Frimley Health and Care

OPIOID INDUCED CONSTIPATION	
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Clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use across Frimley Health and Care ICS only. Any use outside this location will be at the risk of the individual using it.	

OPIOID INDUCED CONSTIPATION

Constipation is the passage of small hard faeces infrequently or with difficulty and less often than is normal for the individual. Constipation can cause unpleasant symptoms including abdominal pain, distension, nausea and vomiting. In debilitated patients it can contribute to distress and agitation. ALL Patients commencing opioids should also routinely be started on laxatives prophylactically[1].

- All opioids will cause constipation (methadone, fentanyl and buprenorphine are possibly less constipating).
- Tolerance to this effect does not develop
- Consider patient preference – titrate up preferred laxative if constipation occurs
- Patients should be advised that regular laxative use is required to avoid opioid induced constipation
- Lactulose requires a high fluid intake to be effective and can cause flatulence and abdominal distension, for this reason it is not the treatment of choice.

An inadequate response is defined as opioid-induced constipation symptoms of at least moderate severity in at least 1 of the 4 stool symptom domains (incomplete bowel movement, hard stools, straining or false alarms) while taking at least 1 laxative class at least 4 days during the prior 2 weeks).

Laxative Choice	Products
Stimulant +/- softener	Senna: Tablets 7.5mg or oral solution 7.5mg/5ml Docusate 100mg capsules or oral solution 50mg/5ml.
Osmotic laxative	Macrogol (Laxido /Movicol/Cosmolol) 1 – 3 sachets daily
Rectal treatment	Bisacodyl suppository 10mg Sodium citrate Micro enema 5ml Phosphate enema 100ml Glycerol suppository 4g Arachis oil enema 130ml AVOID IN PEANUT ALLERGY
Peripheral Mu opioid receptor antagonist drugs (PAMORA). Contraindicated if risk of GI perforation. Avoid in severe hepatic impairment. Interaction with CYP450 inhibitors will increase PAMORA levels; levels reduced with CYP450 inducers e.g., Carbamazepine, Rifampicin, St John's wort.	Specific will only reverse opioid induced component. Naloxegol 25mg once daily – reduced to 12.5mg once daily in renal impairment or if concomitant use of CYP450 inhibitors (e.g., clarithromycin, itraconazole) Naldemedine 200micrograms daily – no dose reduction in renal or hepatic impairment[3].

The guidance above applies to all patients prescribed opioids for any opioid responsive pain. See below for specific guidance in debilitated or severely frail patients.

Key differences from usual care in debilitated patients:

Constipation in palliative patients is multifactorial and an opioid alone is seldom the only cause, hence switching to a 'less constipating opioid' does not make therapeutic sense.

- Lifestyle advice alone (e.g., diet, fluid) is usually inadequate: laxatives are generally required. Good fluid intake should be encouraged,
- Consider medication review – other medication may contribute to constipation – anticholinergic drugs, diuretics.
- Low fluid intake reduces benefit of osmotic agents.
- Patients may assume that reduced dietary intake will reduce frequency of defaecation. Whilst volumes may alter, the aim is still to maintain a regular bowel habit.
- Aim for comfortable defecation rather than any particular frequency.

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Management of Opioid induced Constipation

All patients prescribed opioids should have prophylactic laxatives prescribed regularly.

Senna 7.5mg -15mg at night

Or

Macrogol One sachet daily

Patient preference will dictate choice

Inadequate

Senna

Titrate up to a maximum of 30mg tds

If hard stools add softener Docusate sodium 100mg bd

Macrogol

Titrate up to 3 sachets daily

Bowels not opened for >3 days, rectal discomfort, or faecal impaction

Consider rectal exam +/- rectal intervention

Soft Loading

1. Bisacodyl suppository 10mg

2. Phosphate or Sodium Citrate enema

Hard loading

1. Glycerol 4g suppository followed by Bisacodyl Suppository

Very hard loading

2. Arachis Oli enema followed by phosphate enema

Constipation not responding to the above and primarily opioid mediated:
Peripheral Mu opioid receptor antagonist drugs (PAMORA).

1. Naloxegol 25mg once daily – reduced to 12.5mg once daily in renal impairment or if concomitant use of CYP450 inhibitors (e.g., clarithromycin, itraconazole).
2. Naldemedine 200micrograms daily – no dose reduction in renal or hepatic impairment

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References

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