Bridging Gaps: Clinical and Ethical Challenges for Patients with Addiction and Cancer

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- We will be discussing off-label use of medications
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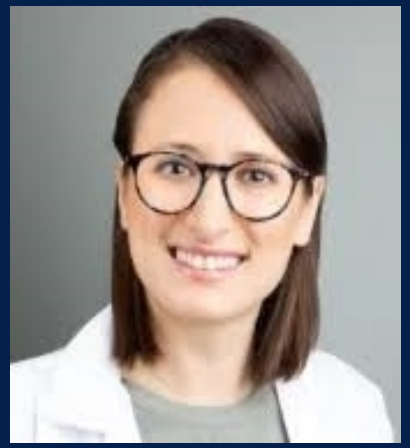

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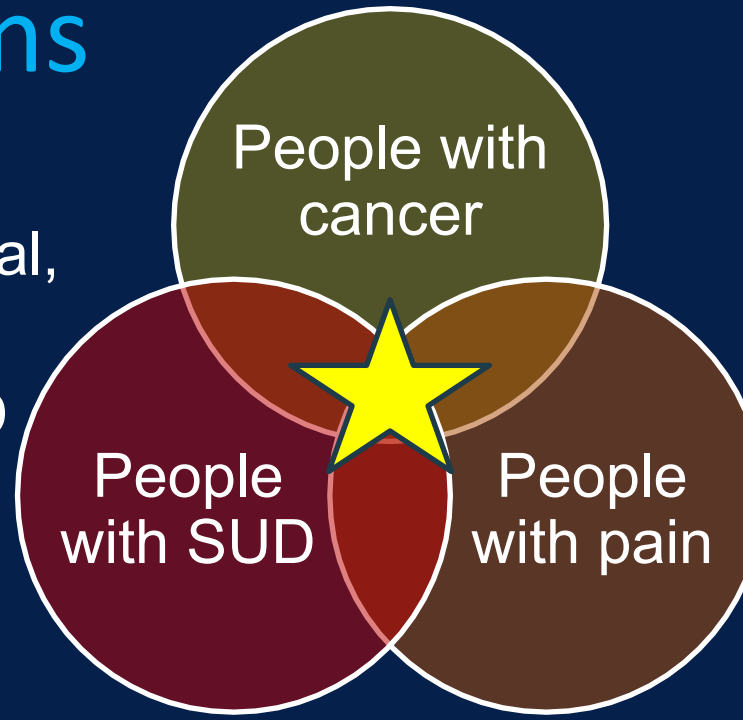
Learning Objectives

- Apply a multi-dimensional assessment (4P framework) to help prioritize more appropriate and safer opioid options in patients with pain, cancer, and addiction
- Compare features and management approaches for chronic cancer pain and OUD, Prescription OUD, or Complex persistent opioid dependence
- Examine ethical and clinical considerations when patients with untreated OUD and cancer decline medications for OUD, cancer treatment, and resuscitation

Session Outline

- 55yo woman with bladder cancer, OUD, and active use of methamphetamines and fentanyl, is admitted for curative cancer treatment and pain crisis
- 40yo man with OUD in remission on buprenorphine and adrenal cancer in remission after treatment continues to have vague abdominal pain treated with high dose oxycodone
- 27yo old woman with cervical cancer and active SUD declines treatment for cancer and MOUD and requests to be DNR/DNI

