GUIDELINES FOR THE MANAGEMENT OF PALLIATIVE CARE PATIENTS WITH A HISTORY OF SUBSTANCE MISUSE

41.1 GENERAL PRINCIPLES

- The ICD 10 diagnostic criteria for dependency syndrome are listed in Table 41.1 below.

<table>
<thead>
<tr>
<th>Table 41.1 ICD 10 Diagnostic criteria for dependence syndrome ¹</th>
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<tr>
<td>A diagnosis of dependence can only be made when 3 or more of the following have been present at some time in the past year:</td>
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<tr>
<td>- A strong desire or compulsion to take the substance</td>
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<td>- Difficulty in controlling substance taking behaviour</td>
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<tr>
<td>- Physiological withdrawal</td>
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<tr>
<td>- Evidence of tolerance</td>
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<tr>
<td>- Progressive neglect of alternative pleasures or interests</td>
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<tr>
<td>- Persisting with substance use despite clear evidence of overtly harmful consequences</td>
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- The General Medical Council has stated “The investigations and treatments you provide must be based on the assessment you and the patient make of their needs. You must not refuse or delay treatment because you believe that a patient’s actions have contributed to their condition. You must treat your patients with respect whatever their life choices and beliefs.” ²

- Drug misusers have the same entitlement as other patients to the services provided by the NHS. ² It is the responsibility of General Practitioners to provide general medical services for drug misusers. ²

- The structure of drug dependency services varies according to local population needs. ²

- Ongoing management of dependence at the end of life can improve quality of life for the patient and reduce stress and frustration in the family. ⁴

- The management of drug misuse may involve several health and social care teams. Ongoing good communication between these agencies is essential. ²

- All patients known to drug dependency services will have a key worker. Their role includes developing and agreeing the treatment plan and providing ongoing advice and support. The key worker may be the GP, a doctor, nurse or voluntary sector drugs worker.²

- Patients with a history of opioid addiction may have a low tolerance to pain due to neuroplastic changes in pain perception.³

- Patients on long term methadone may develop hyperalgesia with increasing doses of opioids. They may display allodynia on examination.³

- Treatment should include both psychosocial and pharmacological measures. ²
Pharmacological management of opioid maintenance includes methadone, buprenorphine or Suboxone® (buprenorphine: naloxone 4:1) (see Table 41.2).  

Supervised consumption is used to decrease adverse events at commencement of treatment and to aid compliance. The use of a single prescriber and close liaison with a named pharmacist can help to avoid overuse and diversion of drugs.  

| Table 41.2. Drugs used in the management of opioid dependence  

<table>
<thead>
<tr>
<th><strong>Drug</strong></th>
<th><strong>Preparations</strong></th>
<th><strong>Key Points</strong></th>
</tr>
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</table>
| Methadone | Oral solution 1mg / ml | Opioid agonist  
Single daily dose  
Long half life (13-50 hours)  
Analgesic effect is 4-8 hours  
Suppression of opioid withdrawal is 24-48 hours |
| Buprenorphine (Subutex®) | Sublingual tablets 400 microgrammes, 2mg, 8mg. | Opioid partial agonist  
Only partially reversed by naloxone  
Single daily dose, maximum 32 mg daily  
Can be crushed and injected by drug misusers |
| Buprenorphine/ naloxone (Suboxone®) | Sublingual tablets 2mg / 500 microgrammes 8mg / 2mg | Buprenorphine and naloxone (opioid antagonist)  
Naloxone has poor bioavailability orally. However this increases when tablets are crushed and injected. Thus Suboxone® is used to discourage misuse. |

41.2 GUIDELINES  

41.2.1 General Management  

The patient’s pain and substance misuse should be managed concurrently as two separate issues.  

The assessment of a patient with substance misuse should include assessment of drug and alcohol use, general health issues, social functioning and criminal involvement.  

