Managing Chronic Pain in Patients With Cancer Who Have a History of Substance Abuse

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Oncology nurses may encounter patients recovering from substance abuse who will need acute or chronic pain management. Knowing how to assess, treat, and manage that pain is a benefit to the nurse and patient. In addition, understanding and overcoming bias toward patients with a history of substance abuse can lead to a trusting relationship and more effective pain management. A thorough assessment and documentation of the patient’s pain during each visit provide a solid basis for prescribing opioids to patients with a history of substance abuse. The use of long-acting and higher-dose opioids in this population will be discussed. Functional improvement versus absence of pain may be a more realistic goal for patients recovering from substance abuse, and complementary and alternative therapy may be considered. Setting standards to deal with lost prescriptions or medication, missed appointments, and the use of contracts for all patients receiving opioids establishes unbiased treatment.

According to the American Cancer Society (JACS, 2008), an estimated 1.5 million people in the United States will be diagnosed with cancer in 2008 in addition to the almost 11 million cancer survivors. With 22.2 million people in the United States aged 12 and older battling substance abuse disorders (Substance Abuse and Mental Health Services Administration, 2006), an oncology nurse likely will encounter patients with cancer and a history of substance abuse. According to the American Society for Pain Management Nursing (2002), “the ethical principles of beneficence and justice oblige healthcare professionals to manage pain and provide humane care to all patients, including those patients known or suspected to have addictive disease” (p. 1). However, many nurses may not have the knowledge or experience to effectively manage pain in patients with cancer and a history of substance abuse. The purpose of this article is to provide oncology nurses with guidance in the treatment of chronic pain in patients with cancer who also have a history of substance abuse.

Pain Treatment for Patients With a History of Substance Abuse

Acute and Chronic Pain

Patients with a history of substance abuse should be treated for acute and chronic pain. This statement is easier to adhere to for acute pain, in which the cause of the pain and the anticipated recovery time is known. However, chronic pain management is more complicated. Some question whether opioids should be given to any patient with chronic pain (Nedeljkovic, Wasan, & Jamison, 2002), let alone patients with a history of substance abuse.

The primary goal in pain management is to provide pain relief regardless of the patient’s past history of substance abuse. To do this, the practitioner must accept the patient’s...
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Educating the patient about the negative consequences of unrelieved pain, such as decreased immune response, anxiety, insomnia, mental confusion, and increased thoughts of suicide may be helpful (McCaffery & Pasero, 1999).

Because of the limited evidence available in the literature regarding patients with various substance abuse disorders, patients receiving methadone maintenance treatment (MMT) will be discussed because of the large number available for study. Methadone is a synthetic opioid that is used for IV drug users to decrease or stop heroin or opiate use. Methadone blocks the euphoric and sedating effects of opiates, decreases craving, relieves symptoms of withdrawal, and is excreted slowly and, therefore, can be dosed on a daily basis (Centers for Disease Control and Prevention, 2002).

Studies of patients with chemical dependence enrolled in MMT programs have shown varying rates of chronic pain occurrence. A survey by Rosenblum et al. (2003) showed that 144 (37%) of the 390 MMT patients surveyed had chronic pain, comparable to the incidence of pain in patients with cancer receiving active treatment. Ilgen, Trafton, and Humphreys (2006) conducted a longitudinal comparison of patients (n = 200) in MMT who had pain when they entered treatment compared to those who did not have pain when they entered treatment, and both groups showed a decrease in substance abuse over one year. Data were obtained through patient interviews and medical record reviews of methadone dosing. The group of patients reporting significant pain at baseline (51% of the study population) reported poorer general health and decreased physical and social functioning. The findings persisted through the end of the study, although some improvement was seen in overall functioning (Ilgen et al.). Peles, Schreiber, Gordon, and Adelson (2005) found that 85 (55%) of 170 patients entering MMT had chronic pain, defined as pain lasting more than six months, and required higher doses of methadone to treat their addiction.