The growing dilemma for clinicians

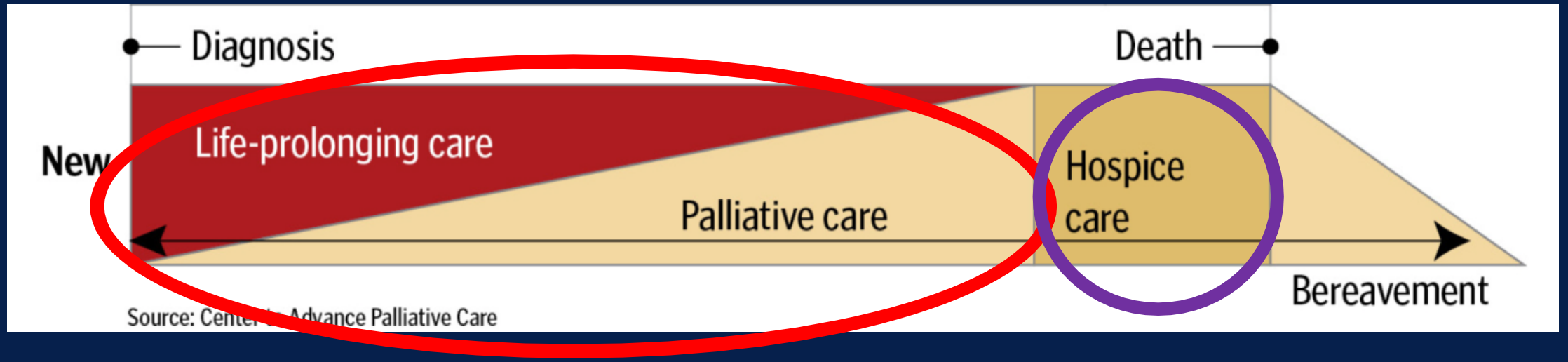


- People with SUD are at a higher risk of CA (Head neck, cervical, GI)
- High prevalence of chronic pain in people with OUD/on MOUD
  - 29-60% of people with OUD report chronic pain

- 40-60% of patients with CA report pain
  - 47% reported pain >3mo <u>after curative</u> CA treatment
  - Opioids are widely accepted as standard of care for patients with moderate to severe CA pain
- Increased exposure to opioids increase risk of opioid-related adverse effects, including misuse, OUD, and accidental overdose
  - Comorbid OUD: 3-8%
  - Opioid misuse: 20-40%[1-3]
  - Unexpected urine tox : 30-50% of patients[4]

van den Beuken, et al. JPSM 2016; Yennu S, et al .JCO 2017; Yennurajalingam S, et al. *Cancer.* 2018; Yong, R, et al. *Pain,* 2021; Speed, T, et al. *Inlt Review of Psych* 2018; Rauenzahn S, et al. *Support Care CA 2017;* Carmichael, *SA and Rehab.* 2016 , Arthur 2021. Jones, et al. JAMA Onc 2022

Palliative care is not hospice



Helping people with serious illness feel as well as possible
…for as long as possible
…to do what is most important

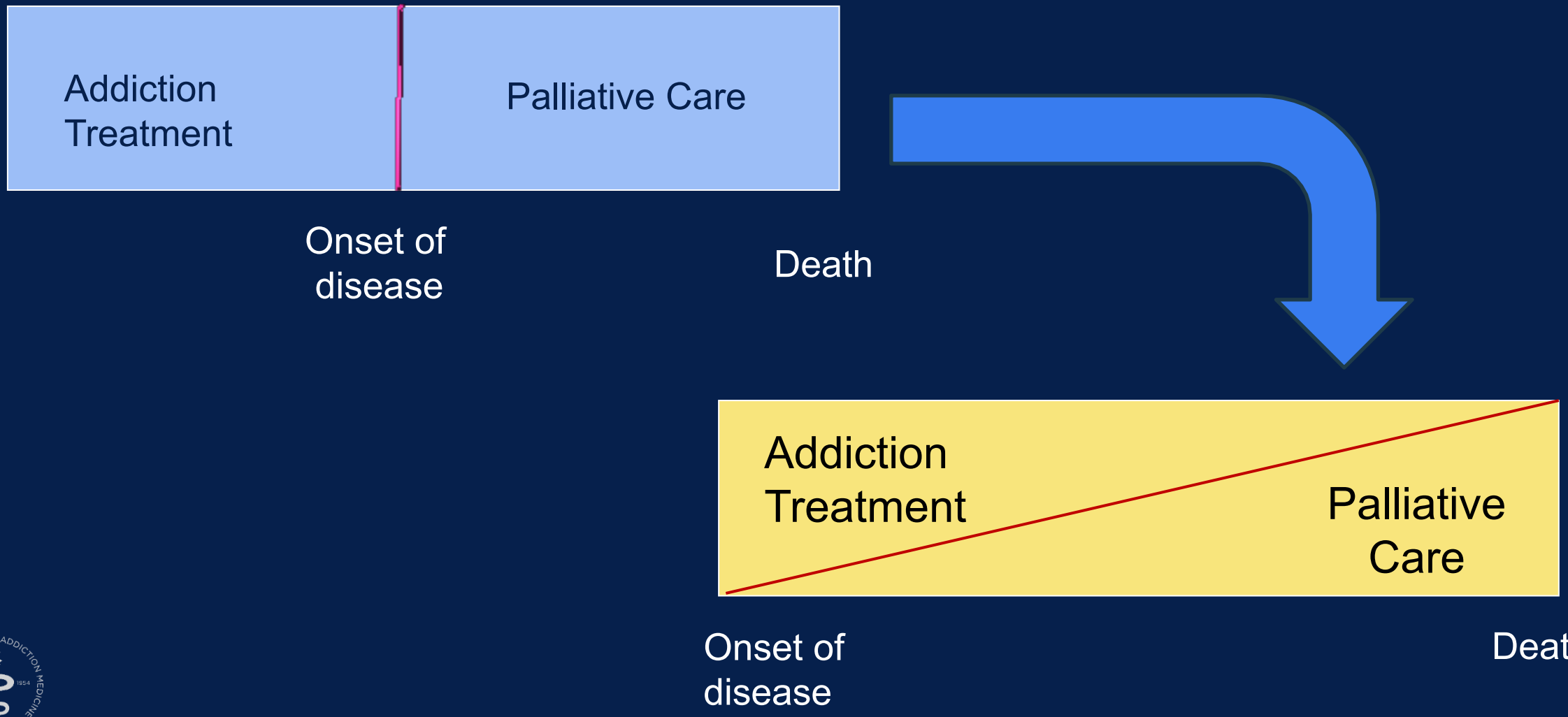
Addiction clinicians will care for more people with serious illness

