Methadone as adjunct rather than replacement analgesia

Audit by Julita Shahab and Prof Derek Willis

Background

At Severn Hospice, oral methadone is used as an adjunct to opioid analgesia to manage complex pain. This includes neuropathic or mixed nociceptive cancer-related pain. Patients are assessed carefully prior to treatment and suitable candidates are admitted to the hospice.

Methadone is introduced at a low dose. As the methadone is increased, the existing opioid is reduced by 20%. Opioids are never discontinued.

The aim of the audit was to look at the safety and efficacy of this method of pain control and to review our internal guideline.

Method

The audit was conducted over 12 months (1/8/19 to 31/7/20). Eleven patients who were commenced on methadone during that time, were identified. We were keen to know:

- if methadone was started as inpatient or in clinic?
- was an ECG done prior to starting methadone?
- the starting dose of methadone
- if methadone was started as an inpatient, how long was the inpatient stay?
- did the patient and GP get methadone information leaflet when methadone was started?
- how long did the patient continue on methadone and how frequent was readmission whilst they were on methadone?
- was oral methadone swapped to subcutaneous infusion?

Results

- Methadone was started during inpatient admission and was followed up by a consultant on discharge (two patients died, when methadone was initiated at day ten and 12). The length of stay varied between a few days to a few weeks (< 3 weeks). All patients were offered a patient information leaflet when methadone was started, and on discharge GPs were forwarded the Methadone Prescribing Guidelines.
- ECGs were done on half of the patients prior to treatment and were never repeated. There was no report of any cardiac complications during treatment. In fact, out of the 11 patients, one experienced nausea and another headache. Both side-effects settled and methadone was never withdrawn.
- The starting dose of methadone was mostly 1mg BD, but two patients had 2mg BD. The highest dose used was 20mg BD, for only one patient and this patient was swapped to subcutaneous methadone as they approached end of life. The other five patients who had died, during the period of the audit, oral methadone was just discontinued towards end of life.
- At the end of the audit (31/7/20), five patients were still alive. They have been on methadone between three and ten months.

Conclusion

Oral methadone, as an adjunct to opioid analgesia, helps improve pain control. It is safe and cheap. However, choosing suitable patients is important.

The hospice guidelines were amended based on this audit.

α. The starting dose of methadone is now 2mg BD.

β. ECG is no longer done when methadone is initiated.

χ. Our local Clinical Commissioning Group does not approve of methadone being initiated in the community; methadone still needs to be started as an inpatient. (However, it is safe, so there is a possibility of starting methadone in outpatients) .

δ. To continue offering patients, information leaflets and forwarding GPs the prescribing guidelines. All patient must be followed up by a consultant in outpatients on discharge.

ε. Subcutaneous methadone is not necessary apart from certain situations.

References:

- McPherson et al. Safe and Appropriate Use of Methadone in Hospice and Palliative Care: Expert Consensus White Paper. Journal of Pain and Symptom Management. Vol 57. No 3. March 2019
- palliativedrugs.com/download/methadoneguidelinesseptembernewsletter
- SPAGG Guidelines – Methadone for Adults with Pain in Palliative Care. December 2019
- Poulain et al. Efficacy and Safety of Two Methadone Titration Methods for the Treatment of Cancer-Related Pain: The EQUIMETH2 Trial (Methadone for Cancer-Related Pain). Journal of Pain and Symptom Management. Vol 52, No 5. November 2016
- Palliative Care Formulary 6th Edition pg 437-442. Palliativedrugs.com

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