rowcroft hospice

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PALLIATIVE CARE PRESCRIBING FOR PATIENTS WHO ARE SUBSTANCE MISUSERS

Background information

Substance misusers who develop palliative care needs are likely to have psychological, social and existential issues that influence the management of their symptom control, particularly that of pain.

The principles of analgesic practice in this group of patients are fundamentally no different from those for other adult patients needing palliative care.

Drug dependent patients may be receiving "Opioid Substitution Therapy" (OST), such as Methadone, Buprenorphine or Naltrexone. Such therapy is always prescribed and monitored by a substance misuse service.

Pain from cancer in substance misusers may be under-treated because of lack of understanding of opioid addiction and prescribed treatments.

General prescribing advice

Each patient requires an individualised approach to their palliative care needs, symptom management and prescribing.

It can be helpful to discuss a "verbal contract" with the patient to explore and clarify the expectations & responsibilities of both the patient and the healthcare professional(s). This is particularly relevant when considering the ongoing prescribing for their drug dependency and the prescribing of analgesia for their pain.

Some patients taking OST may be reluctant to take opioids. Clear information needs to be given regarding the purpose of opioids for analgesia rather than recreational use.

It is usual to approach the patient's OST as a separate entity to their analgesic regime. Analgesics for pain management should be commenced and titrated according to need. It is not necessary to rationalise the patient's entire opioid requirements to one drug.

Breakthrough doses for pain relief are best calculated according to the current analgesic regime only. There is no current evidence to suggest that incorporating OST methadone doses into calculations for breakthrough analgesia confers benefit: there is also potential for errors in prescribing with this approach.

Wherever possible it is advisable to optimise the use of non-opioid analgesics: NSAIDs, paracetamol & adjuvant analgesics (as per the World Health Organisation analgesic ladder). A thorough pain history/assessment is required to establish likely causes for the pain.

It is best to use long-acting opioids and minimise short acting analgesia for breakthrough pain (doses may rapidly escalate). If possible use tablets rather than liquid (e.g. sevredol rather than oramorph).

However, patients taking OST methadone or buprenorphine have the potential for tolerance to other opioids. An individualised approach to tailoring analgesic regimes is required. Such patients may require higher doses of opioids.

Symptoms of drug withdrawal may occur on admission to an in-patient unit (possibly due to cessation of other illicit drug use or deliberate or accidental under dosing by the patient in the community). An awareness of this is important and such symptoms may be difficult to distinguish from those of poor symptom control.

For palliative care patients taking methadone as OST:

- OST methadone is administered once daily, which is adequate to prevent opioid withdrawal symptoms for 24 hours but not to relieve pain.

- OST methadone is best regarded as a separate prescription from that for analgesia

- In the outpatient and home settings OST methadone should continue to be supervised and prescribed by the appropriate Substance Misuse Service/Drug Service team

- Patients admitted to the Hospice Inpatient Unit will receive all their medication from the unit for the duration of their stay. This will include their OST methadone

- Patients discharged from the Hospice Inpatient Unit will then revert back to receiving their maintenance methadone from their substance misuse service/drug service team

- Clear plans for separate follow-up for substance misuse and palliative care must be in place on discharge from the Hospice Inpatient Unit, with documentation of such plans in the GP discharge letter.

- In all circumstances, the patient's Substance Misuse Service/Drug Services key worker should be informed of the patient's planned discharge from the Hospice Inpatient Unit prior to the discharge date. This facilitates the planning of appropriate follow up by the Substance Misuse Service/Drug Services team.

- Regular and robust communication between Specialist Palliative Care, Primary Care and Substance Misuse Service/Drug Services is therefore vital. This is particularly important when any changes are made to drug regimes and/or if the patient moves from one health care setting to another.

- For those substance misuse patients that die in the Hospice Inpatient Unit, there must be prompt communication to the relevant primary health care team and the substance misuse team.

- For patients unable to swallow their oral OST methadone (in the last few days of life or for other clinical reasons) an adjustment to medications will need to be made and delivered by an appropriate route. Abrupt cessation of OST methadone may precipitate opioid withdrawal and may compromise analgesia (it is not known how much baseline analgesia methadone provides in these circumstances).

- For patients approaching the end of life medication is usually delivered subcutaneously via a syringe pump. Adjustment of the analgesic opioid plus other symptom control medications (e.g. midazolam) is likely to be necessary, particularly in the context of cessation of methadone. Please seek advice from Specialist Palliative Care team.

- Converting from methadone to another opioid is difficult given methadone's pharmacology, particularly its long and variable half life. For such an opioid switch, the typical potency ratio of 5-10: 1 (morphine PO: methadone PO) appears appropriate. However, a wide range

of potency ratio has been reported (1-75:1) so it is best to use conservative dose calculations and monitor carefully. Please seek advice from Specialist Palliative Care team.

