# OPIOID RISK ASSESSMENT IN CANCER PATIENTS

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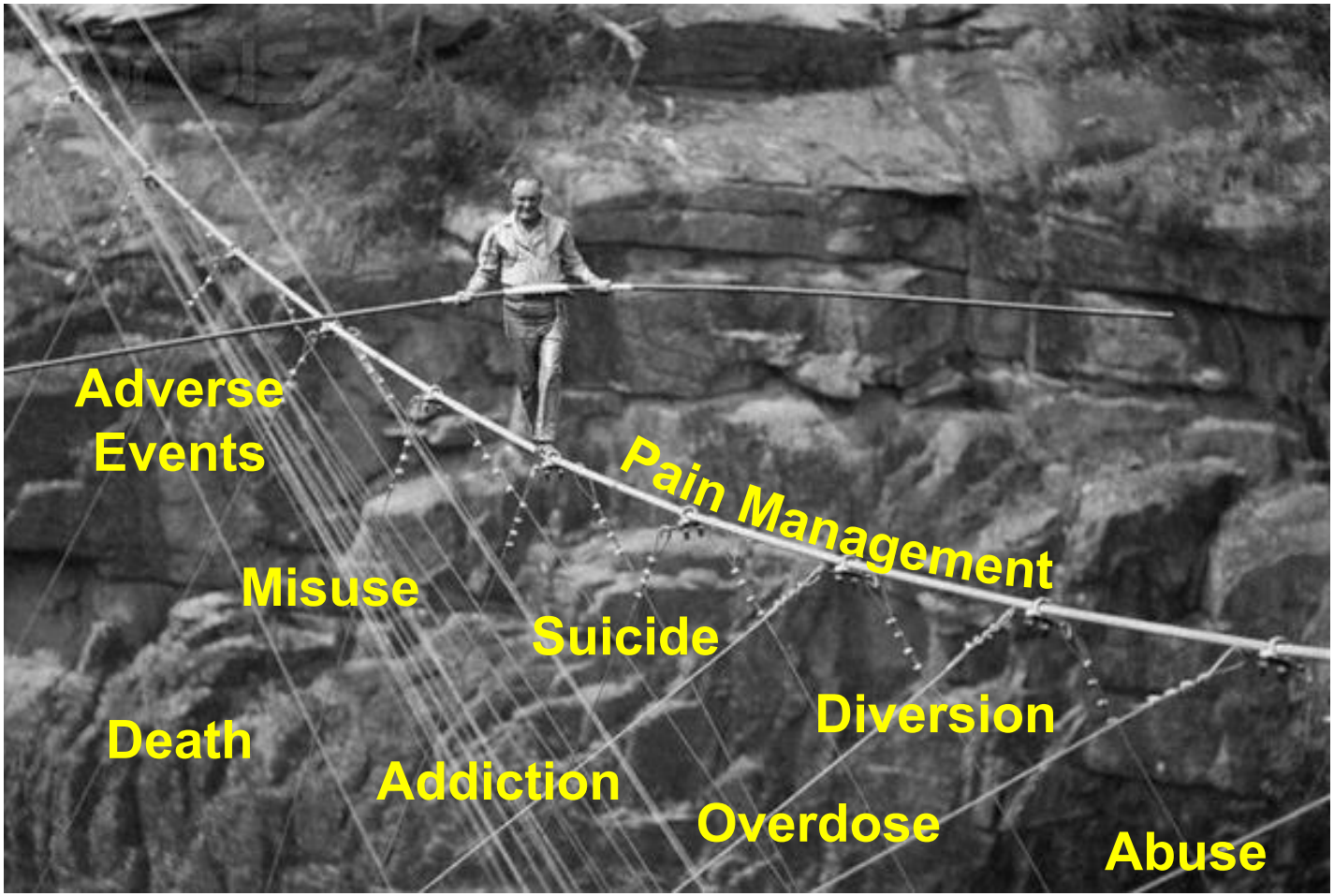
# Walking the Tightrope of Pain Management

