Common Side Effects of Opioid Use

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Opioid Side Effects

CONSTIPATION Duration: Persistent **Start all patients who are on opioids on a bowel regimen.** The following protocol is recommended.
Softening agent and stimulant (senna + docusate, e.g. Senokot S) - 2 tabs hs • If no BM in any 24-48 hour period: *increase dose* (up to 3 tabs TID and q hs) • If no BM in any 72 hour period: ASSESS FOR IMPACTION or ileus
If not impacted, may ADD: • Sorbitol 15-30 ml - may repeat every 3 hours X 3 OR • Bisacodyl tabs, 1-2 tabs hs, may repeat in am OR • Magnesium Citrate 8 oz po
If unable to take PO to promote bowel movement q 48 hours: • Dulcolax suppository 1 PR • Fleet phosphosoda enema 1PR • glycerin suppository 1PR
If impacted: • Lubricate rectal tissues • Use glycerin suppository to soften hard stool in rectum, prior to dis-impacting • Enemas as tolerated until clear, (warm water, soap suds, fleets+water)
If patient has bowel obstruction, all stimulant laxatives are contraindicated
NAUSEA/VOMITING Duration: Usually less than 7 days - common in opioid naive patient Prochlorperazine (Compazine) indicated as first line treatment of opioid induced nausea
• Compazine 5-10 mg. po q 6 h PRN • Compazine Spansules 10-15 mg po q 12 h PRN or 25 mg suppository q 6-8 h PRN
If nausea unresponsive to compazine or patient has sensitivity (EPS) to phenothiazines: • Haloperidol (Haldol) .5 mg to 2 mg q 6 h po PRN or • Haloperidol 1-3 mg q hs po or sl OR: • Metoclopramide (Reglan) 10-30 mg QID + diphenhydramine 25 mg q hs if > 40mg/day
Scheduling antiemetics therapy is not usually necessary, nausea usually resolves within 24-72 hours • Antiemetics have sedating and other anticholinergic effects. • PRN dosing is recommened. • Antiemetics may be scheduled in severe, persistent nausea.

Other Common Opioid Side Effects

Side Effects	Duration	Management
Sedation	Usually resolves rapidly with 24-48 hours. Common side effect in opioid naïve patients who have had unrelieved pain.	If persistent consider, CNS stimulants: • Caffeine • dextroamphetamine 2.5 – 7.5 mg po bid • Ritalin 5 – 10 mg po bid Consider alternative opioid or: Redue opioid in each dose and increase frequency to decrease peak serum concentration but maintain same total dose
Urinary Retention	More common in men with prostatism or in patients with pelvic tumors and bladder outlet obstruction – Usually resolves within one (1) week	Consult for use of antispasmodic agent. Consider eliminating or reducing any anticholinergic agents which may contribute. Consider use of urinary catheter.
Pruritis	Usually transient	Antihistamines (diphenhydramine) 25 mg po q 6 hr prn. If symptoms persist, may need to switch to alternate opioid.
Confusion	Usually transient, resolves in 48-72 hours, may recur at large dose increases	Educate family/patient. Reorient patient, usually occurs on awakening. If symptoms persist, consider other etiologies. If accompanied by persistent hallucinations and no other etiology evident, consider switch to alternative opioid.
Myoclonus	Generally occurs at high doses of opioids.	Reassure patient that myoclonus is not dangerous. If troublesome to patient: • Try dose reduction • Consider renal function, may necessitate change to alternate opioid. • May treat with clonazepam (Klonopin) .25 – 5 mg po bid-tid
Respiratory Depression	Dose related in opioid naïve patients and is associated with sedation and confusion. Tolerance develops rapidly.	If symptoms persist and respiratory rate is not related to dying process, then may reduce dose by 25% and resume cautious titration. In patient who is sedated and can be aroused, instruction to take deep breath is effective.