**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

**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 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
- Rehydrate early
- Consider chlorpromazine if in monitored environment
- If treated early, strong opioids not required
- Treatment failures: morphine IV

**WHY PETHIDINE IS NOT RECOMMENDED**

- Pethidine has a shorter duration of action than morphine with no additional analgesic benefit
- It has similar side-effects to morphine, including increased biliary pressure
- Pethidine is metabolised to norpethidine, which has potential toxic effects (e.g. convulsions), especially in patients with renal dysfunction
- Pethidine is associated with potentially serious interactions in combination with other drugs
- Pethidine is the drug most commonly requested by patients seeking opioids, and
- Pethidine is the drug most commonly abused by health professionals

For further information refer to: