The Duality of Cancer Pain and Substance Misuse

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Learning Objectives

• Review regulations that impact the management of cancer pain
• Apply risk assessment and mitigation strategies into opioid pain management plans in oncology patients
• Identify opioid sparing pain management strategies and their place in therapy

The Duality

• Undertreatment of cancer related pain is UNACCEPTABLE
• People with a diagnosis of cancer have the same risk of substance misuse as the general population

Competing Needs and “Crises”

• Many patients have legitimate pain.
• Opioids must be available when appropriate.
• Prescription opioid drug misuse is (still) abundant.
• Heroin and illicit fentanyl abuse has skyrocketed.
• Addiction and related suffering have placed our society in a public health crisis.
Some of our prescribing practices have contributed to the problem. The “beast of illicit fentanyl” is formidable and is now the primary driver. Complacency is the enemy – “all hands on deck are urgently needed!”

Cancer patients and palliative care patients are not immune to the risks of misuse and addiction inherent to opioid therapy. Opioid medications still remain critically important and essential tools for relieving legitimate and often profound physical suffering from devastating illnesses.

Cancer Patient Pain Scenarios

- 34 y/o man with osteosarcoma, infiltrating his pelvic bones and sacral nerves
- 57 y/o woman with metastatic breast cancer to bone, liver, lung, and brain, with pathologic fracture of femur and humerus, and studding of diaphragm
- 62 y/o woman with ovarian cancer, malignant bowel obstruction, unremitting abdominal pain

Can these patients be managed without opioids?

Heterogeneity of Pain Experienced by Cancer Patients

- Longer survival = more potential opioid exposure
- Multiple different types of pain possible
  - Acute or chronic, cancer- or treatment-related pain
  - Chemotherapy, radiation, and/or surgical
  - Acute or chronic non-malignant pain
- Duration of therapy similarly variable, may be:
  - During active treatment
  - Through survivorship with NED status
  - In end-of-life phase

Pain Syndromes in the Post-Cancer / Treatment Setting

- Chemotherapy-induced peripheral neuropathy
- Lymphedema
- Phantom limb pain
- Graft vs. Host disease, post stem cell transplant
- Post-radiation therapy pain syndromes

“Opioid therapy may be appropriate for a carefully selected subgroup, as long as benefits clearly outweigh risks over time and treatment can be monitored.”

Undertreatment of Pain in Cancer Patients

- Prospective observational study of 3000 outpatients with breast, lung, colorectal, or prostate cancer
- Significant underprescribing of pain medications
  - 68% patients reported pain at first visit to oncologist
  - 72% received inadequate medication relative to degree of pain one month later
  - 43% with severe pain did not receive an opioid at first assessment or one month later; 30% had no analgesic
- Risks for undertreatment
  - Lack of advanced disease
  - Treatment center with predominance of minority patients
  - Minority patients treated at any center

Our conundrum in oncology

- Pain is very prevalent in cancer
- 64% with advanced/metastatic disease
- 53% patients at all stages
- 33% after curative treatment
- 40% survivors live longer than 10 years
- Little is known about the prevalence of addiction or opioid misuse in oncology patients

ASCO Policy Statement on Opioid Therapy: Protecting Access to Treatment for Cancer-Related Pain

Cancer patients represent a special population that should be largely exempt from regulations intended to restrict access to pain relief, in recognition of the unique nature of the disease, its treatment, and potentially lifelong impact. Cancer is very heterogeneous, with some diseases representing high risks of pain and others having no incident biology extending over many years. Care and survival require complex management strategies that may involve chronic use of pain medications, and benzodiazepines may be indicated for pain and sleep disorders. Even if the cause is relatively acute, the complexity of the prescription and causes of cancer must be acknowledged, and these regulations must be considered.

ASCO has taken a number of positions on the appropriate use of opioid medications and the reasons for these positions. ASCO supports the use of opioids to control pain and to improve the quality of life for patients with cancer achieve pain relief and prevent or treat opioid-related side effects. The Committee on Clinical Practice recommends that pain management for cancer patients should be based on evidence-based guidelines and guidelines for the management of cancer pain. ASCO also supports the development of opioid guidelines for the treatment of cancer pain in order to provide patients and caregivers with the best possible care.

