Pain and Drugs: Substance Use in Palliative Care

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Plan

- Case studies
- Categories of patients
- Palliative care patient dependent on opioids
- Palliative care patient develops an addiction
- Addiction patient referred to Palliative Care
- References

Case Studies

Case Study 1
- Mr A 45 attends his local Drug and Alcohol Service. He wants to stop drinking.
- He was diagnosed with terminal bowel cancer and given 3 months to live.
- On Methadone 70 mg prescribed by Palliative Care.
- Professional at sea but Mr A wants to do it for his wife.

Case Study 2
- Mrs B aged 53 diagnosed with diffuse metastatic breast cancer.
- Poor attendance at chemotherapy and radiotherapy.
- Feels that she has not long to live.
- History of IVDU and IMDU. Prescribed Dexamphetamine and Methadone by drug service.
- Partner is Opioid dependent.
- Chaotic home environment.
- Complaining of bone pain and requesting analgesia. What do you think?

Case Study 3
- Mrs C aged 38 diagnosed with Secondary progressive Multiple Sclerosis.
- Practically quadriplegic + recurrent urinary and chest infections.
- Wants to die at home.
- On Methadone for pain relief.
- Call from her main carer: could she have an early repeat prescription?
Categories of Patients

- Palliative Care patient becomes dependent to opioids.
- Palliative Care patient develops an addiction.
- Patient with established addiction referred to Palliative Care.
- N.B Abuse, tolerance, dependence, addiction, pseudoaddiction
- Chemical coping

Myths

- Belief that because the patient is dying we should give them what they want
- Belief that substance abuse is invariably a source of pleasure for the patient
- Addiction and diversion rarely occur in Palliative Care

Palliative Care Patient Becomes Dependent to Opioids

Opioid Treatment in Palliative Care

- WHO guidelines
  - Stepped care
- European Society for Medical Oncology 2011
  - Potent opioid for severe pain
  - By the clock
  - By mouth
  - Short acting opioid medication for breakthrough pain

NICE Guidance 2012

- Communication
- Dose titration
  - Oral sustained-release Morphine + oral immediate-release Morphine for rescue doses
- First line maintenance
  - Oral
  - Transdermal
  - Sub-cut
- Breakthrough pain
  - Oral Morphine
  - No Fentanyl first line
- Manage nausea, constipation and drowsiness
Opioid Treatment in Palliative Care - Risks

- Respiratory depression
  - Low dose of opioids for the treatment of dyspnoea
- Sedation
- Falls and injuries
- Motor vehicle accidents
- Constipation
- Cognitive impairment
- Dependence/Addiction
- Death

Remember
- Attitudes, stigma and fear of addiction are more harmful to patients and can often lead to under utilisation of pain pharmacology
- 30-50% patients receive inadequate or minimal pain relief at some point.
- Double Effect: risk of death may be acceptable as long as the goal of treatment remains the relief of otherwise unmanageable pain

Opioid Treatment in Palliative Care - Challenges

- 70% patients are reluctant to take medications due to fear of addiction
- Up to 1/3 under report their symptoms
- 40% spouses do not think that opioids should be used routinely
- 25% carers underestimate and minimise symptoms
- IV drug users with AIDS receive adequate symptom control only in 15% of the time.

(Please note: Canadian figures)

Palliative Care Patient Referred to Addiction Services

- Treatment as usual
- Special considerations re safety, potential interaction and diversion
- No significant association between pain and illicit drug use in MMT populations (Dhingra et al 2015)

Patient with Established Addiction Referred to Palliative Care
Palliative Care for Patients with Known History of Substance Misuse

- No reliable data
  - Substance misusers are living longer
  - Younger patients at diagnosis
  - Patients referred earlier to palliative care
  - Palliative Care patients are living longer
  - Opioids are introduced sooner.
- Under-reported/under-recognised
  - 9 - 41% Opioid abuse in chronic pain patients (Manchikanti 2006)
  - 16 - 34 % Illicit drug use in chronic pain patients (Manchikanti 2006)
  - 28% Alcohol in palliative care (Allen 2015)
- Lack of staff training
- Fear of challenging patients

Myths

- Maintenance Opioid Agonist (Methadone and Buprenorphine) provides analgesia
  - Analgesic effect 4-8 hours
  - Suppression of opioid withdrawal 24-48 hours
  - Opioid tolerance
  - Opioid-induced hyperalgesia
  - Opioid analgesia results in addiction relapse
  - Additive effects of opioid analgesia and OAT causes respiratory and CNS depression
- Reporting pain is indicative of manipulative and drug-seeking behaviour

Screening Tools

- Current Opioid Misuse Measure (COMM)
  - Detects opioid misuse in patients on opioids
- Opioid Risk Tool (ORT)
  - Risk factors
- Screener and Opioid Assessment for Patients with Pain Revised (SOAPP-R)
  - Need for greater caution and monitoring
- Diagnosis, Intractability, Risk, Efficacy (DIRE)
  - Primary Care
  - 7 Candidate for opioid treatment

Validated Risk Factors for Developing Addiction

- History of substance abuse, including smoking
- Family history of substance abuse
- History of abuse, particularly childhood abuse and PTSD
- Psychiatric co-morbidities
  - Depression
  - Anxiety
  - Personality Disorder
  - ADHD

Aberrant Behaviours Associated with Addiction

- Requests for dose escalation
- Emergency room visits
- Unscheduled clinic appearance related to pain complaints
- Seeking early prescriptions
- Lost opioid prescriptions
- UDS aberrancies
- Doctor shopping
- Forged prescriptions

Principles of Treatment (1)

- Around-the-clock dosing opioid
- Long acting opioid when possible
- Limit or eliminate short acting or breakthrough doses
  - Agree rules on “rescue doses”
- Titrate like all other patients
- Distinction between poor response and withdrawal
- Non-opioid adjuvants and monitor compliance
- Non-pharmacological interventions
  - Relaxation techniques, Biofeedback, TENS, Psychotherapy
**Principles of Treatment (2)**

- SM patients often lack organisational skills
- Staff concerns re their safety
- Abuse
- Boundaries
- Short prescriptions
- Pill Count
- UDS
- Referral to Addictions Services

**Principles of Treatment – Special Considerations (Opioid SM users)**

- Maintenance Therapy from SM services
  - Buprenorphine and Naltrexone
- Should be recognised as a separate prescription
- As an inpatient, all prescriptions should be issued on site.
  - Have a clear discharge plan
- In case of diversion
  - Short prescriptions
  - Advice on storage
- If on-loc use
  - MDT approach
  - Recovery programmes
  - Pill-count
  - UDS

**Principles of Treatment – Special Considerations (Alcohol or Other Depressants)**

- Risk of sedation and respiratory failure
- Hepatic and Kidney Failure
- Potential interaction with other prescriptions
  - Naltrexone
  - Acamprosate

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References (1)


References (2)

- Faculty of Pain Medicine 2016. Substance misuse and palliative Care.