The dog ate my methadone: Challenges in treating patients with advanced illness, pain, and addiction

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CCSP/Palliative Care Rounds
May 24th, 2017
Disclosures

• In theory, there is a forthcoming UpToDate chapter related to this topic
• I am not an addiction psychiatrist
• There is virtually no evidence base to guide discussion
• Cases today will address oncology patients
• This session does not fulfill new CME standards for opioid-prescribers
• I have a buprenorphine license but use it sparingly
Out with the old, in with the new

Palliative Care-Enhanced Model

Disease Management

Pain & Symptom Management

Rehabilitation
Hospice
Palliative Care Unit
End-of-life care

Survivorship
Palliative Care
Bereavement

Bereavement
National Overdose Deaths
Number of Deaths from Opioid Drugs

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths

Number of Deaths from Prescription Opioid Pain Relievers (excluding non-methadone synthetics)

Source: National Center for Health Statistics, CDC Wonder
National Overdose Deaths
Number of Deaths from Benzodiazepines

Source: National Center for Health Statistics, CDC Wonder
In 2007, there were 9.18 deaths per 100,000 population due to unintentional drug overdose, based on 27,658 deaths.

Oxycontin introduced to markets
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Data Source: National Vital Statistics System, National Center for Health Statistics, CDC.
Produced by: National Center for Injury Prevention and Control, CDC using VITALS™.
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Cancer, pain and addiction

- The number of cancer survivors in US expected to exceed 20 million by 2026
- Shift toward chronic disease management (even for those living with metastatic cancer)
  - After curative treatment: 33% [95% CI 21% to 46%];
  - During anti-neoplastic therapy: 59% (CI 44% to 73%);
  - Advanced/terminal illness: 64% (CI 58% to 69%)
  - Highest in patients with head and neck cancer (70%, CI 51% to 88%)

- More people are presenting to cancer treatment already exposed to prescription opioids and benzodiazepines

National Cancer Institute, “Fast Stats”; van den Beuken-van Everdingen, Annals Oncology, 2007
Untreated substance use disorders worsen prognosis and adherence to care

- Worsen prognosis and adherence to care
- Perpetuate suffering and decreases quality of life
- Distracts from other important aspects of life or medical care
- Tend to require larger amounts of resources
- Impaired relationship with treatment team
We are underprepared

- 2012 survey of North American palliative care fellows
  - 41% believed that their training had prepared them to manage opioid misuse
  - 37% felt that they knew how to differentiate pain from addiction

- In a recent survey of accredited palliative medicine fellowship programs, most providers (72%) reported that substance abuse screening occurs when “the provider feels it is appropriate”

- Most opioid risk screening instruments have not been validated for the palliative care population

- Most cancer centers and palliative medicine programs do not have specific substance abuse programs

Self-titration model

- Works for most oncology patients
  - Who don’t have a substance use disorder
- Liberal access to potentially addictive medications
- Monthly supply per prescription
- Minimal monitoring
- Take as much as you need

- Does not work for the clinic of last resort
Case study - GL

• Young woman with metastatic breast cancer and long-standing history of cocaine abuse
• Complicated psychosocial history
  • Childhood trauma
  • Loss of primary custody of her six children
  • Lives with fiance who struggles with addiction
  • Unstable housing
• Variable adherence to outpatient appointments with oncology and supportive care
• Several admissions to MedE2 for pain control; noted to be drowsy when dose converted to IV for PCA titration
Case Study: LD

- 53yo divorced male with h/o stage II breast cancer in remission
- Severe taxane-induced peripheral neuropathy
- History of alcohol misuse pre-cancer
- Multiple psychosocial stressors and co-morbid depression
- Erratic behavior with supportive care team
- Developed alcohol, opioid and benzodiazepine dependence during cancer survivorship period
- Cardiac arrest at home s/p unintentional OD
Risk factors

- Validated risk factors
  - Younger age
  - Male gender
  - Mental health diagnosis
  - Known current or prior substance use disorder
  - Family history of addiction
- Softer risk factors
  - Sexual/childhood trauma or abuse
  - Difficulty with social interactions
  - Lack of family involvement
  - Community/neighborhood
  - Sensation-seeking, impulsivity, anxiety sensitivity and hopelessness
Evaluation goal: systematically assess for risk factors and warning signs

- Goal is to categorize patients in low, medium or high risk
- Is there currently physiologic dependence?
- Are there co-existing psychiatric disorders?
- Is there evidence of multiple prescribers, formulations or concomitant high risk meds?
- Has the primary provider or medical history already indicated concern for substance abuse or misuse?
- Are there family members with substance use disorders?
- What do the family members say?
- Is there under-treatment of symptoms?
- How open is the patient about their history?
- How does the patient cope with stress or unrelieved emotional pain (chemical coping)?
Before you see the patient

