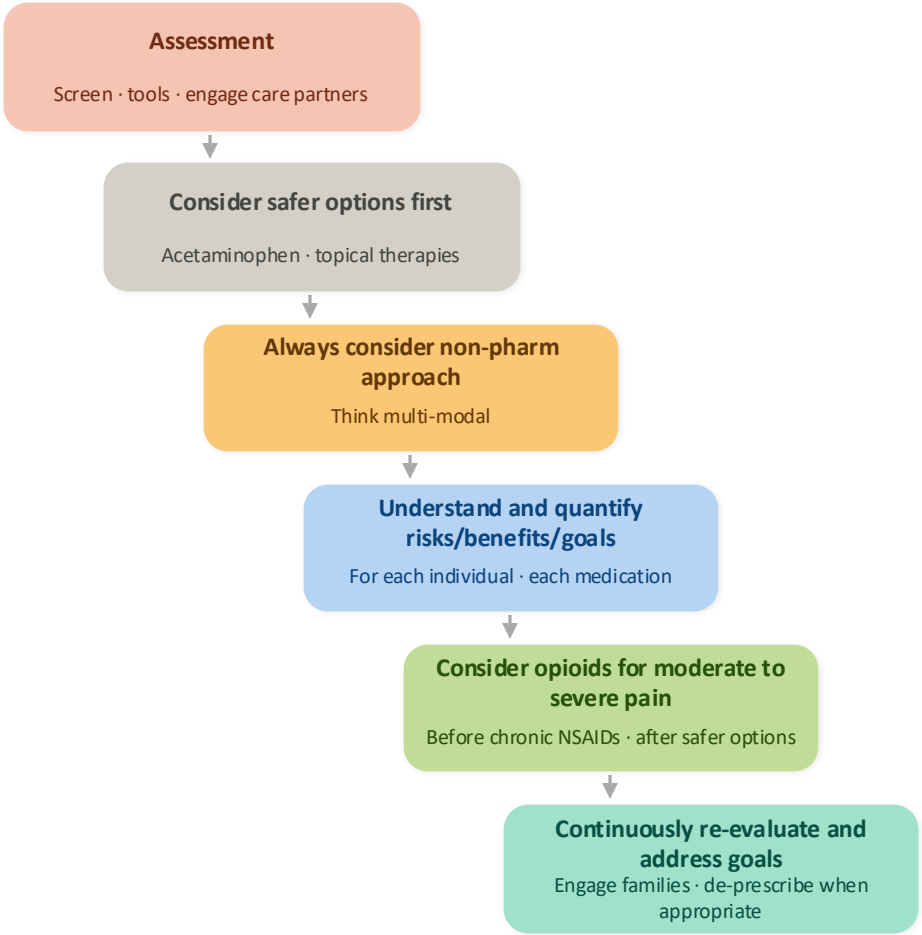
Topical diclofenac gel applied to knees

Music therapy added during all care tasks

PAINAD score dropped from 5 → 2 | Agitation resolved

If agitation persists despite adequate analgesia → investigate other BPSD causes (infection, delirium, medication side effects, unmet psychosocial needs)

One Approach for Assessment and Treatment of Pain in PLWD



Summary

Padlet with resources!

- High index of suspicion for pain in PLWD, it's very common
- Pain is a modifiable cause of behavioral symptoms in PLWD.
- Routine assessment for pain in PLWD
- Stepwise treatment of pain for PLWD
- Don't forget the issue of personhood and training/education of direct caregivers
- Reassess - use the same tool if possible, investigate more if not improving

Pharmacologic options for non-malignant pain in older adults

Geriatric Mini-Fellowship (last updated May 2026)