Updated, Supportive Evidence and Advocacy

- National Comprehensive Cancer Network Guidelines (NCCN) on Acute Cancer Pain
- 2016 ASCO Policy Statement on Opioids
- American Academy of Hospice and Palliative Medicine / Hospice and Palliative Nursing Association – Opioid Policy Statements and Initiatives
- American Society for Pain Management Nursing Position Statements
- Journal of Clinical Oncology – comprehensive series of papers in June 2014 on cancer pain

Opioid-Related Data and Statistics
Photo illustration of 2 mg of fentanyl, a lethal dose in most people.
The 2016 MA Opioid Law (STEP)

- 7-day opioid prescription limits
  - Exemptions for cancer-related pain, chronic pain, and/or palliative care
- Extended-release opioids and Medication Management Agreement
- "Partial fill OK at patient request" on all opioid Rx
- MassPAT – check every time opioid Rx written and with each first benzodiazepine Rx to unique patient (10/15/16)
- Prescriber ranking within specialty/practice (volume and quantity of opioids prescribed) – 3/1/2017
- Voluntary non-opioid directive – January 2017

2018 Massachusetts Legislation

2018 CARE Act (MA legislation)

- MCPAP for Pain: trained teams of pain management specialists for remote consultation
- Improved coverage and access to a broad spectrum of pain management services
- Partial fill of CII's with no additional co-pay
- Pain Management nurse to be added to the Board of Registration in Nursing
- Electronic Prescribing of all controlled substances by January 1, 2020
- PMP check required for ALL benzodiazepine prescriptions
- Search warrant required for law enforcement to search PMP data
- Pharma coupons prohibited on CII's

CDC Guidelines

- Not intended to apply to patients with cancer related pain
- Influence on cancer patients
- Third party coverage restrictions
- State and Federal Legislative changes
- Provider and Health-system practice changes

Universal Precautions

- Medication Management Agreements
- Opioid Risk Tool/SOAPP
- Urine Drug Screening (UDS)
- MassPAT/PDMP
- Interdisciplinary Team approach
- Structured prescribing
- Documentation

How do we incorporate these realities into an oncology or palliative care clinic?
Medication Management Agreements

Opioid Risk Tool (ORT)

<table>
<thead>
<tr>
<th>Item</th>
<th>Item Score If Female</th>
<th>Item Score If Male</th>
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</thead>
<tbody>
<tr>
<td>1. Family history of substance abuse</td>
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<td>3</td>
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<tr>
<td>Alcohol</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. Personal history of substance abuse</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Alcohol</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Illegal drugs</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>3. Age (mark box if 16–45)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>4. History of preadolescent sexual abuse</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Psychological disease</td>
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<td>1</td>
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<tr>
<td>Attention deficit disorder, obsessive-compulsive disorder, bipolar, schizophrenia</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Depression</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total score risk category</td>
<td>Low risk: 0–3</td>
<td></td>
</tr>
<tr>
<td>Moderate risk: 4–7</td>
<td>High risk: ≥8</td>
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Screener and Opioid Assessment for Patients with Pain (SOAPP)

- Tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require
- Score of ≥4 is positive
- 14 question version uses the cutoff of 7 for a positive screen

**Short form**

1. How often do you have mood swings?
2. How often do you smoke a cigarette within an hour of waking up?
3. How often have you taken a medication other than the way it was prescribed?
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past 5 years?
5. How often in your lifetime have you used alcohol or drugs?
6. Have you ever attended an Alcoholics Anonymous or Narcotics Anonymous meeting?
7. How often have you had a problem with alcohol or drugs?
8. How often have others suggested you have a drug or alcohol problem?
9. How often have others expressed concern over your use of medication?
10. How often have you felt a craving for medication?
11. How often have you used illegal drugs (e.g., marijuana, cocaine) in the past 5 years?
12. How often in your lifetime have you had legal problems or been arrested?

Urine Drug Testing (UDT)

- Need to specify pain management panel to get usable results
- Awareness of relevant metabolites and metabolism pathways
- Monitor both for expected and unexpected results
- Frequency based on misuse risk stratification
  - e.g., baseline and annual for low risk, baseline and monthly for high risk
- A retrospective review of medical records of pain patients seen in an outpatient palliative care clinic over a 6-month period found that only 4% of visits included UDT
- 50% of UDT results were aberrant (negative for prescribed opioids, positive for nonprescribed drugs, or positive for illicit drugs)

SOAPP-Screener and Opioid Assessment for Patients with Pain

**MassPAT – Key Points**

- “Prescription Awareness Tool” – Prescribers, Pharmacists, Law Enforcement all have access
- Prescribers need to check:
  - Each time an opioid is prescribed
  - Each time a benzodiazepine is prescribed
- Delegates
- Residents/Fellows
  - Limited vs. Full license status
  - “Resident with Prescriptive Authority”
- Documentation
Interdisciplinary Team

• Prescribing clinician (MD, NP, PA)
• Pharmacist
• Pharmacy Benefits Specialists
• Nursing (program nurse)
• Social work
• Psychosocial Oncology
• Addiction Psychiatry
• Interventional Pain Management Specialists

