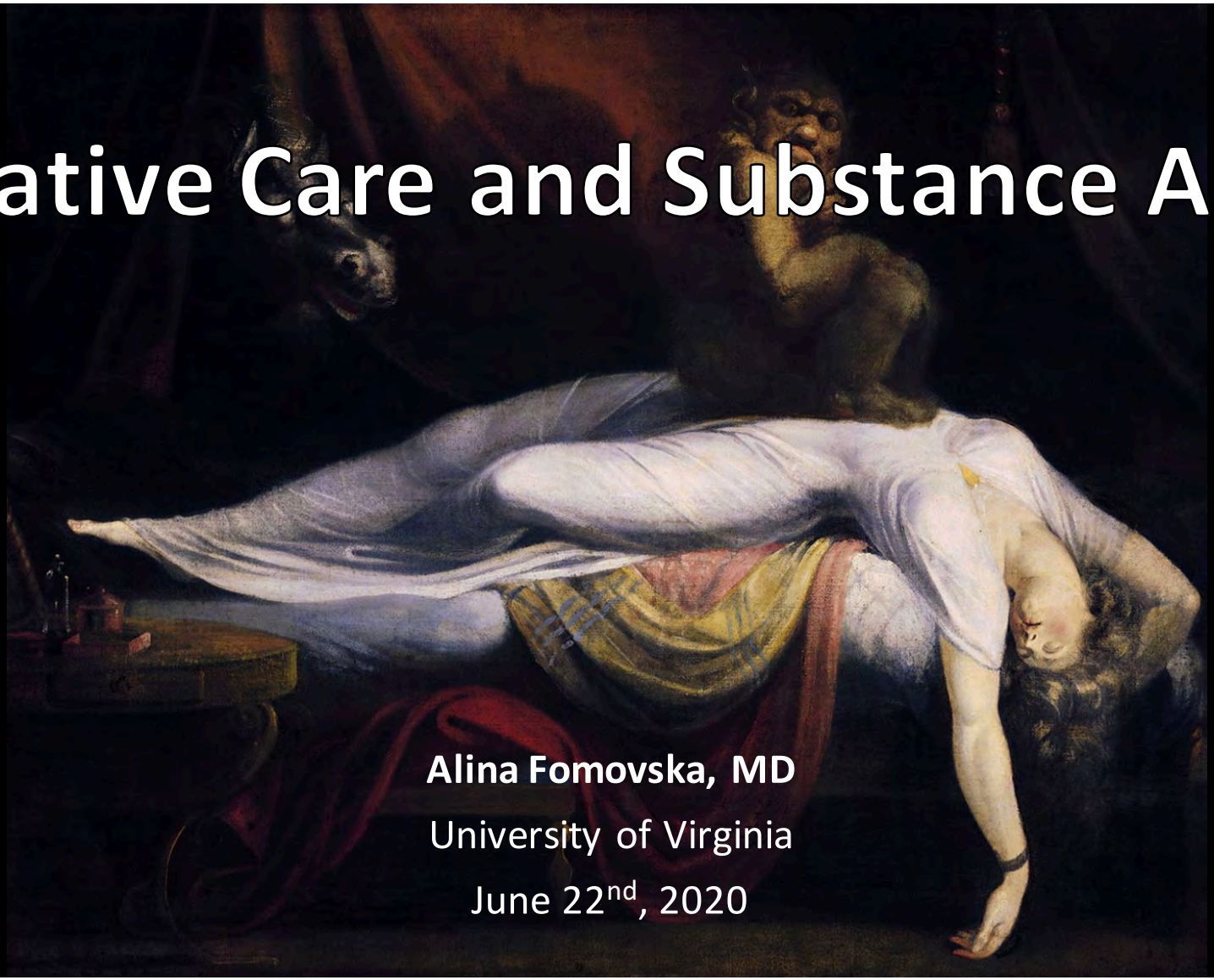
Palliative Care and Substance Abuse



Alina Fomovska, MD

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

FREE

May 1, 2018

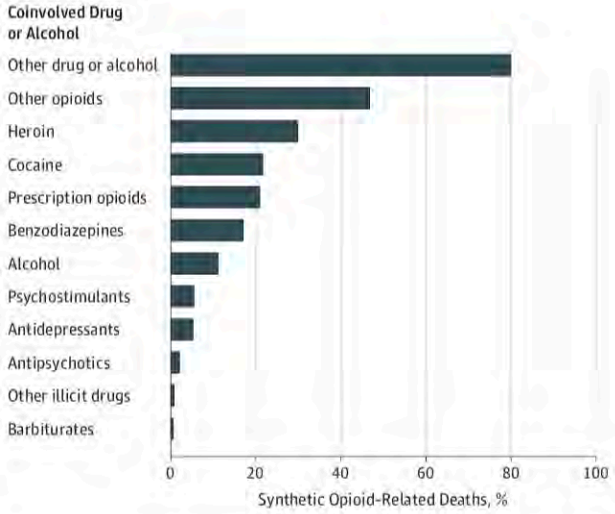
Changes in Synthetic Opioid Involvement in Drug Overdose Deaths in the United States, 2010-2016

Christopher M. Jones, PharmD, MPH[1]; Emily B. Einstein, PhD[2]; Wilson M. Compton, MD, MPE[2]

» Author Affiliations | Article Information

JAMA. 2018;319(17):1819-1821. doi:10.1001/jama.2018.2844

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



[a] 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.

"WE DON'T CARRY THAT" — FAILURE OF PHARMACIES IN PREDOMINANTLY NONWHITE NEIGHBORHOODS TO STOCK OPIOID ANALGESICS

R. SEAN MORRISON, M.D., SYLVAN WALLENSTEIN, PH.D., DANA K. NATALE, M.A., RICHARD S. SENZEL, M.R.P., AND LO-LI HUANG, B.A.

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

TABLE 2. ADEQUACY OF OPIOID SUPPLIES AT 347 PHARMACIES, ACCORDING TO THE RACIAL AND ETHNIC COMPOSITION OF THE NEIGHBORHOOD.

