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Session Date: Friday, February 16, 2024

Didactic Topic and Presenter:
Pain Management at the End of Life for Patients with SUD

Eric Marty, MD
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School of Medicine and Public Health
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Content Experts: Sheila Weix and Joe Galey

- 12:15 PM: Attendance text-in – Introductions
- 12:25 PM: Case Presentation
  - Presenter: Elisabetta Tyriver, MD, PGY-2 UWDFMCH Residency
- 1 PM: Didactic Presentation and Discussion
  - Presenter: Eric Marty, MD
- 1:15 PM End of Session

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Interprofessional Continuing Education Partnership
UNIVERSITY OF WISCONSIN-MADISON
School of Medicine and Public Health
School of Nursing
School of Pharmacy

Project ECHO®
University of Wisconsin

ECHO ACCEPT
Addiction & Co-morbid Conditions: Enhancing Prevention & Therapeutics
2022-2024
Pain Management at the End of Life for Patients with SUD
2/16/24
Didactic Presenter: Eric Marty, MD
Case Presenter: Elisabetta (Betta) Tyriver, MD

Provided by the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP)

Intended Audience:

Nurses, Nurse Practitioners, Pharmacists, Physicians, Physician Assistants, Pharmacy Technicians, Psychologists, Social Workers, Patient/Caregivers, Students

Objectives:

As a result of this educational regularly scheduled series, learners as members of the healthcare team will be able to:

- Define the goals of pain management at the EOL for patients with SUD
- Describe how harm reduction principles apply to EOL care for patients with SUD
- Summarize the unique challenges of managing pain at the EOL in patients on MOUD

Policy on Disclosure

It is the policy of the University of Wisconsin–Madison Interprofessional Continuing Education Partnership (ICEP) to identify, mitigate and disclose all relevant financial relationships with ineligible companies* held by the speakers/presenters, authors, planners, and other persons who may influence content of this accredited continuing education (CE). In addition, speakers, presenters and authors must disclose any planned discussion of unlabeled/unapproved uses of drugs or devices during their presentation. For this accredited continuing education activity, all relevant financial relationships have been mitigated and detailed disclosures are listed below.

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Name	Role	Financial Relationship Disclosures	Discussion of Unlabeled/Unapproved uses of drugs/devices in presentation?	COI completion date
Randall Brown	RSS Chair	Usona Institute (Grant / Contract), multi-disciplinary association for psychedelic studies (Grant / Contract)	Yes	1/29/2024
Nada Rashid	RSS Coordinator	No relevant financial relationships to disclose	No	2/5/2024
Kathleen Maher	RSS Coordinator	No relevant financial relationships to disclose	No	2/6/2024
Ritu Bhatnagar	Planner	No relevant financial relationships to disclose	Yes	2/8/2024
Paul Hutson	Planner	No relevant financial relationships to disclose	Yes	1/29/2024
Susan Mindock	Planner	No relevant financial relationships to disclose	No	1/29/2024
Sheila Weix	Planner	No relevant financial relationships to disclose	No	2/9/2024
Kellene Eagen	Planner	No relevant financial relationships to disclose	No	1/29/2024
Joseph Galey	Planner	No relevant financial relationships to disclose	No	2/13/2024
David Leinweber	Planner	No relevant financial relationships to disclose	Yes	1/20/2024
Eric Marty	Presenter	No relevant financial relationships to disclose	Yes	2/7/2024

Elisabetta Tyriver	Presenter	No relevant financial relationships to disclose	No	2/14/2024

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Case Presentation

Elisabetta Tyriver, MD, PGY-2

UWDFMCH Residency

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Case Introduction

- One-liner (including age/sex):

49 year-old man with PMH including housing instability, OUD, sarcoidosis, spinal stenosis with walker dependence, depression, anxiety, who was recently (11/2023) diagnosed with metastatic adenocarcinoma of the colon s/p R hemicolectomy, wedge resection of 2 liver masses, and biliary stent for BD stricture. Now with severe cancer-related abdominal pain, OIC, and moderate malnutrition.

- Primary question for discussion:

Given significant barriers to close follow-up and patient's risk factors, what are the best practices for cancer-related pain management for this patient?

