Guidelines for Cancer Pain Management in Substance Misusers

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Patients with a substance misuse history are at increased risk of receiving inadequate pain management due to a fear of exacerbating the addiction by using opioid medications and the lack of knowledge about treating patients with addiction[1]

People who have a current or past history of substance misuse are at higher risk of certain diseases– both malignant - for example, lung, hepatic or head and neck tumours - and non-malignant conditions (e.g. HIV, Hepatitis B and C) and are therefore likely to access Palliative Care Services.

Effective pain management is an important part of good medical care and should be addressed appropriately, as with any other patient.[1]

Definitions

Drug addiction is the use of a drug for a reason other than which it was intended or in a manner or in quantities other than directed.[2]
Drug dependence is a compulsion to take a drug to produce a desired effect or prevent unpleasant effects when the drug is withheld.[2]
Drug tolerance is a decrease in susceptibility to the effects of a drug due to its continued administration.[2]

CLINICAL MANAGEMENT OF CANCER PAIN

Taking a Substance History

1. Take a comprehensive history of both the pain and substance misuse.[3]
2. Be non judgemental.
3. To help build rapport whilst taking the history, ask initially about ***licit drugs*** such as cigarettes, caffeine and alcohol.
4. Ask about ***illicit substances***. Ask the patient to clarify if you are unfamiliar with the street names and quantities of the drugs.
5. Ask about ***over–the-counter and prescription medications*** as these can also be misused.

A full history will help to minimise withdrawal symptoms if they are admitted to hospital.

Coexisting psychiatric disorders

Patients with addiction are at higher risk of having depression or anxiety.[4] It is therefore important to treat or seek expert advice on coexisting psychiatric co-morbidities as they may worsen the pain experience.

Assessment

Take a comprehensive pain history – include pain related to the underlying disease and any history of chronic pain.

Examination and Investigation

Consider requesting ***urine toxicology*** on the patient – screen for opioids (including methadone), barbiturates, amphetamines, cocaine and benzodiazepines, "if the story does not fit"

Treatment

Which Analgesic?

The World Health Organization "Analgesic Ladder"[9] should be used, even if actively misusing opioids or on a methadone programme.

If the patient is on a methadone programme [10] – the dose of methadone should not be altered and the appropriate opioid for pain control should be added. This is because the differences in the use of methadone for pain and in the management of substance misuse are marked and therefore should be left alone. [7]

Buprenorphine (s.l tablet) is being used increasingly in the management of opioid addiction[10]. It has both partial opioid agonist and partial antagonist properties. It is also an antagonist of the kappa opioid receptor. Thus it provides a milder, less euphoric and less sedating effect that methadone. Because of its higher affinity for opioid receptors, it reduces the effect of additional use of illicit opioids, and at higher doses has a prolonged duration of action, allowing for alternate day dosing.
If patients require opioids for the management of pain for more than a few days, it is advisable that the buprenorphine is converted to methadone. This should be done by liaising with the drug dependency unit.

Non-opioid analgesics should be used as adjuvants when appropriate – not as substitutes for strong opioids.

Non-pharmacological interventions such as radiotherapy, surgery, anaesthetic techniques etc. should be considered.

Which Preparation?

Use an appropriate opioid (avoid partial agonists i.e. avoid buprenorphine). If there is no contraindication, start with morphine (eg MST Continus®). Titrate the dose as normal but use controlled release rather than normal/immediate release preparations to avoid abuse if possible. (See the local prescribing guidelines for the management of pain).

Which Dose?

Patients with a drug dependency problem may have a greater than expected need regarding pain relief compared to those who are not dependent because they may already have a degree of drug tolerance.[5] A prospective open labelled study comparing morphine dosages and effectiveness in AIDS patients with and without histories of substance abuse demonstrated that both groups benefited, but patients with histories of drug use required higher morphine doses to achieve stable pain control. [6]

Which Route?

Consider the route of administration –patches may be preferable although they do not prevent abuse (there are case reports of patients applying multiple patches or chewing them).

Be careful when changing the route of administration or when opioids are withdrawn.

Avoid injectables, especially when an inpatient, unless necessary.

Communication between professionals

Constant assessment and re-evaluation of the effects of pain interventions must take place in order to optimise care.

There will probably already be many healthcare professionals involved in the care of the patient. Treating pain in cancer patients requires a multidisciplinary approach and will require additional disciplines to be involved if they have a history of substance misuse: involving drug dependency services, primary care, psychiatry, oncology, surgeons and palliative care.[3]

Good communication between teams is essential.

Ensure that there is an agreed and clarified single point of prescribing for analgesic medication. Close liaison with the drug dependency unit managing the patient's dependence and prescribing methadone/buprenorphine is essential.

Recognising specific substance misuse behaviours[8]

The following behaviours may lead you to believe that patients may be continuing to misuse drugs whilst being treated for their underlying disease:
Selling prescription drugs

Prescription forgery
Stealing and borrowing another patient's drugs
Injecting oral formulations
Obtaining prescription drugs from non-medical sources
Concurrent misuse of related illicit drugs
Multiple unsanctioned dose escalations
Aggressive complaining about the need for higher doses
Drug hoarding during periods of reduced symptoms
Requesting of specific drugs
Acquisition of similar drugs from other medicinal sources
Unapproved use of the drug to treat another symptom
Reporting psychotropic effects not intended by the doctor

In these cases you may consider drawing up a contract with the patient. (See appendix 1)

Managing Patients in the Community

- Do not visit alone if there are concerns about behaviour.
- Have a *single point of prescribing* and ensure that all are clear who that person is.
- *Prescribe analgesic medication weekly*. Be willing to prescribe additional medication if disease progressing, pain is worsening or patient may be developing tolerance. It may be appropriate that medication is dispensed in aliquots e.g twice weekly, if patients are unable to regulate their use over the whole week.
- Ensure the *Out–of-Hours* provider is aware of substance abuse issues to prevent additional prescriptions being made. This can be done via handover forms. When making significant dose changes or analgesic requirements are escalating rapidly, particularly at high doses, it may be advisable to admit the patient under specialist care to ensure that the change reflects the patient's need/ usage.
- Be aware of friends or family members who may try to buy or steal prescribed drugs.
- *Removal of drugs from a patients home after death*: after death, all drugs are the property of the deceased's estate. They should be returned to a pharmacy for destruction by a family member. If removal by a health care professional is required, the local PCT policy should be followed.
- If a healthcare professional is concerned about the presence of illicit drugs in a patient's home, it may be appropriate to contact the police.

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