Faculty Response to Live Session Questions

- I have seen that some patients who do well overall with their stable longstanding long-acting opioids, when they get an infection and/or fever, suddenly they no longer tolerate the opioid and have sedation and respiratory suppression. We have a patient in house now to whom this has happened twice - each time associated with an infection. He is in a supervised setting and there is no evidence of opioid misuse. He does not want naloxone and is aware of the risk. What do you recommend for patients like this? **Response:** The most likely cause for this is that the infection *or the medicine(s) used to treat the infection* has affected the individual in such a way as to result in elevated blood levels of the opioid, leading to overdose. This could be hepatic insufficiency with diminished or altered metabolism of the opioid, with elevated blood levels. Or, this could be a drug-drug interaction that leads to increased blood levels of the opioid, either by increased or too rapid absorption, diminished hepatic metabolism, or displacement of opioid by altered protein-binding. Which is most likely depends on the specific opioid and which concomitant medications are used.
  If not already done, consider exploring the patient's reluctance to have naloxone available in the context of his prognosis and goals of care. Those providing care in the supervised setting may also benefit from additional education and advice on the need to consider adjusting opioid medications during times of acute decompensation. Again, this advice should take into account the patient's prognosis and goals of care.

- Do you have recommendations for hospices to have regarding policies for covering medical directors when the hospice has been asked to "assume opioid prescribing or symptom management" for their patients? In particular, I am speaking about routine refills of opioids when nurses call in for them after hours to covering hospice doctors/associate medical directors. **Response:** The following is to supplement the response provided during the web session. AAHPM has created a workgroup to come up with a position statement regarding acceptable practices for opioid prescribing by hospice medical directors who have not seen the patient, in the sense of whether a professional physician-patient relationship exists. From a practical standpoint, if the patient has been seen by one HMD, the rest of that hospice's HMDs are essentially the same practice group and standard rules for coverage would apply. Additionally, it is prudent for the hospice to have operational checks in place such that "routine refills" do not occur outside of normal business hours. These should always be considered with an additional degree of suspicion.

- What other medications apart from amphetamine can cause false positive result for amphetamine in urine drug screen? **Response:** A quick online review reveals the following, which is not necessarily all-inclusive, for immunoassay (IA) false positives when testing for amphetamines: brompheniramine, phenylpropanolamine, phenylephrine, pseudoephedrine, labetolol, oxymetazoline, neosynephrine, buproprion, trazodone, chlorpromazine, promethazine, ranitidine, and metformin. This is why a positive IA test should be verified with the more specific gas chromatography/mass spectrometry or liquid chromatography/mass spectrometry test, which will identify the specific compound (at more expense).

- Comment on role of intrathecal pumps and palliative care physicians learning how to manage them. **Response:** We recommend that hospice providers reach out to pain specialists currently managing intrathecal pumps for patients that are referred to hospice. Adjustments to the intrathecal infusion medications or rate are best done collaboratively with these providers. Arrangements should also be made on a case by case basis for how refills will be managed.

- Comment on Hospice policies for when medical directors are asked to "assume symptom management" of hospice patients. Are there policies, approaches, you can offer to hospices about writing for scripts, refills, covering physicians, etc. **Response:** To a great degree, much of what is required to assess and monitor ongoing symptom management is done quite well by the hospice IDT – perhaps even better than in the traditional outpatient setting with episodic office visits. However, hospice does not preclude the physician's obligation to manage pain in a scientific fashion, in accord with best practices. Trying to answer this question is another lecture (or more), in and of itself. As stated in response to a previous question, AAHPM has a workgroup developing a position statement on some of these issues as well. Stay tuned.

- Have there been incidences of morbidity/mortality when not reducing for incomplete cross-tolerance in palliative care? Or switching to fentanyl using 2:1 to morphine equivalent? Or is this a recommendation to standardize practice? The fentanyl tables are too wide to be believable as much other than over-caution in a well-monitored population. **Response:** Please remember that the CORE curriculum addresses the FDA blueprint for ER/LA Opioid REMS. As such, the course content is significantly limited to discussing what how the FDA has formally approved opioids for prescribing. While there are anecdotal reports of overdoses with over-reliance on conversion by standard equianalgesic dosing tables, this is not well studied in a rigorous fashion. The fentanyl tables represent the wide variability in how different individual characteristics (e.g. skin thickness, body habitus, application location, etc.) can affect bioavailability of transdermal fentanyl. The widely used "2:1 to morphine equivalent" is a misnomer since it is comparing micrograms and milligrams, meaning it has the potential for significant misunderstanding and resultant bad outcomes. All that said, there is a lot to be said for the prescriber's medical judgment and discretion in how conversions are done. It does seem prudent to be cautious, though, especially when death is not an expected outcome.