Use of Narcotics in Acute Abdominal Pain

- 22 Year old male with three year history of Ulcerative Colitis presents to the emergency room with 2 week history of increasing abdominal pain, intermittent rectal bleeding.
- Three year history of colitis with history of recent multiple flares requiring intravenous steroids.
- Current medications included Asacol, Azathioprine and Prednisone (60mg/day x 3 days).
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- Physical exam: nontender abdomen, nondistended, no peritoneal signs.
- Labs: Mostly normal: WBC 13.3
- Given Ativan, Zofran, Morphine?
- Symptoms improved, discharged to see PMD the next day.
Morphine does little or nothing to stop serious intra-abdominal disease, but it puts an efficient screen in front of the symptoms.

Sir Zachary Cope: *The early diagnosis of the acute abdomen*. 1951

An unfortunate practice in the care of patients with acute abdominal pain is the delay in administration of narcotics pending definitive surgical assessment.

Use of Narcotics in Acute Abdominal Pain: Review of the Literature

- Eight randomized double blinded trials of narcotic analgesia versus placebo.

- Total of 922 patients.

- No differences in diagnostic accuracy, appropriate decision making, incorrect decision making, morbidity or length of stay.

- Patients who received analgesia had less pain.

Manterola et al Cochrane Database 2007
**Narcotic Use in Severe Ulcerative Colitis**

Retrospective review of 223 patients admitted to a medical service.

<table>
<thead>
<tr>
<th></th>
<th>Narcotic use (n = 44)</th>
<th>No narcotic use (n = 179)</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Without corticosteroid</td>
<td>1 (2.3)</td>
<td>5 (2.8)</td>
<td>.8</td>
</tr>
<tr>
<td>With tapering corticosteroid</td>
<td>22 (50)</td>
<td>92 (51.4)</td>
<td></td>
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<tr>
<td>With addition of infliximab</td>
<td>2 (4.6)</td>
<td>13 (7.3)</td>
<td></td>
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<tr>
<td>With addition of 6-MP</td>
<td>6 (13.6)</td>
<td>15 (8.4)</td>
<td></td>
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<tr>
<td>Colectomy</td>
<td>13 (29.5)</td>
<td>54 (30.2)</td>
<td></td>
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</table>

No difference in colectomy rate or significant other outcome.

Lian et al, Dis Col Rectum 2010
Precipitating factors for toxic megacolon include electrolyte imbalance (particularly hypokalemia), use of antimitotility drugs including anticholinergic agents and narcotics, and procedures such as barium enema and colonoscopy performed during a severe attack. These procedures should be avoided in the presence of a severe flare of UC.
Treatment of Toxic Megacolon: A comparative review of 29 patients.

- 29 cases of toxic megacolon reviewed.

- Anticholinergic agents, narcotics or barium enema identified as a precipitating cause in 70%.

Hartong W. et al   Am J Digestion 1977
Acute Colonic Pseudo-Obstruction

- Review of 400 cases
- Abdominal pain and distension > 80%.
- Variety of clinical scenarios: trauma, sepsis, cardiac events.
- Narcotics given > 50% of cases.

Saunders M.D. Alimentary Pharm Therap. 2005
Use of Narcotics in Acute Abdominal Pain

- No evidence that the use of narcotics in the acute management of abdominal pain in the ER setting is associated with adverse outcomes.

- In the setting where non-operative management of pseudo-obstruction or toxic megacolon is being considered they should be avoided.