Medical & Behavioral Health Diagnosis:	Current Medications:
Metastatic colonic adenocarcinoma (to liver and left ribs) Opioid-induced constipation Moderate protein-calorie malnutrition Spinal stenosis Sarcoidosis HTN CKD2 OUD Depression Anxiety	Pain: morphine 75mg ER TID, morphine 45mg q2 hrs PRN, tylenol, cyclobenzaprine 10mg TID prn, duloxetine 60mg daily, Mood/appetite: duloxetine 60mg daily, mirtazapine 15mg daily Bowel regimen: linaclotide 290 mcg daily, doc-senna 3 tab BID, PRNs: milk of mag, dulcolax supp, miralax, fleet enema Zofran PPI Simethicone Amlodipine

Substance Use

- History:
  - H/o daily intranasal heroin use
  - During recent admission 11-12/2023 hospitalist service, AODA was consulted for severe OUD and mild to moderate acute opioid withdrawal, was started on suboxone, was given decreased dose at single hosp f/u appt which was not continued due to poorly controlled pain on oxycodone, did not establish with HPC
  - On admission 01/2024 for poorly controlled cancer pain, had endorsed single recent intranasal heroin use for pain, was not restarted on suboxone, AODA and palliative consulted, full opioid agonist therapy
  - 5 days after discharge brought by EMS to UWED for AMS/stupor
- Consequences of Substance
  - Social/occupational/educational: housing instability, unemployed, trying to become substance use counselor
  - Physical (including evidence of tolerance/withdrawal): requiring elevated doses of full agonist for adequate pain control, 11/2023 admission with withdrawal
- Past treatments:
  - None, abstinence for 5 years several years ago

Social History:	Family History:

• Social Factors/History:
  ○ Family is out of state, in living situations where they cannot house him even temporarily
• Education/Literacy:
  ○ interested in becoming a substance use counselor
• Income source:
	Limited family supports
	Father deceased
	Mother alive, h/o heart disease
	Brother, h/o CVA
	Cousins

Patient strengths & protective factors:	Risk factors:
• Motivated to beat cancer or live longer • Relationship with Street Med, PCP clinic, clinic social worker • Relative proximity to clinic	• Housing insecurity (lack of safe storage, privacy, healthy foods) • Lack of phone plan (appts, coordination, access to info) • Lack of own transportation • Dependence on Medicaid (placement options, opioid coverage, OTC) • Lack of local family support • Limited medical literacy • OUD h/o and stigma • Racial discrimination • Mood disorders • Mobility concerns

Labs

	Latest Ref Rng	1/7/2024
CODEINE, URINE (ARUP)		Present
MORPHINE, URINE (ARUP)		Present
6-ACETYLMORPHINE, URINE (ARUP)		Present
OXYCODONE, URINE (ARUP)		Present
NOROXYCODONE, URINE (ARUP)		Present
OXYMORPHONE, URINE (ARUP)		Present
NOROXYMORPHONE, URINE (ARUP)		Not Detected
HYDROCODONE, URINE (ARUP)		Not Detected
NORHYDROCODONE, URINE (ARUP)		Not Detected
HYDROMORPHONE, URINE (ARUP)		Present
BUPRENORPHINE, URINE (ARUP)		Present
NALOXONE, URINE (ARUP)		Not Detected
NORBUPRENORPHINE, URINE (ARUP)		Present
FENTANYL, URINE (ARUP)		Present
NORFENTANYL, URINE (ARUP)		Present
MEPERIDINE METABOLITE, URINE (ARUP)		Not Detected
TAPENTADOL, URINE (ARUP)		Not Detected
TAPENTADOL-O-SULF, URINE (ARUP)		Not Detected
METHADONE, URINE (ARUP)		Negative
TRAMADOL, URINE (ARUP)		Negative
AMPHETAMINE, URINE (ARUP)		Not Detected
METHAMPHETAMINE, URINE (ARUP)		Not Detected
MDMA-ECSTASY, URINE (ARUP)		Not Detected
METHYLPHENIDATE, URINE (ARUP)		Not Detected
MDA, URINE (ARUP)		Not Detected
MDEA-EVE, URINE (ARUP)		Not Detected
PHENTERMINE, URINE (ARUP)		Not Detected
BENZOYLECGONINE, URINE (ARUP)		Negative
ALPRAZOLAM, URINE (ARUP)		Not Detected
ALPHA-OH-ALPRAZOLAM, URINE (ARUP)		Not Detected
CLONAZEPAM, URINE (ARUP)		Not Detected
7-AMINOCLONAZEPAM, URINE (ARUP)		Not Detected
DIAZEPAM, URINE (ARUP)		Not Detected
GABAPENTIN, URINE (ARUP)		Not Detected
PREGABALIN, URINE (ARUP)		Not Detected
NORDIAZEPAM, URINE (ARUP)		Not Detected
OXAZEPAM, URINE (ARUP)		Not Detected
TEMAZEPAM, URINE (ARUP)		Not Detected
LORAZEPAM, URINE (ARUP)		Not Detected
MIDAZOLAM, URINE (ARUP)		Not Detected
ALPHA-OH-MIDAZOLAM, URINE (ARUP)		Not Detected
ZOLPIDEM, URINE (ARUP)		Not Detected
ZOLPIDEM METABOLITE, URINE (ARUP)		Not Detected
BARBITURATES, URINE (ARUP)		Negative
ETHYL GLUCURONIDE, URINE (ARUP)		Negative
CREATININE, URINE (ARUP)	20.0 - 400.0 mg/dL	264.9
MARIJUANA METABOLITE, URINE (ARUP)		PresumptivePOS
PCP, URINE (ARUP)		Negative
CARISOPRODOL, URINE (ARUP)		Negative
TARGETED DRUG PROFILE PANEL (ARUP)		See Below
EER TGT DRUG PROF, MS/EMIT, UR (ARUP)		See Note

