Palliative Care and Substance Abuse

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University of Virginia
June 22nd, 2020
A (Philosophical) Introduction
Our patient, AF
- 50 year old man, no known medical history, out of care, who presented to the hospital with jaundice, nausea, vomiting and abdominal pain.

- Imaging demonstrated a duodenal mass and diffuse lymphadenopathy.

- Initial Heme/Onc evaluation: most likely a metastatic pancreatic adenocarcinoma.

- At this point, very few treatment options, consider hospice.
- Started drinking alcohol at age 12, using crack cocaine at age 14.

- Transitioned from cocaine to opioids.

- Suboxone treatment.

- After several financial set backs, could no longer able to afford Suboxone.

- Started buying Suboxone and Buprenorphine on the street.
- Taking ~2mg PO Buprenorphine daily.

- “Making it stretch” when needed.

- During this hospitalization, was treated for abdominal pain.

- Expressed the desire to protect his sobriety as much as possible.
- Started on Buprenorphine transdermal patch, and PO Hydromorphone.

- Discharged to follow up with oncology and palliative care clinic.
- Pathology results return.

- In a day, he went from carrying a diagnosis of a very terminal cancer with very limited treatment options to a potentially curable disease.

- He was re-admitted to start treatment.
- Pain was controlled, but – he was now going through withdrawal.

- Buprenorphine – 1/8 his “outpatient” dose.

- Irritable, nauseous, sweaty, unable to sleep.

- Threatening to leave AMA.
- Unable to start on oral Buprenorphine while in house.

- Started on Suboxone tablets.

- Symptoms improved.

- Used oral hydromorphone very sparingly.

- After evaluation by the addiction service, financial screening, and emergency Medicaid application, he followed up with the addiction psychiatry clinic for ongoing treatment.
Lessons learned from this case:

- It’s not an us vs them. It is important to patients to protect their sobriety.

- Understand the math. How much, how often, and what patients are using outside the hospital.

- The challenges of logistics.
Opioid medications have long been an important pillar of palliative medicine, particularly when treating patients with serious, life limiting illness.
At the same time, palliative providers are caring for patients earlier in their disease process, who may have longer life expectancies (or less defined disease trajectories), and who may be at risk for opioid and other substance use disorders.
We know the opioid epidemic is real, and prescription opioids play a significant role in opioid related deaths.

**Research Letter**

May 1, 2018

**Changes in Synthetic Opioid Involvement in Drug Overdose Deaths in the United States, 2010-2016**

Christopher M. Jones, PharmD, MPH\(^1\); Emily B. Einstein, PhD\(^2\); Wilson M. Compton, MD, MPE\(^2\)

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*Figure. Percentage of Synthetic Opioid-Related Overdose Deaths Involving Illicit or Psychotherapeutic Drugs or Alcohol in the United States, 2016*

<table>
<thead>
<tr>
<th>Coinvolved Drug or Alcohol</th>
<th>Synthetic Opioid-Related Deaths, %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other drug or alcohol</td>
<td>30%</td>
</tr>
<tr>
<td>Other opioids</td>
<td>20%</td>
</tr>
<tr>
<td>Heroin</td>
<td>20%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>20%</td>
</tr>
<tr>
<td>Prescription opioids</td>
<td>20%</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>20%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>20%</td>
</tr>
<tr>
<td>Psychostimulants</td>
<td>10%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>10%</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>10%</td>
</tr>
<tr>
<td>Other illicit drugs</td>
<td>10%</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>10%</td>
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</tbody>
</table>

*Deaths are not mutually exclusive. Percentages sum to more than 100%.*
Palliative Care facing the Opioid Epidemic
At the same time, we recognize that in light of very legitimate concerns regarding opioid prescribing, it is becoming more difficult for patients to obtain the medications they need.

Importantly, this disproportionately affects individuals from minority groups and disadvantaged socioeconomic settings.

Our duty is to continue to provide excellent care to patients and to do no harm.
Random survey of 30% of NY pharmacies

Results:

- 10% complete stock
- 39% nearly complete
- 35% incomplete
- 16% had no opioids in stock
- Percent of pharmacies with sufficient opioids varied by ethnic composition of the neighborhood
Opioids were prescribed less frequently in areas of higher poverty, lower median income, and lower educational status.

African American and Hispanic patients received opioids at lower rates.
Our Duty
Creating Our Toolbox
Our Patient, XR

- Man with a history of tonsillar SCC, treated with surgical resection, chemotherapy and radiation. He has been disease-free for over a year.

- However, as a result of the radiation treatment, he suffers from chronic osteonecrosis, non-healing oral ulcers, jaw fractures, and neuropathic pain.