- It is not usual practice to administer OST methadone subcutaneously for patients approaching the end of life.

For palliative care patients taking naltrexone as OST:

Naltrexone (opioid antagonist) is used in detoxification programmes to help maintain abstinence. The use of naltrexone will severely impede opioid analgesia. When given long term naltrexone increases opioid receptors in the CNS. This leads to a temporary increase in opioid sensitivity when naltrexone is discontinued. Therefore, any opioid therapy introduced after discontinuation of naltrexone needs careful monitoring.
Naltrexone must be discontinued in patients needing opioid therapy for analgesia.

Please seek advice from Specialist Palliative Care team.

For palliative care patients taking Buprenorphine as OST:

Buprenorphine is a partial mu-opioid receptor agonist and a kappa- and delta-opioid receptor antagonist. Patients taking high dose Buprenorphine (≥ 16mg/day) as substitution therapy may be relatively refractory to opioids prescribed for analgesia (at these doses, Buprenorphine will antagonise the analgesic effects of other mu-receptor agonists).

Mu-opioid receptor agonists can be used for analgesic purposes but higher doses than usual may be required.

It may be appropriate to switch the patient's OST from Buprenorphine to Methadone.

Please seek advice from Specialist Palliative Care team.

Communication

Communication between Substance Misuse Services/Drug Services, Primary Care and Specialist Palliative Care is of the upmost importance in providing care for this group of patients.

All teams should share information in an efficient and timely way regarding the progress of the patient, particularly prescribing issues.

A clear plan should be generated for the patient's prescribing. This will support safe symptom control management and minimise the risk of a patient or carer seeking medications from more than one source.

Specialist Palliative Care health professionals need to ensure they have identified and communicated with the relevant Substance Misuse Service/Drug Services key worker for any such patient referred to them. Clear and timely communication with the prescriber of any drug dependency treatment and the patient's GP is imperative.

Notification of death correspondence sent from the Rowcroft Hospice Inpatient Unit to Primary Care must include notification that the deceased patient was known to the Substance Misuse Service/Drug Services team.

The Substance Misuse Service/Drug Services team should also be notified directly of the patient's death, whether that is in the Rowcroft Hospice Inpatient Unit, in hospital or at home.

CONTACT DETAILS

Torbay Primary Care Drug Service (Torbay and Southern Devon Health and Care NHS Trust) & in partnership with Devon Partnership NHS Trust

Walnut Lodge
Walnut Road
Chelston
Torquay
TQ2 6HP
Tel: 01803 604330
Fax: 01803 604359

Torbay Primary Care Alcohol Service (Torbay and Southern Devon Health and Care NHS Trust) & in partnership with Devon Partnership NHS Trust

Walnut Lodge
Walnut Road
Chelston
Torquay
TQ2 6HP
Tel: 01803 604334
Fax: 01803 604359

Email: torbayalcoholservicetct@nhs.net

Torbay Drug Services (Devon Partnership Trust) in partnership with Torbay and Southern Devon Health and Care NHS Trust

Shrublands House
8 Morgan Avenue
Torquay
TQ2 5RS
Tel: 01803-291129

Devon Drug and Alcohol Services
(South Devon Services- covers Teignbridge and South Hams)

RISE (Recovery and Integration Service);
Templar House
64 East Street
Newton Abbot
TQ12 4PT
Tel: 01626 351144

Rowcroft Hospice

Avenue Road
Torquay
Devon
TQ2 5LS

- **General enquiries**

(Including 24hr telephone advice available from Hospice Inpatient Unit nursing team/Hospice Doctor on call)
Tel: 01803 210800

- **Medical secretary**

(Requests for admission, medical outpatient or domiciliary visit assessments, advice from Consultant)
Tel: 01803 210810 (Mon-Fri 9-5)
Fax: 01803 298559

RESOURCES

Pain and substance misuse: improving the patient experience
A consensus statement prepared by The British Pain Society in collaboration with The Royal College of Psychiatrists, The Royal College of General Practitioners and The Advisory Council on the Misuse of Drugs
April 2007
http://www.britishpainsociety.org/book_drug_misuse_main.pdf

Cancer Pain Management
A perspective from the British Pain Society, supported by the Association for Palliative Medicine and the Royal College of General Practitioners
January 2010
http://www.britishpainsociety.org/book_cancer_pain.pdf

Palliative Care Formulary Fifth Edition
palliativedrugs.com Ltd

Palliative care for substance misusers, Dr Chris Farnham
Hospice Information Bulletin, Help the Hospices. Jan 2012;vol 9,issue 1.
www.helpthehospices.org.uk/our-services/publications/hospice-information-bulletin-january-2012/

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Written March 2012
Updated February 2015