- “Pre-screen” the medical record
  - Allot more time if possible if several risk factors present
- Consult the NC Substance Use Database
- Screen the patients directly (nothing is perfect but something is better than nothing)
  - SOAPP-R or ORT most popular
  - Passik et al also has a scale for medically ill patients
- Everyone completes health authorization to speak to family members and other providers
Low risk patients

- Standard model of oncology care is usually fine
- Establish with the patient and family the goals and expectations of pain and other symptom management
- Everyone receives written notice (and verbal nudges to read)
  - Policies regarding missed appointments, early refills, not sharing rx, etc.
- Shared co-prescribing and q3 month visits reasonable
Behaviors less suggestive of addiction

- Aggressive complaining about medications
- Requests for specific medications
- Hoarding medications during periods of reduced symptoms
- Unapproved use of drug to treat different symptom
- Unsanctioned dose escalation on 1-2 occasions
- Openly acquiring similar drugs from other sources
Behaviors suggestive of addiction

- Multiple dose escalations or other noncompliance with therapy despite warnings
- Stealing or borrowing medications
- Deterioration in work or social functioning
- Resistance to change or discontinue opioids despite adverse effects
- Refusal to comply with random drug screens
- Concurrent use of alcohol or illicit drugs
- Use of multiple physicians or pharmacies without informing prescriber
- Selling prescription drugs, drug forgery, injecting PO medications IV

Passik. Substance Abuse Issues in Cancer Patients, 1998
Medium risk patients: Explicitly discuss and document

- Single prescriber for high-risk medications
- Establish with the patient and family the goals and expectations of pain and other symptom management (e.g. “zero out of ten pain” is rarely a realistic goal);
- Verbal and written expectations and limits regarding early refills, unsanctioned dose escalations, missed appointments, and lost prescriptions
- Prior to lapses in treatment adherence, identify what, if any, consequences will occur if patients do not comply with expectations
- Everyone gets one free pass “my dog ate my meds”
High risk patients: everything before AND

- Frequent visits (e.g., q1-2 weeks)
- Urine toxicology screens
- Explicitly identify sober/stable supports and open line of communication with them
- Call in DEA to pharmacy directly
- Involve psych/addiction/social work specialty care
- Verbal and written treatment agreement to facilitate early identification and response to non-adherent behaviors (may need to include an exit strategy for treatment)
- Therapeutic plan for relapse
- Unerring compliance may not be realistic goal for management
Violated High-Risk Care Plan

- Inhaled naloxone if concern for overdose (with education of family members)
- Escalating structure of care
  - Visits
  - Doses
  - Monitoring
- Joint agreement with caregiver
- Mandatory concurrent care with addiction specialist/program (eg ASAP, etc)
- Anecdotal report of using benzodiazepines in shelter-based hospice patients with addiction

Podymow et al, Pall Med, 2006
Success story

- 59 yoF with stage IV breast cancer, long-standing history of IV heroin dependence, MDD, personality disorder
- Poor adherence to breast cancer and psychiatric treatment
- New desire for abstinence d/t new stable sober support
- Maintained on multiple short-acting opioids
- Suitable candidate for buprenorphine maintenance therapy
- Breakthrough pain treated with buprenorphine, dilaudid and morphine
- Engaged in regular psychiatric care, improved adherence to breast cancer therapies
- One relapse on IV heroin
More topics not covered today

- High risk medications (e.g., methadone, ketamine, buprenorphine)
- Adjunct treatments
  - Disulfiram
  - Naltrexone
  - Acamprosate
  - Bupropion
- Review of specific opioid risk tools
- Behavioral therapies for addiction
- Community resources
Call to action

- Dedicated working group with a clear (not overly-committed) team leader
  - Does not have to be a physician!
  - Might be a great project for a fellow
  - Dot phrases and example policies/contracts
- Addiction education programs for pall med and cancer support clinicians (educational or QI grants)
- Research to identify risk factors among oncology patients
- In-service seminars/rounds
- Clearer communication and coordination among services
24yoM with AML who needs BMT

- Poor prognosis AML who would die without BMT
- Long-standing personal, family, and community history of addiction
- Opioid dependence; cocaine/tobacco abuse
- Undergoes matched allo SCT while maintained on buprenorphine
- IVDU relapse after released to community care
- Re-presents with disseminated MRSA infection, recurrent spinal osteomyelitis, severe pain
Prescribing guidelines

- Scheduled administration with ATC dosing
- Limiting prn or breakthrough medications
- Longer duration medications
- Non-opioid adjuvant therapies
- Limiting the amount of medication prescribed
- Calling in DEA to pharmacy directly
- Everyone gets one “free pass”
- In-person visit/travel for prescriptions
SOAPP-R

• How often do you have mood swings?
• How often have you felt a need for higher doses of medications to treat your pain?
• How often have you felt impatient with your doctors?
• How often have you felt that things are just too overwhelming that you can’t handle them?
• How often is there tension on the home?
• How often have you counted pain pills to see how many are remaining?
• How often have you been concerned that people will judge you for taking pain medications?
• How often do you feel bored?
• How often have you taken more pain medication than you were supposed to?