New guidance for cancer pain and opioid use disorder or opioid misuse

June 30 2022

Credit: Unsplash/CC0 Public Domain

Opioids are a cornerstone of cancer pain management, but there is a lack of consensus on how to treat pain in cancer patients who also have struggled with opioid use disorder or prescription opioid misuse. In a

study published today in *JAMA Oncology*, researchers outline guidance for treating such patients and highlight obstacles and opportunities for better integration of addiction treatment in cancer care.

"There is no standard of care for treating cancer pain and managing opioids in people who come into their cancer diagnosis with a history of substance use, or who are at increased risk for adverse events due to prescription opioid misuse behaviors, such as taking more opioids than prescribed," said first author Katie Fitzgerald Jones, M.S.N., a palliative and addiction nurse practitioner at VA Boston Healthcare System and Ph.D. candidate at Boston College. "As a first step towards improving care of these patients, our study surveyed clinicians to understand how they treat patients with opioid complexity."

The study was led by Jones and study principal investigator and senior author Jessica Merlin, M.D., Ph.D., associate professor of general internal medicine at the University of Pittsburgh School of Medicine and co-director of the Palliative Recovery Engagement Program at UPMC, a clinic that serves patients with serious illnesses, like cancer, who also struggle with opioid use disorder or prescription opioid misuse. In collaboration with colleagues at RAND, the investigators used an online Delphi study platform to explore consensus among 120 palliative care and addiction experts about how they would approach treatment of a hypothetical 50-year-old patient with advanced cancer who has cancer-related pain and either a history of opioid use disorder or prescription opioid misuse.

Participants were asked to rate and comment on various management strategies, such as prescribing methadone and buprenorphine. Experts indicated that both of these medications are an appropriate approach to treating cancer pain in a patient with a history of an opioid use disorder.

Prescribing methadone and buprenorphine for pain requires clinicians to

hold only a Drug Enforcement Administration (DEA) license, but there are additional barriers to prescribing the very same drugs for opioid use disorder. Methadone can be legally used to treat opioid use disorder only in licensed methadone treatment programs. Additionally, clinicians must have what's known as a DEA X-waiver to prescribe buprenorphine for opioid use disorder. According to Jones and Merlin, only a small fraction of oncologists and palliative care clinicians hold an X-waiver, a hurdle for cancer patients who could benefit from this medication.

"Because of the way that methadone and buprenorphine are regulated—one way for pain, another way for addiction—addiction treatment is isolated from mainstream medical care, including cancer care," said Merlin. "It's othering, and it adds to the stigma of opioid use disorder."

Study participants agreed that it is inappropriate to refer a patient with advanced cancer to a methadone treatment program because of the burden of frequent, sometimes daily, visits alongside cancer treatments.

"Interestingly, experts in the study suggested that it was appropriate to prescribe methadone outside of the context of a licensed methadone treatment program for pain in cancer patients with a history of opioid use disorder—even though this is murky legal territory," said Merlin. "This finding highlights the need to improve access to this drug."

According to Jones, methadone is dosed differently for pain and opioid use disorder, and more research is needed to understand the best approach for treating cancer pain and opioid use disorder concurrently.

In scenarios where the hypothetical cancer patient did not have a history of opioid use disorder but was misusing opioids—taking higher doses than prescribed or taking a benzodiazepine that wasn't prescribed—experts recommended continuing their opioid regime but

increasing monitoring through more visits or shorter prescriptions. According to Merlin, this was an interesting finding because these scenarios pose increased risk for overdose and opioid-related harms. Despite these risks, experts were reluctant to transition to buprenorphine, a safer opioid with less overdose potential.

"Drawing from our other research, we think there are many reasons that clinicians were hesitant to use buprenorphine, including knowledge gaps, lack of guidelines for management of opioid misuse, regulation of buprenorphine and stigma," said Jones.

The researchers say that better education around buprenorphine and cancer pain management in the context of an opioid use disorder or opioid misuse is needed.

"There is a tendency to ignore treatment of opioid use disorder in advanced cancer patients because people think, 'Oh, this person has bigger fish to fry,' but that's not a very patient-centric way of looking at things," said Merlin. "We know that opioid use disorder is a really important factor in quality of life, so addressing opioid addiction and prescription opioid misuse in people with advanced cancer is really critical."

Merlin and Jones are working to educate palliative care clinicians around the country about using buprenorphine to treat opioid use disorder, including encouraging them to get X-waivers to treat addiction alongside pain.

"If we are going to prescribe opioids for pain, it is our moral obligation to also treat an important consequence of that opioid prescribing—opioid addiction—if and when it occurs in our patients," said Jones.

More information: Consensus-based guidance on opioid management in individuals with advanced cancer-related pain and opioid misuse or use disorder, *JAMA Oncology* (2022). DOI: 10.1001/jamaoncol.2022.2191