RACIAL AND ETHNIC COMPOSITION OF NEIGHBORHOOD	TOTAL PHARMACIES	PHARMACIES WITH ADEQUATE OPIOIDS	P VALUE FOR TREND
	no.	%	
White			<0.001
0–39%	110	25	
40–69%	72	56	
70–79%	72	50	
≥80%	93	72	
Black			<0.001
<10%	173	61	
10–19%	53	45	
20–39%	57	42	
≥40%	64	30	
Hispanic			0.002
<10%	89	56	
10–19%	108	54	
20–39%	70	50	
≥40%	80	34	
Asian			0.01
<10%	241	54	
10–19%	74	42	
20–39%	16	44	
≥40%	16	25	

The Impact of Neighborhood Socioeconomic Status and Race on the Prescribing of Opioids in Emergency Departments Throughout the United States

Michael Joynt, MD[1,2], Meghan K. Train, DO[1,2], Brett W. Robbins, MD[1,2,3], Jill S. Halterman, MD, MPH[3], Enrico Caiola, MD[1,2], and Robert J. Fortuna, MD, MPH[1,2,3]

[1]Center for Primary Care, Culver Medical Group, University of Rochester School of Medicine and Dentistry, Rochester, NY, USA; [2]Department of Internal Medicine, University of Rochester School of Medicine and Dentistry, Rochester, NY, USA; [3]Strong Children's Research Center, Department of Pediatrics, University of Rochester School of Medicine and Dentistry, Rochester, NY, USA.

