



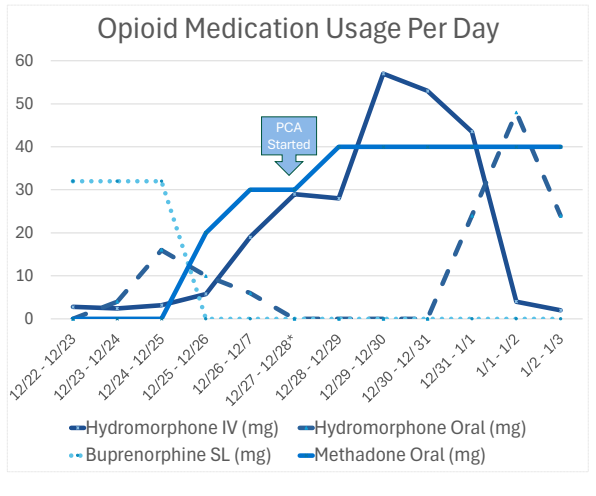
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Eric D. Mecusker, D.O.

ABSTRACT

Buprenorphine has recently gained more traction as a first-line agent for managing mild to moderate, constant pain in a cancer patient population. This case represents a patient who participated in a Chimeric Antigen Receptor T-cell trial while receiving high-dose (32 mg/day) buprenorphine for pain associated with cutaneous T-cell lymphoma. Pain increased immediately after receiving CAR T-cell treatment but was not responding to rapidly escalating doses of hydromorphone via a patient-controlled analgesia device. Supportive Medicine (Palliative Care) was consulted to address pain management in the context of suspected competitive inhibition of opioid agonists by high-dose buprenorphine. The decision was made to stop buprenorphine and start methadone, using the buprenorphine