Pharm Class	Best Use	Caution	Geriatric Pearl	Geriatric Dose
Acetaminophen	OA Mild pain syndrome Adjunct to opioid and NSAID	Hepatic disease Alcohol use	Safe as long-term use Consider routine rather than PRN use Dose during waking hours to avoid interrupting sleep	3000mg/day 3900mg/day for ER formulation
NSAIDS • **Ibuprofen** • **Naproxen** • **Meloxicam** • **Nabumetone** • **Salsalate** **COX2 inhibitor** • **Celecoxib**	Acute inflammatory pain RA OA Gout Acute fracture pain Bone pain	HTN CHF CKD Hx of GI bleed	▪ Use as short term (5 days) with stop date ▪ Include give with food and full glass of water ▪ GI toxicity is related to dose and length of use ▪ Nabumetone, Salsalate have least effect on platelets ▪ Naproxen is safer for CV risk ▪ Celecoxib is safer for GI but higher CV risk ▪ Monitoring: BP, edema, GI symptoms, BMP ▪ May consider H2 blockers, PPI as GI protection if using longer than 7-14 days	Ibuprofen 200-400mg TID Naproxen 220-550mg BID Meloxicam 7.5mg daily Nabumetone 500mg daily Salsalate 500mg BID Celecoxib 100mg daily
Topicals • **Diclofenac 1%** • **Lidocaine 4% (OTC) or 5% (RX) patch** • **Capsaicin cream or patch 0.025%, 0.075%** • **Muscle rub**	Localized pain (knees, back, joints) Musculoskeletal pain Neuropathic pain	Do not apply to broken skin or mucous membranes Do not occlude area after application	• Less systemic side effects • Immediate onset of effect • Local reaction is the most common • Use dose card for diclofenac gel • May cut patch for Lidocaine, capsaicin • Avoid thick application, use gloves for capsaicin cream and other OTC analgesic cream	Diclofenac 1% - 2-4g TID Lidocaine 4% or 5% patch – apply AM and off PM Capsaicin 0.025% cream – apply TID Capsaicin extended release patch up to 3 months
SNRI • **Duloxetine** • **Venlafaxine**	Diabetic neuropathy Fibromyalgia Musculoskeletal pain	Caution in hepatic or renal dysfunction	• CNS side effects including cognitive side effects • Venlafaxine can increase BP • Onset of effect is slow • Useful for patients with depression or anxiety disorders	Duloxetine 30-60mg/day Venlafaxine 37.5mg-75mg/day

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Pharm Class	Best Use	Caution	Geriatric Pearl	Geriatric Dose
Muscle relaxants • **Baclofen** • **Tizanidine**	Spasticity related to TBI, Cerebral palsy, quadriplegia Spasticity related to spinal injuries, multiple sclerosis	CKD	• Short term use • Taper if discontinuing • Dose adjustment needed for renal function • CNS side effects: somnolence, confusion • Bradycardia, hypotension with Tizanidine • Drug-drug interactions with Tizanidine	Baclofen 5mg TID (max 30mg/day) Tizanidine 2mg BID-TID
Anticonvulsants • **Gabapentin** • **Pregabalin** • **Carbamazepine***	Diabetic neuropathy Postherpetic neuralgia Fibromyalgia Trigeminal neuralgia Neuropathic pain	CKD	• Dose adjustment needed for renal function for gabapentin & pregabalin • Caution if using with opioids • Edema, CNS suppressant (dizziness, somnolence, ataxia)	Gabapentin 100-300mg/day Pregabalin 50mg/day Carbamazepine 100mg/day
Opioids • **Hydrocodone +/- APAP** • **Oxycodone +/- /APAP** • **Morphine** • **Hydromorphone** • **Fentanyl** • **Methadone** • **Buprenorphine** **Dual mechanism drug** • **Tramadol**	Visceral pain Chronic pain	Caution with renal dysfunction, slow or rapid CYP 2D6 liver metabolizer	• Start low (using short-acting formulation) go slow in titrating dose • Use MEDD 50 as top dose guide • Don't forget bowel meds • Extended-release tablets are appropriate to use once stable dose is achieved • Tramadol has SNRI activity, analgesic effect may be unpredictable based on liver metabolism, drug interactions • Morphine not the best choice in renal disease • Fentanyl is most potent opioid and do not start in opioid naïve patients, peak effect of first dose takes 18-24 hours, may take more than a week to reach steady state • Switching from one opioid to another, consider decreasing new dose by 30-40% due to variability in response • Opioid conversion to or from Methadone or Fentanyl to other opioids does not follow the same rule	Hydrocodone/APAP 5/325 – ½ to 1 tablet TID Oxycodone/APAP 5/325 – ½ -1 tablet TID Morphine IR (liquid or tab)-5mg-7.5mg TID Hydromorphone -2mg TID

