Opioid Misuse Risk
Implementing screening protocols in an ambulatory oncology clinic

Lynsey Teulings, MS, APRN, and Kathleen Broglio, DNP, ANP-BC, ACHPN®, CPE, FPCN

The treatment plan for a 53-year-old Caucasian woman named P.M. diagnosed with P16-negative squamous cell carcinoma of the right hypopharynx and at the base of the tongue, with right neck node metastases (cT2 N1 Mo), was seven weeks of daily radiation and weekly cisplatin with curative intent. P.M. is a single mother of two adult children who lives alone and works as a director for a behavioral health partner network. Prior to starting treatment, an RN administered the Opioid Risk Tool (ORT) to P.M. as part of the feasibility study. P.M. scored in the high-risk category on the ORT and reported a family history of alcohol abuse, as well as a personal history of depression and alcohol, prescription drug, and illicit drug use. The oncology nurse practitioner reviewed P.M.’s score and referred her to palliative care for complex pain management. At her appointment with the palliative care nurse practitioner, P.M. expressed relief that the ORT was administered because she had concerns about discussing her history of substance abuse and being stigmatized. P.M. reported that she had been in recovery for substance abuse for 10 years and expressed a fear of taking opioids because of the risk for relapse. P.M. said the following about her experience with the risk assessment:

I was grateful we did the assessment. . . . I was grateful we made a plan and communicated. . . . Everyone knew that I was safe, that my recovery was not in jeopardy, that we were treating me as having two conditions, one treatment together. . . . not focusing on cancer and ignoring that fact that I have addiction issues and I am in recovery.

The palliative care and oncology teams collaborated to ensure that P.M.’s cancer-related pain was safely and adequately managed.

Background
Oncology clinicians have expressed concerns about the opioid crisis, which was declared a public health emergency in the United States in 2017 (U.S. Department of Health and Human Services, 2017). Since then, clinicians have focused on improving patient opioid risk assessment, management of patients with a history of opioid use or abuse, and best practices for the prescription of opioids. Based on their meta-analysis of 12 articles on pain and pain severity, van den Beuken-van Everdingen, Hochstenbach, Joosten, Tjan-Heijnen, and Janssen (2016) reported that pain prevalence rates in patients requiring opioid therapy were 40% in those receiving curative treatment, 55% in those receiving active antineoplastic therapy, and 66% in those diagnosed with advanced, metastatic, or terminal disease. Opioid use is also prevalent in cancer survivors who have no evidence of disease, but their use of opioids may be a result of factors other than a previous cancer diagnosis (Barbera et