

Identifying clinicians' practice patterns when managing opioid-induced constipation in patients on long-term opioid therapy: a descriptive study to inform education needs

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Background

There has been a significant increase in the chronic use of opioids in the past fifteen years with over 200 million prescriptions for opioids in the U.S. annually. With increased use of opioids, more patients are presenting with opioid-induced constipation (OIC).¹ It is estimated that 40 to 80 percent of chronic opioid users report constipation. Despite the high prevalence of OIC among opioid users, no formal guidelines, diagnostic criteria, or ICD code exists for making a diagnosis of OIC.² The purpose of this study was to describe practice patterns of US clinicians with regard to the diagnosis and management of OIC in adults on long-term opioid therapy and to identify relevant gaps in clinical knowledge.

The overall objective of this study was to provide data that would address clinical practice gaps, unmet medical information needs, and practice barriers among healthcare professionals who are engaged in the management of patients with OIC.

Methods

To aid in survey creation, two focus groups were conducted using the nominal group technique via a web interface and teleconference to elicit barriers that clinicians face in diagnosing and managing OIC in patients taking chronic opioid therapy. These results framed a case-based survey that was administered between November 2012 and February 2013 to 327 US-based health care professionals including primary care physicians (n=101), pain specialists (n=151) and nurse practitioners (n=75). Its purpose was to explore and quantitatively assess their knowledge and practice patterns with respect to the diagnosis and management of OIC in patients on long-term opioid therapy. Descriptive and inferential statistics were utilized to summarize survey responses.

Results

Table 1. Respondent Demographics*

	Pain Specialist (n = 151)	PCP (n = 101)	NP (n = 75)
Gender, % male	82.1%	78.2%	17.3%
Years since medical school graduation, mean (SD)	24 (8)	25 (11)	14 (6)
Patients seen per week, mean (SD)	111 (156)	151 (185)	85 (48)
Patients seen per week with chronic non-cancer pain, mean (SD)	45 (44)	31 (33)	28 (13)
Patients seen per week with chronic non-cancer pain on opioid treatment, mean (SD)	19 (13)	8 (7)	10 (4)

* Zero percent of clinicians work primarily in a long-term care facility or in an in-patient hospital setting.

