A discussion of the comanagement of cancer pain and opioid use disorder (OUD) is a very timely and critical issue that has been largely overlooked by policy makers, clinical guidelines, and clinical research. Cancer pain is often treated with opioids, a therapeutic regimen that can become a challenge in patients with OUD. Patients with cancer with a history of OUD are at risk for OUD relapse and opioid overdose when they are exposed to prescription opioids amid the stress of a potentially life-threatening illness. According to the National Epidemiologic Survey on Alcohol and Related Conditions III, patients with a cancer diagnosis had a higher 12-month prevalence of posttraumatic stress disorder, bipolar disorder, substance use disorder, and attempted suicide more often than patients without a cancer diagnosis. Having OUD may impair relationships with the clinical team and personal support systems and may put patients at risk for undertreatment of pain and cancer. Although 69% of surveyed clinicians expressed concerns about addiction in patients with cancer and 63% expressed concern about associated undertreatment of cancer pain, only 23% to 35% reported adequate knowledge and confidence in caring for patients with cancer and OUD. Despite known associations between substance use disorder, the negative impact of OUD on cancer treatment, and the perceived need for expertise in OUD in patients with cancer, the availability of chemical dependency services in US cancer centers is insufficient. Of 1144 US cancer centers surveyed, only 45.5% offered either alcoholism or chemical dependency services. Government-run facilities, nonprofit centers, and hospitals that were members of large hospital systems were more likely to offer these services. Without chemical dependency services, especially treatment for OUD, data and an expert consensus guiding clinicians managing cancer pain in patients with OUD become essential.

The study by Merlin et al is a major step in achieving this consensus. This qualitative study solicited the opinion of 120 experts in palliative care, addiction, or both, of whom 70% participated in all 3 rounds. Participants were asked to give recommendations on managing cancer pain in patients with advanced cancer and OUD treated with buprenorphine-naloxone or methadone. The variety of opinions among the experts in palliative care and addiction was striking. One such example was the difference in views regarding continuing the methadone maintenance program for a patient treated for cancer pain. Most responders deemed it appropriate for palliative care clinicians to prescribe methadone 2 to 3 times a day. Although methadone is an effective analgesic used in cancer pain management, most experts agreed to remove the patient with OUD from a structured methadone maintenance program known to provide not only methadone but also monitoring in a way not done in the oncology setting (eg, daily or weekly urine drug screening and frequent visits with clinicians trained in addiction). The methadone maintenance program also provides counseling and behavioral therapies for a whole-patient approach to the treatment of substance use disorders. The second case of the patient receiving buprenorphine with naloxone for OUD and reporting suboptimal analgesia also generated significant variations in opinion. Buprenorphine in patients requiring treatment with full agonists has been a controversial issue because it is a partial opioid agonist and possibly blocks analgesia provided by full opioid agonists. Data on the use of buprenorphine in cancer pain are very limited. A recent study of patients with cancer pain and OUD treated with buprenorphine showed that buprenorphine-naloxone could be the sole effective analgesic in selected patients with cancer pain. Buprenorphine has been successfully combined with full opioid agonists in surgical practice. A recent study showed that patients who continued
buprenorphine perioperatively used significantly fewer opioids than those whose buprenorphine was stopped. A recently published consensus algorithm for perioperative pain management in patients with OUD emphasized minimizing the risk of OUD relapse and prioritized perioperative communication with the buprenorphine prescriber and continuing the patient’s home buprenorphine dose perioperatively.

Merlin et al demonstrated the urgent need for more data to inform the experts. In addition to palliative care and addiction experts, oncologists, interventional pain, mental health, and nursing professionals need to join at the table to discuss best practices in supporting and treating vulnerable patients with cancer pain and OUD. The development of institutional and national guidelines will help frame a standard of care, inform both the patient and the health care professionals of a recommended approach, and allocate institutional resources.

ARTICLE INFORMATION
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REFERENCES