

Managing Opioid Use Disorder in the Setting of a Terminal Disease: Opportunities and Challenges

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Abstract

Opioids have long been a mainstay of symptom management in palliative care (PC), allowing patients with terminal illnesses to have an improved quality of life. Unfortunately, these same medications have contributed to the explosion of the opioid epidemic. This article explores the case of a patient with opioid use disorder (OUD) and pancreatic cancer. We share our experience of managing his symptoms and treating OUD in the setting of an outpatient PC clinic. We explore the challenges and joys of this case while reflecting on the need for more research investigating best practices for individuals where opioids serve as both a pain reliever and contributor to further suffering from their OUD.

Keywords: opioid misuse; opioid use disorder; pain; palliative care; substance use disorders

Introduction

AN ESTIMATED 7.8 MILLION ADULTS in the United States over the age of 26 years misused prescription pain relievers in the past year, and 886,000 individuals of all ages used heroin in 2017.¹ Of surveyed heroin users, ~80% reported using prescription pain medications before transitioning to heroin.^{2,3} Although the majority of these individuals are younger, there are growing number of older adults who misuse opioid medications. A national survey found that of adults 65 years and older who misused opioids in the past month, nearly half (47.7%) obtained their opioids from a physician.⁴ These figures point to the widespread nature of opioid misuse in the United States. In palliative care (PC), accurate measurements of opioid misuse and opioid use disorder (OUD) are difficult to find due to limited application of urine drug screens and existing screening tools simply assessing risk of misuse.^{5,6} As medicine grapples with the current opioid crisis, greater attention is being paid to addressing OUD in serious illness and at end of life.^{7,8} Early research likely underrepresented substance use disorders (SUDs) in patients with cancer⁹ but individuals with serious illness remain at risk for OUD and nonmedical use of opioids.^{10,11}

Despite this increased awareness, there remains a lack of understanding regarding the rates of SUDs in cancer patients and patients with other chronic illnesses seen by palliative

providers.¹² Similarly, there is little in the way of outcomes-based research on how to manage opioid misuse in PC settings. Many of the existing guidelines are adapted from the chronic pain and psychiatric literature, with the CDC explicitly excluding PC and oncology patients from its own guidelines.¹³ Despite the lack of guidelines, several groups have written about and advocated for the need to establish an attitude of “universal precautions” surrounding opioid prescribing in PC.⁵ Still, approaches to management and screening typically differ from organization to organization or rely on the individual provider’s level of comfort.¹⁴ Disparities also exist in the training of PC physicians regarding opioid misuse and SUDs,¹⁵ whereas a more recent survey of PC providers showed continued lack of confidence in managing SUDs.¹⁶

Case Description

A.P. was a middle-aged male who was diagnosed with locally advanced pancreatic adenocarcinoma found incidentally by imaging performed after a fall. An expedited workup was delayed several weeks due to his reluctance in coming to the hospital. During initial PC consultation, he described a 20-year history of OUD including remote history of IV heroin use, last use ~10 years prior. He long had struggled with OUD but had achieved several years of abstinence and was placed back on opioids by his primary care physician for the

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Accepted June 6, 2019.

treatment of abdominal and back pain, now thought to be caused by his cancer. During this time, he began supplementing his prescribed opioids with illicit fentanyl. At our initial meeting, A.P. was receiving a 100 mcg fentanyl patch and as needed oxycodone initiated by his oncologist. He described adequate pain relief from this regimen. His pain and OUD were discussed frankly during these initial visits, and given his initial opioid requirements and severity of his cancer diagnosis, the decision was made to continue with full agonist opioid treatment rather than rotation to buprenorphine. Methadone maintenance was also considered, but with his upcoming treatment schedule and distance from cancer care, it was not felt to be feasible. Full agonist opioid treatment was continued while recognizing the risks of misuse, and these challenges were discussed frankly with the patient. At hospital discharge, he was receiving fentanyl 100 mcg patch and 30 mg PRN oxycodone every four hours.

To manage his pain as in the context of comorbid OUD, the PC team developed a treatment plan with the help of addiction psychiatry that included weekly appointments, prescription of naloxone, limits on opioid prescribing (e.g., no early opioid prescription fills), assessments for nonmedical use and cravings at each visit, regular urine drug screens, and recommend follow-up with a psychotherapist and participation in a recovery support program. Addiction psychiatry provided support for our clinicians during the case, and offered additional supports for A.P. We established with A.P. that the goal of pain treatment was to be able to return to work rather than lowering subjective pain intensity. Although A.P. continued to test positive for illicit opioids over the first six weeks, he gradually reduced the amount of opioid misuse. This period of misuse was followed by eight weeks during which nonmedical use of opioids ceased per his report, and urine toxicology showed only prescribed opioids. A.P. experienced improved relationships with his family and returned to work. Fentanyl was rotated to methadone 10 mg TID when pain began to increase and was initially effective. He was in regular contact with a peer support specialist recommended by addiction psychiatry and our clinical social worker.

In time A.P.'s cancer progressed. He began experiencing increased pain and emotional distress, coinciding with urine drug screens that were positive for nonprescribed opioids. Despite a trial escalation of his opioids, a celiac plexus block, and maximizing nonopioid adjuvants, he continued to test positive for nonprescribed opioids including fentanyl. He expressed increasing frustration and anger with the team, feeling that the focus was solely on his opioid use and not his suffering. The team had increasing concerns regarding the safety of continuing to prescribe opioids. Inpatient admission for symptom control was offered including consideration of rotation to buprenorphine. He refused admission, missed his last appointment with the team, and requested a hospice referral.

Discussion

Opioid risk assessment tools and urine drug screens are necessary but insufficient. PC as a field needs to incorporate evidence-based treatments for OUD into our routine management of pain and other symptoms

Although several original research and review articles have been written about the need to incorporate opioid risk

assessment screening, urine drug testing, and universal opioid prescribing precautions into PC, there is less clarity on how to use these tools to inform clinical decisions. Effective management of pain and OUD should utilize evidence-based pharmacologic and behavioral interventions. For OUD, the only available FDA-approved treatments available are methadone, buprenorphine, and naltrexone.¹⁷ To date, there are no studies exploring the effectiveness of these medications for OUD treatment in the context of PC. Despite this, there is growing interest in how to incorporate buprenorphine treatment into PC, with several concurrent sessions focused on its use at the 2019 Annual Assembly of Hospice and Palliative Medicine.^{18–20} Despite the effectiveness of buprenorphine for pain and OUD, a minority of PC providers have the necessary Drug Enforcement Administration (DEA) certification to prescribe it for OUD.¹⁶

Rotation to buprenorphine was considered for our patient, both at the start of PC involvement and over the course of treatment. Given his high morphine equivalent daily dose (MEDD), our team and addiction psychiatry had concerns about achieving adequate pain control. Limited studies exist assessing pain relief in individuals with cancer rotated from full agonist to buprenorphine, and no studies exist examining buprenorphine use in individuals with cancer, OUD, and pain.²¹ Several studies have been conducted in Europe utilizing formulations of buprenorphine not available in the United States. Insurance prior authorizations were also a concern as buprenorphine would be used for pain and OUD and an additional full agonist opioid may be prescribed for breakthrough pain. Providers may experience difficulties obtaining approval from insurance companies for higher doses of buprenorphine for patients with OUD.²² Finally, our team worried about the induction process for an individual with cancer and a limited prognosis. Clearly, further research and practice guidelines for use of buprenorphine in individuals with serious illness, pain, and OUD are needed.

