People who use drugs get cancer, too

A Concise Guide for Managing Cancer Pain and Opioid Use Disorder

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Key Learnings

1. Methadone and Bureprenophine are recommended opioids to treat cancer pain in patients with existing Opioid Use Disorder

2. Screen and treat all patients with cancer pain for Opioid Use Disorder and psychiatric illness

3. Trauma-informed care lens, multidisciplinary team recommended

Rationale

People who use drugs (PWUD) face ongoing stigmatization in society and also from the healthcare system. It is important to remember that PWUD also receive terminal diagnoses and access the healthcare system for reasons other than the treatment of their substance use. In Addictions medicine, the approach is to use a trauma-informed lens to meet patients where they are at and understand often it is through their previous traumas and suffering that they are in their present predicament.

The palliative care approach is one that focuses on the whole person and takes a compassionate approach to relieve suffering. This document brings together these two approaches and outlines key guidelines for working with patients with cancer pain and concurrent opioid use disorder (OUD).

These guidelines are based on a scoping review of current literature and discussion with experts who work with this patient population. The following recommendations are meant to be taken with individual clinician discretion, and consultation with palliative care specialists and addictions specialists is recommended.

Opioids to Treat Cancer Pain in OUD

Choice of opioid should take into consideration:

- What opioids patients have tried/used in the past
- Patient preference
- Any current opioid agonist therapy (OAT) like Methadone, Buprenorphine/ Naloxone, or slow-release oral Morphine
- OAT treats withdrawal and curtail cravings, does not relieve pain
- Drugs of historically problematic use should be avoided

Opioid	Considerations
Methadone	• Analgesia effect is 4 to 9 hours. When used for pain dose TID. Onset 30-40min • PRN: Use Methadone q3-4h • Rotate to Methadone using Edmonton Method or Morley-Makin method* • More effective when other opioids ineffective1
Buprenorphine	• Buprenorphine patch start q7 days, can increase frequency but no more than q3 days • PRN: Use other opioids and/or NSAIDS • Easier to taper off compared to Methadone • Transdermal Buprenorphine useful in moderate to severe cancer pain2

Both Buprenorphone and Methadone are recommended mainstay opioids for treatment of cancer pain in patients with addictions, they are effective and long lasting.[1,3,4,5]

Prescribing Guidelines for Opioids to treat Cancer Pain for Patients with OUD

- Short prescription intervals: 1-2 weeks
- Co-prescribing of Naloxone kits and education on how to administer it (TowardTheHeart.com)
- Home care nursing or pharmacist may conduct pill counts in an outpatient setting
- Single prescriber of opioids whenever possible
- Ensure safe storage, i.e. lock boxes

Non-Opioid Options to Treat Cancer Pain in OUD

- Continue Opioid Agonist Therapy (OAT) if applicable
- Treat any underlying or undiagnosed psychiatric co-morbidities
- Provide therapy and additional support to address trauma and other forms of existential suffering that contribute to total pain[3,4,6,7]

Pharmacological	Non-pharmacological
• Acetaminophen	• Cognitive Behavioral Therapy
• NSAIDS	• Exercise
• Haloperidol	• Mindfulness based therapy
• SSRIs	• Massage therapy
• TCAs	• Music therapy
• Gabapentin	• Aromatherapy
• Topicals e.g. diclofenac 2.32%	

Practice Approaches

- Non-stigmatizing, trauma-informed approach with this patient population
- Nonjudgmental, empathetic, yet truthful dialogue about pain and illicit drug use history[8]
- Multidisciplinary team needed, ideally including a palliative care physician, palliative trained nurse, social worker, pharmacist or patient advocate.[9]
- Respecting patient self-reported pain[7]

Conclusion

It is the authors hope that this document is helpful in providing treatment approaches to working with patients with concurrent cancer pain and OUD. This document is intended to inform, not replace, clinical judgement. Feedback is welcome and feel free to contact the authors regarding any personal successes and/or challenges working on this very important and complex clinical area.

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Recommended Resources

- May's Place, Hospice referral, Downtown Vancouver
  https://www.thebloomgroup.org/our-work/hospice/
- Palliative Outreach Response Team (PORT), Palliative Consultation, Victoria
  https://www.equityinpalliativecare.com/port
- BC Centre on Substance Use, OAT Guidelines,
  https://www.bccsu.ca/wp-content/uploads/2017/06/BC-OUD-Guidelines_June2017.pdf

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