*Trigeminal neuralgia, screening for HLA-B allele before starting due to fatal dermatologic reactions

JAGS 57:1331–1346, 2009

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Buprenorphine Quick Reference

Key prescribing considerations and formulation comparisons for clinical use.

	Patch (Butrans)	Buccal Film (Belbuca)	Sublingual tablet (Subutex)	Sublingual film or tablet (Suboxone)
Starting dose for chronic pain	• Opioid naive or MED<30: 5 mcg/hr weekly • MED 30-80: taper to 30 MED, then 10 mcg/hr • MED>80: not appropriate	• Opioid naive or MED<30: 75 mcg daily or q12h • MED 30-90: taper to 30 MED, then 150 mcg q12h • MED 90-160: taper to 30 MED, then 300 mcg q12h • MED>160: not appropriate	Micro-induction • Day 1: 0.5 mg daily • Day 2: 0.5 mg BID • Day 3: 1 mg BID • Day 4: 2 mg BID and stop the short acting opioid • Day 5: 3 mg BID • Day 6: 4mg BID • Day 7: 4mg TID and stop all remaining opioid (long acting)	Using 2-0.5mg tablet • 0.5mg (1/4 film/tablet) daily • 0.5mg BID • 1mg (1/2 film/tablet) BID • 2mg BID and stop the shot acting opioid • 3mg BID • 4mg BID • 4mg TID and stop all remaining opioid (long acting)
Outpatient titration	Every 7-14 days	Every 7-14 days in 150 mcg increments	Daily microdosing	Daily microdosing
Available strength	5, 7.5, 10, 15, 20 mcg/hr patches	75, 150, 300, 450, 600, 750, 900 mcg films	2, 8 mg tablets	Film: 2-0.5mg, 4mg-1mg, 8-2mg, 12-3mg Tablet: 2-0.5mg, 8-2mg
Max dose	20 mcg/hour	900 mcg q12h	24 mg per day	16-24mg/day
Dental/oral warning		Regular dental care, swish and swallow a large sip of water after dissolved, avoid brushing for 1 hour	Avoid eating, drinking, or smoking until fully dissolved. May take up to 10 minutes	Film: do not move film after placement under the tongue. Wait for it to completely dissolved, swish a sip of water around teeth and gum and swallow; wait at least 1 hour after to brush teeth. SL tablet: do not chew or swallow tablets and follow same process as film.

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Key Points

- No special DEA X waiver is required to prescribe buprenorphine.
- Buprenorphine can be used for pain, opioid use disorder, or both.
- Doses/dosing for chronic pain is different from dosing for opioid use disorder.
- It is a Schedule III medication, and refills may be written for up to 6 months.
- As a partial mu-opioid receptor agonist, it is associated with fewer opioid-related adverse effects such as euphoria, constipation, nausea, respiratory depression, and sedation.
- Can be used in patients with chronic kidney disease and in dialysis.
- Use caution when co-prescribing with benzodiazepines or gabapentinoids
- Microdose induction allows for transition to buprenorphine while the individual is still taking current opioids, thereby helping to avoid uncomfortable withdrawal symptoms and/or uncontrolled pain

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