Acute pain can be treated in patients with active substance abuse issues. McCaffery and Pasero (1999) suggested that pain relief, not addiction treatment, should be the goal. NSAIDs may be given for mild pain but, if pain relief is inadequate, opioid use is recommended. Avoid agonist/antagonist opioids, such as nalbuphine, in patients dependent on opioids because it may cause withdrawal. Around-the-clock use or patient-controlled analgesia will help avoid drops in serum drug levels, which are associated with withdrawal and breakthrough pain. If the patient is on MMT, the dose should be continued or an equivalent opioid given to prevent cravings (McCaffery & Pasero).

Chronic pain cannot be treated alone, however, if the patient is actively using illicit drugs. Addiction and chronic pain should be addressed concurrently for a successful outcome (Compton & Athanasos, 2003; Gourlay, Heit, & Almahrezi, 2005).

Patients receiving methadone to suppress drug addiction also need opioids to treat pain. A daily dose of methadone does not adequately manage pain because of the slow rate of methadone metabolism. But methadone use should not be stopped altogether; dosing should be strong enough to suppress drug craving and prevent withdrawal (Scimcia, Savage, Portenoy, & Lowinson, 2000). In addition, caregivers at the methadone clinic should be made aware of a patient’s opioid use for pain management. The treatment facility may do random urine screening and the methadone dose may need to be adjusted to prevent opioid craving. McCaffery and Pasero (1999) suggested having the patient contact their treatment facility for support, advice, and information.

A patient’s preexisting tolerance should be taken into consideration when prescribing opioids. Failure to do so can result in under-medicating the patient’s pain and may lead the patient to self-medicate (Passik & Kirsh, 2004). Long-acting opioids will provide a steady state of pain control and have a less euphoric effect than short-acting opioids (Passik & Kirsh).

Inadequate pain management may lead the patient back to illicit drugs for relief. Pain that is not treated adequately can cause stress to the patient, another reason for relapse (Koob & Le Moal, 2001). Undertreated pain may prompt the patient to self-medicate (Merrill, Rhodes, Deyo, Marlatt, & Bradley, 2002). Patients may require larger doses of opioids to achieve adequate relief.

The goal of eliminating pain may not, however, be realistic. Focus instead may be placed on functional status, which will vary from patient to patient. An ideal situation, of course, would be to have a pain management team handle the challenge of a patient with chronic pain from cancer and a history of substance abuse. But, if a pain management team is unavailable, the practitioner should assemble a team of nurses, social workers, physical therapists, and counselors and form a partnership with the MMT facility where the patient receives addiction care (Olson & Alford, 2006). The team also can...
A healthcare team should be created to care for the patient. Include a pain or addiction specialist if available.

The healthcare team should develop a contract with established consequences for lost or misplaced prescriptions and missed appointments.

The healthcare team should consult with the patient’s methadone maintenance treatment facility. Methadone dosing should be high enough to suppress cravings.

Opioids are prescribed without consideration of the methadone and may need to be higher than what is administered to opioid-naive patients.

Long-acting opioids are the best option for patients recovering from substance abuse.

**Figure 1. Treatment Recommendations for Patients With Cancer and a History of Substance Abuse**

Pain assessment, a sole prescriber, a written contract, and ongoing assessment of a patient’s pain and substance abuse should be done in a nonjudgmental way so that the healthcare team can elicit the most accurate information. A trusting relationship between the patient and the healthcare team is crucial for effective pain management, and understanding and overcoming biases is a good first step (Scimeca et al., 2000). The patient needs to trust that the healthcare team believes his or her reports of pain and has his or her best interest in mind. The healthcare team needs to trust that the patient will follow the prescribed treatment plan.

Believing patient reports of pain is an issue because many healthcare providers may be biased against this population and believe the patient is simply seeking out more drugs. A descriptive study by Morgan (2006) examined the perceptions of hospitalized patients with a history of substance abuse and how their pain was managed. Some patients felt that having their reports of pain believed by the staff was a positive experience that brought a small measure of pain relief. Karasz et al. (2004) found similar results in a qualitative study of 12 patients in MMT recovering from substance abuse and their experience with severe chronic pain. Patients enrolled in the study complained of being “unheard” and of the practitioner being “unfeeling.”

A history of substance abuse should be determined for all patients needing pain management. Indicators include prescribed or illicit drug use, alcohol consumption, family history of drug or alcohol abuse, time since last taking an illegal substance, and frequency of substance abuse (Gourlay et al., 2005). The patient should understand that talking about past drug use will not be a deterrent to pain treatment, but rather improve care (Gourlay et al.). A standardized approach to assessing patients experiencing pain is important to the pain management process.

