Mitigating the Risk of Aberrant Use of Opioids in Patients With Cancer Pain

Marcin Chwistek, MD

The burden of cancer pain remains high, and the negative consequences of undertreated cancer pain are far-reaching. Opioids are the gold standard for treating moderate to severe cancer pain and are endorsed by multiple guidelines. Patients with cancer pain receiving chronic opioids are also at risk for aberrant opioid behaviors, perhaps at a higher rate than previously thought.1 Therefore, oncology and palliative medicine clinicians face the dual responsibility of effectively addressing cancer pain while mitigating the risk of aberrant opioid behaviors.2

To make matters more complex, unintentional consequences of policy changes related to the epidemic of overdoses plaguing the United States and other countries might have exacerbated the problem of undertreatment of cancer pain. In this issue, Moryl et al3 reported that between 2000 and 2017, their group saw a decline in opioid prescribing for patients near the end of life by almost 40%, while concurrently, emergency department visits increased by >50%. Haider et al4 reported that between 2010 and 2015, the median morphine equivalent daily dose patients received at the time of referral to their supportive oncology decreased from 78 to 40 mg/d. At the same time, an increase was seen in prescriptions for nonscheduled opioids such as tramadol, suggesting that some oncology clinicians have become less comfortable prescribing opioids for cancer pain.4

This is unsurprising, given that there is a paucity of data, tools, and guidelines to aid clinicians in safe and effective opioid prescribing for cancer pain.5 As a result, clinicians are forced to rely on their subjective assessment of patients, which is primarily based on their previous experience and attitudes toward opioid prescribing. As a result, some refrain from prescribing opioids when it may be appropriate and necessary. At the same time, others ignore potential aberrant behaviors and miss an opportunity to intervene. In a recent study, palliative medicine physicians reported that aberrant opioid use was underdiagnosed, challenging to manage, time-consuming, and stressful.3,6

A recent meta-analysis estimated the prevalence of opioid use disorder (OUD) among patients with cancer-related pain to be 8% and the risk for OUD to be 23.5%.7 This is consistent with another report that determined that at least 1 in 5 patients with cancer are at increased risk for OUD.8 In another study of 432 patients with advanced-stage cancer seen at a supportive care clinic, 18% were identified as using opioids in a way other than prescribed.9 However, it is essential to note the significant heterogeneity of the studies that prevents us from making conclusions about the actual risk of aberrant opioid use.7,10

It is critical to be able to recognize patients at risk for aberrant use of opioids, including substance use disorder (SUD), early and accurately, because there are strategies that help to mitigate the risk. Several factors, such as younger age (<45 years), male gender, a personal or family history of SUD or mental health disorder, and alcohol and tobacco use, have all been associated with the development of SUD. It is essential to highlight, however, that no single factor or a set of factors can reliably predict aberrant opioid behaviors in patients.1

Various screeners, including the Screener and Opioid Assessment for Patients with Pain (SOAPP); the Cut Down, Annoyed, Guilty, Eye Opener Questionnaire

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(CAGE); and the Current Opioid Misuse Measure (COMM), have been used in patients with cancer to assess their risk for aberrant behaviors and SUD; however, they not been validated in this population.7

In this issue, Moryl et al3 specifically examined the utility of COMM for patients with cancer-related pain as recommended by the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for Adult Cancer Pain.11 COMM is a self-administered questionnaire that assesses past-month aberrant medication-related behaviors. It assesses 5 domains and contains questions related to memory problems, emotional issues, changes in appointment patterns, and thoughts and behaviors related to medication use. The questionnaire takes approximately 10 minutes to complete. It was validated among patients treated in specialty pain management clinics and studied in the primary care setting in patients with nonmalignant pain. A score ≥9 suggests prescription opioid misuse in the previous month. A score of 13 has also been used for increased sensitivity and specificity for identifying patients with OUD. Within the primary care population, it was demonstrated that a score <13 strongly suggests that a patient does not have SUD. However, a score >13 had a significant false-positive rate.10

Moryl et al3 evaluated >400 patients with cancer treated in pain clinics at their NCI-designated Comprehensive Cancer Center who completed the Brief Pain Inventory and COMM (adopted as a part of routine care) at 2 time points within 100 days. They then analyzed the prevalence of positive COMM scores (using both cutoff points, 9 and 13) and the direction of change between time points, and compared the results with additional data such as the presence and results of urine drug testing, CPT codes for OUD, and CAGE results.3

What did they find? In short, COMM has a very high false-positive rate in patients treated with opioids for cancer pain. This is not surprising. It is easy to notice that the high score may result from high distress and symptom burden of cancer-related symptoms in patients with cancer who also need to navigate the increasingly complex health care system.

Specifically, the number of patients with COMM ≥13 was 5.3 times higher than with true aberrant positive urine drug studies (UDS) in the studied population. Moreover, there was no association between COMM and CPT codes for OUD (cutoff 9 or 13), and the number of patients with positive COMM (≥13) was almost 4-fold higher than that of patients with a confirmed diagnosis of OUD.3 (However, it is essential to highlight that using ICD codes and grossly abnormal UDS as the only marker for true SUD most likely resulted in the underdiagnosing of SUD in the study. In my experience, oncology clinicians are very reluctant to document the diagnosis of SUD in the chart or even obtain an UDS unless the patient exhibits grossly aberrant opioid-related behaviors.) Additionally, the likelihood of decreasing the COMM score over time was 6-fold greater than the reverse, the opposite of what one would expect in patients with continued exposure to opioids. All of this makes the utility of COMM in patients with cancer quite dubious, and the authors report they have since retired its use from their electronic health record.3

The researchers discovered an unexpected utility of COMM unrelated to aberrant behaviors: positive COMM (≥13) predicts cancer mortality.3 And, in fact, quite well. A score of ≥13 predicted an almost 2-fold increase in 12-month mortality. This is not surprising; with progression of disease, many patients with advanced cancer experience more pain, require opioid dose adjustment, and often visit emergency departments to manage their worsening symptom burden.3

In conclusion, the study by Moryl et al3 highlights the risk of using COMM in patients with cancer pain. The tool may not only misidentify patients at risk but also lead to additional barriers to optimal opioid-based treatment. The oncology community urgently needs an easy-to-use tool tailored to this patient population if we are to continue to improve the care of our most vulnerable patients.12

References


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Correspondence: Marcin Chwistek, MD, Fox Chase Cancer Center, 333 Cottman Avenue, Philadelphia, PA 19111. Email: marcin.chwistek@fccc.edu

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