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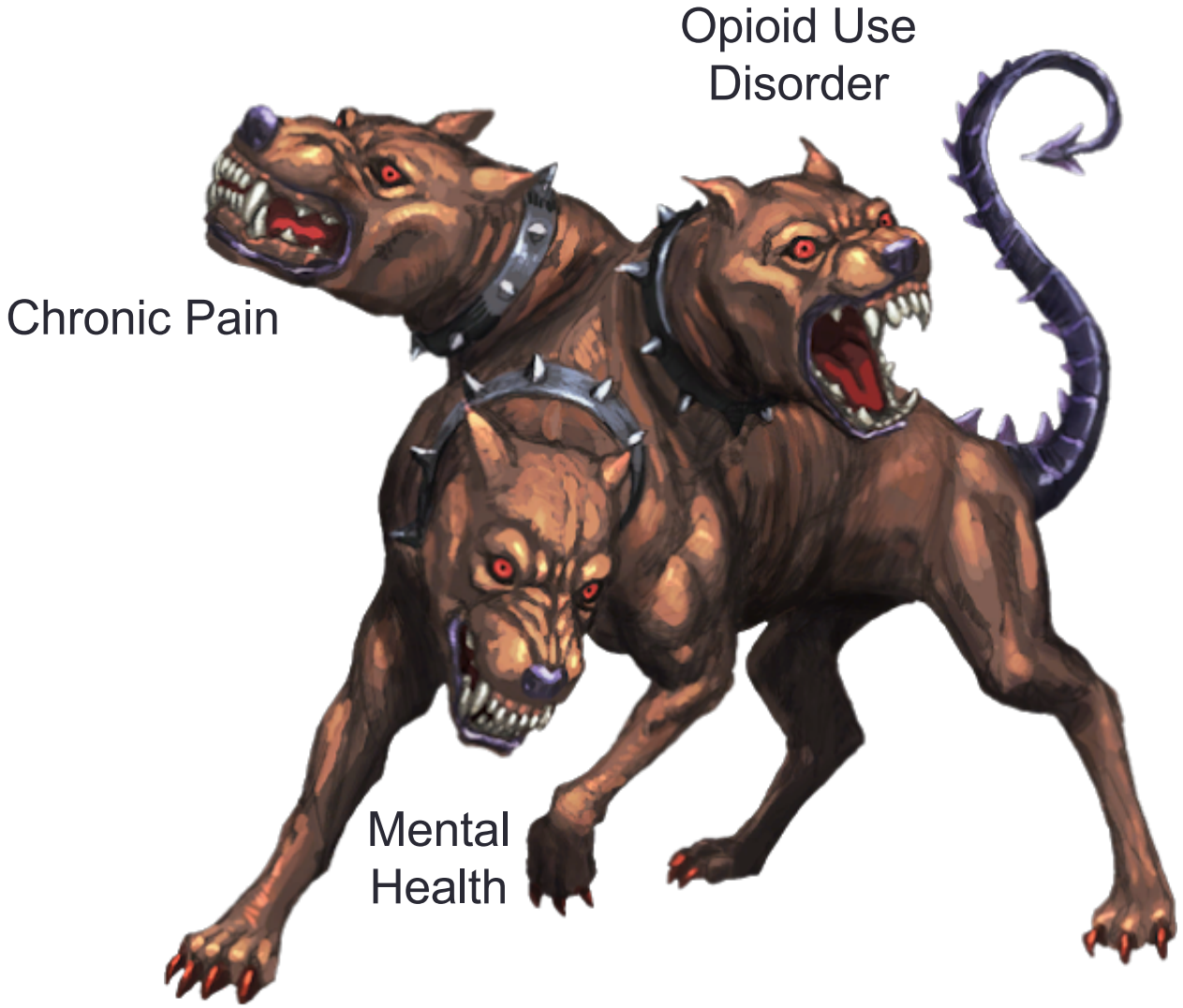
# Meanwhile, Waiting at the End of the Wire…