Increased monitoring: An opportunity and a burden

Although frequent visits were at times burdensome, they also represented an opportunity to provide high-quality PC. It allowed our team to take time to develop a deep level of trust with A.P., cultivate a greater understanding of his life, and understand the impact of his illness on him and his family. The frequent visits also allowed us to acutely manage the symptoms that emerged as his disease progressed and provide support for his significant other. Our team consisted of a palliative-boarded oncologist, licensed independent clinical social worker, and PC fellow who completed a psychiatric residency. This interdisciplinary approach is like other institutions and has demonstrated initial effectiveness in reducing aberrant behaviors of patients receiving opioid therapy.²³ The diversity in backgrounds allowed us to address the many sources of his suffering.

Although unintentional, the increased visit frequency further connected A.P. to the medical system and placed a significant burden on him and his family, from time, travel, and financial perspectives. SUDs disproportionately impact those from lower socioeconomic groups,^{24–26} and increased scrutiny, regardless of its well-meaning underpinnings, may further burden a patient population already stigmatized by the

medical community. A.P. was seen weekly for nearly 6 months, with a typical appointment lasting 30 minutes to 1 hour. The frequent contact required to maintain safe opioid use was at times burdensome to the patient and may also be untenable for many PC outpatient practices.²⁷ Future research, guidelines, and policy decisions should consider both the provider and patient viewpoint. Individuals with OUD represent a marginalized population in health care and adding their voice to research is an important step that aligns with PC's goal of providing patient-directed family centered care.

The urine drug screen is positive, now what?

One of the challenging dilemmas encountered in this case was how to address recurrent drug screens positive for illicit opioids. We chose a harm reduction model focusing on the goal of reducing overall misuse and attempting to help guide A.P. toward meaningful recovery from OUD, something he identified as a goal at the start of treatment.^{28–30} We also prescribed naloxone at the onset of treatment and counseled the patient and his spouse on its use. Given the relapsing–remitting nature of OUD, we did not implement a policy of positive urine drug screens triggering a reflexive change in prescribing. We felt that doing so would penalize the patient for expected findings that may occur during OUD.³¹ With increased services, growing trust between patient and provider, and improved symptom control, the patient's pattern of illicit use decreased, leading to a two-month period without illicit use. This period was also one of personal growth for the patient, with a deepened connection to his family including reconnecting with several estranged relatives. Unfortunately, with increasing pain and overall distress, our patient began to test positive again for illicit opioids. Dose increases did not result in symptom improvement, and adjuvant therapies were met with only transient improvement. Continued positive urine screens led to further frustration from the patient, who described feeling singled out for his opioid use, and worry from providers due to safety concerns and risk for unintentional overdose.

Throughout caring for A.P., the PC team maintained close contact with addiction psychiatry. This relationship was helpful and allowed both sides to better understand the intricacies of managing pain and OUD in seriously ill patients. Frequent discussions with addiction psychiatry helped to provide support to our providers who felt distressed at both A.P.'s suffering and our own concern over opioid prescribing. This case demonstrated the need for continued collaboration. Few guidelines exist regarding when a psychiatry referral should be made for a PC patient, but we found that frequent discussions were helpful to best understand where the line between PC management and addiction psychiatry management lay. In certain instances, an inpatient PC unit admission may be indicated for a primary psychiatric reason.³²

The current treatment paradigm of SUD treatment often centers on the creation of a better future, whereas PC aims to reduce suffering and provide support for the patient and family as life ends. Most PC patients suffer from a terminal and progressive disease. In contrast, SUDs are relapsing–remitting chronic diseases that may lead to death, but more frequently lead to remission, either naturally or with the help of treatment. By employing a harm reduction strategy, A.P. and the PC team worked together to achieve a period of

remission in his OUD while his pancreatic cancer advanced. This provided the PC team an opportunity to reflect on the best methods to care compassionately for someone struggling to recover from one disease while limiting suffering from another. As a field, more research and expert guidelines are needed to increase the awareness of suffering at the end of life related to comorbid SUDs, as well as research to improve pain and symptom management in individuals with OUD.

Acknowledgment

The authors thank Dr. Jessica Merlin for her reading of an earlier version of the article.

Author Disclosure Statement

No competing financial interests exists.

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