

### Editor's Note

#### Reflections on the fringe - Integrating palliative care into the mainstream

Recently, I heard a radio show in which a rabbi was reflecting on the place of the fringe, the Tzitzit, how this is so greatly valued in Jewish religious culture. The Tzitzit serves to remind the observant Jew of all the commandments so that they are observed, to remember G—d and to be elevated to a level of sanctity. The rabbi reflected that it is also the interface between the solid cloth and the air. It is a beautiful concept and one which resonated with me.

We in palliative care are striving for integration so that the care we so value is available to all in need. However, there is also a value in being on the fringe as opposed to part of the solid cloth of mainstream care. It is no accident that much creative change happens at the fringe. An obvious example is "fringe theatre". Is creativity even by necessity found at the fringe, the edge, at the place without form and definition? One can observe without the solidity of form, one can adapt to changing winds. It is not a structure that can hold up and contain. It does not fit with establishment, with firm policy and procedure, but is swayed to and fro ever responsive to change, ever in flux. Others have written about the bureaucratisation of palliative care and what is being lost in the process. How can we maintain our creative energy while still being available to those being cared for within the mainstream of health care?

For me, it is about both, rather than either/or, but balance tends to be elusive in all things. I think our efforts currently are very focussed on creating the solid fabric and we risk ignoring, rejecting or alienating the fringe. Are we at risk of losing our delicacy, perhaps the femininity of our specialty? Hopefully we can live at the edge of the cloth and the air and sustain the tenderness of our model of whole patient care.

### President's Report

It was great to see so many ANZSPM members at the combined 10<sup>th</sup> Australian Palliative Care conference and 8<sup>th</sup> APHC conference in Perth at the end of September. I thought the conference organisers did a wonderful job and the conference was excellent. From an ANZSPM point of view thank you to all members who managed to wake themselves up early and attend the AGM. We introduced a new format this year that seemed to work well. The AGM was followed by an open forum. The focus for the Council at this year's AGM was the new

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Constitution and thankfully it was passed. An enormous amount of work was put into this work by Cathy Miller (Chair), Frank Brennan, Karen Cooper and others. Thanks to all those who contributed.

Hopefully many members have attended the ANZSPM – NZ branch Annual Scientific Meeting in Auckland. It was an opportunity for me to develop a greater understanding of how palliative care works in NZ. I think the close relationship between Australian and New Zealand members is a major strength of our Society.

During September, some members of Council met with The Hon Justine Elliot MP, Minister for Ageing (who has federal responsibility for Palliative Care in Australia), and the Palliative Care Section of the Department of Health and Ageing. At these meetings we provided further feedback on the National Hospital and Health Reform final report and discussed other issues including workforce, training positions, MBS item reform, quality (including clinical indicators) and subacute funding under the National Partnership Agreement. We fed back to the Minister that clinicians in Palliative Care around Australia thought there had been inadequate consultation when it came to proposed state plans for additional funding in subacute services, and a lack of feedback about when money would be actually seen by local services. Subsequently it has become clear that in some states

(especially QLD, WA and NT), plans for enhancement of subacute services did not include any (or very little) increase in palliative care funding. State plans are available at [http://www.federalfinancialrelations.gov.au/content/national\\_partnership\\_agreements/health.aspx](http://www.federalfinancialrelations.gov.au/content/national_partnership_agreements/health.aspx). This highlights the need for ANZSPM to be involved with strategic planning and decision making at state and federal levels to ensure improvements to services and ultimately improved care to our patients.

As mentioned in the last newsletter we are very pleased to have a series of national education forums scheduled to occur again in early 2010. Thanks to a generous sponsorship from MundiPharma, these are planned to be held around Australia and New Zealand. ANZSPM will be organising these evening forums, aimed at both palliative care specialists, other specialists with an interest in palliative care and also general practitioners. The format will be a talk by an invited speaker followed by a panel led discussion based around case presentations by local specialists/general practitioners. Keep a lookout for the dates in your local area.

On behalf of the ANZSPM council we wish you all the best for Christmas and 2010. If you wish to participate in ANZSPM, we are always keen for people to become more active in our Society.

**Phillip Good**

**President**

## *New Zealand Branch Report*

I have just returned from the Annual ANZSPM NZ branch conference which was this year held in conjunction with the Annual RACP NZ conference in Auckland. Other societies involved were the NZ Internal Medicine (IMSANZ) and Geriatric Medicine (ANZSGM) Societies. This was a great opportunity to share our similarities and differences and more importantly to acknowledge the intersections and transitions of our care. It was also a great opportunity to showcase the role of Palliative Care within general and geriatric medicine.

The program was varied to meet many learning objectives but there was a strong Palliative Care input with sessions on communication, advanced care planning, opioid choices and diagnosing dying which highlighted the intersections of care. We have Cathy Miller to thank for this in her role on the conference committee.

We were very lucky also to have the premier of a new documentary called "At Home" made by one of our own

members Sinead Donnelly. This is the fifth documentary Sinead has made and the first in NZ. It was a very powerful and beautifully created short film about the option of dying at home which captivated the audience and hopefully will be shown on NZ TV in the not too distant future.

