INSTITUTE TO ENHANCE PALLIATIVE CARE

PALLIATIVE CARE CASE OF THE MONTH

Addiction in Palliative Care: Leaving the door open for the best possible outcome

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Volume 12, No. 12 **April 2012**

Case: MT is a 24-year-old man with a remote history of IV drug abuse who was diagnosed with nodular sclerosing Hodgkin's Lymphoma 3 years ago. He had a large anterior mediastinal mass that caused chest pain and required large amounts of opioid analgesics. He underwent high dose chemotherapy followed by autologous stem cell transplant, then adjuvant radiation to the mediastinum, eventually achieving a complete remission. Palliative Care followed him for pain control throughout the course of his disease. After going into remission, he continued to complain of chest pain and continued to attend the ambulatory palliative care clinic. As part of the normal protocol in the clinic, the patient received a random urine drug screen and it showed heroin. When confronted with these results, the patient initially said a friend had given him something oral when he forgot his pain medications. When it was noted that he had track marks on his arms, he admitted that he had started using heroin again one month ago. A very honest discussion revealed a desire to stop using heroin as well as some severe personal stressors and incompletely addressed depression and anxiety. The patient agreed to see our palliative psychiatrist and his psychiatric medications were adjusted. He also started attending support groups. His initial goal was to taper off of opioids entirely so he was given a taper in weekly scripts and was seen in the clinic frequently. As his dose decreased, his pain remained manageable but he continued to have relapses with heroin use, which he openly disclosed. The relapses became less frequent but did not completely resolve. It became clear that he had minimal underlying pain but that he was struggling with stopping the heroin more than he anticipated, so he was transitioned into a methadone clinic to help manage his cravings and provide the structure and psychological support that he would need to stop the heroin entirely.

During this entire process his mood improved as did his outlook on the future. He told his family of his struggles and they provided further support. His relationship improved with his girlfriend. Additionally, he enrolled in a trade school and has begun training to be a heating and air conditioning technician.

Discussion: There is a misconception that addiction is not a concern in hospice and palliative care. Some argue that, because the patients are dying, they should be given pain medications and kept comfortable and that little is to be gained by addressing underlying abuse of opioids or other street drugs. This, however, is an entirely false premise. First of all, as palliative care moves upstream and becomes involved earlier and earlier in the disease trajectory, many of our patients are not imminently dying. With the publicity surrounding the finding that early palliative care can prolong survival in lung cancer,[1] patients and their physicians are increasingly requesting palliative care services at diagnosis. Additionally, some patients are cured but continue to attend the palliative care clinic for pain control. One palliative care clinic reported that 40% of their clinic population consists of cancer survivors with chronic pain.[2]

The other part of the statement that is inaccurate is that there is, in fact, much to be gained by addressing the underlying abuse. Treating the addiction can help with adherence to medical therapy and improve patient safety. Potentially dangerous interactions between illicit substances and prescribed medications can be avoided. Continued substance abuse can also weaken or dissolve essential support networks for palliative patients.

Finally, and perhaps most importantly, addiction and substance abuse can prevent patients from completing tasks that they would like to complete near the end of their lives such as mending relationships and working on issues of legacy.[3]

Unfortunately, palliative care practitioners receive inadequate training about how to manage patients with concomitant issues with substance abuse. Hospice and Palliative Medicine fellows encounter these issues frequently but more than half feel unprepared and 80% felt unsatisfied with how they managed these patients.[4]

In the absence of specific training, some fellows may end up following perceived practice patterns in chronic pain clinics where care is often centered around pain contracts and patients are "fired" if the contract is broken. This case is a good example of why that strategy may not be the best approach. As we confronted the patient with a concern for his addiction and offered to treat it, MT stayed engaged with the healthcare system and had his underlying psychological issues addressed. He was weaned from his opioids and avoided a withdrawal syndrome, which may have exacerbated his substance abuse. Finally, he was transitioned to a methadone clinic for management of persistent cravings. While it is understandable that a physician may feel that his/her trust has been betrayed and may want to fire a patient who is found to have a problem with substance abuse, this neglects the true underlying medical problem of addiction. Instead of firing the patient, one can offer to treat the addiction, address other psychiatric issues and find safe strategies to continue to manage pain. This leaves the door open for the best possible outcome, as happened for MT. Keeping him engaged with the clinic and walking this road with him strengthened his relationships with his doctors and allowed him to receive the care he needed which, in turn, gave him the ability to strengthen his relationships at home, go back to school and move his life in a positive direction.

References:

1. Temel JS et al. Early palliative care for patients with metastatic non-metastatic non-small-cell lung cancer. N Engl J Med. 2010;363(8):733-42.
2. Levy MH, Chwistek M, Mehta RS. Management of chronic pain in cancer survivors. Cancer J. 2008 Nov-Dec;14(6):401-9.
3. Kirsh KL, Passik SD. Palliative care of the terminally ill drug addict. Cancer Invest. 2006;24:425-431.
4. Childers JW, Arnold RM. "I feel uncomfortable 'calling a patient out'": educational needs of palliative medicine fellows in managing opioid misuse. J Pain Symptom Manage. 2012;43:253-260.