- Patients with cancer and cancer pain are living longer + guidelines on pain exclude people in PC + Most PC clinicians not trained in core addiction skills→ AM specialists will see more patients with pain, serious illness, SUD

- AM specialists may be the most frequent, and oftentimes only, touchpoint a patient with SUD has with healthcare → key opportunities to understand what is most important for people in difficult conversations or decision-making

- Yet, most AM clinicians are not formally trained in pain management or advance care planning/ goals of care discussions

Bridging gaps in care together



Case 1

Pain in Cancer and Addiction

Case 1

- 55yo mom w/ locally invasive bladder cancer and h/o OUD, admitted for a planned bladder resection as part of curative treatment
- Post-op, she reports severe pain despite restarting OP pain regimen: MSER 30mg TID , Hydrocodone-APAP 5-325mg Q6hr PRN, gabapentin 600mg TID
- Overnight, she had pain, sweating, anxiety, diarrhea
  - Exam: uncomfortable, sweaty, dilated pupils, awake and alert

- Medical History:
  - Anxiety, Depression, Chronic low back pain, PTSD

- Social history:
  - She lives with a boyfriend with untreated OUD and prior unintentional overdose
  - Was working in a grocery store until severe pelvic pain
  - Estranged from 4 kids

- Substance Use History
  - h/o 6 yrs remission on Bup 8mg BID SL then returned to use after divorce
  - h/o 5 yrs remission on Methadone 90mg/d most recently
  - 6mo ago: started use of non-Rx fentanyl and methamphetamine for pain, coping
  - 2mo ago: Self-tapered methadone bc she felt stigmatized at OTP
    - Oncology started hydrocodone-APAP and added MSER 30 TID
    - Ultimately returned to use by injection
    - Last use was DOA
  - Smokes marijuana; Denies use of anything else

- Goal: Treat cancer. Reconnect with kids, “To be normal”. To stop using fentanyl, does not want to be on MOUD ‘when this is all over’

How would you manage pain?

Case 1: 8 months later

- Severe abdominal and pelvic pain has returned and interferes with sleep and daily function
- She now lives in medical respite away from ex-bf
- Still intermittently using non-prescribed methamphetamine despite mirtazapine
- Scans now show progression of disease with widespread pelvic mets
- Oncology mentions hospice would be appropriate

How would you manage pain?

Questions – small group

- What medication would you offer first-line to treat the patient's OUD and cancer pain?
  - At diagnosis?
  - After disease progression?
- When, if ever, is it appropriate to request non-AM specialists to 'take over' prescribing methadone or buprenorphine (for pain) from OTP?

Stratifying the risks/ benefits of opioids

Severe OUD

Active cancer Pain

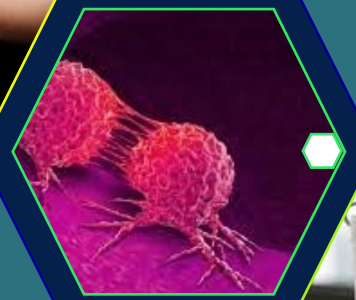
Post-op Pain

Prior OUD remission in OTP

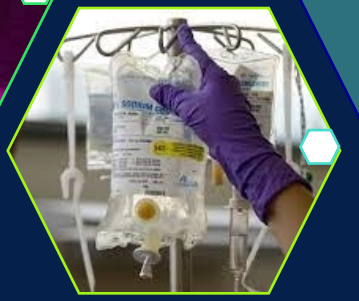
Self-titrated morphine

Chronic Back pain

Bladder Cancer



Caregiver uses IVD



Self-d/c methadone

Recent return to use

4Ps Framework for Opioid Decisions

- Pain
- Pattern for OUD
- Prognosis
- Performance Status

Pattern / Risk of OUD

	Full agonist	Methadone Rx	Buprenorphine	Methadone OTP
Low risk ORT-OUD	X	X	X	No
High risk ORT-OUD	Closely monitor	Closely monitor	X	No
Long term recovery non-opioid SUD	Closely monitor	Closely monitor	X	No
Long term recovery OUD	Closely monitor	Closely monitor	XXX	XXX
Sustained remission OUD	Closely monitor	Closely monitor	XXXXX	XXXXX
Non-opioid SUD	Closely monitor	No	X	No
Prescription opioid misuse	Closely monitor	No	X	No
Early remission OUD	Closely monitor	No	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXX
Active OUD	No	No	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXX

Pattern / Risk of OUD

ORT-OUD (Cheatle 2019)

- Family history of unhealthy substance use
1. Alcohol
2. Illegal drugs
3. Prescription drugs
- Personal history of unhealthy substance use
1. Alcohol
2. Illegal drugs
3. Prescription drugs
4. Age 16-45
- Psychological disease
1. ADD, OCD, bipolar, schizophrenia
2. Depression
- If 2 or less, low risk. If >2, high risk.

- Genetic
- Past Use
- Patterns
- Serious Mental Illness

MOUD Dosing Strategies in Acute Pain

Adjust dosing schedule

- Commonly dosed daily for MOUD due to long half-life
- Analgesic effect lasts 6-12 hours
- Dose at 6-8 hour intervals for acute pain

Increase daily treatment dose

Immediate release FAO

- Higher than typical doses due to opioid tolerance
- Choose opioids with higher receptor affinity (fentanyl and hydromorphone preferred over oxycodone and morphine)
- Consider available route of administration
- Consider pharmacokinetic and pharmacodynamic drug interactions

Pain Pathophysiology Diagnosis

Pain	Full agonist	Methadone Rx	Bup	OTP (Methadone Clinic)	Examples
Acute Nociceptive Pain	XX		X	No	Acute Peri-Op
Acute Neuropathic Pain	XX	X	XX	No	Disk herniation
Subacute Nociceptive Pain	XX		XX	No	Cancer new diagnosis
Subacute Neuropathic	X	X	X	No	Phantom limb
Nociplastic			?	No	Chronic primary and chronic secondary pain syndromes
Chronic, Functional on Long Term Opioid	Consider taper	Consider taper	XX	No	Chronic LBP
Prescription Opioid Dependence Syndrome	TAPER	TAPER	XX	No	

Prognosis (lag time to effect vs long-term harm)

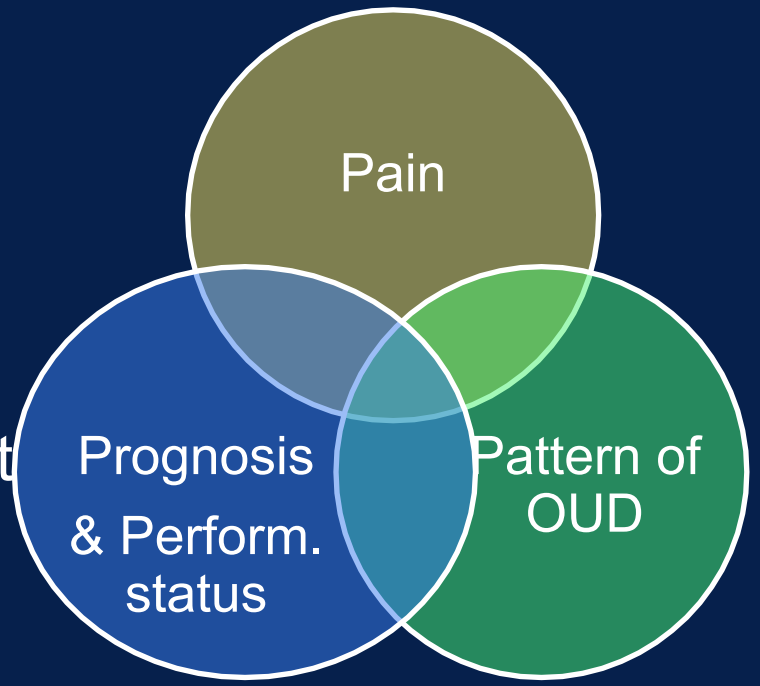
	Full agonist	Methadone Prescribed	Buprenorphine	OTP (Methadone Clinic)
Hours to days	XXX	XXX	X	No
Days to weeks	XXX	XXX	X	No
Weeks to months	XXX	XXX	XX	No
Months to year	XX	XX	XX	XX
Years	?	?	XXX	XX

