Case Conference: Pain, Opioids and a History of Substance Use Disorder

Moderated by:

Russell K. Portenoy, MD
Executive Director, MJHS Institute for Innovation in Palliative Care
Chief Medical Officer, MJHS Hospice and Palliative Care
Professor of Neurology and Family and Social Medicine,
Albert Einstein College of Medicine

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Pain, Opioids and a History of Substance Use Disorder

- A 69-year-old man returns to primary care clinic and reports that leg pain remains severe since cancer surgery 6 months ago
- A quick review of the chart reveals that the patient has had two visits and has made three calls to the clinic during the past three months
- He has been a patient of the clinic for several years

Pain, Opioids and a History of Substance Use Disorder

- The patient's diagnoses include:
  - Osteosarcoma, primary lesion resected 8 months ago
  - History of alcoholism, in recovery for 15 years
  - Peripheral neuropathy
  - Hypertension
  - Hyperlipidemia

Pain, Opioids and a History of Substance Use Disorder

- Medications include:
  - HCTZ 25 mg daily
  - Amlodipine 5 mg daily
  - Simvastatin 40 mg daily
  - Naproxen 220 mg twice daily
  - Oxycodone 5 mg/acetaminophen 325 mg 1-2 tablets q4h PRN; maximum 30 per month

Background to the Case

- Patient was well until 11 months ago when he developed a painful swelling in his right thigh
- Pain, tenderness, and local swelling progressed
- Plain radiography ordered by the PCP revealed a mass consistent with a bone neoplasm in the mid-femur

Background to the Case

- The patient was referred to the Cancer Center, where MRI followed by needle biopsy confirmed a high-grade osteosarcoma
- PET scan was positive only at the primary site, but chest CT identified two masses, each about 4 mm, in the base of the right lung
- The Cancer Center's Tumor Board reviewed the case:
  - *Although osteosarcoma at this age is rare, the recommendation is for aggressive management in the hope of achieving cure or long-term survival*

Background to the Case

- The patient agreed to neoadjuvant chemotherapy followed by surgery
  - Limb salvage surgery would be done if possible
- The lung masses would be followed expectantly
- He was told that there would be about a 60% chance of cure if the treatment was successful

Background to the Case

- Preoperative chemotherapy with cisplatin and doxorubicin produced expected acute toxicities, including nausea, hair loss, fatigue, and a peripheral neuropathy
  - The patient was given oxycodone/acetaminophen tablets for leg pain and took 3-4 tablets daily
  - After two cycles of chemotherapy, the pain lessened

Background to the Case

- After chemotherapy, a preoperative radiograph revealed that the bone tumor had shrunk
- At the time of surgery, almost no viable tumor was found
- Clean margins were obtained, and an endoprosthesis was used to preserve the limb
- After surgery, the medical oncologist told the patient that his response had been excellent and that adjuvant chemotherapy should continue for a year
  - Chemotherapy would begin with the same drugs as those used preoperatively

Background to the Case

- After a week in the hospital, the patient was transferred to a subacute rehabilitation unit
- Three weeks later, prior to commencing chemotherapy, a chest CT revealed that the two masses in the lung base were unchanged from the earlier study

Background to the Case

- The patient made slow progress in rehabilitation
- Pain persisted in the thigh despite uncomplicated healing of the surgical wound
- He returned home after 7 weeks, able to walk slowly with a cane and do self-care

Background to the Case

- After returning home, the pain worsened
- The patient was reevaluated by the orthopedist and underwent imaging of the leg
- The orthopedist found no indication of local recurrence of cancer, infection, or mechanical problems with the prosthesis
- The patient also saw the oncologist, who recommended staying the course and prescribed oxycodone 5 mg/acetaminophen 325 mg for PRN use, raising the monthly total to 100 tablets

Background to the Case

- The patient has a positive history for alcoholism
  - Heavy drinking started in his 20s, and he first went to Alcoholics Anonymous when he was 33 years old
  - During more than 3 decades, he had multiple relapses with periods of recovery that varied between 1 and 14 years
  - Relapses typically occur during stressful periods; during relapses, he stops attending AA meetings whereas recovery is heralded by frequent attendance
  - His last relapse was 8 years ago
  - He tries to attend an AA meeting every week, but has been unable to go while dealing with the cancer