The networking as always was a highlight throughout the conference. The ANZSPM dinner on the first night was held at the Harbourside Restaurant on the Auckland waterfront. There were 50 plus members at this event including a number from Australia. The food, company and entertainment in the form of a quiz made for a great evening. The winners of the quiz will be hosting the quiz at next year's meeting planned for late April / early May in Wellington.

The business meeting was held on the Wednesday afternoon and thank you to Phillip Good who attended from Australia to speak to the NZ members on developments and initiatives this year within ANZSPM. The meeting also included reports from members involved in many committees within NZ and updates on various initiatives including service specifications and workforce planning.

A pertinent and interesting session at this meeting was delivered by a long time ANZSPM member whose primary role is as a GP but who has had a significant and valuable involvement in hospice over many years. His reflections were on the changing face of Palliative Care in relation to GP care of patients. He raised a number of valid points which highlighted the need to continue involving GPs in the care of their palliative patients. This raises the question of whether or not we truly represent our GP members as a Society and by encouraging GP membership we must aim to support them to continue to provide their care.

The NZ executive now has two newly elected members Sinead Donnelly from Wellington and Sara Rishworth from Auckland. We have also co-opted a new trainee representative, Dipti Mittal. Thank you very much to these members for putting their names forward.

I would like to acknowledge and thank Andrew Wilson who is retiring this year after 5 years as treasurer of the NZ executive and has managed our finances exceedingly well during that time. He has also played a large part in increasing our membership to record levels of 70 at last count and keeping a very up to date effective database which has meant contact with the membership has been possible at the touch of a button. Thank you Andrew for all your hard work. Not quite sure how we will replace you.

Finally best wishes to all members for the Christmas season. I hope it is a happy and safe season for you all.

**Joy Percy ( NZ Branch Chairperson )**

## *Trainee Awards*



*One of two ANZSPM trainee awards for 2009 was awarded to Gregory Parker, MBBCh FRACGP, for his presentation at the Together 2009 Palliative Care Conference, Perth, September 2009. The second trainee award was awarded at the New Zealand branch meeting in November 2009 and the winner will appear in the next newsletter.*

*Greg is working at Metro South Palliative Care Services and presented on a project entitled 'Lack of analgesic effect of paracetamol for palliative patients requiring high-dose opioids: a randomised controlled trial'. His fellow authors were A/Prof Liz Reymond (Metro South Palliative Care Services), Fiona Israel (Brisbane South Palliative Care Collaborative) and Dr Margaret Charles (Psychology Department, University of Sydney).*

**Abstract:** The usefulness of the addition of paracetamol for pain relief in palliative patients already requiring high-dose opioids is questionable. This study investigated potential analgesic benefits from 4g paracetamol tablets daily for patients using at least 200mg of oral morphine equivalent daily. Thirty-one patients were recruited to the prospective, double-blinded, randomized crossover trial. They received usual medications plus 4g paracetamol or placebo for five days each in random order. Primary outcome, effect on pain, was assessed using daily diaries including numeric rating scales (NRS) from 0 (no pain) to 10 (unbearable) and recording numbers of breakthrough analgesics. Secondary outcomes – nausea, vomiting, cognitive impairment, constipation and overall well-being - were assessed similarly. Data from the last four days of each treatment were analysed. Patients indicated in which part of the study their pain was better controlled. Twenty-two patients completed the trial. There were no significant order or treatment by order interaction effects for any variable; paired t-tests were conducted to investigate change in mean levels on outcome variables with placebo vs paracetamol. For none of the variables was there a statistically significant difference when assessed with placebo compared to

paracetamol. No change approached clinically significant levels, with a mean difference in rated pain of 0.16, and mean difference of 0.42 for number of breakthrough medications. Fifteen patients were undecided whether paracetamol improved pain. These data do not support the common practice of adding regular paracetamol daily as an adjunct to high-dose strong opioids for pain control in palliative cancer patients.

**Learning experience:** My involvement with this study is the first time I have participated in a research project. The processes commenced long before attaining ethical approval, and required self imposed deadlines, the back and forth of numerous emails just to get the wording right, not to mention the statistics, which is a whole new language in itself. It all initially appeared too daunting.

For me, having an enthusiastic clinical and research leader, Assoc Prof Liz Reymond as mentor and driving force, together with an equally dedicated research manager, Fiona Israel, and a nurturing team has made this a positive experience. I would also like to acknowledge the integral part played by our statistician Margaret Charles, and the patients who agreed to participate. Following on from this project, I intend to continue participating in research in the field of palliative care.

The primary learning experience from this study is the realisation of the fundamental role of a team effort in research. Contributing actively to this process has given me the sense of being able to add to the huge knowledge pool that we all draw from to give the best care to our patients. It has also given me a new appreciation of the time and effort that goes into each research project, each one the product of many hours by many people, to result in an evidence base to help guide clinicians in their daily practice.

We know that in our profession valid research is imperative. When opportunity avails itself, may I encourage all trainees to consider accepting the challenge of research.

**Greg Parker**

## *New Council member*

**Michael Chapman - Trainee representative**

*After Scott King resigned from ANZSPM Council, Michael Chapman was coopted onto Council as the new trainee representative. The Council welcomes Michael and looks forward to working with him.*

Michael was born in Sydney, as the first child of two young



doctors. The whole family moved to Orange NSW and then to Canberra where he completed high school. Michael then went to study medicine at the University of Adelaide as an undergraduate. Six years later he returned to the ACT with the dual treasures of a degree, and his enchanting and inspiring wife.

Subsequent years of trench work as a JMO, basic physician trainee and exam candidate flew by in a whirl of unpaid overtime. More recently Michael has embarked on training in Palliative and Geriatric Medicine, a mix which he feels represents a logical and compassionate extension of both specialties. His clinical and research interests include issues related to death and dying of dementia sufferers and at residential aged care facilities, and management of advanced cancer in the elderly.

Michael, Bree, and their little terriers are currently up-rooting to move to Melbourne for further training next year. When not at work Michael enjoys music, skiing, cycling, Buddhism and technology in its many guises.

**Michael Chapman**

## *Letters from Abroad*



*This is the second of this series. Dr Sushma Bhatnagar is the head of the Unit of Anaesthesiology at Dr B.R.A Institute Rotary Cancer Hospital, All India Institute of Medical Sciences, New Delhi. She was the conference organiser for this year's Indian Association of Palliative Care conference, New Delhi in February. Dr Bhatnagar describes the "high tech" end of pain and palliative care practice in India, available to patients referred to her unit. This is the privilege of the few in India. A recent 102*

*page report from Human Rights Watch ([www.hrw.org](http://www.hrw.org)) has highlighted the pressing need for more government action to improve palliative care provision across India and states that "Many major cancer hospitals in India do not provide patients with morphine, despite the fact that more than 70% of their patients are incurable and likely to require pain treatment and palliative care."*

Welcome to the Unit of Anesthesiology at Dr. B.R.A. Institute Rotary Cancer Hospital (IRCH), All India Institute of Medical Sciences (AIIMS)! Working at a premier medical institute of not-so-long ago a developing country imparts a great responsibility on our shoulders as we have to lead the clinical and research scenario of our medical specialty in the country by exemplifying works without forgetting for one single moment that the outside world is peeking at the possibilities that we create for our people. The world may not look up to us as our history is a tell-tale of being led than leading the world. However, times are changing and we are developing into an accommodative scientific society that does not hesitate in sharing our outlook for the clinical problems common and universal to the world, and motivating our progeny into a hard-working and brain teasing lot by providing them with the right amount of opportunities and facilities.

Our aim is to deliver the highest quality of clinical care to our patients from the pre-anaesthetic workup of the surgically respectable disease to the palliative management of the terminally ill cancer patients. During this clinical journey of the patient, our team provides continuum of clinical and pain management in the peri-operative period, in the critically ill settings, during the transition from curative management to pain and palliative care and end-of-life care in the terminally ill stages.

Our faculties are committed to achieving excellence in clinical care and education, and they hold deep academic values. We continue to draw the brightest and most talented senior residents who, after completing their post-graduation (Doctor of Medicine, i.e., M.D.) in anaesthesiology from various reputed institutes in India, have shown dedicated interests in onco-anaesthesiology, critical care, pain management and palliative care. Our long-term goal in education and clinical experience is to train senior residents to become future leaders in onco-anaesthesiology, critical care, pain management and palliative care.

Our unit conducts research in the fields of cancer pain, palliative care and perioperative anaesthesia. Our faculty and senior residents engage in multidisciplinary

projects with intervention radiology, surgical oncology, radiation oncology and medical oncology while taking full academic advantage of the rich resources of AIIMS. Critical observation and learning are translated into innovation throughout the department.

Our palliative care team comprise of two faculties, one senior research associate and 12 senior residents. All of them are professionally qualified anaesthesiologists and critical care physicians and have gained experience as palliative care personnel in the advanced cancer patients referred for pain and other symptoms. We have been managing them as outpatients for last nine years with the inpatient facility being a recent addition since January 2007. The free service of home care team of CANSUPPORT has been a collaborative force since the time of our outpatient palliative care. The hospice referrals are being sent to SHANTI AVEDNA SADAN for free service of hospice care. Besides our six-bedded independent inpatient facility, we also take care of outpatients in four-days-a-week OPD, interventional operation theatres two-days-a-week, daily emergent follow-up of OPD patients, daily elective or emergent bedside palliative interventions, 24-hours on-call facility for oncology ward inpatients and 24-hours telephonic guidance for emergent palliative needs of our patients. The inpatient facility has been a recent addition to our palliative care delivery system. Our team has utilized this opportunity of caring for the incurable patients on inpatient basis by aggressively intervening to treat the difficult pains and complex symptoms at the end-of-life.

Educational experience is achieved through lectures, seminars, clinical care, procedural interventions, and involvement with ongoing research. There are semi-weekly oncology conferences, weekly grand rounds, weekly journal clubs, as well as weekly radiology conferences with interventional radiologists. Senior Residents are encouraged to participate in ongoing clinical research. Senior Residents become proficient in the performance of numerous procedures including celiac plexus blockade, hypogastric plexus blockade, ganglion impar blocks, stellate ganglion blocks, neurolytic techniques, spinal cord stimulation, implantable intrathecal pumps, epidural steroid injections, and peripheral nerve blocks. Exposure and experience in ultrasound-guided procedures are immense. Efficient nursing care is provided by a dedicated professional staff who have demonstrated competency in the management of cancer patients needing critical care, pain relief and palliation.