Performance Status

	Full agonist	Methadone Rx	Buprenorphine	OTP (Methadone Clinic)
Cognitive High Function	X	X	X	X
Cognitive Impairment	Closely monitor	Closely monitor	XX	X
High Functional Mobility	X	X	X	X
Home limited	X	X	XX	No
Cardiopulmonary morbid condition	Closely monitor	No	XX	No
Renal impairment	Closely monitor	Closely monitor	XX	X
Hepatic impairment	Closely monitor	Closely monitor	XX	X
Age, low body mass	Closely monitor	Closely monitor	XX	Closely monitor

Questions - Panel

- What medication would you offer first-line to treat the patient'sOUD and cancer pain?
  - A. Methadone from opioid treatment program
  - B. Methadone prescribed by non-addiction specialist
  - C. Buprenorphine at OUD treatment doses
  - D. Other full agonists prescribed by non-addiction specialist
  - At diagnosis?
  - After disease progression?



- When, if ever, is it appropriate to request non-AM specialists to'take over' prescribing methadone or buprenorphine (for pain)from OTP?

Case 2

Chronic Pain and Opioids in Cancer Survivors

Case 2

- 60 year old man diagnosed with metastatic adrenal cancer
- OUD in remission on buprenorphine
- Started on oxycodone for cancer-related pain
- Buprenorphine 16 mg daily continued
- No recurrence of substance use

Case 2: Two years later

- Treatment for adrenal cancer completed
- On surveillance only, no evidence of disease
- Continues to have abdominal pain (no findings on scans) as well as shoulder pain due to rotator cuff disease
- Buprenorphine 16 mg daily, oxycodone 180 mg daily

Case 2

- Concerning signs:
  - Running out early
  - Declining function
  - Pain worsening

- “Oxycodone is the only thing that helps my pain”
- Not willing to taper despite repeated education about the risks of opioids

Questions – small group

- How would you approach addressing pain in this patient?

- Would you taper this patient off full agonist opioids? If so,
  - How would you communicate the decision?
  - How would you design a taper?

Challenge: Chronic Pain in Cancer Survivors

- Five-year survival rate across types of cancers averages 70%[1]
  - 35% for metastatic disease
- Approximately 30-40% of cancer survivors experience chronic pain[2]
- Etiology may not be able to be traced to the cancer or its treatments
- Central sensitization frequent[3]

1 Siegel et al. Cancer 2026.

2 Sanford et al. Cancer 2019

3 Leysen et al., Pain Practice. 2019

Guidelines

- Opioid efficacy in long-term cancer survivors has not been established
- Prioritize non-opioid and non-pharmacologic management
- Assess risk and benefit of opioids
  - Prioritize function
  - Monitor for aberrant behaviors, including OUD
  - Taper opioids if risk exceeds the benefit

Paice JA et al. J Clin Oncol 2016

Questions - Panel

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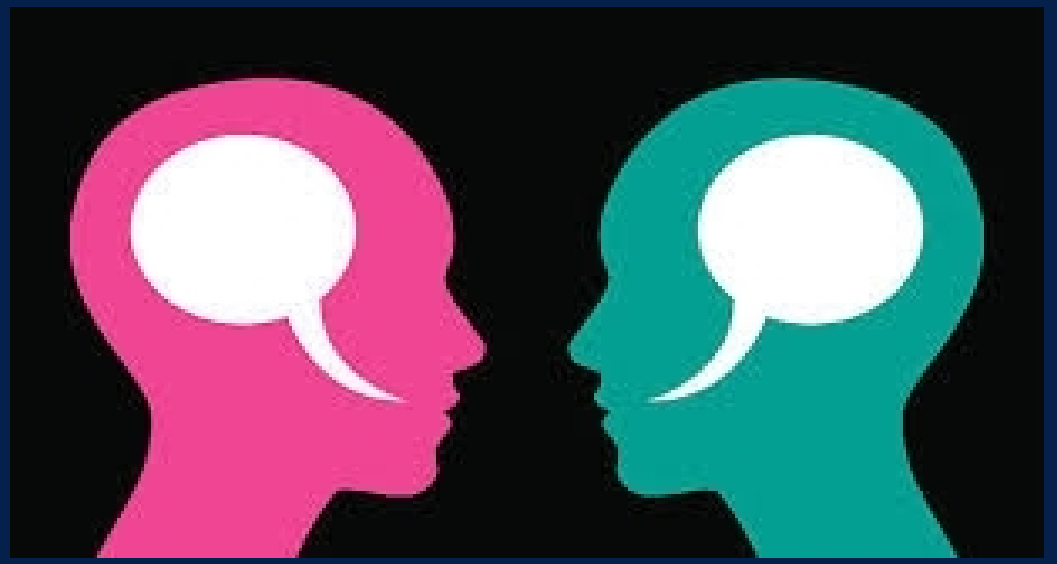


