Twin pandemics: Opioid abuse epidemic and COVID 19 pandemic: Addressing substance abuse in the hospice patient

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Addressing opioid abuse in the terminally ill patient: To treat or not to treat?

Dr. Kavita Sharma
Disclosures

• None
Background

• Goal of hospice is to promote a peaceful death.
• Opioids are the mainstay for management of EOL pain and dyspnea.
• Up to 25% of hospice patients have SUDs
• Hospices exempt from restrictions like PDMP.
• Most hospices do not have policies or guidelines in place to monitor SUDs.
• Unmanaged SUDs can cause increased suffering, mistrust, tolerance and risk for diversion.
Challenges in the hospice patients

- Pain may be undertreated due to tolerance.
- Prior addicts may hesitate to take opioids for fear of relapse.
- There is an overlap of both mental health and substance abuse disorder with the use of opioids often as a means of chemical coping: concerns for suicide as EOL approaches.
- Risk for diversion from caregivers.
Case presentations

- Case 1. 86 yr M metastatic colon cancer with bone mets under hospice care with a prior history of substance abuse 20 years ago. Patient on MS contin 15 mg BID, has sudden escalation of symptoms and using increased break through meds

- Case 2. 65 yr old prior Alcoholic with metastatic lung cancer. Increased dyspnea and agitation. Refusing narcotics for fear of addiction
• Case 3 Mr J is a 67-year-old M met pancreatic CA Uses Oxy CONTIN 40 mg twice a day, and Oxycodone 10 mg 4 hours prn
• Recently daughter moved in to help care for him (he was previously living alone).
• Hospice RN notes increased pain, daughter seems “out of it”. The patient’s pill count is low, indicating shortfall of 10 oxycontin and 20 oxycodone over the last 7 days.
• Mr J states his pain has been 6 to 7 on a scale of 1 to 10 for several days.
• Refuses inpatient admit to evaluate pain
Case 4

• 57 yr old F with met pancreatic cancer
• Prognosis is days to short weeks
• Sleeping more, doing less, rarely out of bed, complaining of more pain
• Goal is to “have her here where we can talk” as long as possible
• Husband is very hesitant to give pain medicines. What are the barriers?
Case 5

- 55-year-old homeless Veteran with non-small cell lung cancer, persistent pneumothorax requiring a permanent chest tube
- Prior prison for drug related charges, admitted Heroin addict in the past
- Mostly bed bound now, complains of pain
- Primary service is very suspicious of patient’s pain complaints; he takes Dilaudid prn 4-5/day
- Plan is for transfer to a long-term nursing facility. How to approach his pain? Barriers?
Objectives

• Discuss the recent history of pain management and prescription drug abuse
• Identifying patients who are drug seekers vs drug diverters
• Identify risk factors of abuse and strategies to curb diversion
• Case discussions
Introduction: scope of the problem

- Drug OD is a leading cause of injury death in US (more than road accidents) CDC: 115 death/day from OD
- $78.5$ billion/yr in health care cost, lost productivity, addiction Rx and criminal justice
- $116$ mil Americans with chronic pain
- $21$-$29\%$ of chronic pain pts misuse Rx drugs
- $4$-$6\%$ transition to heroin, $80\%$ heroin users misused prescription opioids first
- Midwest region saw opioid OD > $70\%$ (‘16-’17)
Overdose Deaths Involving Opioid Analgesics, Cocaine and Heroin: United States, 1999–2010

<table>
<thead>
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<th>Year</th>
<th>Opioid Analgesic</th>
<th>Cocaine</th>
<th>Heroin*</th>
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<tr>
<td>2010</td>
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<td>4183</td>
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</tbody>
</table>

% CHANGE 2006-10
- Opioid Analgesic: +21%
- Cocaine: -44%
- Heroin*: +45%

Note: Not all overdose deaths specify the drug(s) involved, and a death may involve more than one specific substance. The rise in 2005-2006 in opioid deaths is related to non-pharmaceutical fentanyl (see [http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5729a1.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5729a1.htm)). *Heroin includes opium.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012. Extracted on February 11, 2013.
Opiate overdose deaths (per 100,000 population) in Midwest, 2014

Source: U.S. Centers for Disease Control and Prevention
Introduction: scope of the problem

