Palliative Care and OAT

Victorian Opioid Management ECHO
Department of Addiction Medicine
St Vincent's Hospital Melbourne 2019

Overview

Presentation focused on the palliative care of patients with opiate use disorders

Percentage of palliative care patients with opiate use disorders is unknown.

General population estimated between 5-15% of ANY substance use disorder.

Aging population of opiate users results in increased frequency of co-morbid palliative conditions and opiate dependence.

Palliative care management needs tailored patient care to ensure best outcomes.

Palliative care does not always equal terminal care.

Pain and Opioid Dependence

Patients with chronic opioid use:

- **Increased sensitivity to pain**
- **Decreased threshold for pain sensation**

Stigma of "drug seeking"

Under-reporting of pain due to worry about stigma

Under treatment due to system related misunderstanding of dependence and pain

Myths

Patients on OAT do not experience pain in the same way as those not on OAT

- OAT patients (and other opioid dependent patients) experience pain both in the same way and are often more sensitive with lower thresholds for pain

Opioid dependent patients will receive the same analgesic effect from similar doses of opiates to patients that are not dependent

- Opioid dependence and tolerance often leads to a lower effect from a similar dosage.

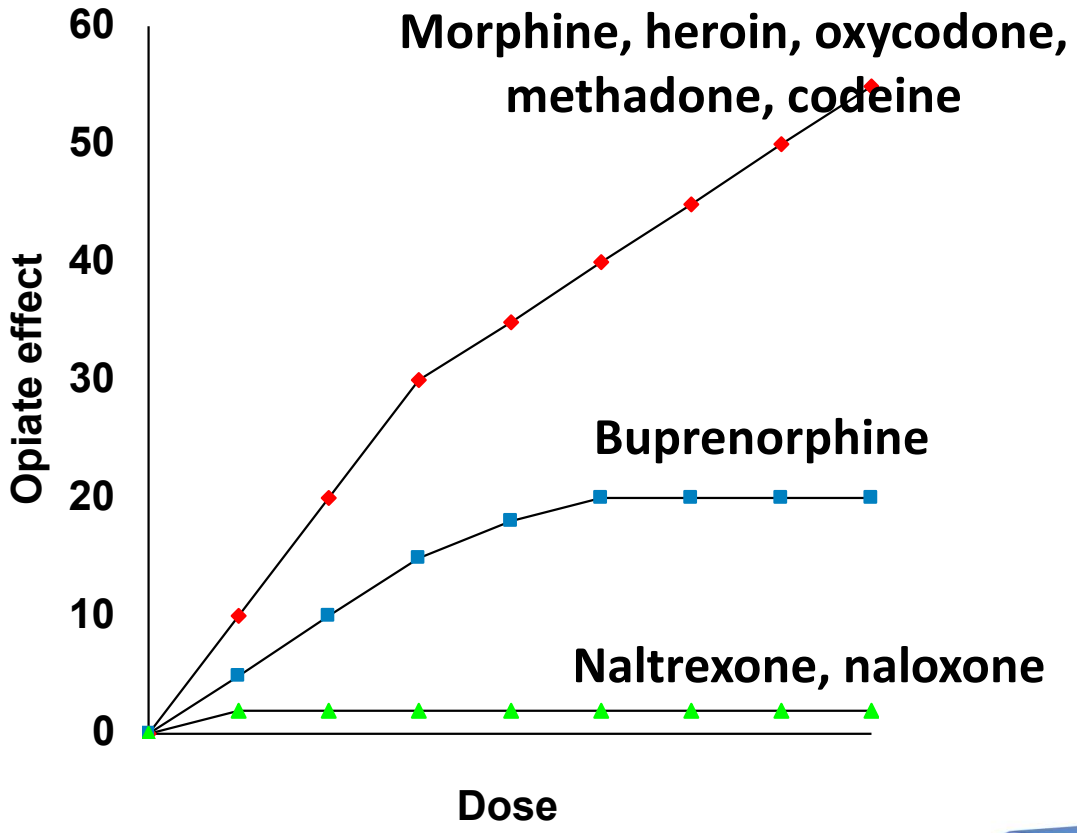
Palliative care patients on OAT can simply have their OAT doses increased to manage their pain

- Not always a viable option.
- May not result in increased analgesia
- May not be suitable for the situation and symptoms

Opioids – full or partial

- Full Agonists - bind completely and strongly to receptors creating maximum effect.
  - *These include oxycodone, heroin, fentanyl*
- Partial Agonists – are similar to full agonists at low doses, however cause less receptor activation, and at high doses analgesic effects plateau.
  - *These include buprenorphine and tramadol*
- Antagonists – Bind and **block** receptors and therefore biological response.
  - *This includes naloxone and naltrexone*

Effect of Opioids



Pain management

Patients on OAT that have increased pain need both analgesia and dependence management.

Methadone is a full agonist – opioid analgesia will work synergistically with it. Be aware that patients will likely require larger doses of opiate analgesia to achieve the desired effect.

Buprenorphine is a partial agonist – its opioid effect has a ceiling. Additional opioids should be tailored to ones with a higher binding affinity such as fentanyl, hydromorphone or morphine.

Don't forget non-opioid analgesia – WHO guidelines, physiotherapy, massage, heat wraps.

How to manage?

Involve the patient!

Be flexible

A multi-disciplinary approach is key

- Patient centred
- All teams aware of the situation
- Issues can be discussed openly
- Knowledge can be spread
- Increased understanding of patient needs
- Options for the unexpected can be explored
- Planning for the future of patient care

Considerations

Is it a viable option to simply increase OAT dosage to manage new pain symptoms?

Can we separate out acute pain versus withdrawal symptoms?

How should breakthrough pain be managed?

Should the patient be converted from methadone liquid to physeptone?

For patients on buprenorphine, should this continue, or should the patient be converted to methadone?

How should end of life care be managed?

Caveats

Not all palliative care patients will be stable with regards to opiate use

Many patients will have triggers to return to opiate use

Patients may be on haemodialysis which may interact with some analgesic agents (Methadone and buprenorphine are not affected)

Palliative care patients are not immune to diversion (individuals as well as family members)

Palliative care does not always equal end of life care – consider take home naloxone for patients with high opiate requirements

More Considerations

Consider treating OAT and palliative needs as separate issues

- Involve addiction medicine service for complex patients
- Ensure that palliative medications will not detract from OAT support and efficacy

If patient is still mobile – consider staged supply of OAT and other opiate analgesia

Once patient mobility decreases, good communication with local pharmacy and carers is required to ensure medication supply and patient support

Once a patient is no longer able to take oral medications, adequate opiate agonist will still be required.

Consider an in-home safe for medication storage to minimize risk of diversion

Schedule 8 medications may require special treatment after a patient passes away

Summary

Palliative care and OAT are complex and need a tailored approach to manage

The patient should be involved in all steps and discussions

Patients on OAT are likely to require large doses of opiate analgesia in order to achieve the desired effect

Consider changing from buprenorphine to methadone as analgesia requirements increase

A multi-disciplinary approach has the best chance of a dignified outcome

Take consideration around instability and always remember that diversion is a possibility