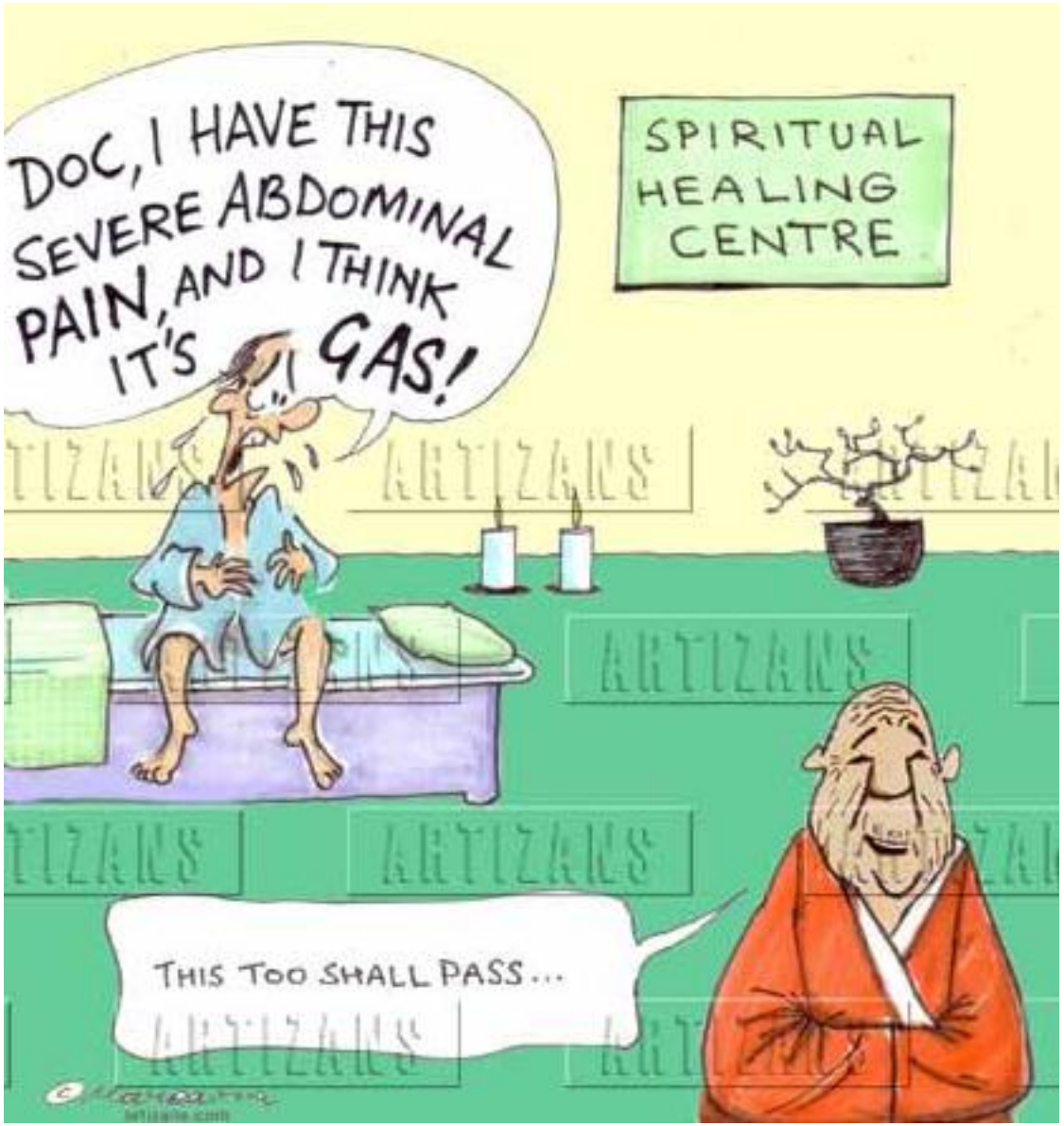
NON OPIOID ANALGESIA IN ABDOMINAL PAIN, WHEN OR WHY?