Case 3

People Who Decline Treatment

Case 3

- A 27-year-old patient is seen in clinic.
- She has active SUD
  - Non-prescription fentantyl and methamphetamine
- She has been newly diagnosed with cervical cancer
  - Treatment Intent: Curative

Case 3

- She is declining MOUD
- She is declining cancer-directed treatments
- She is declining full resuscitation and wants to sign paperwork to be do-not-resuscitate (DNR)

Questions

- What ethical obligations or responsibilities should be considered?
  - *Can a person with addiction exercise full autonomy in decision-making, or is autonomy fundamentally constrained by the disorder?*
  - *How do we balance respect for patient autonomy with recognition that addiction may impair decision-making capacity?*

Principles of Clinical Ethics

Beneficence

- The duty to **try to bring about improvements** in physical and psychological health that medicine can achieve

Non-maleficence

- Diagnosing and treating conditions in ways that **prevent further injury or reduce its risk**.

Justice

- The ways in which **professional, family, religious, financial, legal, and institutional factors** influence clinical decisions.

Autonomy

- The moral right of every competent individual to choose and follow his or her own plan of life and actions.
- It is one aspect of the larger principle of **Respect for Persons**

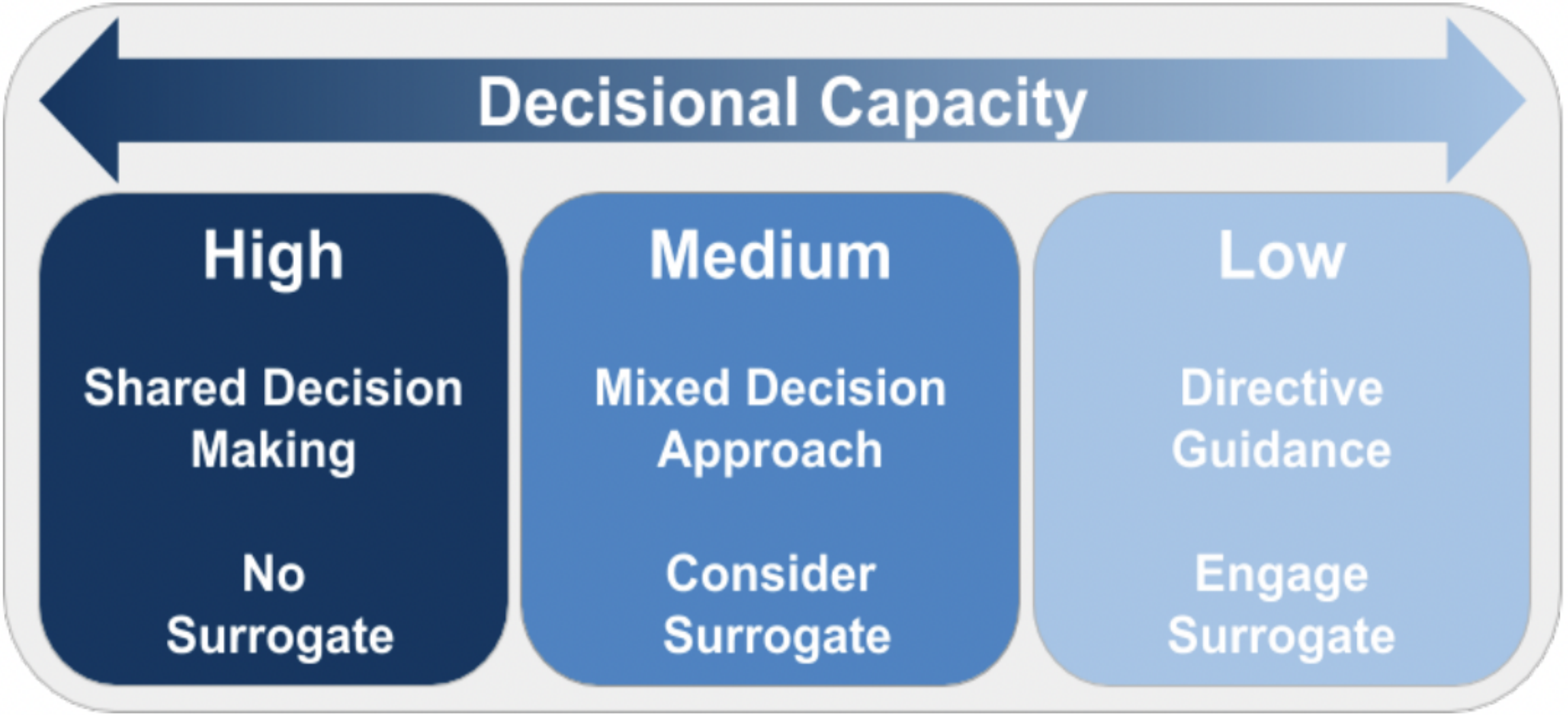
Jonsen AR, Siegler M, Winslade WJ. (Eds.), (2022). *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine*, 9e. New York, NY: McGraw-Hill

