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If you take opioid medicines regularly

> **The short version.** Do not stop your usual opioid before surgery without advice. Tell me the names, doses and who prescribes them. You will usually continue them with a plan for extra pain relief around the operation, because tolerance changes what is needed.

Why this needs planning

If you have taken opioids for weeks or months, your body has adapted to them. That means the dose that would help someone else may do very little for you, and stopping suddenly can cause withdrawal — sweating, agitation, goosebumps, stomach cramps, diarrhoea and a raised heart rate — in the middle of a hospital stay, when you are least able to cope with it.

What I need to know

- Every opioid: oxycodone, morphine, fentanyl patches, buprenorphine (including as a patch or for dependence), methadone, tapentadol, tramadol.
- The dose and how often, and how long you have taken it.
- Who prescribes it — GP, pain specialist, or a clinic — and when it was last reviewed.
- Whether you also take benzodiazepines, gabapentin or pregabalin, which add to sedation.
- Any history of dependence or of withdrawal, and how it was managed.

The usual plan

- **Your regular opioid continues** through the fasting period, with a sip of water. Patches stay on.
- Extra pain relief comes from medicines that work differently — local anaesthetic blocks, paracetamol, anti-inflammatories where safe, ketamine in some settings, and nerve catheters — rather than simply raising the opioid.
- Doses may need to be higher than usual to achieve the same effect, and that is expected rather than a sign of weakness.
- Buprenorphine and methadone need particular planning: tell me well before the day, because the prescriber and I may need to talk. Do not adjust them yourself.
- Constipation is almost universal on opioids — a laxative is part of the plan, not an optional extra.

Going home

- Return to your usual dose as soon as the acute pain settles; do not increase your regular dose yourself.
- Ask for a review if you are still needing extra doses a fortnight after surgery — that is a sign the pain plan needs rethinking, not that you need a stronger opioid.
- Keep medicines locked away, and return leftovers to a pharmacy.

Contact us before the operation if: you have run out, your prescriber has changed the dose, you are in withdrawal, or you are worried about being judged. It is far easier to plan this in advance than to sort out on the day, and it does not affect the care you get — it improves it.

On your phone: anaesthesia.herman.au/p/17

Prepared by Dr Herman Lim for patients of his anaesthetic practice · version 1.0, 27 November 2026.

Continuing opioids, tolerance and discharge planning follow ANZCA **PS01(PM) Statement regarding the use of opioid analgesics in patients with chronic non-cancer pain**, with acute-pain standards from **PS41(G) (2023)** and adjunct options from **PS12(PM) Ketamine in chronic non-cancer pain**.

This pamphlet is general information and does not replace individual advice. If my rooms, your surgeon or your hospital have given you different instructions, **those instructions take priority** over anything written here.

Scan to read on your phone