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Objectives

1. Identify the attitudes and specific practices of general practitioners regarding opioid prescription.
2. Recognize general practitioners' perceived barriers and facilitators of opioid prescription.
3. Describe how general practitioners' knowledge of opioids influence opioid prescription.

Original Research Background. Understanding key attitudes, barriers and facilitators of opioid prescription can help overcome the current undertreatment of pain in Low and Middle-Income Countries (LMICs).

Research Objectives. Identify barriers and facilitators for opioid prescription by GPs in Medellin, Colombia.

Methods. Descriptive-quantitative, cross-sectional study. A 53-item questionnaire was designed to assess: 1) attitudes (concerns and confidence when prescribing opioids), 2) practices related to opioid prescription, 3) perceived barriers and facilitators of opioid prescription; and 4) knowledge of opioids. We surveyed GPs who graduated from medical schools in Medellin, and GPs currently practicing in ten institutions in Medellin, Colombia. 179 participants completed the questionnaire. Descriptive and correlational analyses were conducted.

Results. The mean age was 33.3 years old (SD 10.43), 53.3% were female, 47.8% had been practicing for over 5 years, 51.66% did not receive training in pain management during medical school and only 2.8% received training after medical school. Regarding knowledge, 49.5% responded accurately. Common concerns were managing adverse effects and potential opioid abuse. Participants felt less confident to prescribe opioids to pediatric, pregnant patients, and those with history of substance abuse. Common barriers to opioid prescription were restriction to access, high costs, and insufficient training. Adequate opioid prescription practices were significantly and positively correlated with confidence when prescribing opioids (0.466; $p<0.01$), knowledge of opioids (0.422; $p<0.01$), age (0.233; $p<0.01$), and training in pain management (0.308; $p<0.01$); and significantly and negatively correlated with perceived barriers (-0.332; $p<0.01$).

Conclusion. Adequate practices regarding opioid use are related to training, knowledge and confidence when prescribing opioids. However, GPs in our context have insufficient knowledge about pain control and opioid use.

Implications for Research, Policy, or Practice. These results indicate the urgent need to increase pain management training for current and future GPs.

Efficacy Variables in Cancer Versus Noncancer Patients Treated with Methylnaltrexone or Placebo: An Analysis of 2 Placebo-Controlled Studies (S811)

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Objectives

1. Describe that methylnaltrexone is effective in treating opioid-induced constipation in patients with advanced illness with and without active cancer regardless of baseline opioid requirements.
2. Articulate that treatment with methylnaltrexone improves laxation response, has a fast onset of laxation in patients with or without cancer, and reduces the need for rescue laxatives versus placebo.
3. Describe that methylnaltrexone taken every other day or as needed is effective in patients with advanced illness.

Original Research Background. Methylnaltrexone (MNTX) inhibits opioid peripheral adverse effects.

Research Objectives. Post-hoc analysis of pooled data from randomized, double-blind studies and open-label extensions of adults with advanced illness and opioid-induced constipation.

Methods. Patients received SC MNTX 0.15 mg/kg or placebo (study 302) and SC MNTX 8 mg (38−<62 kg), 12 mg (≥62 kg), or placebo (study 4000) every other day for 2 weeks and MNTX (same doses as needed) during the first 2 weeks of open-label extensions. Double-blind populations were stratified by those with/without cancer. Endpoints included rescue-free bowel movements (RFBM) within 4 hours after each dose for ≥2 of the first 4 doses; time to rescue-free laxation; rescue laxatives use; and ≥3 RFBMs/week with ≥1 RFBM/week increase in ≥3 of 4 weeks.