- 1990s drug companies spread myth “narcotics were non addictive” increase use for non cancer chronic pain
- 2 parallel opioid epidemics: Rx drugs and heroin
- 1996 OxyContin: coupons for one time free Rx
- US uses 83% of world’s oxycodone, 99% of hydrocodone
- Tolerance → frequency → crush/snort pills to get high → dissolve powder and inject → black tar heroin (cheaper, oxycodone $1/mg)
Substance abuse and chronic pain

• A systematic review of 38 studies suggests opioid misuse rates of 21% to 29% and addiction rates of 8% to 12% in patients with chronic pain

Prescribing opioids at EOL

• As many as 71% of CA pts fear addiction and undertake/skip doses
• This can be a barrier to adequate symptom control identified by hospice RN
• 25-33% under-report pain symptoms due to fear of addiction
• The number who refuse medications for fear of relapse is unknown
Concept of “total pain”

- Co-morbid causes
- Caused by treatment
- Caused by cancer

Physical
- Anxiety
- Fear of suffering
- Depression
- Past experience of illness

Psychological

Social
- Loss of role and social status
- Loss of job
- Financial concerns
- Worries about future of family

Spiritual
- Anger at fate/anger with God
- Loss of faith
- Finding meaning
- Fear of the unknown

Dependency
Prescribing opioids at EOL

- 40% of spouses don’t think opiates should be taken routinely
- 25% of caregivers underestimate/minimize symptoms because they fear addiction
- Health care providers have biases against ‘addicts’ that greatly impact care
- Diversion is often not addressed
- RNs often discount pain reports and under-treat pain in patient’s they suspect of substance abuse
Opioids

- Opioids bind to opiate receptors in specific areas within the reward pathway (including the VTA, nucleus accumbens, and cortex).
- Opioids also bind to areas involved in the pain pathway (including the thalamus, brainstem, and spinal cord).
- Binding of opioids to areas in the pain pathway produces analgesia (decreased perception of pain).
Poppy, Papaver somniferum L.,
Natural opiates

- Alkaloids found in the resin of the opium poppy:
  - Morphine
  - Codeine
  - Thebaine
Semi-synthetic opiates

• Chemically altered derivatives of natural opioids:
  • hydromorphone,
  • hydrocodone,
  • oxycodone,
  • oxymorphone,
  • diacetylmorphine (heroin)
Synthetic opiates

- Artificial compounds with opioid activity:
  - fentanyl,
  - methadone,
  - tramadol (ultram), and
  - propoxyphene (darvon).
Endogenous opioid peptides

- Substances produced naturally by the body: endorphins, enkephalins, dynorphins, endomorphins
- These bind to opiate brain receptors and play role in emotion, motivation, attachment behavior, response to stress and pain, control of food intake
- Morphine is “Endorphin’s evil twin”
Addiction

- Psychological dependence
- Punishment is not a deterrent
- **Extreme compulsion** is the overriding feature.
- Using drugs and/or ETOH to the point of intoxication/grossly impaired function, e.g. a person gets arrested for drunk driving. Two days later back on the road drunk
- Consider true addiction vs. under-treatment of pain behavioral/family/psychological disorder drug diversion
4 Cs of addiction

- Loss of control over use;
- continued use despite consequences;
- compulsion to use;
- and cravings

Addiction is a psychological and behavioral syndrome

“pseudoaddiction”: patients may act out when distressed and may be seen as drug seeking
Dependence

• Dependence: state in which body relies on a substance for normal functioning.

• Eg: A person with a ruptured disk and severe low back pain which is debilitating.

• Opiate pain medication reduces the pain to the point where they can function normally.

• In the presence of the substance, function normalizes. You can be dependent but not addicted. If you are addicted you are dependent.
Substance abuse

• A process of neuro adaptation
• Abrupt withdrawal may lead to abstinence syndrome
• If dose reduction required, reduce by 50% q 2–3 days
• avoid antagonists
• Eg: person uses a drug for recreational purposes has a bad experience: OD or brush with the law. Voluntarily decides “That’s it – I’m through with this stuff.”
Tolerance
Reduced effectiveness to a given dose over time
More medication to get the same effect
Not clinically significant with chronic dosing
If dose is increasing, suspect disease progression
Rarely, sensitivity to a drug may increase with repeated exposure, called reverse tolerance.
Having high tolerance, e.g. needing high doses of a drug is NOT addiction.
Withdrawal

• Group of negative physical/mental effects resulting from cessation of substances by pts who are habituated to their use.

