Opioid side-effects management

General Approach to Treating Opioid Adverse Effects

- Distinguish opioid side effects from co-morbid conditions or other concurrent medication.
- Reduce the dose of the opioid if the pain is well controlled. If pain not controlled:
- Add a non-opioid co-analgesic (NSAID for MSK pain)
- Add a specific adjuvant pain medication (gabapentin for PHN)
- Target the source of the pain (hip replacement for severe osteoarthritis)
- Regional anesthetic or ablative neurosurgical techniques (radio-facet neurotomy)
- Symptomatic treatment of the adverse effect (see below)
- Switch opioids to see if another opioid has a better balance of analgesia vs. adverse effects
- Switch the opioid route from oral to parenteral or intraspinal (if available)

1. Constipation

Almost all patients will get some degree of constipation initially

– the best strategy: anticipate and prevent!
– consider other causes – medications, metabolic, pathophysiologic
– all patients should be on >20 gm fiber diet & 4-6 glasses of water +/- 6-12 prunes daily
– (1 bowl All Bran cereal=18 gm fiber; flax seed raw or in baked goods is a natural laxative)
– initially, all patients should be started on regular laxative therapy (usually a stool softener such as docusate sodium – 1 tab bid up to 2 tabs tid plus a stimulant laxative (e.g., senna – 2 tabs qhs up to 8 tabs/day)). Early on, it is better to keep patients somewhat "loose" rather than allow severe constipation to occur. If the patient develops diarrhea, the stimulant laxative should be discontinued first.

For more resistant constipation try the following in an additive, stepwise progression:

1. Lactulose – start 15mL bid up to 30mL tid po or Milk of Magnesia – 30 to 60mL daily
2. Magnesium citrate (8 oz po) or colonoscopy prep solution 1-2 liters po prn
3. Fleet regular enemas bid for short-term use only
4. Fleet oil-retention enemas or high volume saline enema +/- mineral oil pr for impacted stool

5. If no bowel movement in 96 hrs, perform a rectal examination to R/O impaction.
6. Oral Naloxone – start 0.8 mg bid po and titrate to effect or to withdrawal symptoms (two non-absorbable, gut-selective, mu antagonists may soon be available)
7. Temporarily decrease the dose or stop opioids until evacuation occurs

– the patient should be taught to adjust the above regimen to have a stool at least every 2-3 days with minimal abdominal bloating
– contrary to what has been taught, many patients do develop tolerance to the constipating effects of opioids but very slowly – sometimes after 1-2 years of stable dosing.

2. Nausea

– occurs in 50-70% of patients, often passes within 1-2 weeks, worse when patient upright
– if patient very sensitive: prescribe antiemetic(s) routinely when starting opioids
– titrate the dose of opioid very slowly
– if nausea recurs during therapy, make sure that the patient is not constipated *****
– try dimenhydramine 25-50 mg po or 50-100 mg pr q 4-6 hr prn
– next try haloperidol 0.5-5 mg po to bid (usual dose: less than 2 mg/day)
– next try prochlorperazine 5-10 mg po or pr q 4-6 hr prn
– next try or add metoclopramide or domperidone 10-40 mg po (esp. if gastric motility decreased)
– try transdermal scopolomine patch, one applied every 2-3 days
– if intolerable nausea, try switching to another opioid
– some patients will continue to have 1-2 hours of nausea after each dose – lying down may help

3. Sedation

– mild sedation occurs in most patients on opioids when first starting or with dosage titration
– it usually decreases with stable dosing within 7-14 days if the dose is correct
– methadone-induced sedation may take longer to clear
– therefore *no driving or dangerous machinery use while titrating dose:* If patient not compliant advise the Ministry of Transport
– prolonged drowsiness should cause you to search for and stop all other sedating medication
– if drowsiness still persists, try lowering the opioid dose or switch opioids
– in cases of persistent drowsiness with good analgesia, a cautious trial of psychostimulants (Ritalin or Dexedrine or Modafenil) may be attempted.