GENERAL PRINCIPLES

• Consider non-opioids first
• Check time and dose of last analgesia
• Check for drug dependence e.g. methadone
• If opioids required for chronic pain: use oral route
• Only use injectable opioids for severe acute pain unrelated to existing chronic pain e.g. fracture
• Morphine preferred (IV/SC for titration or repeated doses)
• Don’t withhold analgesia if indicated
• Treat pain effectively – don’t under-dose
• Observe patient after dosing

Back Pain Exacerbation

• Stepwise approach:
  - Paracetamol or aspirin
  - NSAIDs or weak opioid (e.g. codeine)
  - If strong opioids required, use oral route
• Investigate appropriately
• Avoid prolonged bed rest and encourage early return to normal activity
• Explain condition and promote self-management with non-pharmacological approaches

Renal colic

• Rectal NSAIDs as effective as parenteral NSAIDs
• Parenteral NSAIDs better than opioids
• Metoclopramide and hyoscine-n-butylbromide may also be effective

Biliary colic, pancreatitis

• NSAIDs effective in biliary colic
• Use morphine IV or NSAID (PR or IM)
• Consider smooth muscle relaxants e.g. hyoscine-n-butylbromide
• No evidence to support use of pethidine

Migraine

• Review effectiveness of previous anti-migraine therapy (must be used early)
  - Paracetamol or aspirin
  - NSAIDs (oral / rectal / IM)
  - Triptans, ergotamine
• Rehydrate early
• Consider chlorpromazine if in monitored environment
• If treated early, strong opioids not required
• Treatment failures: morphine IV

WS THERAPEUTIC ASSESSMENT GROUP

FOR FURTHER INFORMATION REFER TO:

