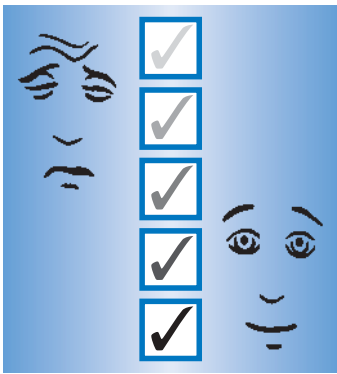


WHY PETHIDINE IS THE WRONG CHOICE



WHY PETHIDINE IS NOT RECOMMENDED²

- 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 (eg 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

GENERAL PRINCIPLES¹

- Consider non-opioids first
- Check time and dose of last analgesia
- Check for drug dependence eg methadone
- If opioids required for chronic pain: use oral route
- Only use injectable opioids for severe acute pain unrelated to existing chronic pain eg 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 Exacerbation¹

- Stepwise approach:
 - Paracetamol or aspirin
 - NSAIDs or weak opioid (eg 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 colic²

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

Biliary colic, pancreatitis³

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

Migraine¹

- Review effectiveness of previous anti-migraine therapy (must be used early)
 - Paracetamol or aspirin (with metoclopramide)
 - 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



For further information refer to:

1. NSW Therapeutic Assessment Group. Prescribing Guidelines for Primary Care Clinicians: Rational use of opioids in chronic or recurrent non-malignant pain (Series: General Principles, Low Back pain, Migraine). Sydney: NSW TAG, 2002. (Online access available via NSW TAG website, www.nswtag.org.au)
2. National Health and Medical Research Council. Acute pain management: scientific evidence. Canberra: Commonwealth of Australia, 1999. (Online access available via NHMRC website, www.nhmrc.gov.au or via link from TAG website)
3. Therapeutic guidelines: Analgesic, 4th ed. Melbourne: Therapeutic Guidelines Limited, 2002. (Online access available to NSW public hospitals via CIAP website, www.clininfo.health.nsw.gov.au)



NSW
THERAPEUTIC
ASSESSMENT
GROUP