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# Three Major Public Health Problems

- Prescription opioid abuse:
  - 12.5 million non-medical users per year
  - $70-120 billion cost per year
  - 16,000-19,000 overdose deaths per year
- Chronic pain:
  - >100 million with chronic pain, ~25-39 million with daily chronic pain, ~10 million disabled
  - $560-635 billion cost per year
  - Suicide risk doubled
    - 41,400 suicide deaths in 2014
    - ~28,000 were people with chronic pain

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# Three Major Public Health Problems

- Mental Disorders:
  - Around 20% of American adults estimated to have a mental illness during the previous 12 months, excluding SUDs; 4-6% had serious mental illness
  - Estimated direct and indirect cost per year in the US was about $201 billion in 2013
  - Suicide estimated at 13 per 100,000 population in 2014, or around 41,400 that year

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# More Commonalities than Differences

- Prescription drug abuse, chronic pain, and mental disorders are more alike than different:
  - All are highly prevalent
  - All are very costly, in economic and human terms
  - All highly stigmatized--patients can be blamed
  - All are poorly understood by the medical profession
  - All are under-resourced vis-à-vis treatment
  - All are complex problems, with many moving parts
  - All best addressed with a biopsychosocial approach
  - Most importantly: All involve tremendous suffering

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# Not A Zero-Sum Game

Often, it feels like preventing prescription opioid abuse must be accomplished by reining in prescribing, potentially increasing pain and decreasing function, and increasing depression and other mental disorders

Similarly, it often seems as though improving pain management must involve increased opioid prescribing, which could, in turn, lead to more opioid abuse

I believe this mis-states the case, and that it is possible to address all three problems without adversely affecting any—by providing balanced pain management and attending to mental health needs

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# A Thought

*"For every complex problem, there is a solution that is neat, simple, and wrong"—H.L. Mencken*

I believe that implementing overly simplistic policy solutions for these three very complex problems leads to the zero-sum game that we so often perceive

Perhaps the solutions we should be seeking are as complex as the problems we are trying to solve

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# Policy Makers Are Reaching For Simple Solutions

- To date, most policy efforts have focused on three things:
  - Reducing opioid prescribing
  - Increasing access to naloxone
  - Increasing access to medication-assisted treatment
- Most policies that restrict prescribing exempt people:
  - Receiving active cancer treatment
  - Receiving palliative care, hospice care, or end-of-life care
- Some policies exempt people receiving “cancer aftercare”, i.e., cancer survivors

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# What Does It Mean To Exempt Cancer Patients?

- These policies are intended to promote safe use of opioids by preventing misuse, abuse, addiction, and overdose
- Logically, exempting cancer patients suggests that either:
  - Cancer patients are not vulnerable to misuse, abuse, addiction, or overdose; or
  - It is acceptable if these things happen to cancer patients
- It is unlikely that this is what policymakers intend

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# Exempting People with Cancer

- Question: Should these groups be exempted? Are exempted groups vulnerable to opioid misuse/abuse/addiction and overdose?
- Very little research on prevalence of opioid use disorders in people with cancer
- In cancer pain management, the attitude has essentially been “anything goes”
- People with cancer may be MORE vulnerable to opioid use disorders and overdoses

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# Cancers Associated With SUD

- Lung (Tobacco)
- Larynx (Tobacco)
- Head and Neck (Tobacco, Alcohol)
- Esophagus (Tobacco, Alcohol)
- Bladder (Tobacco)
- Kidney (Tobacco, IVDA—hepatitis)
- Liver (Tobacco, Alcohol, IVDA—hepatitis)
- Stomach (Tobacco)
- Pancreas (Tobacco)

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# Cancers Associated With SUD

- Colon (Tobacco, Alcohol)
- Cervix (Tobacco, IVDA—HIV)
- AML (Tobacco)
- Breast (Alcohol)
- Kaposi sarcoma (IVDA—HIV)
- Non-Hodgkin lymphoma (IVDA—HIV)

