AN APPROACH TO SERIOUSLY ILL PATIENTS WITH SUBSTANCE USE DISORDERS

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SPEAKER DISCLOSURES

✓ No disclosures to report
OBJECTIVES

1. State the importance of managing substance use disorders in individuals with limited life expectancy

2. Describe a framework to assess pain, addiction and prognosis to develop a management plan in patients with life-limiting illness

3. Identify strategies to balance pain control with management of addiction in palliative care patients
Where Palliative Care (PC) Started

Disease-focused Treatment

Palliative Care

Onset of disease

Death

Last few days – weeks of life
Primarily provided in hospice settings
Exclusive of disease-focused treatments
People with serious illness living *much* longer:

- Better cancer treatments
- Advanced heart therapies
- Transplants
- Other technologies
THE POPULATION

- Serious illness
- SUDs
- Chronic pain
PEOPLE WITH SUDS HAVE MORE MEDICAL COMORBIDITIES AND DIE YOUNGER

• Studies:
  – OUD: 18% of non-elderly SUD patients died over a 4 year period
  – AUD: 2x mortality from CVD, 3x from lung disease
  – Stimulants: Persons using amphetamines had a 6.3x mortality risk of age-matched peers

• Why?
  – Tobacco use
  – Lack of preventative care
  – Social determinants of health
  – Mental health co-morbidities
  – Lack of social support
CHRONIC PAIN IN INDIVIDUALS WITH SUDS

• Chronic pain in general population: 20-30%
• Chronic pain in individuals with SUDs: 40-60%
• Possible overlap syndrome, common pathways
WHY DO WE CARE ABOUT ADDICTION IN PATIENTS WITH SERIOUS ILLNESS?

“Chemically-dependent patients spend very little time high; the lion's share of their time is spent feeling depressed, being isolated, withdrawing, being obsessed about drug procurement, behaving in a fashion that they themselves consider demeaning or degrading”

CASE

- S is a 35 year old man with history of stage II melanoma
- In treatment for opioid use disorder (OUD) on buprenorphine
- Found to have a recurrence with a painful mass in the axilla
- Started on treatment
- Buprenorphine is stopped and he is started on opioids and benzodiazepines
- Runs out of prescribed opioids several times, gets early refills
The Current Model

- Addiction Treatment
- Palliative Care

Onset of disease  Death
CHALLENGES FOR INDIVIDUALS WITH SUDS WHO DEVELOP A SERIOUS ILLNESS

• Loss of their usual routines, roles and responsibilities
• Challenges to coping mechanisms which may already be stretched
  – High prevalence of psychiatric illness
• Increased access to prescribed opioids and benzos
• Lose access to a recovery community
CHALLENGES OF CARING FOR INDIVIDUALS WITH SERIOUS ILLNESS IN THE ADDICTION CARE SYSTEM

• Patients with advanced medical needs are often disqualified from inpatient or outpatient addiction treatment
• Patients receiving intensive medical treatments don’t have time to attend intensive addiction treatments
• Frequent hospital admissions interrupt addiction care and increase chance of inappropriate prescribing
• Decreased functional status limits participation
A TRADITIONAL APPROACH

• Larger and larger amounts of opioids (often with benzos)
• No boundaries or accountability
• Lack of skills in diagnosing SUDs, and discussing substance use with patients

   Result....

• When behavior escalates so much it can’t be ignored, the patient is “fired”
  – Discharged from outpatient clinic or hospice
  – Loses access to prescribed opioids entirely
  – Does not participate in further treatment of their medical illness

• Falls out of care entirely and dies a difficult, painful death
ADDICTION IN OUTPATIENT PALLIATIVE CARE

• 2018 survey of 169 outpatient palliative care clinicians
• Nearly all reported encountering at least one concerning sign for substance use disorders
• Over half reported spending more than 30 minutes a day managing concerning behaviors related to opioid or other substance use
  – 5% spent more than two hours per day
• 36% reported no access to an addiction medicine specialist
• Only 13% had a waiver to prescribe buprenorphine
How do we accomplish this?

Addiction Treatment

Palliative Care

Adapted from Lipman, AG, J of Pharmaceutical Care Pain Symptom Control, 1999
ASSESSMENT IN THREE DIMENSIONS
1ST DIMENSION: PAIN

Principle: Not all pain is opioid responsive. Assess likelihood that opioids are likely to be helpful for the pain at all.

Is it:
  – Cancer-related? (Exactly where the tumor is?)
  – Chronic nonmalignant? Duration? Generalized all over body pain?
  – Related to withdrawal?
  – Affected by anxiety, depression, PTSD, etc?
2ND DIMENSION: SUBSTANCE USE

• Principle: Substance use disorders (SUDs) are diseases that vary in severity and time course.

• Ask:
  – Currently using substances? Which ones? How often? Attempts to control use?
  – Involved in treatment program?
  – Social network supports recovery?
3RD DIMENSION: PROGNOSIS/FUNCTION

Principle: The risk/benefit calculus changes in someone with a poor functional status and very short prognosis. And – metastatic cancer does not necessarily mean very short prognosis!

• Ask:
  – How much of the day spent in bed or chair?
  – Alert, talking, eating?
  – Are they currently taking treatments and are there more treatments after this one?
  – To their oncologist – what is expected prognosis?
RETURN TO CASE

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RETURN TO CASE

• S was started on buprenorphine through low-dose induction method
• Oxycodone continued
• Provided mental health counseling and treatment of anxiety disorder
• Now on buprenorphine alone
CASE 2

- Mr. M was a 55 year old man with stage II lung cancer
- Referred to me in the outpatient PC clinic by his oncologist
- Had a history of opioid use disorder on methadone maintenance
- Told me he was “thrown out” of his methadone clinic because he was taking oxycodone prescribed by his oncologist
- Complained of all-over, aching pain
- Asking for an increase in dose and frequency of oxycodone
- How would you manage him?
CASE 3

• 48 year old woman
• On hospice for metastatic pancreatic cancer
• History of IV heroin use prior to diagnosis
• Complaining of all-over body pain
• Admitted to the inpatient hospice unit
• Stabilized on a high dose hydromorphone PCA
CASE, CONTINUED

• Discharged to home with PCA
• One day later, PCA cartridge is empty
• Patient re-admitted to inpatient hospice unit with withdrawal and uncontrolled pain
REFERENCES