

Opioid Allergic Reactions #175

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PATIENT REPORTS OF OPIOID “ALLERGIES” are common, most often due to symptoms of nausea, vomiting, itching, hypotension, or constipation. This *Fast Fact* reviews signs, symptoms, and management options of opioid allergies and pseudo-allergies.

Allergies can be defined as an exaggerated immune reaction to an antigen. There are different types of allergic, or hypersensitivity, reactions (immediate, cytotoxic, immune complex, and delayed), but the common feature is that all such reactions are mediated by the immune system. In contrast, the vast majority of opioid side effects are not immune related. Opioid side effects can be divided into three categories: those that have no element of an immune reaction, those that mimic an immune reaction, and those that are immune mediated.

- **Side effects with no immune mechanism**—these include nausea/vomiting, constipation, sedation, delirium, respiratory depression, and urinary retention.
- **Side effects that mimic immune reactions**—common signs/symptoms include mild itching, urticaria, bronchospasm, or hypotension. Note: if all these occur soon after an opioid dose and the patient appears acutely ill, this may represent an anaphylactoid reaction (see below). For most patients, these symptoms are mild and self-limited. The etiology most commonly involves direct mast cell degranulation with histamine release, unrelated to a true immune-mediated reaction. Such reactions to opioids are usually idiosyncratic and may or may not recur with rechallenge of the same opioid. They are not a contraindication to continued opioid use, since an al-

ternative opioid may be well tolerated. Hypotension can also occur due to arterial and venous vasodilation, and thus hypotension is more common in a volume depleted patient. Opioids can also have negative inotropic effects and induce a vagally mediated bradycardia leading to hypotension; again, not a true allergic reaction.

- **Immune-mediated reactions**—allergic dermatitis to opioids has been described, characterized as erythroderma, scarlatina, eczema, or exudative vesicular eruptions; these may represent a type IV (delayed) hypersensitivity reaction. Patients can undergo diagnostic patch testing for confirmation.
- **Anaphylaxis/anaphylactoid reactions**—anaphylaxis is a systemic immunoglobulin E (IgE)-mediated reaction resulting in the immediate release of potent mediators; anaphylactoid reactions are clinically the same, but not IgE mediated. Early symptoms include nasal congestion, flushing, pruritus, angioedema. If the process worsens, patients can develop nausea, diarrhea, urinary urgency, bronchospasm, hypotension, and death. Opioids can lead to an anaphylactoid reaction, but such events are very rare.

MANAGEMENT

True allergic reactions appear to be very rare. If you suspect an immune-mediated skin rash you should consult with a dermatologist or allergist to establish a definitive diagnosis and determine the need for desensitization, or to help identify appropriate alternatives. Anaphylactoid reactions require emergent man-

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agement with epinephrine and histamine blockers. For milder histamine-related symptoms, common practice is to rotate to an opioid in a different pharmacologic class (see below) along with use of antihistamines or steroids. Anecdotal reports suggest that methadone and fentanyl cause fewer instances of itching.

<i>Opiate class</i>	<i>Drugs</i>
Phenanthrenes	Morphine; codeine; hydrocodone; oxycodone; oxymorphone; hydromorphone; levorphanol.
Phenylpiperadines	Fentanyl; meperidine; sufentanil; remifentanyl
Diphenylheptanes	Methadone; propoxyphene

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Professional-Patient Boundaries in Palliative Care #172

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BOUNDARIES IN PATIENT CARE are “mutually understood, unspoken, physical and emotional limits of the relationship between the trusting patient and the caring physician or provider.” Health professional boundaries represent a set of culturally and professionally derived rules for how health care providers and their patients interact. Boundaries serve to establish and maintain a trusting provider–patient relationship and help clinicians main-

tain “justice and equity in dealing with all of their patients,” not only a special few. This *Fast Fact* reviews issues in health professional-patient boundaries in palliative care.

In caring for seriously ill or dying patients it is common for strong emotional bonds to develop. However, when the limits of the provider–patient/family relationship are not clear or where normal professional boundaries are not respected, problems are likely to

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arise. Common reasons for boundary problems include:

- Personality styles or psychiatric disorders in which normal boundaries are not recognized or respected.
- Health professional stress/burnout (see *Fast Facts* #167–170).
- Cultural misunderstandings.

Warning signs and examples of potential boundary blurring include:

- Gift giving from/to patient/family;
- Patients having or wanting access to provider's home phone number, or other personal information;
- Patient/family expectations that the provider will provide care or socialize outside of clinical care settings;
- Patient/family requests that the provider participate in prayer (See *Fast Fact* #120);
- The health care provider revealing excessive personal information with patient/family.

Note: Not all boundary issues are detrimental to the provider–patient relationship: some clearly enhance compassionate care and serve to reinforce a trusting therapeutic relationship. However, it is important for the provider to self-reflect when boundaries are approached:

- Am I treating this patient or family differently than I do my other patients?
- What emotions of my own does this patient/family trigger and are the emotions impacting my clinical decision-making?
- Are my actions truly therapeutic for the patient, or am I acting in a manner to meet my personal needs?
- Would I be comfortable if this gift/action was known to the public or my colleagues?
- Could this boundary issue represent a sign that I am experiencing professional burnout?

MANAGING BOUNDARY CONCERNS

- Set clear expectations with patients and families as to your role in the context of their care, your availability, and best ways to communicate with you.
- Use professional colleagues or a mental health professional as a sounding board when you are uncertain about your own or your patient/family behaviors.
- Address issues as they arise with the patient/family; acknowledge importance of feelings, emphasize the provider–patient relationship and the importance of maintaining objectivity; emphasize that the rejection of a requested behavior does not imply a lack of caring.
- Seek professional counseling for yourself or the patient/family when boundary issues impact your ability to provide objective, compassionate care.

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