We offer training in the following:

1. Observership in Onco-Anesthesia and Cancer Pain Management Short-term comprehensive observership program covers the routine and state-of-art procedures and techniques in onco-anesthesiology, onco-critical care and pain and palliative care.
2. Indian Association of Palliative Care's Certificate Course in Palliative Care Unit of Anesthesiology, IRCH is Nodal Center for conducting Indian Association of Palliative Care's Certificate Course in Palliative Care
3. Annual Foundation Course in Palliative Care This is conducted in collaboration with CANSUPPORT Home Care Team in the month of February.

Outpatient services include palliative care consultations and follow-up care for inpatients, pain and palliative care clinic four days a week, dispensing of analgesics and drugs for pain and palliation, referral to non-profit (free service) home care support team CANSUPPORT and non-profit (free service) hospice care SHANTI AVEDNA SADAN for patients with advanced malignancies, emergency consultations, care and follow up for pain, palliation and critical management available 24x7.

We provide the following inpatient services:

The Unit of Anesthesiology, IRCH, AIIMS, operates one six-bedded Oncology Intensive Care Unit (ICU) for critically ill adult as well as paediatric cancer patients. ICU caters to the postoperative surgical oncology patients, the chemo-toxicities in medical oncology patients and deteriorating post-radiation patients. Besides the critical care in ICU, the team also provides advanced care to patients in high dependency units of medical oncology and radiation oncology wards. The wholesome experience provides an educational experience for the anaesthesiologists interested in critical care in cancer patients. Equipment reflecting our commitment to the critical care includes echocardiography, video bronchoscopy, portable ultrasound and the like.

The Unit of Anesthesiology, IRCH, AIIMS, is committed to providing excellence in patient care for cancer pain patients in all age groups. The team members evolve invaluable insight and experience in the diagnosis and treatment of cancer pain from a variety of perspectives. The team works in close association with intervention radiologists, psychiatrists, non-government organisations' home care and hospice support for effective pain relief and timely palliation. Special focus is on interventional pain management as well as interventional palliation. The goal is to provide active and aggressive care without losing insight into the psycho-socio-spiritual aspects of the pain management and palliation.

Patient education is another important aspect of the care provided and includes involvement of home care team and counsellors for the effective evaluation of the psycho-socio-spiritual aspects of the cancer pain, information and instructions for oral use of morphine in cancer pain and need for good compliance with answers to fear of opioid addiction, physiotherapist who teaches physical rehabilitation in palliative patients' end-of-life care, home care and hospice support counselling for terminally sick patients with help from National Cancer Institute's online patient educational resources

We offer many other facilities including:

- Examples of types of surgical/interventions managed under anaesthesia include all types of surgically respectable cancers and interventional radiotherapy procedures, paediatric radiotherapy, paediatric central line placements, paediatric radiological procedures (USG, CT, MRI, PET-CT)
- Services provided under fluoroscopy: Spinal cord stimulation, intrathecal programmable pumps, Peripheral nerve stimulation, peripheral nerve field stimulation
- USG guided procedures: Celiac plexus block, superior hypogastric plexus blocks, ganglion impar blocks, stellate ganglion blocks
- Other procedures planned in near future: Pulsed radiofrequency ablation procedures



Team in operating room: lead placement for spinal cord stimulation for difficult pain management in advanced cancer patient



Team in a chill-out mood at palliative care conference

## *Draft National Pain Strategy*

In September 2009, at ANZCA House in Melbourne, a Leaders Meeting took place to review the draft National Pain Strategy (NPS) that is to form the basis of a National Pain Summit on the proposed date of Thursday 11 March 2010 in Parliament House, Canberra. The Steering Committee for the National Pain Strategy (NPS) is under the leadership of the Australian and New Zealand College of Anaesthetists (ANZCA), the Faculty of Pain Medicine (FPM), the Australian Pain Society (APS) and consumer group Chronic Pain Australia (CPA), in collaboration with inaugural supporters, MBF Foundation and the Pain Management Research Institute. Several working groups had been formed in the preceding months, to draft this Strategy. The draft NPS proposed the following 6 key strategic areas for improvement:

1. People in pain as a national health priority
2. Knowledgeable, empowered and supported consumers
3. Access to skilled professionals and evidence based care
4. Access to interdisciplinary care at all levels
5. Quality improvement and evaluation
6. Research

Following the Leaders Meeting, four reference groups were convened to continue developing strategies to be incorporated into the updated draft NPS at a later date. These groups were acute pain, cancer pain, paediatric pain and pain in the older age group. The cancer pain group is being led by Dr Melanie Lovell, Greenwich, Sydney.

The draft NPS was launched during the FPM meeting in Melbourne on 18th October, with the headline "World-first National Pain Strategy launched" giving it some prominence.

This document is available now for expert and community consultation on the Pain Summit website; [www.painsummit.org.au/strategy/Strategy-NPS.pdf](http://www.painsummit.org.au/strategy/Strategy-NPS.pdf)/view. A feedback form is available at: [www.painsummit.org.au/strategy/feedback](http://www.painsummit.org.au/strategy/feedback).

