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Attendee's questions:

1) **I use methadone for hospice and outpatients with chronic pain. Is methadone more problematic than other opioids? I think it is an effective long acting opioid.**

   Marsha Farrell (MF): Methadone is a wonderful opioid choice to use with hospice patients. But having said that, you must carefully select patients for use of this drug. Methadone is a *"different type of animal"* and I would only use it if the nurses and prescribing physicians are familiar with the unique pharmacokinetic and pharmacodynamics of this opioid. Conversions for this opioid are ALSO non-linear and unique.

   Pts that I would NOT USE Methadone with are: patients with a history of non-compliance; patients who live alone (need a caregiver to help monitor pt. responses); patients with cognitive impairment (unless a reliable caregiver is present and administering patient's medications) AND I would not use methadone with a patient who has family members and folks in and out of the house with a history of abuse.
   I love methadone as a second or third-line choice to rotate to. Dr. Jim Joyner with Outcome Resources has a wonderful webinar class on methadone. Look it up on their website. I also teach a class entitled: Methadone: Are You Prepared to Use It?

2) **Is there a step-wise bowel regimen that she has found effective with short and long-term opioid patients?**

   MF: YES! I'm familiar with a Laxative protocol that is found in the Oxford Textbook of Palliative Nursing, 3rd edition, Edited by Betty R. Ferrell and Nessa Coyle. P 275. (There is a newer addition than my 2010 copy.) The protocol titrates Senokot S step-wise. (Beginning dose for an adult is typically Senokot S 2 tablets at bedtime.)

   I like this protocol because on Day 3 if NO BM, the nurse is required to r/o an impaction. If on Day 3 if No BM and patient is NOT IMPACTED another laxative with a different mode of action is added to the protocol. Outcome Resources newsletter *"The Clinician"* has some good articles on treating constipation. Look for back issues.

3) **Does she recommend provigil for sedation with opioids?**

MF: I have never heard of using this drug for unintentional opioid-induced sedation. In fact, I just looked at the website http://www.provigil.com/hcp/ and read this: "PROVIGIL is indicated to improve wakefulness in adult patients with excessive sleepiness associated with narcolepsy, obstructive sleep apnea (OSA), or shift work disorder (SWD)." No mention of an indication for use with opioid-induced sedation.

I did not mention this during the webinar but when you have a patient showing signs of sedation, look for other sedating medications that he/she is taking. Often hospice patients are on a benzodiazepine and other sedating meds which are compounding the drowsiness. The FDA recently published a warning about combining benzodiazepines with opioids.
See the FDA's warning:
http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm518697.htm

4) **Regarding safety protocols with seniors, do you recommend dose reduction and also still consider a longer interval for seniors?**

MF: YES, initially. Remember, the reason for dosing an IR opioid less frequently is because changes in liver& kidney function. The liver is metabolizing the opioid slower and the kidneys are eliminating the drug slower due to decreasing creatinine clearance.

5) **When doing opioid rotation, we need to consider about incomplete cross-tolerance but you also mention if pain was poorly controlled, may consider using the dose without reduction. In this case, what things we need to consider other pain scale to ensure we are not giving too much of the new opioid?**

MR: If your hospice team is rotating an opioid secondary to unrelieved pain, then find an equivalent dose of another opioid. You know that the dose of opioid #1 DID NOT relieve the pain adequately. Hopefully, the patient will be more sensitive (i.e.not completely tolerant) to the new opioid #2.

Remember, you still have to monitor the patient's response just like you would if you were beginning an opioid. Titrate up OR down according to the individual's response.

***What if the hospice nurse made a titration upward per orders… NO response; another titration upwards… NO response… another titration… No response. Obviously this opioid isn't working. When rotating, the nurse should consider going back to the opioid dose before the series of titrations, find the equivalent dose of a different opioid and titrate as needed. Also, consider Opioid-induced hyperalgesia in this case.

Thanks for the great questions! Feel free to contact me at
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