to morphine ratios published by Safer Care Victoria, a program from the state health service of Victoria, Australia, and the morphine to methadone ratio recommended by McPherson. The patient was successfully discharged from the hospital 6 days after methadone initiation, starting at 10 mg every 8 hours and discharging with 20 mg every 12 hours. Breakthrough pain was relieved with hydromorphone 6 to 8 mg every 3 hours as needed at the time of discharge. There was significant improvement in response to breakthrough opioids after stopping buprenorphine.

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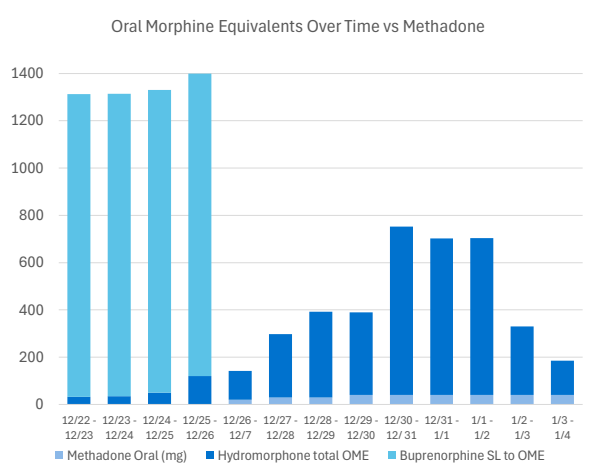
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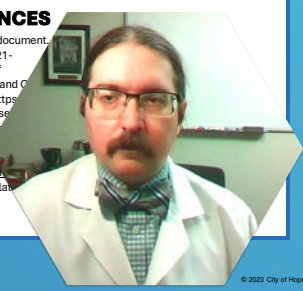
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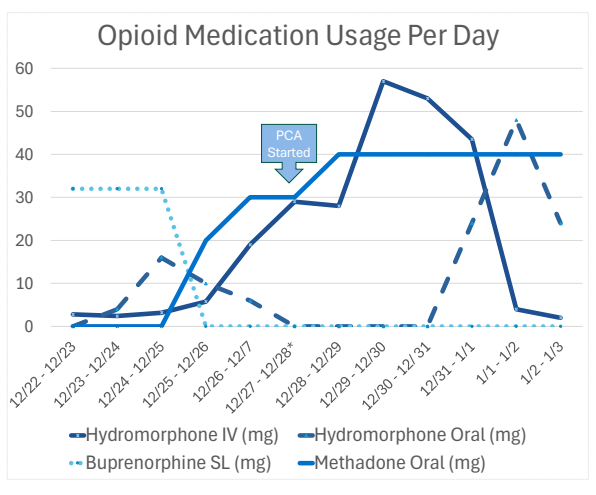
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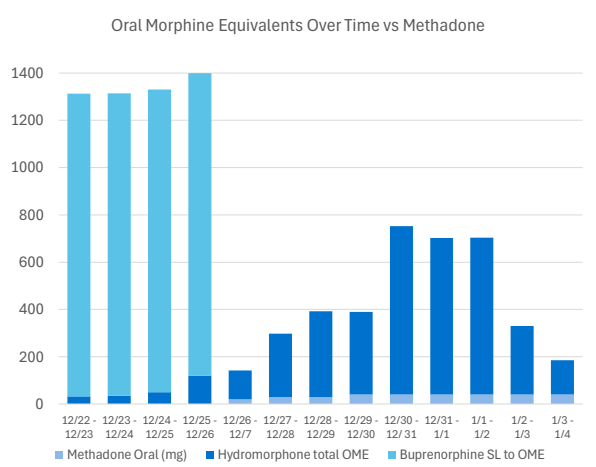
