PALLIATIVE CARE CASE OF THE MONTH

"The urgent need for care coordination and expertise in the Management of patients with Opioid Use Disorder and Cancer"

by
Ethan Silverman, MD

Volume 22, No. 120 **January, 2022**

Case: Ms. H is a 54-year-old woman with metastatic pancreatic cancer. She initially presented and established care with the Internal Medicine Recovery Engagement Program (IM-REP) prior to her pancreatic cancer diagnosis in 2020. She has a history of opioid use disorder (OUD)and cocaine use, and she had been intermittently on buprenorphine/naloxone (bup/nx) in the past. After presenting to IM-REP, she was restarted on bup/nx, was titrated to 8mg BID and reported having improvement in cravings. She engaged with the clinic counselor and had two episodes of using illicit substances (methadone, intranasal heroin, crack), which the patient attributed to an episode of theft of her suboxone and the life stressor of living with a roommate with active illicit drug use. She worked on moving out of this environment. Starting in the fall of 2021, she had progressively worsening abdominal pain and weight loss and presented to the hospital in November 2021. She was found to have pancreatic cancer. The hospitalist service continued her bup/nx and started her on a full opioid agonist (immediate release oxycodone). Palliative care was not consulted, and it is unclear if the primary team consulted with IM-REP.

Ms. H was discharged with a plan for follow up with Hillman Oncology and at IM-REP. During her initial outpatient oncology appointment, she was referred to palliative care for pain management. Palliative care immediately reached out to IM-REP to coordinate care. Together, IM-REP and palliative care decided to continue her bup/nx but increase it from 8mg BID to 8mg TID, and to continue her oxycodone with close monitoring.

Discussion: It is important to understand how to manage cancer-related pain in individuals with OUD. It is generally appropriate to continue treatment for OUD, a chronic disease like any other for which treatment would not be disrupted during a time of stress and increased pain. Options for managing pain in individuals with OUD who develop cancer while on bup/nx include increasing the dose/frequency of the bup/nx and/or adding a full agonist opioid, as occurred in this case.

Based on growing evidence in the surgical literature about patients with OUD and perioperative acute pain, [1-3], it is now standard of practice to continue buprenorphine and add a full agonist opioid for acute pain. Buprenorphine is a partial opioid agonist that binds very strongly to the mu opioid receptor[4]. As a result, it is theoretically possible that the full agonist dose will need to be higher than expected, but this is not true for everyone, and the general rule of "start low, go slow" should be observed.

Although it can be appropriate to prescribe a full agonist opioid to a patient with OUD on bup/nx, it is important to weigh the potential benefits of this approach (i.e., improved pain control) with potential harms (i.e., triggering OUD symptoms), particularly when it is likely that the full agonist opioid may need to be continued longer-term. Many addiction medicine and palliative medicine clinicians are unfamiliar with caring for patients who have both OUD and a serious illness, which is one reason why care coordination, improved knowledge, and comfort with managing these patients, and clear communication is vitally important.

Back to the patient: Though the plan was to increase the patient's bup/nx from BID to TID for improved pain control, this was delayed while waiting for the patient to see her addiction medicine physician and unfortunately the patient was admitted for nausea and poor PO intake after chemotherapy prior to her appointment at IM-REP. During this second admission, palliative care was consulted and recommended that the primary team consult with Addiction Medicine. This did not occur, but palliative care eventually reached out directly to IM-REP, and the decision was made to increase her bup/nx from BID to TID during the admission as previously planned. The patient was on TID dosing for several days but was then decreased back down to BID after discussions with her outpatient prescriber. Oxycodone was also increased to 40mg q4h PRN. She was discharged with plan for follow up with both palliative care and IM-REP, on bup/nx 8mg BID and oxycodone 40mg q4PRN. In January 2022, she finally went to IM-REP for the first time since her pancreatic cancer diagnosis. The plan at that time was to start a long-acting full opiate agonist for better pain control. Unfortunately, Ms. H was again admitted shortly after her clinic appointment for generalized edema and shortness of breath. The first several days of this admission, the patient was managed on bup/nx 8mg BID, Oxy 40mg q4PRN and IV hydromorphone. After four days of admission, palliative care was consulted to help with pain management and to "get patient off of IV so she can be discharged." Palliative care recommended reaching out to the patient's outpatient prescriber for better coordination of care and the decision was to reduce the Suboxone dose from 8mg BID to 4mg BID in hopes of better pain control.

Discussion: The importance of knowing how to manage cancer pain in patients with OUD is of growing importance in our field. A recent article using the Delphi method[5] (a panel of experts through successive review comes to a joint decision) determined treatment recommendations for patients with cancer pain and on buprenorphine.

There was agreement of continuing buprenorphine and adding full agonist when time was short (weeks to months,) but questionable when prognosis is longer (months to years.) There was not consensus on stopping buprenorphine when time is short, but concordance on not stopping buprenorphine when prognosis is longer.

For our patient, there were many instances of decisions being delayed while waiting for coordination between the various services. While coordination is important, better knowledge and comfort amongst the palliative care group in buprenorphine management could have gone a long way in more quickly adjusting and adapting to the patient's needs. Had either the outpatient palliative care provider or the inpatient team (one of whom was me) been waivered, dose titration and ultimately patient comfort would have been achieved faster, with potentially better patient pain control and outcomes.

Back to Patient: Sadly, subsequent testing revealed progression of patient's disease, and the decision was to transition care to focusing on comfort.

Take Home Points:

1. Continue Medication Assisted Therapy (Buprenorphine/Methadone) when a patient has acute pain and a history of OUD
2. Discussing care with outpatient provider should become standard practice
3. Our own comfort and active engagement with managing these medications is of growing importance and needed to ensure quality care for patients
4. Link for buprenorphine waiver: https://buprenorphine.samhsa.gov/forms/select-practitioner-type.php

I would like to thank Drs. Jessie Merlin and Julie Childers for their contributions to the field.

References:

1. Macintyre, P.E., et al., Pain relief and opioid requirements in the first 24 hours after surgery in patients taking buprenorphine and methadone opioid substitution therapy. Anaesthesia and intensive care, 2013. 41(2): p. 222-230.
2. Kornfeld, H. and L. Manfredi, Effectiveness of full agonist opioids in patients stabilized on buprenorphine undergoing major surgery: a case series. American journal of therapeutics, 2010. 17(5): p. 523-528.
3. Vilkins, A.L., et al., Comparison of Post-Cesarean Section Opioid Analgesic Requirements in Women With Opioid Use Disorder Treated With Methadone or Buprenorphine. Journal of addiction medicine, 2017. 11(5): p. 397-401.
4. Buresh, M., et al., Treating Perioperative and Acute Pain in patients on Buprenorphine: Narrative Literature Review and Practice Recommendations. Journal of general internal medicine : JGIM, 2020. 35(12): p. 3635-3643.
5. Merlin, J.S., et al., Expert Panel Consensus on Management of Advanced Cancer-Related Pain in Individuals With Opioid Use Disorder. JAMA network open, 2021. 4(12): p. e2139968-e2139968.