The closing date for comments is 31 January 2010.

This is an important opportunity to improve pain management on a national level and to ensure that the challenges specific to pain management in palliative care practice are addressed. The NPS is likely to lead to articulation of Key Performance Indicators for cancer pain and the work of the ANZSPM Clinical Indicator Working Group will be useful to help inform these.

Queries about the plans for the summit can be directed to Lesley Brydon, Executive Director for the National Pain Summit at: lbrydon@nscchahs.health.nsw.gov.au.

### **Odette Spruyt**

## *The Opening of Townsville Palliative Care Centre*



It was a delight to be able to attend the opening of the Townsville Palliative Care Centre on Friday the 9 October 2009. I attended together with Dr Louise Welch, currently the President of Palliative Care Queensland, and we completed a successful accreditation as well. We were welcomed by Will Cairns and Ofra Fried. Long

in the planning, this dream of Will Cairns and North Queensland is now a stunningly beautiful reality. The Centre is in the grounds of the Townsville Hospital, and connected to it by a flying walkway. It consists of 20 inpatient beds and accommodation for the home care team, an education and research centre and more.

The building has been funded via the Cancer Council of Queensland with large donations from the Sylvia and Charles Viertel Foundation, BHP Billiton and Xstrata and others. Queensland Health will ensure ongoing funding.

Representatives from all the major organisers and donors were present at the opening, which was ably managed by Prof Jeff Dunn, the CEO of Cancer Council Queensland. Assoc. Prof. Gracelyn Smallwood, a Birrigubba woman and an expert in Aboriginal health, gave a welcome to Country, and this was followed by thoughtful comment from the Chair of CCQ, The Hon Mr Justice Richard Chesterman, and a local identity (perhaps idol would be a more appropriate descriptor) Mr Peter Parr. Mr Parr is the CEO of the Cowboys. I am told that the North Queensland Cowboys are a Townsville institution that has something to do with rugby league. Will spoke about the history behind palliative care in Queensland generally and in Townsville, and acknowledged the remarkable contributions of the many people who were responsible for this project.

Following all of this, the Acting Premier and Health Minister of Queensland, the Hon Paul Lucas MP opened the Centre.

Staff had been in training for two weeks prior to the opening, and a decision to fill only some of the beds for the first few weeks seems a very sensible one, allowing time to settle in to these beautiful surroundings.

Many of the staff who will work in the new unit have been working in the hospital previously, and it is clear from just a short visit that the "vibe" is wonderfully positive. Louise and I are sure that the Centre is off to a wonderful start in inpatient care with able senior medical input from Will and Ofra. Go well, Townsville, and congratulations.

### **David Brumley**

## *Management of Cancer Pain in the Patient with an Opioid Substance Use Disorder*

*Dr James Pang is a geriatrician who worked as a palliative care registrar/fellow for 12 months in specialist palliative care. This is an edited version of the case and review paper which Dr Pang submitted as his project for the Diploma of Palliative Medicine.*

### **Introduction**

Opioids are a mainstay of therapy for moderate to severe cancer pain, and are often utilised in chronic non-malignant pain.

Drug abuse has been widely studied in patients with chronic non-malignant pain, where the threshold for commencing opioid analgesia is much higher, but is less well studied in the cancer population.

Terminology related to substance use disorders is in a state of flux. Whilst the term "drug abuse" is generally agreed upon to refer to consumption, which although may be intermittent, causes some consequences to the user, the terms "addiction" and "dependence" are more problematic, especially in patients being treated with opioids for chronic pain. Addiction has been defined in a consensus statement by major pain and addiction medicine societies as "a primary, chronic, neurobiological disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterised by behaviours that include one or more of the following: impaired Control over drug use, Compulsive use, Continued use despite harm, and Craving." (the "4 Cs", emphasis added). The term "addiction" is not used in many major diagnostic manuals including ICD-10 and DSM-IV, which instead

use the term "dependence syndrome." However, dependence includes criteria such as tolerance and physical dependence (as evidenced by a withdrawal syndrome on drug cessation or antagonism), which are potentially expected effects of chronic medical use. The term "addiction" is also felt by some to better reflect the neurobiological concept of "brain reward" related to dopamine release in the mesolimbic system.

"Aberrant drug-taking behaviour" is a useful term that refers to behaviours which deviate from a medically prescribed plan, including use of opioids for non-analgesic purposes.

Studies have thus suffered from a consistency of definitions. However, Western population-based surveys consistently rate lifetime rates of drug and alcohol abuse or dependence at around 10%.

Opioid abuse in the setting of pain treatment is a complicated phenomenon. Issues of impaired pain control, drug diversion, which globally is increasing, and difficulties in diagnostic criteria as discussed all pose a challenge.

Treatment of pain in patients on opioid agonist maintenance treatment for established dependency also is challenging, as they have been shown to be undertreated, and frequently require higher doses of opioids.

This case report will discuss 2 patients with differing issues related to past or present opioid abuse and the management challenges they presented: one with a past history of illicit opioid abuse on methadone maintenance therapy; and one with no previous history of drug abuse who demonstrated aberrant drug-taking behaviours.