Results. Median baseline opioid use (mg/day) was greater in cancer (187.9 placebo [n=114]; 180.0 MNTX [n=116]) versus non-cancer patients (80.0 placebo [n=71]; 120.0 MNTX [n=62]). MNTX significantly ($P<0.0001$) improved the proportion of cancer (56.9%) and non-cancer (58.1%) patients

with an RFBM within 4 hours after each dose for ≥2 of the first 4 doses versus placebo (5.3% cancer; 11.3% non-cancer). Median time to laxation was significantly ($P \leq 0.0002$) shorter in cancer (0.96 hours) and non-cancer (1.25 hours) patients 24 hours after the first dose versus placebo (≥23 hours). Rescue laxatives were used by 39.7% of cancer and 30.6% of non-cancer MNTX patients versus 51.8% and 39.4% of placebo patients. Of 108 open-label extension double-blind MNTX patients, 79 (73.1%) achieved ≥3 RFBMs/week with ≥1 RFBM/week increase in ≥3 of 4 weeks versus 48 (46.6%) of 103 double-blind placebo patients (data from double-blind and 2 weeks of open-label).

Conclusion. MNTX improved laxation with a faster onset and reduced rescue laxative use.

Implications for Research, Policy, or Practice. These data support the efficacy of MNTX in cancer/non-cancer patients.

Treatment with Methylnaltrexone in Patients with Opioid-Induced Constipation with or Without Active Cancer (S812)

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Objectives

1. Describe that methylnaltrexone is equally effective in treating opioid-induced constipation in patients with advanced illness with and without active cancer.
2. Articulate that treatment with methylnaltrexone does not increase pain scores in patients treated with opioids for pain due to advanced illnesses independent of cause.

Original Research Background. Subcutaneous (SC) methylnaltrexone is approved for opioid-induced constipation (OIC) in adults with chronic non-cancer pain and OIC in adults with advanced illness or with active cancer who require opioid dosage escalation for palliative care.

Research Objectives. Post hoc analysis of pooled data from 3 randomized studies of patients with advanced illness and OIC.

Methods. Patients received single doses of SC MNTX 0.15 or 0.30 mg/kg or placebo (study 301); SC MNTX 0.15 mg/kg or placebo every other day for 2 weeks (study 302); and SC MNTX 8 or 12 mg in patients 38−<62 or ≥62 kg, respectively, or placebo every other day for 2 weeks (study 4000). Data were stratified by those with/without cancer. Efficacy endpoints included laxation ≤4 hours and rescue-free laxation (RFL) ≤24 hours after the first dose; time to RFL; and pain scores.

Results. Median baseline opioid use was higher in cancer (MNTX: 190 mg/d, n=198; placebo: 200 mg/d, n=157) versus non-cancer patients (MNTX: 120.0 mg/d, n=82; placebo: 80.0 mg/d, n=80). MNTX significantly increased the percentage of patients with a laxation response ≤4 hours and RFL ≤24 hours after the first dose in cancer (MNTX: 61.1% and 71.2% vs placebo: 15.3% and 41.4%, respectively; $P<0.0001$) and non-cancer patients (MNTX: 62.2% and 74.4% vs placebo 17.5% and 37.5%, respectively; $P<0.0001$). MNTX significantly reduced the median time to RFL at 4 hours in cancer (MNTX: 1.1 h, placebo: >4 h; $P \leq 0.0001$) and non-cancer patients (MNTX: 1.1 h, placebo: >4 h; $P \leq 0.0001$). Mean changes in pain scores were similar (cancer patients, MNTX: −0.4 vs placebo: −0.2; non-cancer patients, MNTX: −0.4 vs placebo: −0.4).

Conclusion. MNTX increased laxation responses and improved clinical signs of constipation in OIC patients with/without cancer.

Implications for Research, Policy, or Practice. MNTX patients continued opioid treatment with a reduction in constipation symptoms.

Physician Use of Empathy During Clinical Practice (S813)

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Objectives

1. Discuss mixed methods research outcomes of how and when physicians use empathy when interacting with their patients during clinical practice.
2. Demonstrate the importance of empathy and its use during clinical practice.

Original Research Background. The use of empathy during clinical practice is paramount to delivering quality patient care and is important for understanding patient concerns at both the cognitive and affective levels. Physician use of empathy is associated with better patient and family experiences, higher patient satisfaction, increased patient compliance, and trust. Conversely a lack of empathy may adversely impact