Assessing Decisional Capacity

- Understanding
- Appreciation
- Reasoning
- Communication

Barstow C, Shahan B, Roberts M. Evaluating Medical Decision-Making Capacity in Practice. Am Fam Physician. 2018 Jul 1;98(1):40-46. PMID: 30215955.

Figure. Capacity-Adjusted Sliding-Scale Shared Decision Making



AMA J Ethics. 2020;22(5):E358-364. doi: 10.1001/amajethics.2020.358.

Capacity-Adjusted Sliding Scale Based on Risk and Consequences

LOW risk & consequence

HIGH risk & consequence

Virtual Mentor. 2010;12(6):444-449. doi: 10.1001/virtualmentor.2010.12.6.ccas2-100

Addiction and Autonomy

What is the meaning of autonomy?

- Basic autonomy vs Ideal autonomy
- Procedural vs Substantive autonomy
- Self-government vs Self-determination
- What constitutes a person's goals, preferences, and values to be considered "their own"

Ambivalence & Oscillation of Preferences

Emotional dysregulation

Treatment Over Objection

Core questions to guide treatment over objection in patients without decisional capacity:

- What is the likely severity of harm without intervention?
- How imminent is harm without intervention?
- What is the efficacy of the proposed intervention?
- What are the risks of the intervention?
- **What is the likely emotional effect of a coerced intervention on the patient?**
- **What is the patient's reason for refusal, and can it be addressed?**
- **What are the logistics of treating over objection?**

Fischkoff D, Prager K, Dastidar J, Dugdale L, Neuberg G, Nemeth S, Fischkoff K. Ethical Framework to Guide Decisions of Treatment Ove
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Four Models of the Clinician-Patient Relationship

Comparing the Four Models

	Informative	Interpretive	Deliberative	Paternalistic
Patient values	Defined, fixed, and known to the patient	Inchoate and conflicting, requiring elucidation	Open to development and revision through moral discussion	Objective and shared by physician and patient
Physician's obligation	Providing relevant factual information and implementing patient's selected intervention	Elucidating and interpreting relevant patient values as well as informing the patient and implementing the patient's selected intervention	Articulating and persuading the patient of the most admirable values as well as informing the patient and implementing the patient's selected intervention	Promoting the patient's well-being independent of the patient's current preferences
Conception of patient's autonomy	Choice of, and control over, medical care	Self-understanding relevant to medical care	Moral self-development relevant to medical care	Assenting to objective values
Conception of physician's role	Competent technical expert	Counselor or adviser	Friend or teacher	Guardian

Emanuel EJ, Emanuel LL. Four models of the physician-patient relationship. JAMA. 1992 Apr 22-29;267(16):2221-6. PMID: 1556799.