Figure 1: Side Effects of Opioid Therapy

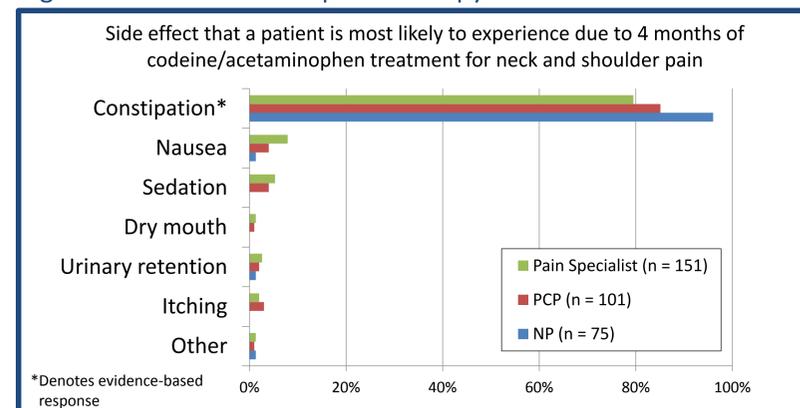


Figure 2: Communicating Side Effects of Opioid Therapy

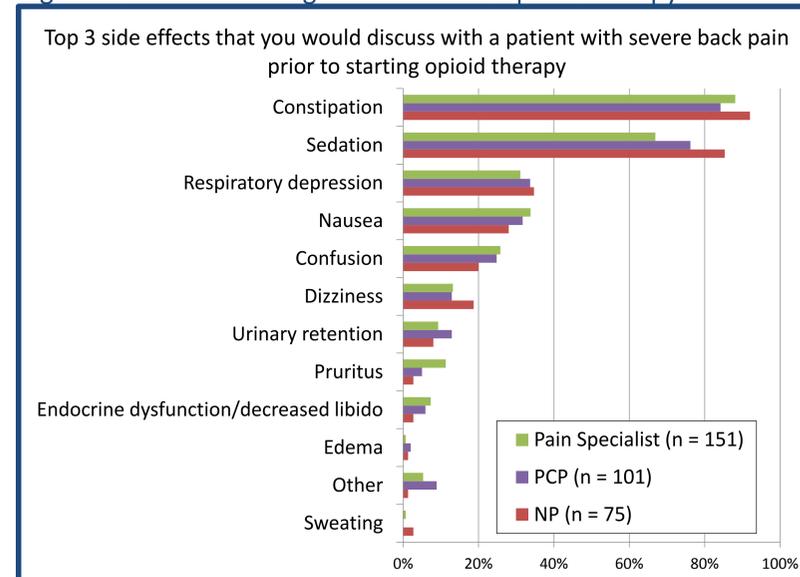


Figure 3: Providing a Prophylaxis Regimen for OIC

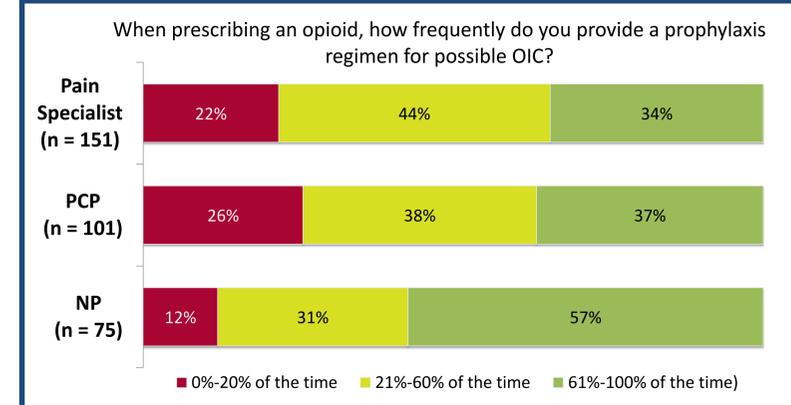
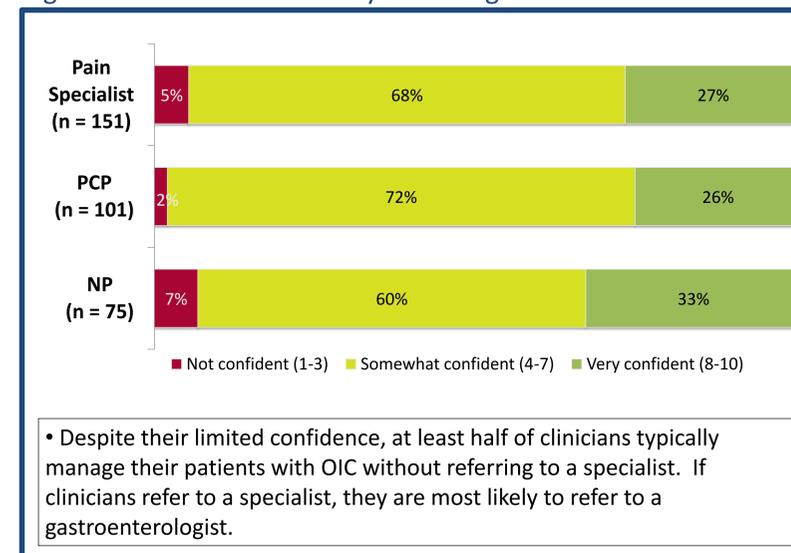


Table 2. Factors That Guide Clinician Treatment Decisions in OIC

	Pain Specialist (n = 151)	PCP (n = 101)	NP (n = 75)
Bowel movement symptoms, such as consistency, frequency, pain, etc	80%	77%	87%
Patient experience with previous constipation therapies	70%	80%	83%
Patient characteristics (age, mobility, dietary habits, general hydration, etc)	64%	72%	76%
Patient access to medication, due to cost or insurance coverage	50%	63%	76%
Patient preference	57%	59%	64%
Length of patient time on opioids	48%	45%	53%
Frequency of constipation medication doses	37%	32%	49%
Personal professional preference	22%	27%	27%
Other	0%	0%	0%

Figure 4: Confidence in Ability to Manage Patients With OIC



Results

- The great majority (80-96%) of respondents indicated that the most common side effect experienced with the chronic use of opioids is constipation (figure 1). Clinicians included constipation (84-92%) in the top 3 side effects that they would discuss with a patient prior to starting him or her on opioids (figure 2). Forty percent of pain specialists and one third of PCPs recognized that OIC is a subset of opioid bowel dysfunction (OBD).
- A prophylaxis regimen is infrequently prescribed for patients starting on opioids (figure 3). When clinicians do prescribe prophylaxis, they are most likely to use a stool softener, an osmotic laxative, or a high fiber diet. Clinicians are most likely to consider a stool softener, osmotic laxative, or bulk laxative as an initial treatment option for a patient diagnosed with OIC.
- The main factors that guide clinicians' treatment decisions for a patient with OIC are bowel movement symptoms, patient experience with previous constipation therapies, patient characteristics, patient access to medication, and patient preference (table 2).
- Forty-nine to 61% of clinicians feel that constipation and sedation would most likely result in discontinuation and/or poor adherence to long-term opioid therapy. Similarly, over half (51-77%) of clinicians feel that the fear of addiction, level of pain control for the patient, and cost of medications are factors that are most likely to limit patient adherence to long-term opioid treatment.
- Clinicians indicate that the most significant barriers to the optimal management of patients with OIC are lack of patient adherence to treatment recommendations, lack of patients' reporting of symptoms, and the additive impact of comorbidities on constipation.
- All respondents have some degree of confidence in their ability to manage patients with OIC; however, only 26-33% were "very confident" (figure 4).

Conclusions

These data highlight many gaps in the care of patients with chronic pain and OIC that can be addressed by educational, informational, or policy interventions. Clinicians would benefit from further information on:

- the differentiation of OIC from opioid bowel dysfunction,
- the importance of open discussion of side effects of opioid therapy with patients at each visit, and
- identification of treatment choices for patients with OIC.

References

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- Carson S, et al. Drug Class Review: Long-Acting Opioid Analgesics: Final Update 6 Report. Drug Class Reviews. Portland (OR): Oregon Health & Science University; 2011 Jul.

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