## Case presentation

### Case 1

The patient is a 32 year old woman who was diagnosed with a synovial sarcoma involving her left hemithorax. She underwent surgery and chemoradiotherapy. She subsequently developed local tumour recurrence, and her disease continued to progress through further chemotherapy and radiotherapy.

She had a previous history of heroin addiction, and had been on methadone maintenance treatment for 10 years. She had a relapse with heroin 4 years ago. She had a complicated social situation. Her biological mother had a history of heroin addiction and adopted the patient out. There was a history of domestic violence towards her by the father of her young son.

Her methadone was prescribed by her local doctor. She had ongoing left sided mixed nociceptive and neuropathic chest wall pain, and was commenced on regular analgesia including oxycodone by the palliative care team.

I became involved in her care in February 2009. She presented as open and honest. A monthly supply of her analgesia was continued. She was compliant with this treatment.

Two months later, she unexpectedly requested a review, stating that she had lost her medication box. This coincided with her resumption of a relationship with a former boyfriend, who was also on methadone maintenance therapy. Her pain was stable. I gave her story the benefit of the doubt, and prescribed an additional month's supply of oxycodone.

Over the next 6 weeks, 3 more requests for early prescriptions of oxycodone were made. A weekly pick-up from a single pharmacy which also supplied her methadone was arranged.

She was confronted with the discrepancy between the amount she had been prescribed and what she claimed she had received. Her pharmacy was contacted, and they stated that she had on occasion pressured them to be given more than a weeks' supply at a time. She was informed that no further opioids could be prescribed until her next monthly prescription would be due, which was 2 weeks away. However, after discussion with a senior colleague, it was decided that she be given a limited supply of medication for the next 2 weeks, and liaison with her local doctor, and pharmacy about being stricter with dispensing, took place. She initially denied that she had been prescribed the additional medication, but when the dispensing details were discussed she agreed that she could not account for all the dispensed medication.

She ended the relationship with her boyfriend who she claimed she discovered was stealing her opioids. Subsequently, no further requests for early prescriptions took place.

### Case 2

The patient was an 18 year old woman who was diagnosed with a cervical paravertebral Ewing's sarcoma in early 2008. She was treated with chemoradiotherapy with curative intent. She had significant pain of both a nociceptive and neuropathic nature involving her neck and right arm. She was commenced on analgesia including opioids. She was stated to be using opioids for non-analgesic purposes, transmucosal fentanyl in particular.

She relapsed with her sarcoma in February 2009 after

presenting with recurrence of neck and arm pain, at which time I became involved in her care. She recommenced chemotherapy, but her disease progressed and she developed right arm weakness. She had been weaned off all opioids, but these were re-introduced. Her requirements rapidly escalated, and within a few weeks she was requiring the daily equivalent of more than 2,500mg of oral morphine. She was taking breakthrough opioid analgesia more than 20 times per day. She stated that oral breakthrough medications were not as effective as subcutaneous injections, although equi-analgesic doses were prescribed. Her pain remained poorly controlled throughout this period despite close follow-up and trial of various pharmacological approaches.

She did remain as active as possible, and pursued vigorous activities at times, which also tended to produce pain flares.

A psychiatric assessment revealed major depression, with significant anxiety about facing a terminal illness, and grief issues of loss of body function and unfulfilled ambitions. She appeared to be using opioid analgesia in part as a way of coping with distress.

Her condition subsequently deteriorated over a short number of months and, though her opioid requirements remained high, she died peacefully at home with community palliative care support.

### **Discussion**

These 2 cases illustrate difficulties posed by real or apparent aberrant drug-taking behaviours. In case 2, pain was also poorly controlled, which I found distressing, given that good pain management is a cornerstone of palliative medicine.

Medically prescribed opioids are said to have low addictive potential, typically citing the landmark Boston Collaborative Drug Surveillance Project, which found only 4 cases of addiction out of 11,882 patients with no previous history of substance abuse who received at least one dose of opioid during an inpatient stay.

However, the risk is not negligible. Rates of abuse in patients treated with opioids for chronic non-malignant pain are probably at least as high as the general population. A recent study of 801 patients with chronic non-malignant back pain receiving daily opioid therapy disturbingly found a rate of opioid substance use disorder four times higher than the general population (3.8% vs 0.9%), although it could not be determined how many had the disorder before opioid therapy was commenced.

Prevalence of substance use disorders in the cancer population has not been widely studied, but rates of

0-7.7% have been found. It has been argued that, because pain clinicians still face a battle to destigmatise the use of opioids, which pose a barrier to their acceptance, the risk of addiction is deliberately understated. However, in my personal experience and that of more experienced colleagues, drug abuse in patients being treated for cancer pain fortunately does seem to be rare.

Case 1 had some identified risk factors for prescription drug abuse, including personal or family history of substance abuse, psychiatric co-morbidity and young age. Others, however, have found that past opioid or alcohol abuse or psychosocial testing fail to predict risk of abuse.

In light of this, Gourlay et al have developed "universal precautions" to inform opioid prescribing for chronic pain, including formulating a written contract specifying goals of care and defining consequences for aberrant drug-taking behaviour which may involve withdrawal of opioid therapy.

