



2019

21-23 JUNE

SAN FRANCISCO

SUPPORTIVE CARE
MAKES EXCELLENT
CANCER CARE POSSIBLE

Opioid-induced bowel dysfunction

MASCC/ISOO

Annual Meeting on Supportive Care in Cancer

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MASCC
Multinational Association
of Supportive Care in Cancer

ISOO
INTERNATIONAL SOCIETY
OF ORAL ONCOLOGY



#MASCC19

Disclosures

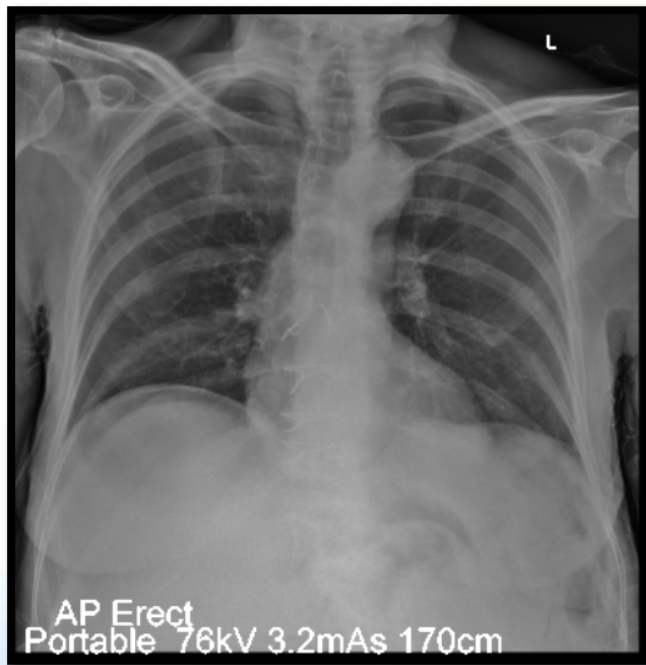
I have received honoraria for speaking at satellite symposia from Astra Zeneca, Kyowa Kirin, and Wyeth Pharmaceuticals.

I have received honoraria for attending advisory boards from Astra Zeneca, Kyowa Kirin, Shionogi, and Wyeth Pharmaceuticals.

I have received research funding from Kyowa Kirin.



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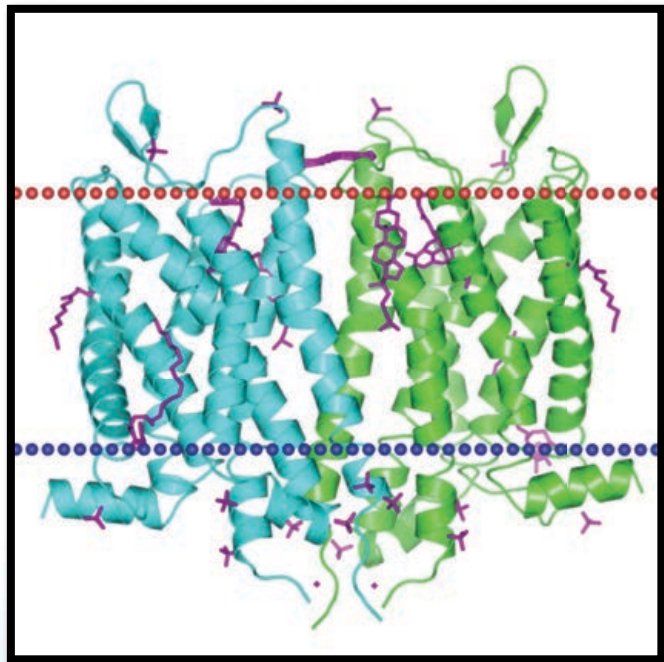




BACKGROUND



Introduction



- ❖ Endogenous opioids regulate GI tract function
- ❖ Mu opioid receptors occur throughout enteric nervous system (myenteric plexus, submucosal plexus)