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# The Triangle of Fire


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# The Triangle of Addiction


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# “Cancer” Versus “Non-Cancer” Pain

- Distinction between “cancer” and “non-cancer” pain is a vestige of the state of cancer care in the 1980s-90s
  - Treatment of pain in people with cancer was poor
  - Cancer treatment rarely produced long-term survival
  - Many people with cancer died with uncontrolled pain
- Oncology and pain communities advocated for increased access to opioids for cancer patients
- Distinction persists despite substantial increases in long-term cancer survival and in chronic pain due to cancer and its increasingly toxic treatments

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# How Do You Distinguish?

- At what point does persistent pain from cancer therapy become chronic non-cancer pain?
- Case example:
  - 17-year-old female, s/p allogeneic BMT for treatment of ALL
  - Graft-vs-host disease treated with long course of high-dose corticosteroids
  - Patient developed avascular necrosis in both shoulders and both hips
  - Required high-dose opioid therapy to achieve pain control
  - Able to function productively for several years before undergoing 4 joint replacement surgeries
  - Discontinued opioid therapy post-operatively
- Is this “cancer” pain or “non-cancer” pain?
- How would the appropriate treatment differ if the AVN was not even remotely related to cancer therapy?

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# How Do You Distinguish?

- How would you treat the following differently?
  - Compression fracture from multiple myeloma or osteoporosis
  - Phantom limb pain from osteosarcoma or traumatic amputation
  - Peripheral neuropathy from chemotherapy or from diabetes
  - Post-thoracotomy pain syndrome from pneumonectomy for lung cancer or from post-traumatic chest tube placement
- Does our nociceptive apparatus know if we have cancer?
- Do our opioid receptors know if we have cancer?

Conclusion: Creating policy exemptions based on whether the cause of pain originates with cancer or not is inappropriate.

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# Assessing OUD and OD Risk in People With Cancer-Related Pain

- A complete biopsychosocial pain assessment needs to be completed for every patient
  - Assess the anatomic, physiologic, and mechanical aspects of the pain report (biology)
  - Assess the patient's cognitions, emotions, and behaviors related to their pain experience (psychology)
  - Assess the way people in the patient's social milieu respond to the patient's pain (social)

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# Assessing OUD and OD Risk in People With Cancer-Related Pain

- A complete opioid risk assessment needs to be completed for every patient
  - Assess the patient's history of substance use (including marijuana, nicotine, and alcohol) as well as the patient's family history of substance use (biology)
  - Assess the current stressors affecting the patient, symptoms of mental health disorders, the patient's history of abuse/trauma, and the patient's coping skills (psychology)
  - Assess the patient's social milieu for presence of others with SUD as well as for presence of others who may provide positive support (social)

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# Appropriate Treatment for Chronic/Cancer Pain

- Appropriate treatment for chronic/cancer pain is multimodal
- Treatment focuses primarily on improving function, rather than focusing on pain intensity
- Using multiple types of treatment should reduce reliance on opioid analgesics
- Multiple barriers exist to providing this type of care for chronic/cancer pain

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# Patient Self-Management Strategies

- People with pain can do many things to help themselves
- These include:
  - Weight loss
  - Exercise/conditioning
  - Proper nutrition
  - Good sleep habits
  - Regular relaxation practice
  - Maintaining positive social connections
  - Learning effective coping skills
- Patients need to feel empowered, and treating them as members of the pain care team can help achieve that

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# Best Practices

- Be sure to evaluate for, and treat: pain, substance use, and mental health issues
- Pursue a balanced, multi-disciplinary approach to providing pain care
- Individualize treatment plans—there is no cookbook, and one size doesn't even fit most
- Decrease opioid prescribing by incorporating multimodal analgesia
- Discuss safe storage and effective disposal of controlled substances

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# Thank you!

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