Serpil Yaylacı, MD
Department of Emergency Medicine
Acıbadem University, School of Medicine
İstanbul Turkey

ACIBADEM ÜNİVERSİTESİ

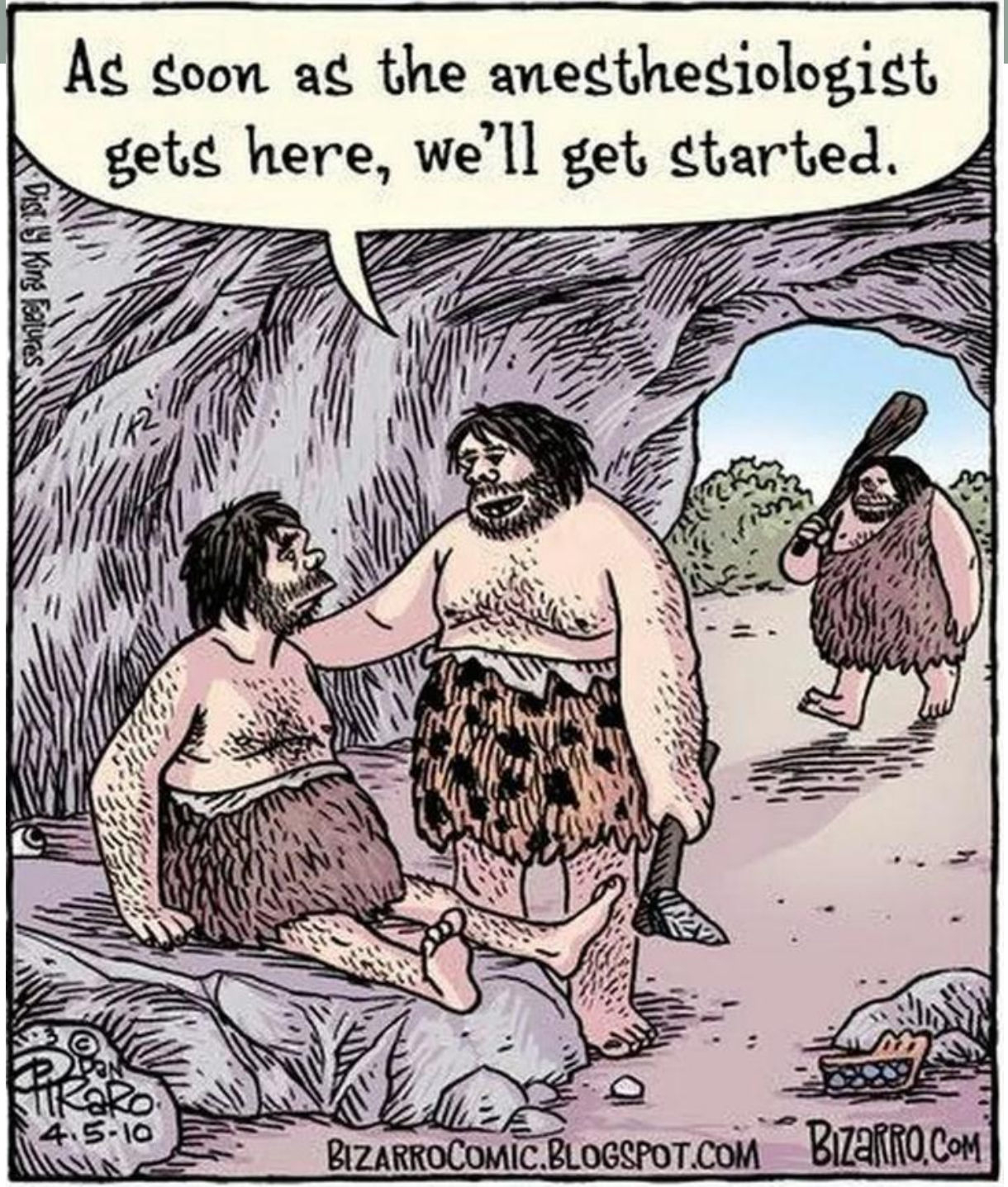
Content

- When
- Why



Abdominal Pain

- One of the most common reasons for patients presenting to the ED, but it is often not treated effectively


As soon as the anesthesiologist gets here, we'll get started.
Dist. by King Features
PIRARO
4-5-10
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BIZARRO.COM

Perception of Pain

- Modified by the complex interaction of cognitive, behavioral, and sociocultural dimensions
- Not static, but varies depending on current and past medical history, physical and emotional maturity, cognitive state, family attitudes, culture, and environment.