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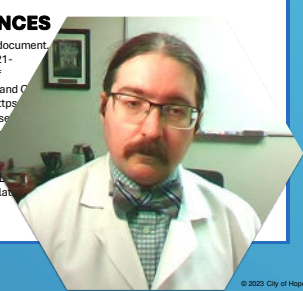
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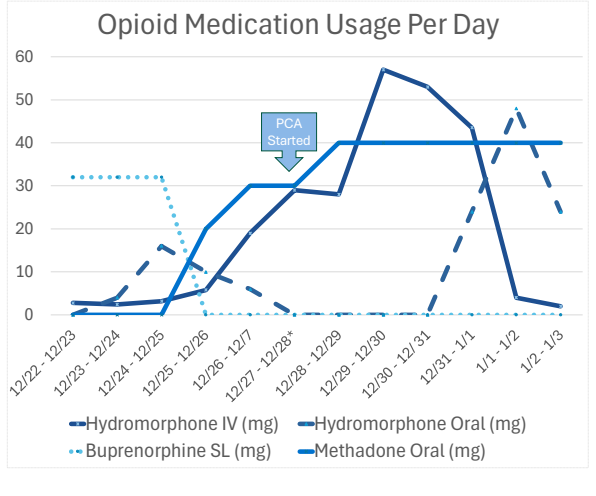
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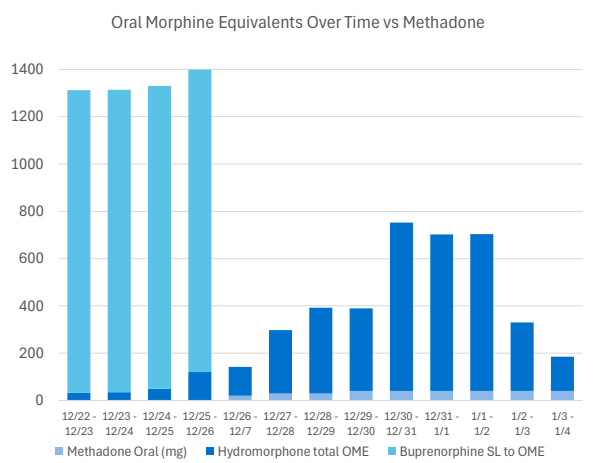
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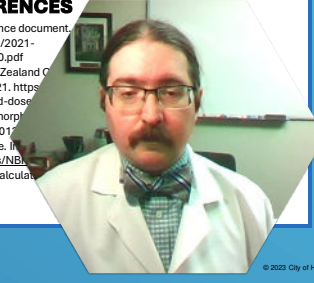
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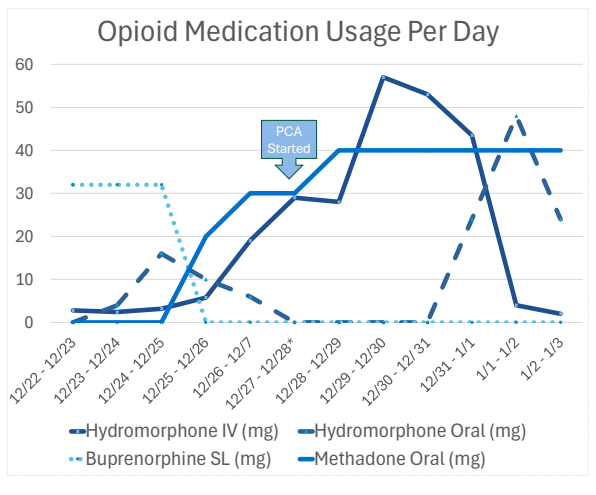
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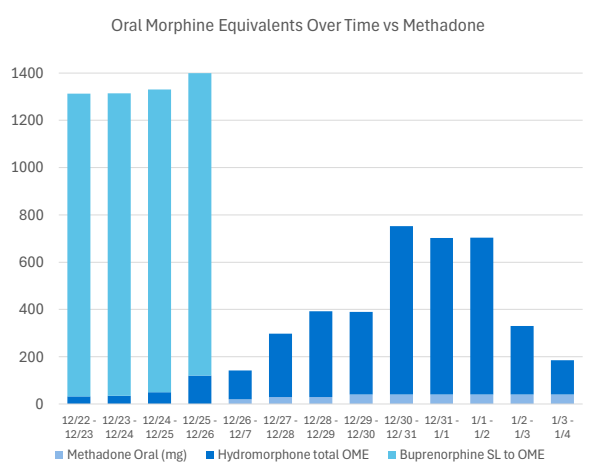
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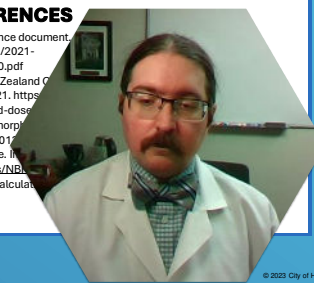
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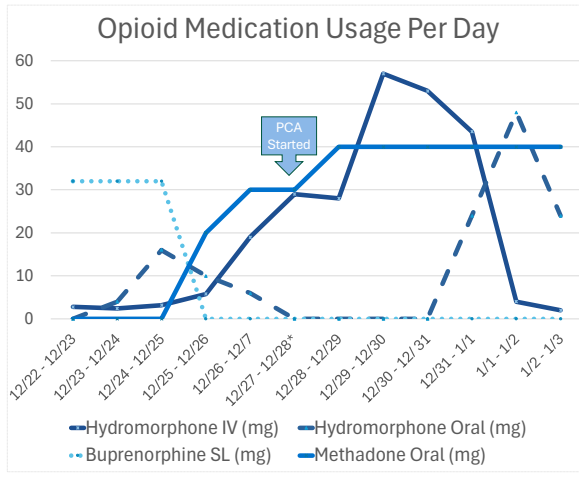
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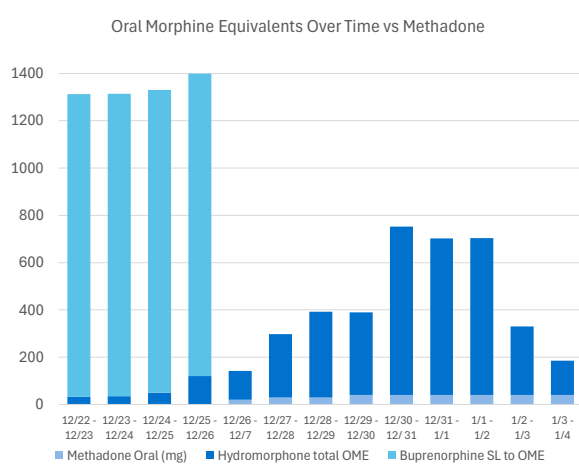
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