Background to the Case

- The patient has a positive history for alcoholism
  - He has had alcoholic hepatitis on 3 occasions—the last was 13 years ago—and evidence of chronic liver scarring on CT scan
  - He had several episodes of pneumonia during his 40s and 50s
  - A serious motor vehicle accident in his early 40s resulted in a subdural hematoma, which required surgery for drainage
- There was no other history of illicit drug use (except for cannabis years ago) or prescription drug abuse
- There was no documentation in the chart and no report from the patient suggesting problems with the current opioid

Background to the Case

- Social history:
  - Retired businessman, who previously owned a restaurant
  - Married for 35 years; never had children
  - Close relationship with his sponsor from AA, but no other close friends
  - No involvement with a church

Background to the Case

- Family history:
  - Mother died in an automobile accident when the patient was a child; she was reportedly alcoholic
  - Father died from MI at 60 years
  - One brother, health unknown

Background to the Case

- Advance care planning:
  - In the chart is a legally executed health care proxy designating his wife as the agent
  - The proxy indicates that the patient does not want extraordinary means of life support if a terminal illness meant that he would not return to normal functioning

Back to the Visit

- The patient starts his visit with the PCP by asking for help with his pain
  - He states that it is 'chronic' and is the main reason that he cannot function
  - He indicates that the oncologist is trying to treat the pain with the oxycodone tablets but each dose works for a short time and, overall, 'it is not working'
  - He would prefer that the PCP take over pain management

Back to the Visit

- The patient describes his pain:
  - It is located in the thigh, as it was prior to diagnosis
  - There is a continuous deep aching, which is mild when he rests but moderate whenever he stands
  - The constant pain is irritating and distracting
  - The pain increases after walking half a block and he must stop to rest; it is severe at these times

Back to the Visit

- As a result of the pain,
  - The patient is housebound except for PT; he spends most days sitting in a chair
  - His limp is not improving, and his gait is unsteady
  - He interacts with his wife but no longer visits his friends
  - He is irritable and upset; he denies being depressed or hopeless
  - He acknowledges that there are lesions in his chest that might be the cancer but expresses hope that they are 'little lumps of scar tissue by now'

Back to the Visit

- To manage the pain, he continues to take the oxycodone 5 mg/acetaminophen 325 provided by the oncologist
  - He takes 2 tablets per dose and tries to limit himself to 2 doses; he has run out of the prescription and is due to get a refill from the oncologist next week
  - He indicates that each dose of the oxycodone reduces the pain to 'definitely mild' for about 2 hours
  - He also continues to take naproxen 220 mg twice daily

Back to the Visit

- On review of systems,
  - The patient describes fatigue, which is worse in the afternoon and evening, and difficulty sleeping, which he attributes to pain
  - He denies fever or night sweats, and indicates that his weight is back to baseline after losing 20 lbs during cancer treatment
  - He has continuous mild tingling of the toes and an unsteady gait

Back to the Visit

- A focused examination reveals:
  - Body habitus is thin, not cachectic
  - There is diffuse tenderness in the right thigh and the mid-thigh circumference is 2.5 cm larger on the right
  - The surgical scar is well-healed, but the skin surrounding it is erythematous and sensitive to light touch
  - On neurological exam, there is:
    - Hyperesthesia and hyperalgesia in the region of the scar in the right thigh
    - Hypesthesia of the feet to above the ankles and moderate loss of toe proprioception
    - Moderately antalgic gait
  - Otherwise unremarkable

Back to the Visit

- Summary:
  - A 69 year-old-man with a significant history of alcoholism in recovery who has chronic pain following resection of an osteosarcoma arising from the femur
    - Pain is poorly controlled and disability is worsening despite current treatment with naproxen and oxycodone 5 mg/ acetaminophen 325 mg, and PT
  - There is probable metastatic disease in the lung but life expectancy is indeterminate

Pain, Opioids and a History of Substance Use Disorder

- Understanding the pain
  - Evaluation of the pain did not reveal a cause, but the examination demonstrates neurological signs
    - The syndrome is "chronic post-surgical pain," which is presumed to be a mixed nociceptive and neuropathic disorder related to injury to bone, soft tissues, and nerves from the tumor and from surgery
    - Repeated evaluation over time may be needed to fully exclude other causes, including recurrence at the surgical margin
    - Psychological factors may be contributing to the pain intensity, pain-related distress, and adverse impact of the pain on functioning