Structured prescribing

• More frequent prescriptions (weekly, every 2 weeks)
• Precise duration (7, 14, 28 days)
• Prescriptions only with visits
• Clear daily prn limits
• ePrescribing where available

Documentation

• Pain Diagnosis
• Substance abuse screening performed
• Risk stratification assessment / pt education
• Counseling re: driving, lockbox use, disposal
• Anticipated duration of opioid treatment
• Use of abuse deterrent formulations (or not)
• PMP reviewed; irregularities or not
• Prior authorization activity
• Medication management agreement on file including designated opioid prescriber
• Urine toxicology results
• Plan for follow-up including interim prescriptions / coverage-based care

Current Opioid Misuse Measure (COMM)

• Brief patient self-assessment to monitor chronic pain patients on opioid therapy (17 questions)
• Six key determinants for aberrant medication-related behaviors
  • Signs and Symptoms of intoxication
  • Emotional Volatility
  • Evidence of poor response to medications
  • Addiction
  • Healthcare Use Patterns
  • Problematic Medication Behavior
Naloxone

- Prescribed vs. standing order
- Risk stratification
- Social/family considerations
- MME trigger?

Interventional Pain Management

- Nerve blocks (e.g. celiac plexus block)
- Neuroaxial infusions (epidural, IT pumps)
- Vertebroplasty/kyphoplasty

Opioid Sparing

Integrative Pain Management

- Acupuncture
- Massage
- Music Therapy

Psychological Approaches

- Cognitive behavioral therapy
- Distraction
- Mindfulness
- Relaxation
- Guided Imagery

Medication Assisted Therapy

Medication Assisted Therapy: The Characteristics of Added Value in the Management of Opioid Use Disorders in Outpatient Settings

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Methadone</th>
<th>Buprenorphine</th>
<th>Naltrexone</th>
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<td>Characteristics</td>
<td>Methadone</td>
<td>Buprenorphine</td>
<td>Naltrexone</td>
</tr>
<tr>
<td>Class</td>
<td>Opioid agonist</td>
<td>Partial agonist</td>
<td>Full antagonist</td>
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<tr>
<td>Abuse potential</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Use and abuse</td>
<td>Tolerant to drug and limited risk of overdose</td>
<td>Tolerant to drug and limited risk of overdose</td>
<td>Tolerant to drug and limited risk of overdose</td>
</tr>
<tr>
<td>Advantages</td>
<td>High efficacy and low abuse potential</td>
<td>High efficacy and low abuse potential</td>
<td>High efficacy and low abuse potential</td>
</tr>
<tr>
<td>Disadvantages</td>
<td>Easy to overdose</td>
<td>Easy to overdose</td>
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Neuro-stimulatory Therapies
- Transcutaneous electrical nerve stimulation (TENS)
- Peripheral nerve stimulation
- Transcranial stimulation

Co-Analgesics
- NSAIDs
- Antidepressants
- Corticosteroids
- Antiepileptics

Survivorship
Management of Chronic Pain in Survivors of Adult Cancers:
ASCO Clinical Practice Guideline

- 63 studies included in systematic review of the literature by expert panel
- Key Question: How should chronic pain be management in the adult cancer survivor?
- Target Patient Population: Any adult diagnosed with cancer and experience pain that lasts > 3 months
- Key Recommendations in 3 primary areas
  - Screening and Comprehensive Assessment
  - Treatment and Care Options
  - Risk Assessment, Mitigation and Universal Precautions with Opioid Use

Opioid Specific Recommendations
- Assess and stratify risk of opioid misuse
- Decide whether or not to prescribe
- Minimize risk (adherence monitoring, use of co-analgesics and nonpharmacologic and interventional approaches)
- Monitor drug-related behaviors
- Respond to aberrant behaviors
Closing Thoughts – All Hands On Deck

• Opioids and illicit drugs (heroin, fentanyl) are part of a major public health crisis.
• We’ve an opportunity (no, MANDATE) to update and improve our practice, awareness, and education.
• How do we achieve balance with opioids
  • Preserving access when medically appropriate
  • Eliminating outdated, unsafe prescription habits
  • Providing the help that is needed (pain management, addiction management, or both) through structured practice
• We need to work together to address these crises.

Bottom Line

• We can still care for our patients by prescribing opioid therapy when indicated.
• There are more necessary steps, and more potential impediments to such care.
• Sometimes, though, our care may need to address misuse or addiction issues. These cannot be overlooked.
• Make it clear in what we say, document and do when prescribing opioids – i.e. we are paying attention and being compliant.