DDx

Diffuse Pain

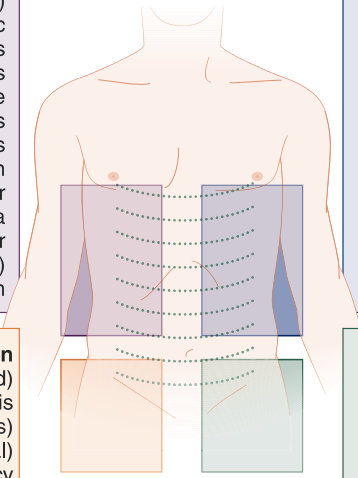
Aortic aneurysm (leaking, ruptured)
Aortic dissection
Appendicitis (early)
Bowel obstruction
Diabetic gastric paresis
Familial Mediterranean fever
Gastroenteritis
Heavy metal poisoning
Hereditary angioedema
Malaria
Mesenteric ischemia
Metabolic disorder (Addisonian crisis, AKA, DKA, porphyria, uremia)
Narcotic withdrawal
Pancreatitis
Perforated bowel
Peritonitis (of any cause)
Sickle cell crisis
Volvulus

Right Upper Quadrant Pain

Appendicitis (retrocecal)
Biliary colic
Cholangitis
Cholecystitis
Fitz-Hugh-Curtis syndrome
Hepatitis
Hepatic abscess
Hepatic congestion
Herpes zoster
Myocardial ischemia
Perforated duodenal ulcer
Pneumonia (RLL)
Pulmonary embolism

Left Upper Quadrant Pain

Gastric ulcer
Gastritis
Herpes zoster
Myocardial ischemia
Pancreatitis
Pneumonia (LLL)
Pulmonary embolism
Splenic rupture/distention



Right Lower Quadrant Pain

Aortic aneurysm (leaking, ruptured)
Appendicitis
Crohn's disease (terminal ileitis)
Diverticulitis (cecal)
Ectopic pregnancy
Endometriosis
Epiploic appendagitis
Herpes zoster
Inguinal hernia (incarcerated, strangulated)
Ischemic colitis
Meckel's diverticulum
Mittelschmerz
Ovarian cyst (ruptured)
Ovarian torsion
Pelvic inflammatory disease
Psoas abscess
Regional enteritis
Testicular torsion
Ureteral calculi

Left Lower Quadrant Pain

Aortic aneurysm (leaking, ruptured)
Diverticulitis (sigmoid)
Ectopic pregnancy
Endometriosis
Epiploic appendagitis
Herpes zoster
Inguinal hernia (incarcerated, strangulated)
Ischemic colitis
Mittelschmerz
Ovarian cyst (ruptured)
Ovarian torsion
Pelvic inflammatory disease
Psoas abscess
Regional enteritis
Testicular torsion
Ureteral calculi

FIGURE 71-1. Differential diagnosis of acute abdominal pain by location. AKA = alcoholic ketoacidosis; DKA = diabetic ketoacidosis; LLL = left lower lobe; RLL = right lower lobe.

“There’s no smoke without a fire”

- The differential diagnosis is wide, ranging from benign to life-threatening conditions.
- Causes include medical, surgical, intraabdominal, and extraabdominal ailments.

Initial Evaluation of ED Patients with Abdominal Pain

- Check vital signs
- Consider comorbidities
- Physical Examination
- Easily localized
- Poorly localized
- Document the degree of pain on initial assessment.

Door to DiagnosisTime

- History, physical examination, and laboratory studies can be helpful, but imaging is often required to make a specific diagnosis.