- Some concerning behaviors: He has frequently run out of opioid medications early. Calls for prescription re-fills on nights, weekends, and off-hours. Urine toxicology screens have been positive for cocaine and marijuana.

- He has been followed by the palliative care clinic for symptom management.
Universal Policy for Opioid Safety

• Set Up
• Screening
• Monitoring
• Supporting
Set up

• Opioid Safety Education
• One prescriber agreement
• Who to call with questions
The majority of the guidelines recommend that clinicians who prescribe opioids employ strategies such as risk assessment instruments. Three types of risk assessment instruments have been designed to detect different dangers:

- Opioid misuse prior to initiating long-term opioid therapy
- Signs of misuse in patients currently using opioids.
- Non-opioid general substance abuse.
The Opioid Risk Tool (ORT) is a 5-item, patient administered, validated questionnaire designed to predict the risk of problematic drug-related behaviors.

A score of 8 or higher is considered high risk for opioid misuse.
Screening for substance abuse risk in cancer patients using the Opioid Risk Tool and urine drug screen

Joshua S. Barclay · Justine E. Owens · Leslie J. Blackhall

• Retrospective chart review of cancer patients seen at the Palliative Medicine Clinic at the University of Virginia
• Evaluation of patients using Opioid Risk Tool and urine drug screen results
• 43% of patients were defined as medium to high risk by the ORT
• 40% of patients screened with UDS, 47% with abnormal findings
Monitoring

- Prescription Monitoring Program
- Urine Drug Screen
- Risk assessment tools
On Urine Drug Screens

- Screening vs Confirmation Procedures
- Substances screened
- Cut off values
- Detection windows
- How to interpret and act upon results
## Interpreting Results

<table>
<thead>
<tr>
<th>Prescribed drug not present</th>
<th>Un-prescribed drug present</th>
<th>Illegal drug present</th>
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<tbody>
<tr>
<td>• Drug taken outside of the detection window</td>
<td>• PMP review</td>
<td>• Assessment of symptom burden</td>
</tr>
<tr>
<td>• Not taking medication</td>
<td>• False positive, test interaction, or drug metabolism</td>
<td>• False positive</td>
</tr>
<tr>
<td>• False negative</td>
<td>• Medication impurities</td>
<td></td>
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<tr>
<td>• Pharmacogenetic variability</td>
<td>• Dietary ingestion</td>
<td></td>
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<tr>
<td>• Medication interaction</td>
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Supporting

• Plan modification based on risk
• Commitment to care
• Commitment to safety
• Communication with providers
Medication Considerations

- **Individualized approach**
- Consider the “euphorigenic” aspects of medications
- Consider long vs short acting agents
- Tamper resistant formulations
- Limited supplies / Frequent evaluations
- Partial opioid agonists (Buprenorphine)
A note on Buprenorphine

- Potent opioid receptor agonist-antagonist that is thought to have a lower side effect profile, including a ceiling affect on respiratory depression but not efficacy.

- We have considered the use of Buprenorphine in patient populations where there exists a concern for opiate misuse, in cases where the side effects of opiates are becoming difficult to tolerate, or for patients who need a simplified medication regiment.
Sublingual buprenorphine vs intravenous morphine in pain
Eur J Transl Myol 29 (2): 124-129, 2019

Comparison of sublingual buprenorphine and intravenous morphine in reducing bone metastases associated pain in cancer patients
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Review Article
Buprenorphine versus Morphine in Paediatric Acute Pain: A Systematic Review and Meta-Analysis
Nathan Murray,1 Utsay Malla,1 Ruan Vlok,1,2 Alice Scott,2 Olivia Chua,2 Thomas Melhuish3,4 and Leigh White1,4

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Control of Medications

• Who dispenses the medications – patient directly vs family member or caregiver?

• If concern for SUD in others – do they have access to patient’s medication?

• Setting – inpatient vs outpatient vs nursing home?
What goes up does not always come down so easily...

• An important note on inpatient vs outpatient patient management.
• Dose up-titration during inpatient hospital stays.
• Finding a balance between identifying the correct dose to control symptoms vs promote progressively escalating doses.
XR, Follow Up

- Maximizing adjunctive medications.
- Started on a Butrans transdermal patch for long acting pain control.
- Still required occasional doses of opioids for breakthrough pain.
- Dispensed 2 week limited supply at a time.
- Close UDS monitoring.
- Nursing visits, involvement of social work, chaplaincy.
Universal Policy for Opioid Safety

• Set Up
• Screening
• Monitoring
• Supporting
Challenges

• Resources required to support patients as well as staff
• Finding the balance between treatment symptoms and protecting patients
• Availability of medications
• Ability to prescribe medications
• Accessibility of addition services
• And a reminder to check our bias
Special thank you to Dr. Josh Barclay at the University of Virginia!
References

Discussion