1. Introduction

This guideline is designed to provide guidance for the Intensive Care Units to encourage enteral feed absorption in adult critical care patients.

Background

Gastrointestinal (GI) smooth muscle has intrinsic activity which can be modified by nerves, local reflexes, and gastrointestinal hormones. This activity produces waves of contraction, which move the gut contents from the stomach to the anus encouraging digestion. Impaired GI motility arising from functional disorders such as constipation dependent irritable bowel syndrome and functional dyspepsia, as well as chronic constipation and gastro-oesophageal reflux disease may be improved by the use of prokinetic drugs. In addition, post-operative ileus, diabetic gastroparesis and delayed gastric emptying in critically ill patients have also been treated with prokinetic agents.

Prokinetic drugs either stimulate the motility of the GI tract or promote the electrolyte/water secretion across the GI tract lumen. A number of drugs with prokinetic properties have been considered for clinical use, including metoclopramide, domperidone, tegaserod, cisapride and erythromycin. None have a UK license for use as a prokinetic and tegaserod and cisapride are not licensed in the UK.

2. Guideline

Drug therapy options

Preventative measures

- Maintain Euglycaemia
  High blood glucose has a detrimental effect on gastric motility in both diabetic and normal patients. Erythromycin is not as effective when hyperglycaemia is present.

- Consider drugs which may be aggravating the problem; can they be stopped or decreased? e.g. Morphine, dopamine and antimuscarinic agents

Drug treatment options

Laxatives

Consider Lactulose 20ml tds and Senna 15mg nocte (contra-indicated in Gastro-intestinal obstruction, digestive perforation or risk of digestive perforation). For alternative agents please discuss with a pharmacist and refer to the UHL Algorithm for the Use of Laxatives in Adults available on INsite via link below:

http://www.lmsg.nhs.uk/wp-content/uploads/2015/05/Laxative_Algorithm_Adults.pdf?UNLID=629387614201813151112
Prokinetics

- Metoclopramide 10mg IV tds for maximum 5 days (due to risks of neurological adverse effects and tachyphylaxis)
  - Promotes gastric emptying by acting as an antagonist (D2 receptors) to inhibitory actions of dopamine in the gut – results in increased tone of lower oesophageal sphincter, accelerated gastric contractions, increased small bowel transit time
  - Will be ineffective in the presence of a dopamine agonist
  Contraindication: Gastrointestinal obstruction, perforation or haemorrhage, phaeochromocytoma, Parkinson’s disease and epilepsy

The European Medicines Agency’s Committee on Medicinal Products for Human use and the MHRA advice limits the use of metoclopramide to 5 days at a total daily dose of 30mg due to the risk of neurological adverse effects.

- Erythromycin 250mg IV or enteral bd, for maximum 3 days (due to tachyphylaxis)
  IV route should be reserved for patients with no viable oral/enteral route
  - Prokinetic action due to agonism at motilin receptors – stimulates the migrating motor complex enhancing gastrointestinal contractility
  - Can be increased to 500mg bd by consultant only
  - Given the increasing antibiotic resistance think carefully about prescribing an antibiotic for a non-microbial indication.
  - Beware of Clostridium difficile risk
  - Erythromycin interacts with drugs metabolised by the cytochrome P450 system including: alfentanil, carbamazepine, cyclosporin, digoxin, disopyramide, midazolam, phenytoin, tacrolimus, theophylline, valproate, statins and warfarin. Careful monitoring and dose adjustments may be necessary. Increased risk of myopathy when erythromycin is given with statins, withhold statins for the duration of erythromycin treatment.
  - Contraindications: patients on terfenadine and ergotamine
  - Avoid if patient is already on macrolide class of antibiotic

- Combination: Limited evidence exists that combination may be more effective than erythromycin alone or can be used as an alternative when single agent therapy fails. Maximum duration 3 days (due to tachyphylaxis)

3. Education and Training

None'

4. Monitoring Compliance

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5. Supporting References


What is the optimal prokinetic dose of erythromycin in adults? Prepared by UK Medicines Information (UKMi) pharmacists for NHS healthcare professionals. Published 27th January 2015, updated 23rd March 2016 · UKMi

van der Meer et al. Should we stop prescribing metoclopramide as a prokinetic drug in critically ill patients? Critical Care 2014 18:502


M Hersch et al Drugs for gastric emptying in critically ill ventilated patients: analysis through breath testing Journal of Critical Care 30(2015) 655e7-655e13 Prokinetic

Nguyen et al Risk of Clostridium difficile diarrhoea in critically ill patients treated with erythromycin-based prokinetic therapy for feed


Prokinetics DAT, Ratified CMM in March 2004. Updated in February 2017 by ITAPS Pharmacy Team

6. Key Words

Prokinetic

Metoclopramide

Erythromycin

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