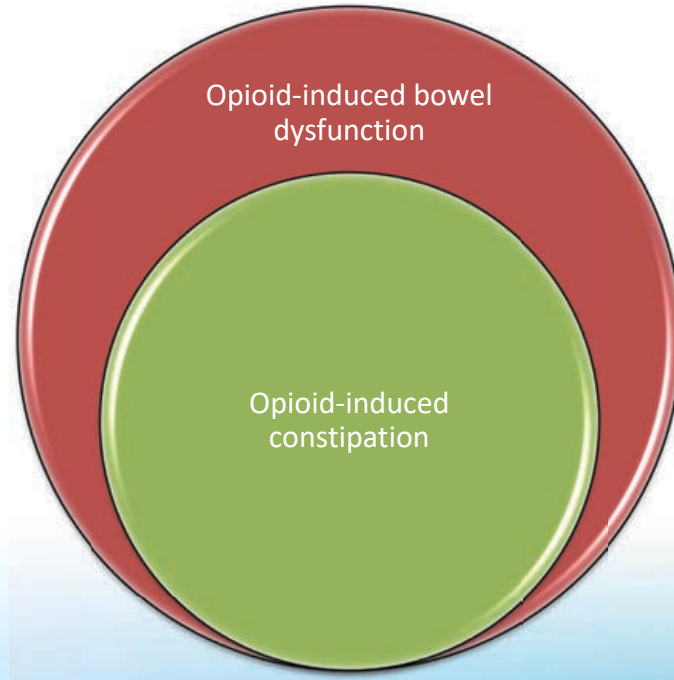


Introduction

Opioid-induced bowel dysfunction (OIBD)
≠
Opioid-induced constipation (OIC)



Introduction



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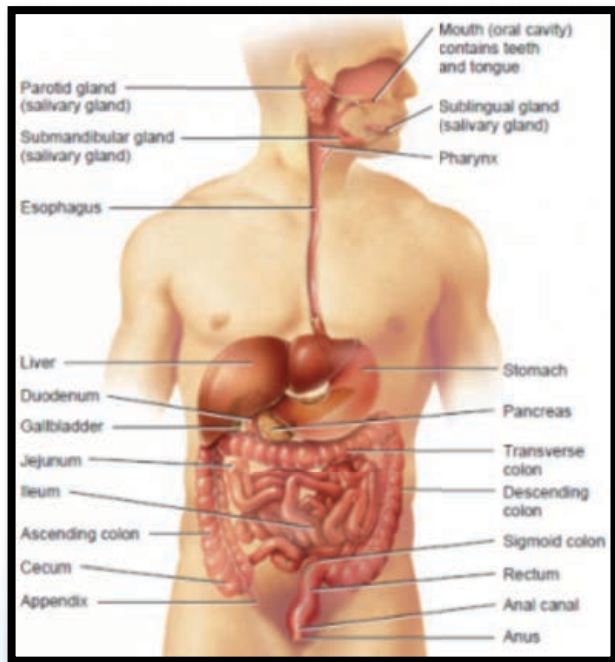
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Introduction



Opioid-induced bowel dysfunction:

- ❖ Salivary gland dysfunction
- ❖ Oesophageal dysfunction
- ❖ Gastroparesis
- ❖ Sphincter of Oddi dysfunction
- ❖ Other problems

Narcotic bowel syndrome
(central effect)





OPIOID-INDUCED CONSTIPATION



Introduction



Functional constipation
≠
Opioid-induced constipation (OIC)



Opioid-induced constipation

Pathophysiology:

- ❖ Decreased small bowel motility
- ❖ Decreased water & electrolyte secretion small bowel
- ❖ Increased tone ileocaecal valve
- ❖ Decreased large bowel motility
- ❖ Increased water & electrolyte absorption large bowel
- ❖ Increased tone anal sphincter
- ❖ Reduced anorectal sensitivity (to distension)



Opioid-induced constipation

Rome IV diagnostic criteria:

- ❖ New or worsening symptoms of constipation when initiating, changing, or increasing opioid therapy that must include 2 or more of the following:
 - a) straining during $> \frac{1}{4}$ (25%) of defaecations
 - b) lumpy or hard stools (BSFS 1-2) $> \frac{1}{4}$ (25%) of defaecations
 - c) sensation of incomplete evacuation $> \frac{1}{4}$ (25%) of defaecations
 - d) sensation of anorectal obstruction/blockage $> \frac{1}{4}$ (25%) of defaecations
 - e) manual manoeuvres to facilitate $> \frac{1}{4}$ (25%) of defaecations