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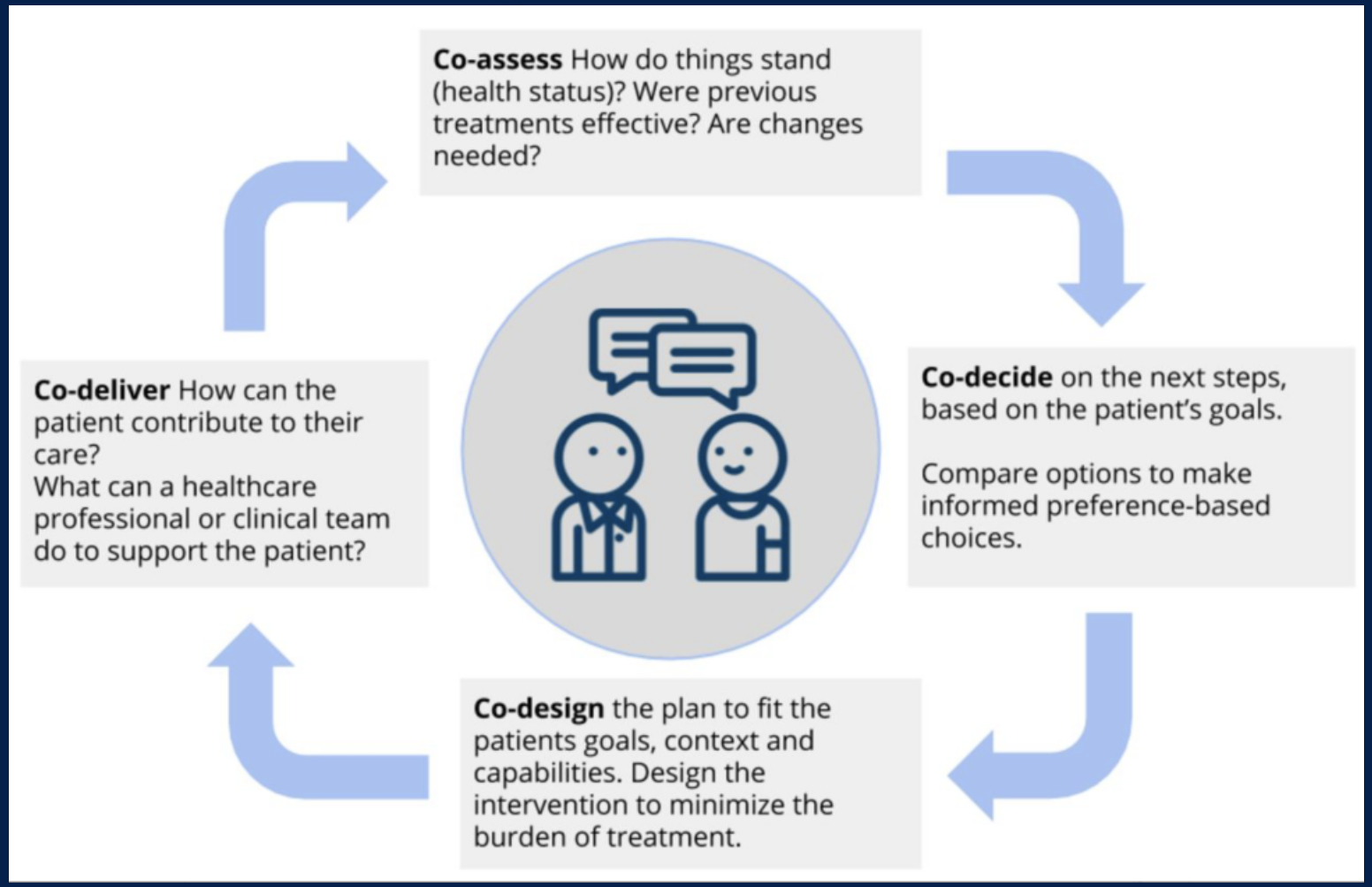

Elwyn G, Nelson E, Hager A*, et al* Coproduction: when users define quality *BMJ Quality & Safety* 2020;**29:**711-716.

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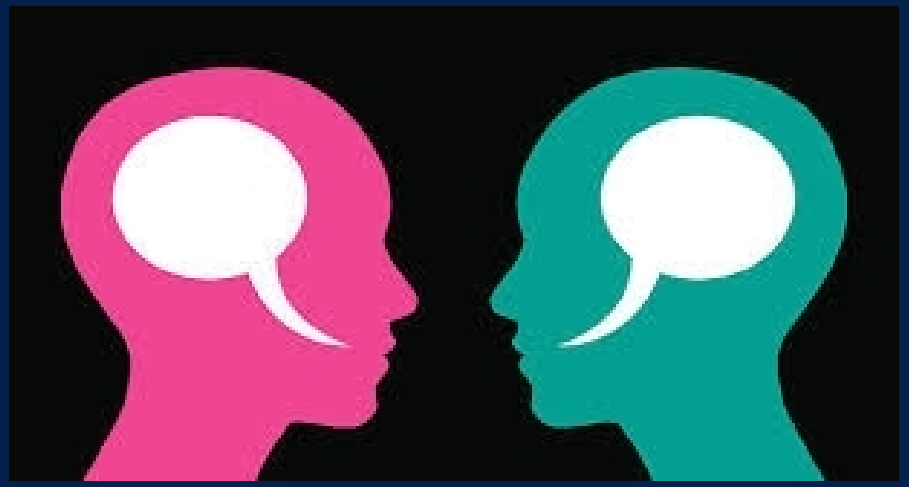

Final Takeaways/Summary

- Consider 1) pain type, 2) pattern of substance use or SUD, and 3)prognosis/ performance status to determine the most appropriate opioid to offer in cancer pain
- Not all pain in people with cancer is cancer-related pain where opioids are the most appropriate treatment, especially when chronic
- Medical decision making varies depending on a patient's decisional capacity and level of risk and consequence regarding specific decisions
- Addiction clinicians can support other clinicians by helping to interpret patient risk for high-risk med prescribing

Thank you!

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