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