Opioid-induced constipation

Rome IV diagnostic criteria:

- ❖ New or worsening symptoms of constipation when initiating, changing, or increasing opioid therapy that must include 2 or more of the following:
 - f) fewer than 3 spontaneous bowel movements per week
- ❖ Loose stools are rarely present without the use of laxatives



Opioid-induced constipation

Epidemiology:

Common



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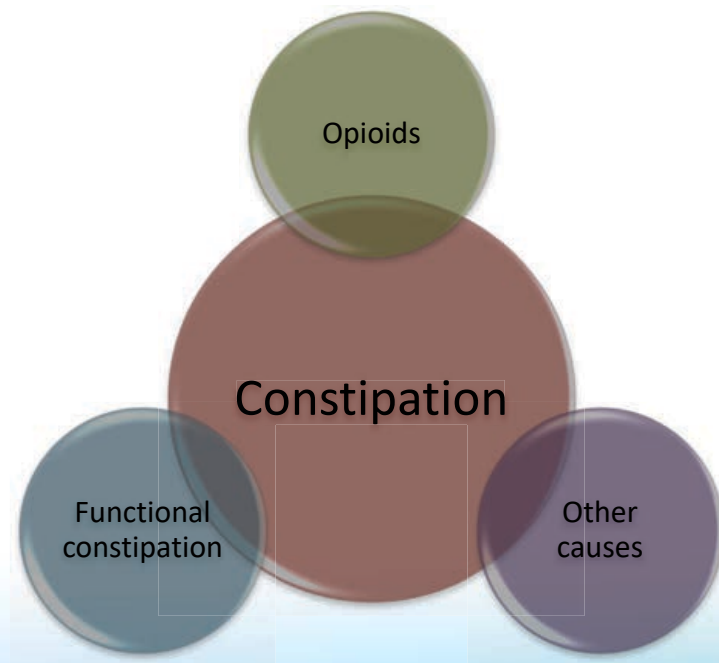
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Opioid-induced constipation



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Opioid-induced constipation

Clinical features:

- ❖ Abdominal pain
- ❖ Anorexia
- ❖ Early satiety
- ❖ Nausea
- ❖ Vomiting
- ❖ Abdominal distension
- ❖ Diarrhoea (“overflow”)



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Opioid-induced constipation

Clinical features:

- ❖ Flatulence
- ❖ Halitosis
- ❖ Heartburn
- ❖ Intestinal obstruction
- ❖ Intestinal perforation
- ❖ Anal fissure
- ❖ Haemorrhoids



Opioid-induced constipation

Clinical features:

- ❖ General malaise
- ❖ Confusion
- ❖ Headache
- ❖ Pulmonary embolism
- ❖ Urinary retention



Opioid-induced constipation

Clinical features:

- ❖ Psychological problems
- ❖ Social problems

- ❖ [Health economic burden]



Opioid-induced constipation

“When I am faced with taking a pain med, I will always think about the constipation that might result, and so I will try to take the smallest dose possible or do without”

Dhingra L et al. A qualitative study to explore psychological distress and illness burden associated with opioid-induced constipation in cancer patients with advanced disease. Palliat Med 2012; 27: 447-56.



Opioid-induced constipation

Management:

- ❖ Lifestyle measures
- ❖ Conventional laxatives
- ❖ Rectal interventions
- ❖ Lubiprostone*
- ❖ Prucalopride*
- ❖ Peripherally acting mu opioid receptor antagonists (PAMORAs)*
- ❖ Opioid switching
- ❖ Other interventions

