

FAST FACTS AND CONCEPTS #248 COUNSELING PATIENTS ON SIDE EFFECTS AND DRIVING WHEN STARTING OPIOIDS

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Background Opioids have side effects which can limit their acceptability to patients. This *Fast Fact* gives expert opinion recommendations about patient counseling when initiating opioid therapy. See *Fast Fact #83* for a discussion of patient fear of opioids, including addiction and tolerance.

Key Symptoms *Patients should be reassured that most opioid side effects are short-lived or otherwise manageable, and they should seek help immediately for intolerable side effects.*

- **Constipation**

- *Background for clinicians:* Very common, reported by 23-84% of patients in various studies. It does not diminish over time, even on a steady dose. Opioids delay gastric emptying, decrease peristalsis, decrease secretions, and slow small bowel transit time.
- *Key counseling points:*
 - Most patients need an ongoing bowel regimen involving stimulant laxatives (stool softeners such as docusate or bulking agents like fiber are ineffective), which should be used as maintenance therapy to *prevent* constipation, not just rescue therapy to *treat* it after it has developed (1). See *Fast Facts #294* and *#295* for more information.
 - Patients should aim for an unstrained bowel movement at least every other day. *“If you have not had a bowel movement in 4 days, call me for advice.”*

- **Nausea**

- *Background for clinicians:* Nausea occurs in ~25% of patients given opioids (2). There are many effective strategies to prevent and ameliorate opioid-induced nausea – see *Fast Fact #25* for more details. Make sure patients have access to your anti-emetic of choice. There is no consensus as to whether anti-emetics should be given *prophylactically* when initiating or increasing opioids.
- *Key counseling points:*
 - Nausea is usually transient and resolves in several days on a stable dose (3).
 - Patients should use their prescribed anti-emetic if nausea develops, but should contact you immediately if ineffective and/or vomiting occurs so you can prescribe alternative agents.

- **Sedation** (See also the section on driving below.)

- *Background for clinicians:* Sedation occurs in 20-60% of patients (2), usually during opioid initiation or around the time of dose increases. Mild-to-moderate sedation usually resolves in a few days; if persistent, it may improve with drug therapy (4). Moderate-to-severe sedation responds to dose reduction, but may also necessitate opioid rotation.
- *Key counseling points:*
 - Reassure patients that mild-to-moderate sedation usually resolves in a few days.
 - Encourage patients to accept mild sedation (e.g. noticeable drowsiness, falling asleep unintentionally during relaxing activities such as watching TV or reading) for a few days as long as they are in a safe environment. Moderate (falling asleep during stimulating activities such as eating or having a conversation) or severe sedation should prompt a call to you immediately to discuss next steps.

Less Common Symptoms

- **Pruritus** is rare and does not require extensive pre-emptive counseling. *“If you feel itchy it might go away after a few days. If it’s really bothering you or not going away, call me and we can make some changes.”* See *Fast Fact #37*.
- **Urinary retention** is rare but potentially an emergency. Counsel patients to seek medical care immediately if they lose the ability to urinate. See *Fast Fact #287* for further information.

Driving Safety There are no large, randomized studies directly examining the risk of driving while on opioids (6). Opioids can slow reaction time, cause drowsiness, or cloud judgment when they are first started or increased (7). Most experts agree that driving or operating heavy machinery is unsafe and should be avoided until a stable dose has been reached (8). Multiple smaller studies suggest that many

patients on chronic opioids (defined as no dose change within the last week) have no increased risk of motor vehicle collisions compared to the general population and no reduction in concentration or perception compared to controls(9). According to one study, which videotaped patients while actually driving, those on chronic opioid therapy versus healthy controls displayed neither a difference in driving errors in community or obstacle course driving nor in tests of attention (10). **Counseling bottom line:** patients who have been on a stable dose for a week, who feel no cognitive changes (drowsiness, 'fuzziness,' difficulties in concentrating) can drive.

For **commercial driving**, the Federal Motor Carriers Safety Administration generally prohibits opioid use, but with the caveat that these rules "do not apply to the possession or use of a substance administered to a driver by or under the instructions of a licensed medical practitioner...who has advised the driver that the substance will not affect the driver's ability to safely operate a motor vehicle" (11). Individual states, employers, and insurance agencies may have further restrictions, and patients should be advised to investigate these prior to driving commercially.

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Version History: Originally published December 2011; Copy-re-edited August 2015.

Fast Facts and Concepts are edited by Sean Marks MD (Medical College of Wisconsin) and associate editor Drew A Rosielle MD (University of Minnesota Medical School), with the generous support of a volunteer peer-review editorial board, and are made available online by the [Palliative Care Network of Wisconsin](#) (PCNOW); the authors of each individual *Fast Fact* are solely responsible for that *Fast Fact's* content. The full set of *Fast Facts* are available at [Palliative Care Network of Wisconsin](#) with contact information, and how to reference *Fast Facts*.

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