• Symptoms may include severe cravings as well as a group of negative physical effects upon suddenly stopping the to which patient has become dependent.

• Generally, severity depends on the length of drug use and doses of drugs
Diversion

• The intentional removal of a medication from legitimate distribution and dispensing channels

• Also involves sharing or purchasing prescription medications between family members and friends or individual theft from family and friends
“Red flags”

- Vague, non-specific description of pain
- Is the reported pain congruent with patient history and presentation?
- Overwhelming interest in a particular analgesic (particularly by family member)
- Resistance to change
- Pattern of running out on weekends, evenings, when another doc is on call
Identifying patients with history of substance abuse

- Use tools (e.g., CAGE, CAGE-AID, and ASSIST questionnaires) to identify patients with a history of substance abuse
- Be nonjudgmental, empathetic, yet truthful
- If pts get defensive explain that the details will ensure that you can prevent withdrawal and prescribe the right drug to allow pain relief and eliminate any serious adverse events.
CAGE/CAGE-AID: screening tool

1. Have you ever felt you needed to cut down on your drinking/ drug use?
2. Have people annoyed you by criticizing your drinking/ drug use?
3. Have you ever felt guilty about drinking/ drug use?
4. Have you ever felt you needed a drink/ drug use first thing in the morning (Eye-opener) to steady your nerves or to get rid of a hangover?

Two "yes" responses indicate that the possibility of alcoholism or drug use should be investigated further.
Opioid Risk Tool


• Does your family have a history of substance abuse?
• Do you have a history of substance abuse?
• Age, if between 16-45
• Do you have a history of preadolescent sexual abuse?
• Do you have a history of psychological disease?
• Low Risk 0 – 3 Moderate 4 – 7 High Risk > 8
The Alcohol, Smoking and Substance involvement Screening Test (ASSIST)

• Q1 asks about which substances have ever been used in the patients lifetime.

• Q2 frequency of substance use in the past 3 mo (indicates those that are most relevant to current health status)

• Q3 frequency of craving to use each substance last 3 mo.

• Q4 frequency of health, social, legal or financial problems related to substance use in the last 3 mo.
The Alcohol, Smoking and Substance involvement Screening Test (ASSIST)

- Q5 frequency with which use of each substance has interfered with responsibilities in the past three months.
- Q6 has any one expressed concerns about pts use of each substance
- Q7 has pt tried to cut down/stop use and failed in that attempt, and how recently that occurred
- Q8 has pt ever injected any substance and how recently that occurred.
Pain management and substance abuse

• Multi-disciplinary team approach to handle medical/psychosocial/administrative issues
• They may be too draining for a solo provider
• High risk of relapse related to stress of chronic illness and availability of drugs
• Evaluate and treat comorbid psyche issues
• Be mindful of tolerance in a substance abuser
• Begin with a conservative dose of and rapidly titrate with frequent reassessments until the patient is comfortable
Principles of prescribing opioid in prior substance abuse

• Ensure that 1 provider manages prescriptions
• Written agreement about treatment plan, roles and expectations of the team members and pt.
• Outline consequences of abuse or diversion
• Involve family for patient support/supervision
• Use 1 pharmacy; pharmacist is part of team, oral medications are preferred, long acting preferred
• If parenteral route needed, continuous subcut infusion is the route of choice.
Principles of prescribing opioids in prior substance abuse

• Use non opioid adjuvants when possible
• Use non pharmacologic adjuvants when possible (relaxation therapy, music, guided imagery, biofeedback, etc)
• Limit the quantity of medication dispensed
• Conduct pill counts and request the return of used transdermal patches
• Spot urine toxicology screening (consider if suspecting diversion)
Prescription monitoring program

• New York State 1918, California-1939 (Oldest Continuous Program)
• Oklahoma (1990) First to Require Electronic Transmission of Data, reduced Operational Costs, increased accuracy and timely submissions. Enabled other States to Consider
• Nevada (1995) First to Require the Reporting of More than Schedule II drugs (Schedules II-IV) First to provide Unsolicited Reports to Practitioners
Final thoughts

Managing pain in a patient with a life-limiting illness and a history of substance abuse is complicated and challenging.

It is our moral duty to treat pain in patients with substance abuse.

Follow a consistent set of prescribing principles

Use an interdisciplinary team approach, consisting of palliative medicine and addiction medicine expertise.