Addiction at the End of Life
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Substance use disorders have a substantial impact on care at all levels.
End of life care has its own unique challenges.
Since end of life care encompasses whole families and multiple disciplines, it also offers an opportunity to examine the impact of problems like substance misuse, abuse and addiction at multiple levels.

Substance use disorders impact care in multiple ways.

I. Attitudes about SA and addiction impact care at multiple levels
    A. Patients often fear addiction
        As many as 71% of cancer patients do not take pain medicines as prescribed, usually undertaking them or skipping doses, often because of fear of addiction
        Patient (and family) fears of addiction or habituation is the primary barrier to adequate symptom control identified by hospice nurses in surveys
        About ¼ - 1/3 of patients under-report symptoms and under treat pain due to fear of addiction
        The number who refuse medications for fear of relapse is unknown
    B. Family members often fear addiction
        40% of spouses do not think opiates should be taken routinely
        About 25% of caregivers underestimate and minimize symptoms because they fear addiction
    C. Health care providers have heavy biases against 'addicts' that greatly impact care
        Nurses often discount pain reports and under-treat pain in patient s they suspect of SA
        AIDS patients in EOL care (with a high rate of history of IVDA) only receive adequate symptom control 15% of the time

D. In addition, substance abuse may be more common at the end of life
   One study showed a prevalence of alcohol misuse of 28% among late stage cancer patients
   Another study showed that 25% of patients entering inpatient hospice had a problem with alcohol use

II. Monitoring is haphazard and little exists on how to handle the problems
   A. One survey of Palliative Oncologists showed the providers failed to recognize any negative consequences of untreated addiction
   B. Another showed that UDS and other screenings are rarely done, and when done positive results are acted on only 14% of the time, negative results are never acted on
   C. No consensus or standards exist for routine screening or monitoring of patients or families
   D. A survey of Hospices in Virginia showed only 43% screen for SUD; only 30% screen the family; less than 20% screen for diversion; less than half require any training in addiction.

III. Diversion is a major problem not often addressed

IV. New medications and strategies used in addiction may offer improved care for everyone
   A. Buprenorphine is safe and effective for the very elderly and frail
   B. Buprenorphine, Methadone and other harm reduction strategies may lead to better outcomes in the future

Strategies for improvement are needed.

I. Clearly define goals of care
II. Clearly identify barriers to those goals
   A. Screen for SUD in the patient and family
   B. Screen for diversion
III. Implement clear strategies for dealing with problems when identified
IV. Monitor outcomes and continue to improve care

Case 1

Mr J is a 67-year-old white male with a history of metastatic pancreatic cancer. His pain has been controlled with extended release oxycodone 40 mg twice a day, and oxycodone immediate release 10 mg every 4 hours as needed.
Recently, his functional status declined and his daughter moved in to help care for him (he was previously living alone).
The hospice nurses note that the patient's pain is increased lately, and when they visit, the daughter seems ''out of it''. The patient's pill count is low, indicating a shortfall of 10 extended release oxycodones and 20 immediate release tablets over the last 7 days.
Mr J states his daughter gives him his medicine, and that his pain has been 6 to 7 on a scale of 1 to 10 for several days.
When asked about the missing oxycodone tablets, Mr J becomes very defensive, stating his
daughter would never take his medicine. The daughter also denies diversion, though she falls asleep
twice during the interview.
Mr J declines inpatient hospice to control his symptoms and to monitor his medication use, stating ''you can take care of me, I just need more medication"[1]

What are the ethical and legal responsibilities here?
How should this case be handled?

1. Baumrucker, S.J., et al., *Diversion of opioid pain medications at end-of-life.* Am.J.Hosp.Palliat.Care, 2009. **26**(3): p. 214-218.

Case 2

26 year old female, diagnosed with ALL
Multiple treatments including BMT x 2 have failed
Now coming out of a blast crisis
Life expectancy of weeks to short months

Married, lives with husband
Parents live nearby and are very supportive
One small child

Husband often asks for Xanax, often noted to appear intoxicated
Patient complains of generalized pain, no apparent cause for pain
Rates pain as '10/10' always
When allowed free access to pain meds is often found stuporous
Admitted to the hospital with 'altered mental status'
After 2 days in the hospital, is up walking in the halls and visiting with friends

Current medicines:

1. Citalopram 40mg daily
2. Oxycontin 30mg every 8 hours
3. Ativan as needed
4. Oxycodone 10mg as needed
5. Chemotherapy injections per Hematology

How should this case be handled?

Case 3

55 year old homeless Veteran with non-small cell lung cancer, persistent pneumothorax requiring a permanent chest tube
Prior prison for drug related charges, admitted Heroin addict in the past
Mostly bed bound now, complains of pain
Primary service is very suspicious of patient’s pain complaints; he takes Dilaudid “as needed”

Plan is for transfer to a long term nursing facility
What should his pain regiment be?
What are the barriers?

Case 4

57 year old female with pancreatic cancer (advanced),
Life expectancy of long days to short weeks
Sleeping more, doing less, rarely out of bed, complaining of more pain
Goal is to “have her here where we can talk” as long as possible

Husband is very hesitant to give pain medicines

What are the barriers?

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