- Do not withhold analgesia from patients with acute undifferentiated abdominal pain.

Stop the Dilemma

- Abdominal pain reduction does not indicate improvement in pathophysiology.
- Analgesia without proper evaluation is as inappropriate as proper evaluation without analgesia.

Opioids Acquitted

- Relieve pain and will not obscure abdominal findings, delay diagnosis, or lead to increased morbidity/mortality.
- Early administration of IV opioids is safe and does not affect the accuracy of the evaluation, diagnosis, or management.
- The dogma against the use of opioids for patients with acute abdominal pain stated in previous researchs since 2000.

Warning for NSAIDS

- The information on the safety of opioids cannot be extrapolated to NSAIDS.
- NSAIDS are not pure analgesics and can mask early peritoneal inflammation.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ASAP

- Delaying analgesic administration in order to observe pain has become unnecessary thanks to aggressive patient imaging.
- Instead of physician's impression, the patient's subjective reporting of pain must be the basis for pain treatment.

When

- Mild
- VAS: 0 to 30–40 mm
- Moderate
- VAS: 40 to 60–70 mm
- Severe
- VAS: >60–70 mm

- NSAIDS should be considered for mild to moderate pain plus severe colicky pain.
- Systemic opioids for moderate to severe pain.

Key to Effective Pharmacologic Pain Management

- When selecting a suitable analgesic
  - intensity of pain
  - onset time of analgesic activity
  - ease of administration
  - safety, and efficacy
- Select initial analgesics that are appropriate to treat the intensity (whether it is mild, moderate, or severe).

Comforting the Patient

- The goal is to control pain to the level the patient desires.

- Asking if the patient requires more analgesic may even be simpler and accomplish more than using any standardized pain evaluation tool.

Non Opioid Drugs Warnings

- **NSAID**
- GI upset, platelet dysfunction, renal dysfunction, bronchospasm.
- Increase the risk of cardiac death in patients with ischemic heart disease
- Induced acute renal failure is more common in elderly patients and in those who are volume depleted, have preexisting renal or cardiac disease, or are taking loop diuretics

- **Paracetamol**
- Liver dysfunction
- No change is required for renal or mild hepatic impairment

Single or Combined?

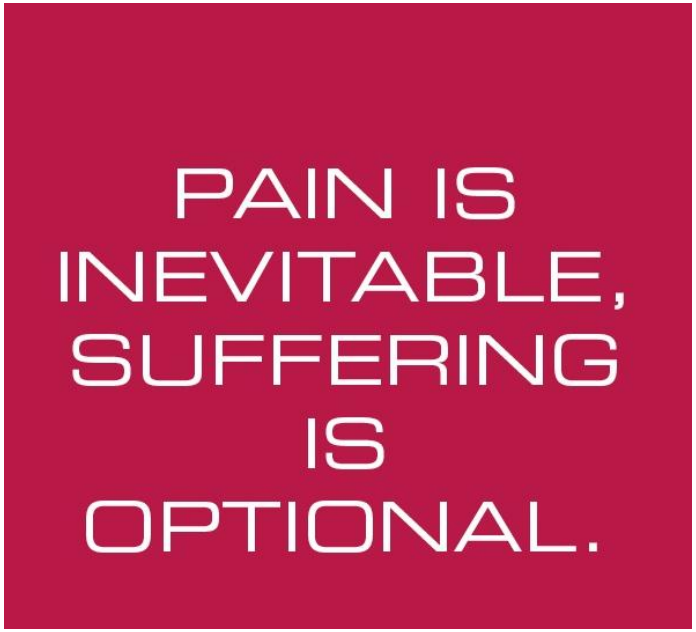
- In cases such as renal and biliary colic, a parenteral NSAIDS may control severe pain, although combination therapy with an opioid is usually superior.
- Have significant opioid dose-sparing effects.

A Better Option?

- Patient-controlled IV analgesic systems are particularly effective for ED patients with acute abdominal pain.

Last But Not Least…

- Symptom treatment
- Underlying etiology treatment




YOU ARE LEAVING
PAIN
ENJOY THE JOURNEY!