- 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

Table 1. Examples of Instruments Assessing Opioid and Nonopioid Risk

Category	Items, No.	Administered By
Patients considered for long-term opioid therapy:		
ORT: Opioid Risk Tool[7]	5	Patient
SOAPP®: Screener and Opioid Assessment for Patients with Pain[8]	24, 14, and 5	Patient
SISAP: Screening Instrument for Substance Abuse Potential[9]	5	Patient
DIRE: Diagnosis, Intractability, Risk, and Efficacy Score[10]	7	Clinician
Assess misuse once opioid treatment initiated:		
PDUQ-p: Prescription Drug Use Questionnaire-patient[11]	31	Patient
COMM: Current Opioid Misuse Measure[13]	17	Patient
PMQ: Pain Medication Questionnaire[14]	26	Patient
PADT: Pain Assessment and Documentation Tool[15]	41	Clinician
ABC: Addiction Behavior Checklist[16]	20	Clinician
Nonopioid general substance abuse:		
CAGE-AID: Cut Down, Annoyed, Guilty, Eye-Opener Tool, Adjusted to Include Drugs[19]	4	Clinician
RAFFT: Relax, Alone, Friends, Family, Trouble[20]	5	Patient
DAST: Drug Abuse Screening Test[21]	28	Patient
SBIRT: Screening, Brief Intervention, and Referral to Treatment[22]	Varies	Clinician
AUDIT-C: Alcohol Use Disorders Identification Test: Consumption[23]	3	Patient
DUDIT-E: Drug Use Disorders Identification Test: Extended[24]	54	Patient

Screening

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.

OPIOID RISK TOOL©

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥ 8

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.

Support Care Cancer (2014) 22:1883–1888
DOI 10.1007/s00520-014-2167-6

ORIGINAL ARTICLE

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

Prescribed drug not present

- Drug taken outside of the detection window
- Not taking medication
- False negative
- Pharmacogenetic variability
- Medication interaction

Un-prescribed drug present

- PMP review
- False positive, test interaction, or drug metabolism
- Medication impurities
- Dietary ingestion

Illegal drug present

- Assessment of symptom burden
- False positive

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.

Annals of Emergency Medicine
Volume 59, Issue 4, April 2012, Pages 276-280

Pain management and sedation/original research

Sublingual Buprenorphine in Acute Pain Management: A Double-Blind Randomized Clinical Trial

Mohammad Jalili MD [a], Marzieh Fathi MD [a], Maziar Moradi-Lakeh MD [b], Shahriar Zehtabchi MD [c]

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https://doi.org/10.1016/j.annemergmed.2011.10.021

Hindawi
Critical Care Research and Practice
Volume 2018, Article ID 3792043, 5 pages
https://doi.org/10.1155/2018/3792043

Review Article

Buprenorphine versus Morphine in Paediatric Acute Pain: A Systematic Review and Meta-Analysis

Nathan Murray,[1] Utsav Malla,[1] Ruan Vlok,[2,3] Alice Scott,[2] Olivia Chua,[2] Thomas Melhuish,[4,5] and Leigh White[1,6]

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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

Seyed Mohammad Jamalian (1), Mohammad Sotodeh (2), Fathollah Mohaghegh (3)

(1) Department of Forensic Medicine and Poisoning, Arak University of Medical Sciences, Arak, Iran; (2). Department of Oncology, Arak University of Medical Sciences, Arak, Iran; (3) Department of Radiotherapy and Oncology, Arak University of Medical Sciences, Arak, Iran

The American Journal of Emergency Medicine
Volume 37, Issue 3, March 2019, Pages 381-386

Original Contribution

Sublingual buprenorphine versus intravenous or intramuscular morphine in acute pain: A systematic review and meta-analysis of randomized control trials

Ruan Vlok [a, b, c], Gun Hee An [e], Matthew Binks [b], Thomas Melhuish [b], Leigh White [d, e]

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https://doi.org/10.1016/j.ajem.2018.05.052

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!

