# Pain Management in the Individual with Serious Illness and Comorbid Substance Use Disorder

Anne F. Walsh, ANP-BC, CWOCN, ACHPN[a], Kathleen Broglio, DNP, ANP-BC, ACHPN, CPE, FPCN[b,*]

**KEYWORDS**

• Advanced disease • Drug addiction • Hospice • Pain management • Palliative care • Serious illness • Substance use disorder

**KEY POINTS**

- Pain is prevalent in individuals with serious illness and comorbid substance use disorder and requires a comprehensive assessment and treatment plan.
- A comprehensive pain assessment includes risk assessment for misuse of opioid medications.
- "Universal precautions" should be used when designing a pain management treatment protocol for all individuals.
- Pain management in individuals with serious illness and comorbid substance use disorder requires a unified interdisciplinary team approach.

**Case study**

John is a 45-year-old man with metastatic non–small cell lung cancer with extensive bony metastases. Before the diagnosis, he experienced lower back pain and his primary medical team prescribed him immediate-release opioids and referred him for further workup. Because of insurance issues, he delayed further workup and began obtaining analgesic medications from friends. As his pain worsened, he started to use heroin to control the pain.

Although he is now receiving treatment, including radiotherapy to the spinal bony metastases, he has continued pain. He has had intolerances or lack of efficacy to multiple opioids, and has refused to take extended-release opioids stating that they do not work. His pain is now being treated with hydromorphone 8 to 16 mg orally every 3 hours as needed for pain and at times, he is using more than 200 mg daily. He is followed weekly in the palliative care clinic and each time he is seen he is out of medications. During a recent hospitalization, there was a concern that he was injecting the oral medications and tampering with the patient-controlled analgesia machine.

Disclosures: No disclosures (A.F. Walsh); Consulting fees – Purdue Pharmaceuticals, Emmi Solutions; speaker's bureau Genentech, Mallinkrodt; Royalties – UpToDate (K. Broglio).
[a] Visiting Nurse Service of New York, Hospice and Palliative Care, 1250 Broadway, 7th Floor, New York, NY 10001, USA; [b] Section of Palliative Medicine, Dartmouth Hitchcock Medical Center, 1 Medical Center Drive, Lebanon, NH 03756, USA
* Corresponding author.
*E-mail address:* kathleen.broglio@me.com

Nurs Clin N Am 51 (2016) 433–447
http://dx.doi.org/10.1016/j.cnur.2016.05.003 **nursing.theclinics.com**
0029-6465/16/$ – see front matter 

## INTRODUCTION

Individuals with serious illnesses including cancer often have unmanaged pain.[1,2] In a systematic review of 40 years of cancer treatment, 24% to 60% of those undergoing treatment, 58% to 69% of those with advanced cancer and 33% of cancer survivors experienced pain.[3] According to Laroche and colleagues,[4] pain is a common reason for persons with drug addiction to seek medical care. People with a history of substance use disorder (SUD) face a risk of undertreated pain often due to clinician biases and regulatory fears.[2,4,5] Nurses must possess the knowledge and skills to ensure appropriate and safe pain management in this population.

## PREVALENCE OF SUBSTANCE USE DISORDER

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) national survey data on drug use and health, an estimated 24.6 million adults (9.4% of US population 12 years old or older) used illicit drugs in 2013.[6] Although marijuana has continued to be the most commonly used drug, the nonmedical use of pain relievers (opioids) is the second most commonly misused class of medications.[6] Results from the SAMHSA survey also showed that nearly 1 (18.5%) in 5 adults 18 years old or older have a mental illness.[6] Drug abuse is more prevalent in those with mood disorders or anxiety.[7–9] With the increased use of opioids for chronic pain, opioid prescriptions increased from approximately 76 million in 1991 to almost 207 million in 2013.[10] With this increase in opioid availability, there has been an increase in unintentional deaths, more than quadrupling since 1999.[10] According to the US Centers for Disease Control and Prevention (CDC), a total of 47,055 drug overdose deaths occurred in the United States in 2014.[11] Opioids and heroin were responsible for 28,647 (61%) of these drug overdose deaths.[11]

Earlier studies have reported less prevalence of substance abuse in individuals with serious illnesses.[12] These estimates may not be adequate because of underreporting or access to care barriers for those with SUDs.[12] Chesher and colleagues[13] found that individuals entering treatment facilities for SUD have a higher incidence of chronic illnesses, such as asthma and hypertension, in addition to mental illnesses, and are more likely to be using tobacco, leading to a higher incidence of morbidity and mortality. A recent study on risk stratification for those with cancer pain found that the number of those with SUD risk factors were similar to those in the chronic pain population.[14] Although there are limited recent data available on the prevalence of SUD in those with serious illnesses, it likely can be extrapolated from the studies of the general population.[15,16] Until more studies are conducted that adequately reflect the true prevalence of SUD in this population, safeguards should be in place to address the potential for substance misuse.[12]

## SCOPE OF PROBLEM IN HOSPICE AND PALLIATIVE CARE

Data about the scope of the problem in hospice and palliative care are limited. Pancari and Baird[17] point out the risks for opioid misuse and diversion when patients are receiving home hospice services where there may be limited oversight and where large quantities of opioids may be delivered to the home to manage uncontrolled symptoms. Risks may be higher in the home population than previously reported, as more than 70% of prescription drugs that are diverted or otherwise misused are by family and friends.[6] Blackhall and colleagues[1] found that training policies for handling patient and family substance abuse and diversion issues within hospices were lacking in Virginia. Most palliative care programs surveyed did not have policies