Back to the Visit

- Summary:
  - The PCP informs the patient that the symptoms are consistent with a chronic post-surgical pain syndrome
    - It is difficult to predict the course and the plan should focus on pain control and functional restoration with repeated assessment by the specialists when appropriate
  - The PCP also states that there is concern about relapse and the plan must include management of risk, including at minimum, a return to AA meetings
  - The PCP also notes that there may be residual cancer in the lung and watchful waiting is appropriate

Pain, Opioids and a History of Substance Use Disorder

- Background:
  - The patient is a cancer survivor, and survivorship provides a context for the plan of care
  - Although the term "survivor" has no clear definition, 5% of US population is living after a diagnosis of cancer
  - Survivors often are treated by primary care, with or without co-management by oncologists
  - Studies demonstrate high rates of physical and psychosocial symptoms, including fear of recurrence and numerous functional impairments in survivors

Mayer DK, Nasso SF, Earp JA: Defining cancer survivors, their needs and perspectives on survivorship health care in the USA. Lancet Oncol 2017:18:e11-118; Economou D. Palliative care needs of cancer survivors. Semin Oncol Nurs 2014;30:262-267

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- Background:
  - The relationship between palliative care and survivorship is evolving
  - Palliative care is now viewed as a model appropriate for all populations with serious chronic illness— which is dedicated to the relief of suffering and illness burden of the patient and family from the time of diagnosis forward
  - This framework supports the view that palliative care—particularly generalist-level palliative care—includes symptom management in survivors

Economou D. Palliative care needs of cancer survivors. Semin Oncol Nurs 2014;30:262-267

Pain, Opioids and a History of Substance Use Disorder

- Role of opioid therapy in cancer survivors
  - Key considerations:
    - There is broad agreement that opioid analgesics are first-line for moderate or severe chronic pain due to an active, serious, or life-threatening illness
    - New evidence-based guidelines by the American Society of Clinical Oncology (ASCO) emphasizes that the survivor population is different

Paice JA, Portenoy R, Lacchetti C, et al: Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology Clinical Practice Guideline. J Clin Oncol 2016; 34:3325-45

Pain, Opioids and a History of Substance Use Disorder

- According to ASCO guidelines:
  - Clinicians may prescribe a trial of opioids in carefully selected cancer survivors with chronic pain who do not respond to more conservative management…
  - Clinicians should incorporate a "**universal precautions**" approach to minimize abuse, addiction, and adverse consequences of opioid use…

Paice JA, Portenoy R, Lacchetti C, et al: Management of chronic pain in survivors of adult cancers: American Society of Clinical Oncology Clinical Practice Guideline. J Clin Oncol 2016; 34:3325-45

Pain, Opioids and a History of Substance Use Disorder

- The "Universal Precautions" approach recommended by ASCO can be applied to all populations with chronic pain in the absence of active serious chronic illness
  - Premise: Although the risk of drug abuse outcomes—including abuse, addiction, unintended overdose and diversion—varies across patients and clinical conditions, the risk is seldom absent and a standard approach to risk assessment and management may yield the best outcomes

Gourlay DL, Heit HA, Almahrezi A: Pain Med 2005;6(2):107–12

"Universal Precautions" in Opioid Therapy

- 5-step approach:
  1. Assess and stratify risk
  2. Choose to prescribe or not to prescribe
  3. Structure therapy to minimize risk
  4. Monitor drug-related behaviors over time
  5. Respond to aberrant drug-related behaviors
- At all steps, document and communicate

Portenoy RK, Ahmed E. J Clin Oncol. 2014;32(16):1662-70

"Universal Precautions" in Opioid Therapy

- **5-step approach**
  1. Assess and stratify risk
     - Most important history
       - Personal history of alcohol abuse or drug abuse
       - Family history of alcohol or drug abuse
       - Any significant psychiatric history

Portenoy RK, Ahmed E. J Clin Oncol. 2014;32(16):1662-70

"Universal Precautions" in Opioid Therapy

- **5-step approach**
  1. Assess and stratify risk
     - Other important history
       - Smoking
       - Younger age
       - Better performance status
       - Some medical conditions
       - Poor social adjustment
       - Physical/sexual abuse
       - History of incarceration
       - Prior involvement in drug abuse culture

Portenoy RK, Ahmed E. J Clin Oncol. 2014;32(16):1662-70

"Universal Precautions" in Opioid Therapy

- **5-step approach**
  2. Choose to prescribe or not to prescribe
     - Do not prescribe if risk of diversion is high
     - If risk of drug abuse is high, and the controlled drug is preferred or a standard of care, proceed only with appropriate controls and adherence monitoring in place