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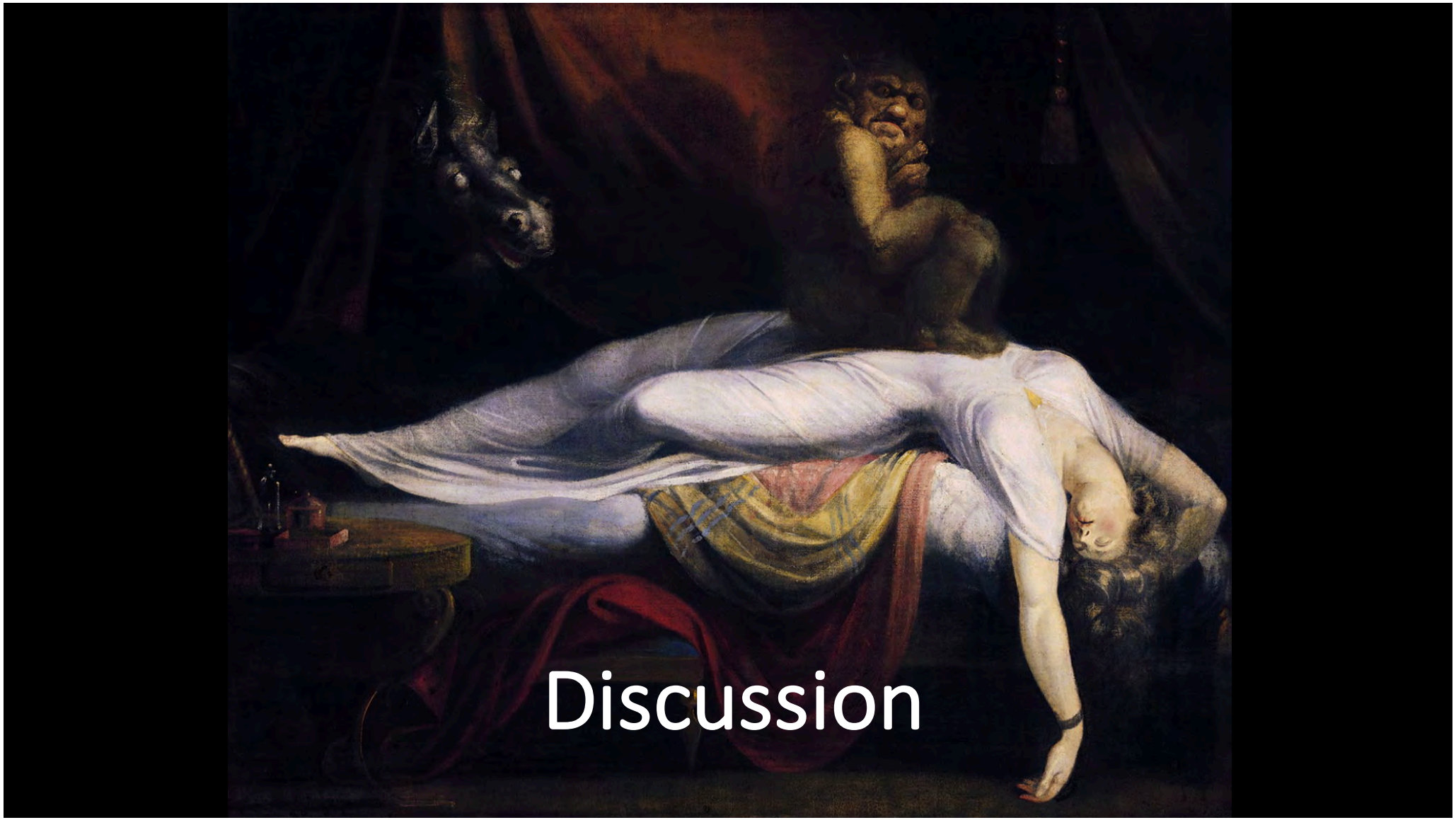
Discussion