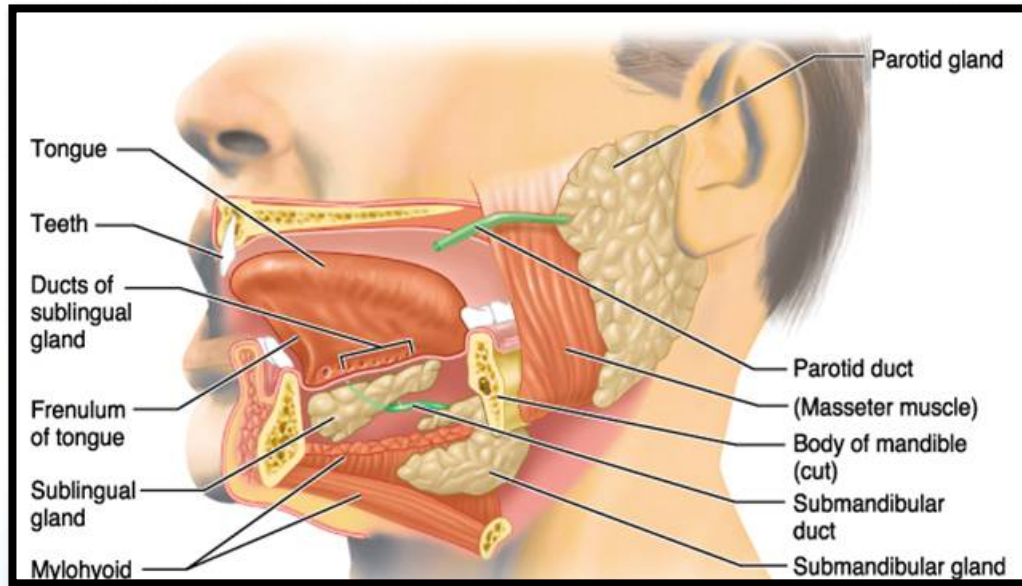




OPIOID-INDUCED BOWEL DYSFUNCTION



Salivary gland dysfunction

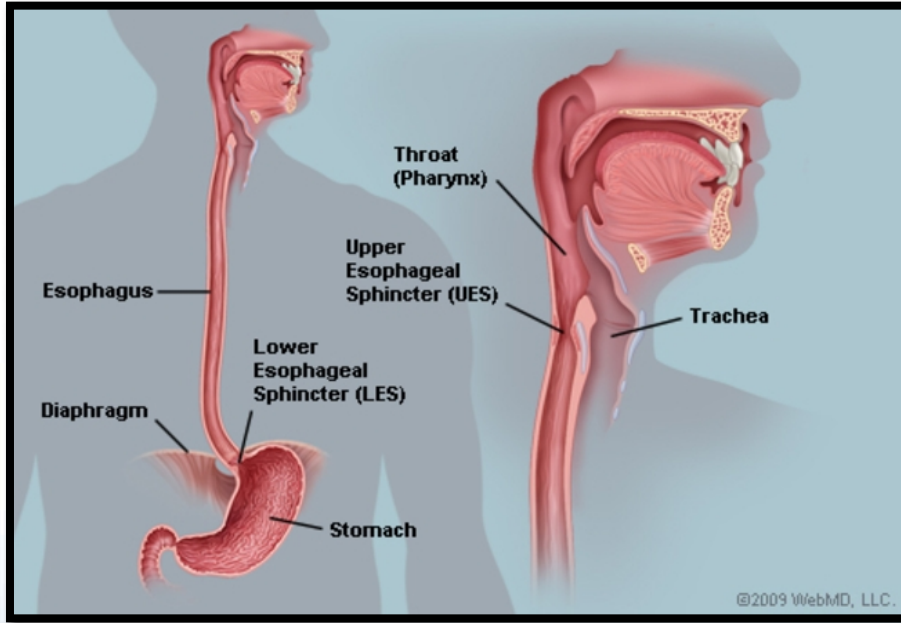


Salivary gland dysfunction:

- ❖ general problems (e.g. oral discomfort)
- ❖ eating-related problems
- ❖ speech-related problems
- ❖ poor oral hygiene
- ❖ oral infections
- ❖ systemic infections
- ❖ dental / denture problems
- ❖ psychosocial problems
- ❖ miscellaneous problems (e.g. oesophagitis)



Oesophageal dysfunction



Oesophageal dysfunction:

