Substance Abuse Issues in Cancer Patients:

Passik and colleagues address an important and badly neglected issue in cancer care. Alcoholism has been reported to occur in 5% to 15% of the North American population, and drug abuse in approximately 5%. In hospitalized patients, the prevalence of alcoholism increases to approximately 20%. In 200 patients admitted to a tertiary palliative care program in a health care system providing universal access, the prevalence of alcoholism was 27%.

Passik et al appropriately discuss a number of reasons why the frequency of alcoholism may be lower among patients in some tertiary cancer centers. Unfortunately, probably the main reason for the low frequency of diagnosis of alcoholism and drug addiction among cancer patients is underdiagnosis.

Between 66% and 75% of patients identified as alcoholics in prospective studies had not been diagnosed before, even though many of these patients had been admitted to hospitals for diseases that are normally recognized as complications of chronic alcohol abuse. Passik et al also review the difference between tolerance and addiction. Although these phenomena frequently coincide in patients who "cope chemically" and are a common source of severe neurotoxicity, both tolerance and addiction are independent prognostic factors for poor pain control and should not be considered synonymous.

"Chemical Coping"

Our group shares the authors' concern about the term "addiction." A working definition frequently used by our group is "chemical coping." This definition allows the clinical team to "quantify" the patients' intake of alcohol or other drugs on a scale that spans the two extremes of complete abstinence and "total addiction" or "substance dependence," as defined by the *Diagnostic and Statistical Manual for Mental Disorders* IV (DSM-IV). Most adults fall somewhere between the two extremes, and therefore, one needs to establish the degree of chemical coping and the role of alcohol or drugs in the coping strategy of the vast majority of cancer patients.

The authors appropriately comment on the inadequacy of the DSM-IV criteria within the context of advanced cancer. Psychooncologists need to assume increased leadership in defining diagnostic criteria for psychosocial conditions in advanced cancer. This applies not only to substance abuse but also to delirium and severe psychosocial distress associated with terminal illness that does not meet DSM-IV criteria for anxiety or depression.

**Methadone as an Analgesic**

The authors discuss the difference between the use of methadone for maintenance in opioid addicts and its role as an analgesic. It is important to stress that the doses used for maintenance of addicts are much lower and undergo much less variation than those used for cancer pain. In addition, recent evidence suggests that methadone is much more potent than other opioid agonists. For these reasons, physicians who have received training only in methadone maintenance should not attempt to use methadone as an analgesic for cancer pain. Ideally, patients who require methadone analgesia should be referred to palliative care or cancer pain experts.

**Important Practical Recommendations**

The review contains a number of important practical recommendations. Perhaps, the most relevant of these relates to the importance of taking a substance use history. The CAGE questionnaire takes only a few minutes to complete and can be performed by the nursing staff or even volunteers. This test is more useful in screening for alcohol abuse than the assessment done by a physician during the course of an inpatient or outpatient visit and at least as effective as a multidisciplinary palliative care team intervention.
Benefits of Substance Abuse Screening and Counseling in the Terminally Ill

The purpose of palliative care is to control distressing symptoms and to allow patients to fulfill their maximal physical and psychosocial potential. In this context, many oncologists may wonder what type of contribution substance abuse screening and management can make at the end of life. Two prospective studies by our group found that, in cancer patients seen in a cancer center, a history of alcohol or drug abuse was an independent poor prognostic factor for pain control.[6,7] These patients underwent a regular medical and nursing assessment. No specific tools were employed to screen for alcoholism or drug abuse, and no specific counseling program was in place for patient management. At the end of a 3-week follow-up period, alcoholic patients complained of a higher intensity of pain, were receiving higher doses of opioids, and developed neuropsychiatric toxicity more frequently than did nonalcoholic patients.[3,4]

After a screening process (CAGE questionnaire or multidisciplinary assessment) was regularly performed and a management strategy was implemented, both opioid dose and pain intensity did not differ between alcoholic and nonalcoholic patients.[2] In summary, these studies demonstrate that a program of screening and counseling regarding substance abuse can improve the quality of life of patients and their families.

As discussed above, chemical coping is a frequent problem in cancer patients that is frequently underdiagnosed. Patients in whom chemical coping is identified early in the course of their illness should be referred to a palliative care or cancer pain programs when such programs are available. In settings where these services are not available, the practical recommendations of Passik et al should empower clinicians to improve the care of these very complex patients and their families.

References:

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