11th Annual Palliative Care Summit

Communicate
Collaborate
Innovate

Building Partnerships in Palliative Care
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Brief Opioid History

- Derived from opium poppy (*Papaver somniferum*)
- Natural components include morphine and codeine
- Recognized for their analgesic and euphorogenic properties from ancient times
- Tolerance, dependence, addiction potential also identified centuries ago
- Very useful in the field of medicine
  - The best treatment for most types of pain
  - Excellent for treatment of dyspnea—we know this in hospice/palliative care
    - Unlikely to cause respiratory depression in therapeutic doses
    - More dangerous when combined with benzodiazepines
  - Also useful and often prescribed for cough, diarrhea
  - Side effects include constipation, nausea, somnolence, pruritus
    - Saunders: “The hand that writes the opiate prescription should also write the laxative”
Brief Opioid History

• Perennial search for safer, less addictive modified or synthetic alternatives (e.g., heroin, pentazocine, methadone)
  • Has not really been a success, but some very potent agents have been developed (e.g., fentanyl)
• Controlled Substances Act of 1970
  • The most potent legal opioids (fentanyl, morphine, oxycodone, others) are C-II, cannot be phoned in and cannot be refilled
  • Hydrocodone combinations were reclassified as Schedule II
  • Only codeine combinations, tramadol, mixed agonist/antagonists, antidiarrheals not C-II
    • Note that buprenorphine (including Subutex/Suboxone), nalbuphine, others are C-III
  • Heroin and illicit fentanyl derivatives are Schedule I (no legally recognized use in U.S.)
• New Rx forms will be required for all controlled substances HSC 11162.1, sequential numbers, etc.
• In California, HSC 11159.2 exemption can be used to write Rx for terminally ill patients on nonconforming Rx blank (terminal = life expectancy < 12 months)
Great Article on Opioids by Andrew Sullivan (NY Mag.)