Portenoy RK, Ahmed E. J Clin Oncol. 2014;32(16):1662-70

"Universal Precautions" in Opioid Therapy

- **5-step approach**

3. Structure therapy to minimize risk
   - If the decision is made to prescribe, implement controls and adherence monitoring as necessary to reduce risk and help some patients maintain control
   - If the risk is very low, no specific approach may be needed
   - If the risk is not very low, consider strategies that are commensurate with assessed risk

Portenoy RK, Ahmed E. J Clin Oncol. 2014;32(16):1662-70

"Universal Precautions" in Opioid Therapy

- **5-step approach**

3. Structure therapy to minimize risk
   - Strategies may include small prescriptions, frequent visits, pill counts, use of one pharmacy, use of formulations with low street value
   - Urine or saliva drug screening is common, but there is no consensus about standard of care
   - Use of 'patient agreement' is controversial
   - Use of required consultations, attendance at groups, or psychotherapy may be considered

Portenoy RK, Ahmed E. J Clin Oncol. 2014;32(16):1662-70

"Universal Precautions" in Opioid Therapy

- **5-step approach**

4. Monitor drug-related behaviors
   - Assess adherence on a routine basis
     - In addition to using the PDMP, consider drug screens, pill counts, information from family members or others
     - If aberrant drug-related behaviors occur, consider differential diagnosis
       - Reassess
       - Diagnose
       - Act

Portenoy RK, Ahmed E. J Clin Oncol. 2014;32(16):1662-70

"Universal Precautions" in Opioid Therapy

- **5-step approach**

5. Respond to aberrant behaviors
   - If diversion is likely, do not prescribe
   - Consider whether to stop therapy or institute enhanced adherence monitoring approaches

Portenoy RK, Ahmed E. J Clin Oncol. 2014;32(16):1662-70

Back to the Visit

- The PCP contacts the oncologist and describes the plan of care for pain and related problems
- The PCP decides to continue limited access to opioid therapy, instituting adherence monitoring using the PDMP and urine drug screening
  - He explains that the patient is at risk from opioids because of his history and that continued opioid treatment is to help manage pain flares while other treatments are tried
  - He also makes continued access to any opioid therapy contingent on the patient's return to AA meetings

Back to the Visit

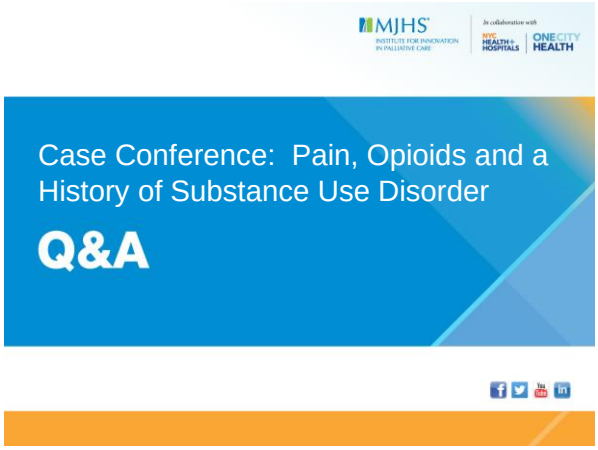
- In addition to PRN oxycodone 5 mg/acetaminophen 325 mg at 100 tablets per month, the plan of care includes:
  - Doubling the naproxen dose
  - Providing a trial of an analgesic antidepressant, duloxetine
  - Providing a trial of a topical lidocaine patch applied to the scar
  - Referral to Cancer Care for counseling
  - Continued PT
  - A follow-up visit with the patient and his wife to address concerns about recurrence, coordination of care with the oncologist and orthopedist, and need for regular discussion of goals and preferences for treatment

Back to the Visit

- The patient's pain improved and gabapentin was added as a second adjuvant analgesic
- With regular attendance at AA meetings, his outlook greatly improved
- He completed adjuvant chemotherapy and is undergoing chest imaging every 3 months to assess for progression of disease

Pain, Opioids and a History of Substance Use Disorder

- **Conclusion:**
  - Chronic pain is a significant problem after cancer treatment, and comorbid substance use disorder is a significant challenge during pain management
  - Cancer survivors need a "palliative care approach", including the type of case-by-case evaluation of risk and benefit appropriate for all patients being considered for opioid therapy
  - Primary care can provide a multimodality approach to the treatment of complex pain and disability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Q&A