PALLIATIVE CARE CASE OF THE MONTH

"Incorporating active addiction in goals of care decision making"

by
René Claxton, MD MS

Volume 23, No. 131

Case: Mr. B is a 44-year-old man with a history of hepatitis C, bipolar disorder and substance use disorder (opioids and alcohol since age 12 with multiple inpatient rehabilitation admissions) who had been experiencing homelessness. He was admitted to the hospital with altered mental status and new onset hemiplegia. He was found to have a large brain mass causing mid-line shift. Biopsy confirmed metastatic non-small cell lung cancer (NSCLC). As the patient did not have decision making capacity, the medical team met with the patient's daughter to determine his goals of care. Based on the patient's verbal and physical dissent with medical interventions at the time and the daughter's understanding of his prior expressed wishes, a plan was created to avoid surgical resection and move forward with radiation treatment. As the patient's mental status improved, he grew increasingly frustrated with his hospitalization and advocated successfully for immediate discharge. A week later, he sought readmission for cancer treatment and consented to surgical resection. After surgery, the oncology team consulted palliative care to discuss goals of care regarding further cancer directed treatment. There was concern about the frequent changes of his treatment plan up until then, and his impulsivity made it difficult for the primary team to assess his values.

Discussion: How do we incorporate active addiction in assessing the risks and benefits of medical treatment?
Addiction can be a complicating factor in determining medical management. In the setting of infections that require extended intravenous antibiotics for treatment such as endocarditis or dialysis graft infection, we balance the risk of misuse of the indwelling catheter needed for treatment versus the risk of not treating the infection.

For patients who inject drugs and require intravenous antibiotics, researchers suggest using a 9-point risk-assessment to assess the likely impact of addiction on treatment. This risk assessment identifies patients at "low-risk" and therefore safe for discharge with outpatient intravenous antibiotics versus "high-risk", which describes those who would benefit from continued inpatient management. One point is given for each of nine risk factors. Mild risk = total score of 1-3. Moderate risk = total score of 4-6. High risk is = total score of ≥ 7 (1). Risk factors include cravings, unstable home environment, dual psychiatric diagnosis, history of drug overdose, history of multiple relapses, polysubstance abuse, family history of addiction, history of trauma, and limited willingness to change. Of note, this tool has been used to assess cost avoidance in the inpatient setting but has not been validated in its ability to predict adverse events.

Incorporating active addiction into goals of care conversations: eliciting values and determining risk of treatment in the case of Mr. B.
Mr. B's total score on the above risk assessment was 6, placing him in the moderate risk category. However, Mr. B's case is different than the above examples in that the underlying medical issue is not reversible and proceeding with chemotherapy carries more significant risk than a course of intravenous antibiotics. Still, this risk assessment is helpful as it can serve as a guide for consideration of degree of support a patient may need to complete therapy successfully.

During goals of care conversations, Mr. B expressed an understanding that he had an incurable cancer with an overall prognosis of months. The oncology team shared that chemotherapy could potentially prolong his survival and would require the placement of an indwelling central venous catheter. Mr. B shared that it was important to him to die from complications of cancer rather than drug overdose. He worried about relapse of his substance use disorder and asked for methadone maintenance treatment rather than buprenorphine to decrease cravings. He also worried that his current homelessness would lead to drug relapse, as it made it difficult for him to avoid exposure to friends who were using substances.

How can we mitigate the risk of relapse (harm reduction) during medical treatment (2)?

- Offer and initiate substance use disorder treatment
- Provide person-centered non-judgmental care with the understanding that the patient may have had prior experiences with the healthcare system resulting in mistrust
- Support the patient emotionally through social work and psychology/psychiatry services
- Use the interdisciplinary team to provide holistic care including assessment and provision of spiritual-based support
- Be flexible in accommodating patient requests regarding tobacco use

Case Conclusion: In collaboration with toxicology, Mr. B started on methadone maintenance therapy in the hospital. Given that one of the factors driving him to request discharge during his first admission was the inability to smoke tobacco, we worked with nursing leaders to allow smoking breaks at specific times in a designated location. He completed one fraction of stereotactic radiation as an inpatient and then remained in the inpatient setting for chemotherapy (rather than receiving outpatient treatment). An addiction social worker identified safe housing on disposition as well as an accepting methadone clinic. The oncology team planned for inpatient admissions for future chemotherapy cycles to accommodate daily methadone administration and chemotherapy infusions.

References:

1. Eaton EF et al. A 9-Point Risk Assessment for Patients Who Inject Drugs and Require Intravenous Antibiotics: Focusing Inpatient Resources on Patients at Greatest Risk of Ongoing Drug Use. Clinical Infectious Diseases. Brief Report. 2019:68 (15 March). 1041-1043
2. Fitzgerald Jones K et al. Adapting Palliative Care Skills to Provide Substance Use Disorder Treatment to Patients with Serious Illness. Am J Palliat Med. Vol 39(1): 101-107, 2022