No written contracts were established in any of these cases before initiating opioid therapy, but it seems to me it would have been unduly burdensome on the patients to do so. There is a moral and ethical imperative to not withhold opioids from sufferers of cancer pain, and so establishing consequences for aberrant drug taking behaviour is extremely difficult. The 4 "A"s have been described as a tool for evaluating success of analgesic therapy: assessment of Analgesia, Adverse events, Activities of daily living, and Aberrant drug-taking behaviours. These, however, can be difficult to apply in the cancer population, as increasing pain and decline in function can be a result of disease progression, and adverse events may arise from factors other than opioid therapy.

"Pseudo-addiction," where drug-seeking behaviour can develop in response to inadequately treated pain, is important to diagnose; the significant issue being that the behaviour stops once pain is controlled.

I found the apparent aberrant drug-taking behaviours of Case 1 very challenging. I think my judgement was affected by a degree of prejudice towards her, common amongst doctors treating patients on methadone maintenance, who do not wish to be "duped", as well as lack of knowledge, including an erroneous belief that her maintenance methadone would provide adequate analgesia. In fact, patients on methadone maintenance programmes may experience greater pain than the general population. I was also placed in an invidious position of being asked to provide authority prescriptions for a controlled drug with increasingly greater frequency.

A balance between protecting the patient (and the

medical practitioner) against the consequences of abuse, and not imposing undue burdens on them needs to be reached. The weekly pick-up arrangement of her opioid medication worked well, and was not unduly burdensome, as she needed to pick up her methadone from the same pharmacy. Unfortunately, she subsequently developed a lung abscess, with increased pain requiring more frequent use of breakthrough medication. This put her at risk of running out of analgesia, and so required frequent (and time-consuming) review and liaison with her pharmacy.

Case 2 exhibited many aberrant drug-taking behaviours, which I believe led to her being unfairly regarded as a drug abuser. Clearly a substantial amount of her pain was "existential," and compounded by depression. She is probably best classed as a "chemical coper," defined as those who "occasionally use their medications in non-prescribed ways to cope with stress," with an "overly central place occupied by the procurement of drugs for pain." Certain associated features of chemical coping are described. "Alexithymia," the inability to connect with, process, or express feelings, was identified on psychiatric review of the patient.

Whilst not described in the literature, I speculate that the presentation of transmucosal fentanyl lozenges, which look not unlike lolly-pops, may especially appeal to young women. Her preference for the subcutaneous route I also speculate may relate to a non-analgesic therapeutic effect of injections themselves. Her chaotic lifestyle and non-adherence to medical recommendations, including limiting physical activity, was probably an important part of a teenager trying to complete developmental tasks in the face of extreme circumstances.

### Conclusion

A written contract with the patient is often established in treatment of chronic non-malignant pain before initiation of opioid analgesia, but this is often impractical in treatment of cancer pain.

Aberrant drug-taking behaviours in patients with cancer pain raise the need for a more in-depth assessment, including ensuring that pain is adequately treated to avoid pseudo-addiction, examining psycho-social factors including depression and existential distress, as well as evaluation of whether true addiction is present, which may need involvement of addiction medicine specialists.

Even if addiction is present, however, patients may not have the physical or emotional energy to participate in rigorous recovery programmes. The goals of care, therefore, may move to optimizing support, placing reasonable restrictions on access to opioids to protect patients and the wider community from harm, and optimizing symptom control.

The cases demonstrate that, in the setting of advanced cancer with unresolved existential, psychiatric or active addiction issues, these goals cannot always be met. It is a source of comfort to me, however, that, as disease enters a terminal phase, and the significance of these issues diminish, a peaceful death can be achieved with good palliative care.

## *The Palliative Care Clinical Studies Collaborative*

### Opening up Membership

The Palliative Care Clinical Studies Collaborative is a national initiative to improve the evidence base for the community availability for medications which do not have sufficient data for either registration or subsidy applications. Collateral benefits include building capacity in the palliative care clinical community for clinical research, improving the care that is offered as a collateral benefit of services participating in active, rigorous clinical research and better interacting with our peers and colleagues in other disciplines so that those patients who are not referred to palliative care have access to a wider range of symptom control medications than are currently available.

It is proposed that PaCCSC actively open up membership to prioritise subsequent studies which, among other funding streams, would seek competitive Category 1 funding.

Membership through its program would be at three levels.

- Full Clinical Researcher Membership
- Associate membership
- Invited experts

The benefits of membership would be:

- attendance at the Annual Scientific Meeting
- the ability to join trial sub-committees
- a quarterly newsletter with updates on studies
- the ability to collaborate actively with the largest networked palliative care clinical trials group nationally.

More information and membership form: Email Tania Shelby-James: [Tania.Shelby-James@health.sa.gov.au](mailto:Tania.Shelby-James@health.sa.gov.au)

### *Palliative Medicine Retreat in Hobart*

The Tasmanian Association for Hospice and Palliative Care & the Tasmanian Palliative Care Service invites palliative medicine specialists to a retreat in 2010 with the principal theme of Palliative and Supportive Care – the Interface.

Date: 4-5 March 2010                      Convenor: Dr Paul Dunne

Co-facilitators: Professor Michael Ashby and Professor Ian Olver.