The patient should be involved in the development of their treatment plan including a strategy for responding to non-compliance. An individual opioid agreement for both the maintenance opioid and the analgesic opioid may aid this process. This may take the form of a verbal or written contract (see Table 41.3).
Table 41.3 Key elements of an opioid agreement

<table>
<thead>
<tr>
<th>Explain the expectations of the patient</th>
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<tbody>
<tr>
<td>– Use clear and concise language</td>
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<tr>
<td>– Write flexibly and avoid ultimatums</td>
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<table>
<thead>
<tr>
<th>Explain the role of the physician e.g.</th>
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<tr>
<td>– Medications will be provided by a single provider</td>
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<tr>
<td>– Medications will be prescribed on a regular basis</td>
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<td>– Lost or stolen medication will not be replaced</td>
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<table>
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<tr>
<th>List risks and benefits of the proposed therapy</th>
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<tbody>
<tr>
<td>Designate a single pharmacy Provide</td>
</tr>
<tr>
<td>a rationale for your policies Get</td>
</tr>
<tr>
<td>consent for treatment and testing</td>
</tr>
</tbody>
</table>

- If known to drug dependency services, the patient’s key worker should be included in the development of the treatment plan and informed of all changes. [2] [Level 4]

- The patient’s community pharmacist should be informed if a patient is admitted to or discharged from a hospital or hospice. [2] [Level 4]

- If on opioid maintenance therapy, a single prescriber should be responsible for the prescribing of their opioid maintenance. This is likely to be the GP or the Substance Misuse Doctor. [2] [Level 4]

- The analgesia should be prescribed by a single named prescriber. This is likely to be the GP with guidance from the Palliative Care Team. This will avoid duplicate prescribing. [2] [Level 4]

- There should be separate monitoring procedures for substance misuse and symptom control, except during the terminal phase. [7] [Level 4]

41.2.2 Pain Management

- Discontinuation of long-term methadone therapy can lead to an increase in pain, even when other opioids are added. [3,8] [Level 3]

- The principles of analgesic practice in substance misusers are fundamentally no different from those for other adult patients needing palliative care. [7] [Level 4]

- Titration of opioid, non-opioid and adjuvant analgesics should be regulated against analgesic response in the usual way. Distinctions between symptoms of poor analgesic response and withdrawal should be recognised. [7] [Level 4]

- Disease related pain should be managed according to the WHO analgesic ladder. Where strong opioids are required for pain management, oral morphine remains the strong opioid of choice. [6,7] [Level 3]

- Where a patient is on dialysis, fentanyl or methadone should be considered for pain management as these drugs will not be removed by dialysis. [12] [Level 4]
If a patient is on buprenorphine or Suboxone® opioid maintenance and requires a strong opioid for pain management then switching the buprenorphine / Suboxone® to methadone should be considered. A switch should only be made in conjunction with the drug dependency team.  

[Level 4]

### 41.2.3 Management of the Dying Phase

- If a patient is on methadone maintenance therapy and a second opioid for pain, then both the methadone and the second opioid should be administered separately via continuous subcutaneous infusions when the patient is no longer able to take oral medication. This is to avoid the symptoms of opioid withdrawal in the dying phase.  

[Level 4]

### 41.3 Standards

1. All patients who are known to both palliative care and drug dependency services should have the name and contact number of their drug dependency key worker documented in their palliative care notes.  

[Grade D]

2. All patients on opioid replacement therapy should have the name and contact number of their community pharmacist documented in their palliative care notes.  

[Grade D]

3. The key worker and community pharmacist should be informed of changes to medication.  

[Grade D]

4. Disease related pain should be managed according to the WHO analgesic ladder.  

[Grade D]

5. If a strong opioid is required for pain management, morphine should be the opioid of choice.  

[Grade D]

6. A single named prescriber should be responsible for opioid maintenance therapy. A separate single named prescriber should be responsible for opioids used for symptom control.  

[Grade D]

7. Any changes in the opioids used for these patients e.g. type or dose should be communicated clearly to all health care professionals involved with the patient.  

[Grade D]

8. Each palliative care service should have the contact details for their local drug dependency team.  

[Grade D]

### 41.4 References


**41.5 CONTRIBUTORS**

**Lead Contributors**

Dr C Finnegan  
Specialist Registrar in Palliative Medicine  
St John’s Hospice  
Wirral

Dr L Chapman  
Consultant in Palliative Medicine  
Royal Liverpool and Broadgreen University Hospitals NHS Trust  
Liverpool

Dr A Fountain  
Consultant in Palliative Medicine  
Halton and St Helens Primary Care Trust  
Halton

Mrs L Cannell  
Clinical Nurse Specialist in Palliative Care  
Royal Liverpool and Broadgreen University Hospitals NHS Trust  
Liverpool

**External Reviewers**

Dr M Goulden  
Consultant in Anaesthesia and Pain Relief  
Royal Liverpool and Broadgreen University Hospitals NHS Trust  
Liverpool