END OF LIFE CARE FOR PATIENTS WITH SUBSTANCE USE DISORDERS

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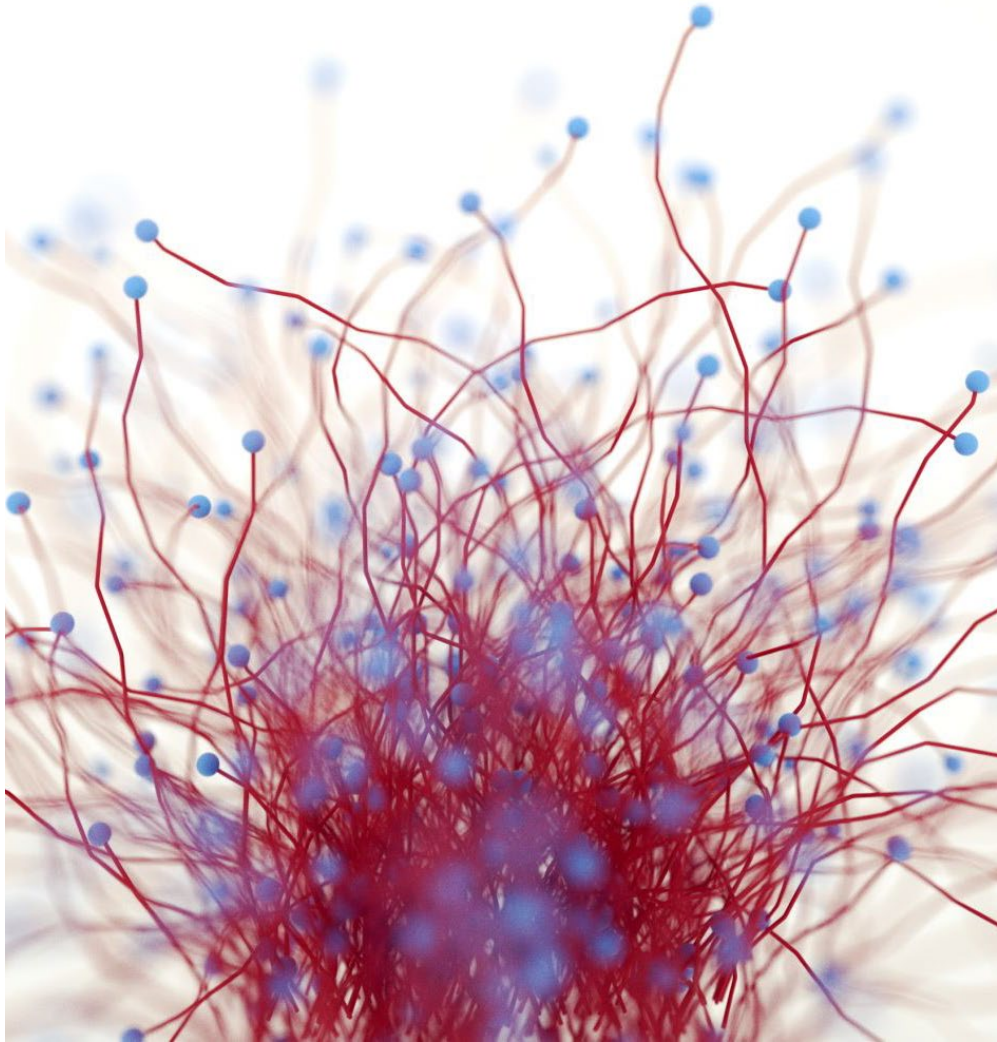
STIGMA

Mindful of end of life reflection and considerations

Especially dependent on cause may have significant guilt

Encourage connections with previous support system

Monitor mental health!



OPIOID USE DISORDER

OPIOID USE DISORDER & PAIN (ACUTE OR CHRONIC)

- Continue to utilize non-opioid modalities if possible and optimize these

- Change in mobility and addition of comfort care meds likely to add to constipation and urine retention

- Are having pain meds available triggering?
  - How can we support this?
    - Longer acting medications?
    - Narcan in house
    - Administration/ short Rx/ delay open boxes

OPIOID USE DISORDER & PAIN

Patients on methadone	Patients on buprenorphine
• May need dose increases/ split dosing as tolerance builds and pain worsens • Constipation is incredibly common	• Maintain buprenorphine dose as long as possible • Will likely need higher dose opioids • Consider long acting (full agonist) opioid transition • Watch for withdrawal symptoms closely

OPIOID USE DISORDER & ALTERED MENTAL STATUS

- Consider lower doses before discontinuing MOUD
- Ensure evaluation for other possible contributors
- If discontinuing methadone- consider length of half life, watch for extended time withdrawal symptoms (may present differently)
- If discontinuing buprenorphine- may be challenging to restart depending on regimen
- What if they can't remember if they've taken their MOUD anymore?

OPIOID USE DISORDER & RESPIRATORY FAILURE

- Again consider a dose decrease here- small changes if possible especially with buprenorphine
- Monitor when combining with benzodiazepines
- Hard differentiation of anxiety vs withdrawal symptoms vs organic respiratory worsening

ALCOHOL USE DISORDER

ALCOHOL USE DISORDER & CIRRHOSIS

- Often complicated mental health component, may be dealing with complex feelings from loved ones
- Confusion and decreased inhibitions may bring back old cravings/ patterns and habits
- Likely can no longer tolerate naltrexone which may have been a support for them
- Often a very visible disease

ALCOHOL USE DISORDER & B1 DEFICIENCY

- Wernicke's Encphalopathy-
  - Acute condition
  - Symptoms: confusion, gait, ataxia, oculomotor dysfunction
  - Treatable with IV thiamine
  - Residual effects are common
- Korsakoff Syndrome-
  - Long term memory loss from #1
  - Confabulation common (often cog and social processing intact initially)
  - Irreversible

ALCOHOL USE DISORDER & DEMENTIA

- Not uncommon for cravings/ habits to return as dementia progresses
  - Nonalcoholic beverages of choice
  - Attention to the times of day they typically would have alcohol
- Isolation from even early dementia can cause return to drinking

ACTIVE ALCOHOL USE DISORDER

- Quality of life considerations
- Safety with comfort meds?
- Naltrexone and opioids
  - Consider low dose gabapentin swap
- Safety plan with patient and families
- Withdrawal management support