Clear rules should be established about renewing prescriptions, what to do about lost or misplaced prescriptions and prescription bottles, and the use of urine drug screening. Reconnecting with the treatment facility or a sponsor can provide the patient with psychosocial support and enhance the treatment outcome (McCaffery & Pasero, 1999; Passik & Kirsh, 2004). A discussion about the risk of dependence and possible misuse should be held with the patient before initiating opioid therapy (Gourlay et al., 2005). Patients may fear that using opioids will lead to a reemergence of their substance abuse. They can be reassured that the euphoric effects of the opioids will be absent or diminished if they continue their methadone treatment. If they refuse opioids, their decision should be respected and other pain medications and approaches administered (Scimeca et al., 2000).

**Concerns for the Healthcare Team**

**Administering Opioids to Patients With a History of Substance Abuse**

Several concerns arise for the practitioner or nurse treating patients with a history of substance abuse, particularly if no team is available to assist the patient with his or her concerns. Addiction is a chronic illness with known risk factors, characteristic progression, and effective treatment options (McCaffery & Pasero, 1999). Prescribing opioids to a patient with a history of substance abuse has been questioned, but opioids can be administered using specific criteria such as careful assessment, a sole prescriber, a written contract, and ongoing...
evaluations at each visit. Careful assessment and good documentation at the initial evaluation and during subsequent visits will strengthen the decision to prescribe opioids. Gourlay et al. (2005) recommended evaluating analgesia, activity, adverse effects, and aberrant behavior at each visit. A written contract is important to document the pain management agreement and the consequences of missed appointments, lost prescriptions, and use of urine drug screening. Educating the patient about the medications and their reason for use also may be helpful. Although the use of contracts is mentioned in several articles (Compton & Athanasos, 2003; Gourlay et al., 2005; Olsen & Alford, 2006), little information exists on their effectiveness; however, they are not seen as a deterrent to pain treatment. Only one practitioner should prescribe opioids, which provides continuity of care, reduces the risk of drug interactions, and makes it easier to keep track of how much medication is used (Scimeca et al., 2000).

The quantity of pills dispensed with each prescription should be limited to what the patient will need between appointments. Frequent appointments may be needed to refill prescriptions and assess adherence, but they also provide an opportunity for the healthcare team to assess the effectiveness of the pain management and reassure the patient that the pain is being taken seriously (Jones, Knutson, & Haines, 2003).

A pain diary kept by the patient can provide useful feedback to the practitioner on medication use and possible changes in medication. Although information may be recorded incorrectly or missed, a diary may provide more accurate feedback than verbal report or memory (Nedeljkovic et al., 2002).

Patients who are in recovery and receive counseling for their substance abuse have more positive outcomes in maintaining abstinence (Olson & Alford, 2006). Assessment of psychosocial support can be helpful and the counselor can assist the patient to better cope with the chronic pain and treatment (Olson & Alford, 2006). More contact by the patient with support systems should be encouraged (Jones et al., 2003).

The healthcare team may have concerns about the potential to mishandle prescriptions. Patients should be asked to bring their medication to each appointment so a pill count can be conducted. A police report may be required for lost or stolen prescriptions (Scimeca et al., 2000). The healthcare team should have a standard response to lost or misplaced prescriptions. Suggestions for handling patients requesting replacement opioids may include a one-time replacement, requiring a police report before a replacement prescription will be issued, advising the patient that they will have to adjust to the lost medication, or if frequent loss is reported, discontinuation of therapy. Ultimately, patients are responsible for the safety of their medications. However, the healthcare team chooses to handle lost or stolen prescriptions, the procedure should be included in the written agreement or documented in a chart (Scimeca et al., 2000).