More information including registration: [paul.dunne@dhhs.tas.gov.au](mailto:paul.dunne@dhhs.tas.gov.au)

### *Conference Update*

<p><b>3<sup>rd</sup> African Palliative Care Association Conference</b></p> <p><b>International Primary Palliative Care Research Group</b></p> <p><i>Date:</i> 15-17 September 2010</p> <p><i>Venue:</i> Windhoek, Namibia</p> <p><a href="http://www.apca.org.ug/index.php">http://www.apca.org.ug/index.php</a></p>	<p><b>The Impact of Pain</b></p> <p><i>Date:</i> 28-31 March 2010</p> <p><i>Venue:</i> Gold Coast, Queensland</p> <p><a href="http://dcconferences.com.au/apsnzps/">http://dcconferences.com.au/apsnzps/</a></p>
<p><b>Third National Palliative Care Education Conference</b></p> <p><i>Date:</i> 11-12 February 2010</p> <p><i>Venue:</i> QUT</p> <p><a href="http://www.pcc4u.org">www.pcc4u.org</a></p>	<p><b>Indian Association of Palliative Care Conference</b></p> <p><i>Date:</i> 12-14 February 2010</p> <p><i>Venue:</i> Hotel Sangam, Tiruchirappalli, Tamil Nadu, India</p> <p><a href="http://www.palcontrichy.com/main/index.php">http://www.palcontrichy.com/main/index.php</a></p>
<p><b>The Inaugural International Advance Care Planning Conference</b></p> <p><i>Date:</i> 22-24 April 2010</p> <p><i>Venue:</i> Melbourne, Victoria</p> <p><a href="http://www.internationalacp2010.com/">www.internationalacp2010.com/</a></p>	<p><b>6<sup>th</sup> Research Forum of the European Association of Palliative Care</b></p> <p><i>Date:</i> 9-12 June 2010</p> <p><i>Venue:</i> Glasgow, Scotland</p> <p><a href="http://www.eapcnet.org/research2010/index.html">http://www.eapcnet.org/research2010/index.html</a></p>
<p><b>13<sup>th</sup> World Congress of Pain</b></p> <p><i>Date:</i> 29 August-2 September 2010</p> <p><i>Venue:</i> Montreal, Canada</p> <p><a href="http://www.iasp-pain.org/AM/Template.cfm?Section=13th_World_Congress_on_Pain&amp;Template=/CM/HTMLDisplay.cfm&amp;ContentID=7940">www.iasp-pain.org/AM/Template.cfm?Section=13th_World_Congress_on_Pain&amp;Template=/CM/HTMLDisplay.cfm&amp;ContentID=7940</a></p>	<p><b>18<sup>th</sup> International Congress on Palliative Care</b></p> <p><i>Date:</i> 5-8 October 2010</p> <p><i>Venue:</i> Montreal, Canada</p> <p><a href="http://www.palliativecare.ca/en/index.html">http://www.palliativecare.ca/en/index.html</a></p>

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*Advertisement*

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**Palliative Care Consultant - Northern Territory Palliative Care Services**

Territory Palliative Care (TPC) is seeking to appoint a Palliative Care Consultant (1 FTE) for the Northern Territory, Australia, to assist in delivering high quality palliative care services to Top End Territorians.

TPC provides the only Specialist Palliative Care Service in the Northern Territory. Two interdisciplinary teams of health professionals (based in Darwin and Alice Springs respectively) provide a consultancy and case management service to a culturally diverse population, both within the hospital, hospice and community settings. This support is provided throughout the urban and rural settings and extends to all the remote areas of the Northern Territory, including off-shore islands and border regions with other states. The provision of a high quality service requires innovative and inclusive approaches to the delivery of palliative care in the Northern Territory. The Consultant would join the multidisciplinary team of highly skilled professionals that provide palliative care in the Top End, including in-patient, out-patient and domiciliary settings, both urban and rural/remote. Working at TPC encourages both professional and personal growth through broadening the way practitioners deliver palliative care. This is an exciting opportunity to make a significant difference in Palliative Medicine.

Key responsibilities for the Consultant include assisting in providing medical care to terminally ill patients in both in-patient facilities (Hospice and Royal Darwin Hospital) and within the community to ensure optimal comfort focused outcomes for clients referred to TPC. Participation in the 1:3 on-call medical rosters and assisting with supporting the Central TPC team in Alice Springs (as required) is essential to ensuring our patients have access to a 24 hour advice service for optimal symptom control. The Consultant would be encouraged to participate in quality activities for continuous service improvement and contribute to the enhancement of professional development within the team. It would be expected that the Consultant would be actively involved in teaching at all academic/non-academic levels.

The ideal candidate would hold either a Fellowship of the Royal Australian College of Physicians (specialising in Palliative Care) or the Chapter of Palliative Medicine or Royal Australian College of General Practitioners (or equivalent). A proven commitment to maintaining professional standards in Palliative Medicine and involvement in quality assurance activities are essential criteria, with a good teaching record.

Enquiries:

For further information, please contact Dr Maureen Mitchell (A/Director of TPC) either via email: [Maureen.Mitchell@nt.gov.au](mailto:Maureen.Mitchell@nt.gov.au) or on 0413 455 756.