Patient Goals & Motivations for Treatment

- Pain control
- Prolong life

Proposed Diagnoses

Moderate to severe OUD
Cancer-related pain
Opioid-induced constipation

Proposed Treatment Plan

- Full opioid agonist therapy

- Other options considered:
  - Suboxone
  - Methadone

Discussion:

Primary question: Given significant barriers to close follow-up and patient's risk factors, what are the best practices for cancer-related pain management for this patient?

DSM-5 Substance Use Disorder ("Addiction")

Tolerance
Withdrawal
} Physical Dependence ≠ Use Disorder

Larger amts/longer periods than intended

Persistent desire/failed attempts to quit/control use

Much time obtaining/using/recovering

Important activities sacrificed

Continued use despite known adverse effects

Failure to fulfill major obligations

Recurrent hazardous use

Craving

Ongoing use despite interpersonal problems

2-3 = mild
4-5 = moderate
≥ 6 = severe

Department of Medicine
UNIVERSITY OF WISCONSIN
SCHOOL OF MEDICINE AND PUBLIC HEALTH

Pain Management at the End of Life for Patients with SUD

Eric Marty, MD

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Objectives

- Understand the goals of pain management at the EOL for patients with SUD
- Understand how harm reduction principles apply to EOL care for patients with SUD
- Understand the unique challenges of managing pain at the EOL in patients on MOUD

- Everything we discuss today will be in this context – SUD at EOL.

What defines EOL

- EOL care refers to care for those in the terminal phase or stage of illness (regardless of hospice enrollment) AND those at very high risk of dying in coming days/weeks from acute illness or injury
- These are patients whose survival is expected to be on the order of months, or less
- EOL care includes but is not exclusively the care of those actively/imminently dying
  - The first stage of imminent dying is becoming bed bound, minimal oral intake, daytime somnolence

What defines SUD

- DSM-V
- Mild vs moderate/severe SUD
- High risk chemical use, prescription or otherwise, not meeting criteria for SUD
  - Prescription opioid use for pain evolving into use for anxiety or existential angst or avoidance coping
  - Prescription opioid use and non-dependent but risky alcohol use
  - Escalating prescription opioid therapy in a patient with chronic lung disease and hypercarbic respiratory failure (CO2) retention not adherent to BPAP therapy.

Care Goals at EOL for patients with SUD

- Relief of suffering and promotion of comfort
- Pain vs. suffering
  - “Suffering is the state of severe distress associated with events that threaten the intactness of the person”
    - EJ Cassell NEJM – The Nature of Suffering and the Goals of Medicine
  - Physical pain often results in suffering – but not always
    - “Suffering is pain without a purpose.”

Care Goals Re: Pain at EOL for patients with SUD

- Relieve suffering
  - Early in terminal phase: Improve functioning and QOL
  - Later in terminal phase: Provide comfort = Treating pain aggressively while balancing other priorities such as quality wakeful interactive time, minimizing adverse effects of analgesics, optimizing autonomy, etc
- Approaches to relief of suffering
  - Physical comfort
    - **Pain**
    - Symptoms of withdrawal
    - Assistance w ADLs / bedbound care
  - Emotional and psychosocial support
    - Concurrent symptoms from mental illness
    - Coping
    - Communication
    - Isolation
  - Spiritual care
    - Meaning
    - Regret
    - Reconciliation / Closure
  - Family/caregiver support
    - Complicated grief
  - Practical tasks
    - Identifying surrogate decision-maker
    - Where to be cared for and by whom