Patients with a history of substance abuse also may have other comorbid psychiatric conditions which may interfere with their pain management. Between 19%–65% of patients with a history of substance abuse also have comorbid mental health issues (Olson & Alford, 2006), including major depression, generalized anxiety, and borderline personality disorder, that make managing pain and interacting with patients challenging. Depression also can exacerbate pain (Olson & Alford, 2006). Rosenblum et al. (2003) surveyed patients with a history of substance abuse and found that having a psychiatric diagnosis and chronic illness were associated with chronic severe pain, although specific diagnoses were not reported. Patients may have used illicit substances to treat a variety of symptoms, including insomnia, depression, and loneliness (Compton & Athanasos, 2003). Little has been written about treating these symptoms and pain management in patients with a history of substance abuse.

Case Study
Treating pain in a patient with a history of addiction can be challenging. The following case study is illustrative of the difficulties facing the healthcare team and patient.

D.S., a 24-year-old woman diagnosed with acute lymphoblastic leukemia, had a 10-year history of multiple substance addiction. She had been in a methadone maintenance treatment (MMT) program for approximately three months prior to her diagnosis. The MMT program was her latest treatment option for substance abuse. D.S. was initially hypersensitive to touch, making a physical examination difficult. She cried easily, particularly if the day was not going as she anticipated. D.S. was started on quetiapine fumarate during her initial hospital stay. An outpatient psychiatrist started her on a selective serotonin reuptake inhibitor (SSRI) and slowly increased the dose. The SSRI eventually was stopped because of a serotonin reaction. Over time, celecoxib, clonazepam, and zolpidem tartrate were added to her drug regimen. For the leukemia treatment, D.S. was given vincristine, doxorubicin, L-asparaginase, dexamethasone (which were discontinued after the diagnosis of avascular necrosis), mercaptopurine, oral methotrexate, leucovorin, intrathecal methotrexate, cytarabine and hydrocortisone, cyclophosphamide, and IV cytarabine.

D.S. developed avascular necrosis of both knees and right hip after about eight months of therapy, and she had difficulty walking. She was given a long-acting opioid and a short-acting opioid for breakthrough pain. The doses were increased with minimal relief so her opioid medications were changed to see if one worked better than the other. D.S. twice lost a bottle of opioids. She also was admitted to the hospital once when she could not tolerate the pain in her home setting. She was then placed on slow-release oxycodone 100 mg twice daily and hydromorphone 16 mg for breakthrough pain.

D.S. next saw an orthopedic surgeon because she needed bilateral knee replacements, but the surgery had to wait until her leukemia treatment was complete. Increasing doses of opioids did not bring relief from the pain; therefore, the treatment started to focus on function. D.S. received home physical therapy and pool therapy. Two pain clinics were contacted about managing her pain, but both declined and said her case was too complex. After six months of treating D.S. in the outpatient setting, a local pain clinician was consulted and adjunct therapy with acupuncture was tried without success.

During that time, open communication with D.S. was maintained. No one doubted her pain level, and her input about what medications do and do not work for her was accepted. She was aware of the healthcare team’s attempts at treatments, including alternative methods, to ease her pain, but the best she could be offered was functionality. During the course of therapy, D.S.’s pain was managed by her oncologist and nurse practitioner. D.S. did not have concerns about taking opioids and her primary care physician prescribed quetiapine fumarate and clonazepam.

D.S.’s leukemia treatment was scheduled to end in August 2008. She continued to receive methadone maintenance, joined a gym, and attended a camp for young adults with cancer and participated as much as her abilities allowed her.
Conclusion

Oncology nurses likely will be involved in the pain management of patients with a history of substance abuse. To be prepared, nurses should educate themselves about the issues and potential bias these patients face. Overcoming these challenges can lead to improved care (Merrill et al., 2002). The oncology nurse also should examine his or her own bias regarding the management of chronic pain with opioids in patients with a history of substance abuse. The next step is to develop a standardized approach to all patients with pain, including an assessment of the patient, having a contract about the pain management plan, and handling lost or stolen prescriptions or drugs. Treating all patients in the same manner decreases bias.

Patients can have bias toward the healthcare team as well. Past experiences may have given them a negative view about the medical community (Olson & Alford, 2006). Patients also may fear a relapse to substance abuse from the opioids and refuse to take them. This decision should be respected but the patient should be educated about the potential benefits of pain management. When oncology nurses work in a skilled and knowledgeable manner with patients with a history of substance abuse, they foster an environment of effective pain management and positive outcome for the patient.

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References


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