- ❖ dysphagia (liquids)
- ❖ regurgitation
- ❖ chest pain



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Gastroparesis

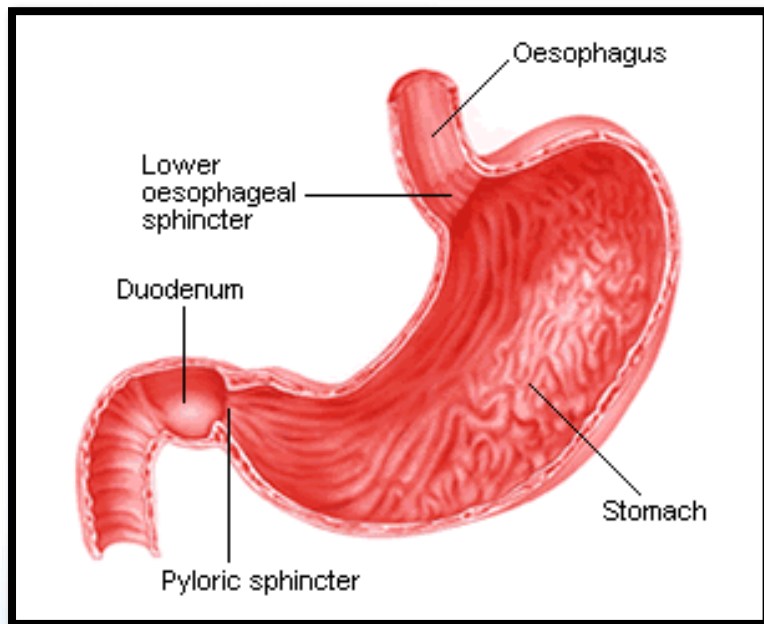


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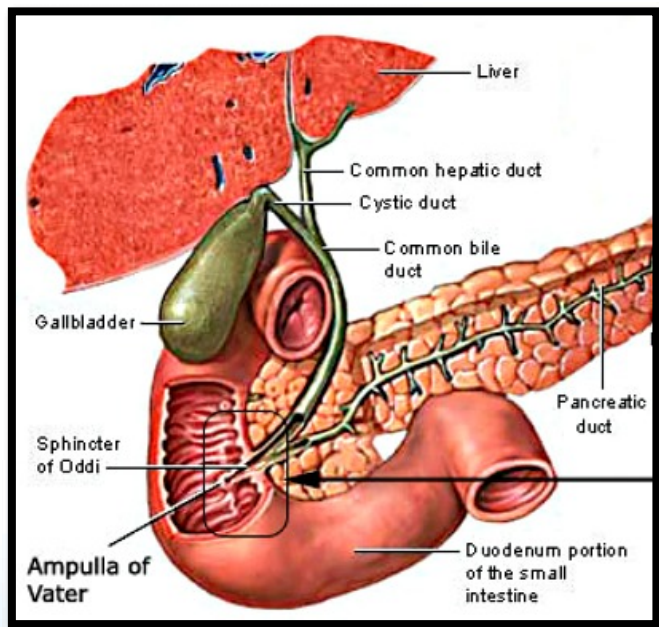


Gastroparesis:

- ❖ early satiety
- ❖ postprandial fullness
- ❖ nausea / vomiting
- ❖ bloating
- ❖ upper abdominal pain
- ❖ hiccoughs



Sphincter of Oddi dysfunction



Sphincter of Oddi dysfunction:

- ❖ biliary colic
- ❖ acute pancreatitis



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Opioid-induced bowel dysfunction

Management:

- ❖ Discontinue opioid ✓
- ❖ Dose reduce opioid (x)
- ❖ Switch opioid (✓)
- ❖ PAMORAs (?)
- ❖ Symptomatic management (✓)
- ❖ Other strategies (?)



Sphincter of Oddi dysfunction

Management:

❖ Switch opioid

“Good” opioids: buprenorphine, pethidine, tramadol

“Bad” opioids: fentanyl, morphine, oxycodone, tapentadol, loperamide

❖ PAMORAs

Prevention: naloxegol (case report)

Treatment: naloxone (case reports)



Sphincter of Oddi dysfunction

Management:

❖ Symptomatic management*

Antispasmodic medication: nifedipine, GTN, hyoscine butylbromide, phosphodiesterase type 5 inhibitor, tricyclic antidepressants, somatostatin analogues, botulinum toxin

❖ Other strategies

Sphincterotomy: endoscopic, surgical





CONCLUSION



Conclusion

Message to non-specialists:

Opioids are not the cause of every problem!



Conclusion

Message to specialists:

Opioids can be the cause of many problems

(so it could be the opioid!)