Pain Management at EOL

- Opioids
- Non-opioids
  - Acetaminophen
  - NSAIDs
  - Glucocorticoids
  - SNRIs/TCAs
  - Anticonvulsants
  - Local anesthetics
  - NMDA antagonists
- Radiation therapy
- Interventional
  - Nerve/plexus blocks/ablations, arthrocentesis/joint injection, joint repair/replacement, paracentesis, epidural/intrathecal therapy, vertebral augmentation
- Other: Rehabilitation, mindfulness meditation, CBT, spiritual care, etc
- Palliative sedation

Opioid Therapy in SUD at EOL

- There is a high likelihood of pain and need for opioid therapy at EOL in those w SUD
- While we also use non-opioid analgesics in terminal patients w SUD, we do not withhold opioids even in those w active SUD including OUD
    - Requires intense oversight and partnership w caregivers, community supports, hospice agencies, long term care, etc.
- Patients with SUD who are dying can be expected to require higher doses of opioids and benzodiazepines than those without SUD
    - In those with OUD, especially active OUD, pain outcomes are worse, and these patients are more likely to require palliative sedation

Applying Harm Reduction Principles in SUD at EOL

- Balancing risks and trade offs in context of disease status, prognosis, and goals/values/priorities
  - Abstinence / maintenance of remission is less of a priority
  - Embracing the opportunity to provide comfort is a higher priority
  - Avoiding overdose death remains a priority – but in actively dying patients, naloxone contraindicated.
  - Safety of caregivers, family/housemates, and the community in general remains a high priority
    - E.g., accidental overdose in a child, intentional or unintentional diversion

What Does Harm Reduction Look Like?

- Address the suffering coming from non-physical realms
- Optimize non opioid analgesics/adjuncts
- Routine prescribing precautions + more intense oversight
  - Education, consent/agreement, PDMP, limited disp #, pill counts, safe/proxy disp, frequent visits, +/- UDS
- Optimize use of long-acting opioids and minimizing short acting opioids where appropriate
- Use of buprenorphine as first line opioid analgesic where appropriate
  - e.g. - patient w active OUD, not on treatment, prognosis of months
    - Can treat both OUD and pain effectively. Can always add full agonists if needed
  - e.g - patient w h/o SUD, prognosis of months, high concern about prescribing full agonists related to risks of diversion/misuse
    - Safer in OD or when other substances may be in the mix, less risk if diverted.

What Does Harm Reduction Look Like?

- Partnership with caregiver or community agency to secure the opioid and dispense daily or weekly supply
- Considering level/place of care. Home vs hospice facility vs LTC
  - Home hospice can make or break ability to rx opioids safely
    - Hospice agencies often willing to care for people and manage rx opioids even in setting of active SUD +/- MOUD
  - Securing admission to hospice facility can be challenging
  - If patient in LTC and meds are being dispensed to them, many of the safety concerns are mitigated
- Partnership with OTP – can be challenging

Managing pain at EOL in patients on MOUD

- Methadone
  - Continue care at OTP as symptoms, functional status, social situation, and care environment allow
  - Add additional opioids
    - After notifying OTP
    - Will need higher than typical starting doses
  - OTP regs make it very difficult to continue methadone when patients cannot attend clinic
    - Federal regulation has exceptions to allow dispensing through a family member
    - State Opioid Treatment Authority rarely approves this
    - Methadone can be prescribed outside OTPs to treat pain, but in a patient recently on methadone as MOUD, this is legal gray area, even if documenting pain.
    - Likely will need to rotate off methadone to an alternative opioid regimen
      - Unless in hospital, then can continue methadone and divide dose TID while adding additional opioids as needed
      - No strong preference for opioid to rotate to. Some prefer transdermal fentanyl

Managing pain at EOL in patients on MOUD

- Suboxone (buprenorphine-naloxone)
  - Continue and divide dose to TID for better analgesia
  - If pain is not severe and there is great concern about adding full agonists, can try a dose increase of Suboxone

  OR
  - Continue and divide dose to TID for better analgesia

    and
  - Add additional opioids for pain or dyspnea
    - Probably will need higher than typical starting doses

  OR
  - If uncontrolled pain despite titration of full agonists, or if unable to hold film SL / actively dying, likely need to rotate off Suboxone

Managing pain at EOL in patients on MOUD

- Naltrexone: Discontinue naltrexone and consider whether to start alternative MOUD such as buprenorphine-naloxone, reassessing pain thereafter, or, alternatively, use full agonist opioid therapy alone

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