Alternative options to codeine in the pharmacy

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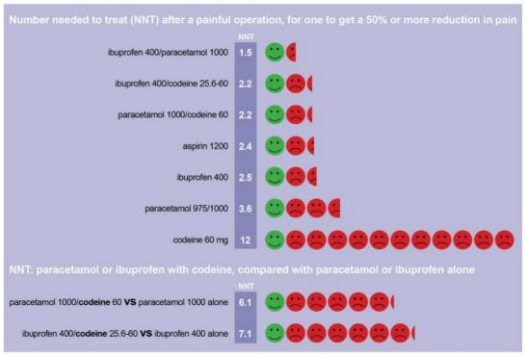
phn WESTERN VICTORIA
An Australian Government Initiative

Together with our partners and communities, Western Victoria PHN identifies priority health care needs, improves access through government funding, and co-designs localised solutions to improve health care systems across western Victoria.

Codeine containing combination analgesics

- Codeine is a weak, short-acting opioid which achieves its analgesic action through conversion to morphine in the liver
- Only 5 to 15% of a dose of codeine is metabolised to morphine.
- Approximately 6 to 10% of Caucasians and 1 to 2% of Asians lack the enzyme which converts codeine to morphine and are unlikely to achieve any pain relief with codeine
- Rarely first line therapies
  - Single ingredient preparations i.e. paracetamol, aspirin or NSAIDs should be trialled first
  - Non-drug therapies for all pain types should be explored

Summary of Cochrane systematic reviews of the medical literature



Appropriate questioning

- Location
- Intensity
- Nature
- Duration
- When is it occurring
- Are there other symptoms
- What makes it worse
- What makes it better
- Medications & medical conditions
- Is there anything that indicates referral

Migraine and other headache

- Treat at first sign of symptoms
- Initial treatment for acute migraine
  - Aspirin soluble 900 to 1000mg orally. Wait 4 to 6 hours before repeating dose if needed (maximum dose 4g in 24 hours)
  - Ibuprofen 400 to 600mg orally. Wait 4 to 6 hours before repeating dose if needed (maximum dose 2.4g in 24 hours)
  - Diclofenac potassium 50mg orally. Wait 4 to 6 hours before repeating dose if needed (maximum dose 200mg in 24 hours)
  - Naproxen 500 to 750mg orally. Wait 4 to 6 hours before repeating dose if needed (maximum dose 1250mg in 24 hours)
  - Paracetamol soluble 1g orally. Wait 4 to 6 hours before repeating dose if needed (maximum dose 4g in 24 hours).

Migraine and other headache

- If response is suboptimal an antiemetic may be an option (especially metoclopramide)—the antiemetic can improve treatment response by increasing drug absorption.
  - Metoclopramide 10 mg orally (available OTC in combination with paracetamol)
  - Prochlorperazine 5 to 10 mg orally
- Non-migraine headache
  - Explore underlying cause and address i.e. hydration, injury, stress, eye strain, medication overuse, cough, hormonal
  - Refer if ongoing, no obvious cause, alarm symptoms

Primary dysmenorrhea

- Prostaglandins released by endometrial cells at the start of menstruation cause vasoconstriction, muscle contraction and compression of the spiral arteries, leading to myometrial ischaemia
  - Severity directly related to the prostaglandin concentration in the menstrual fluid
- NSAIDs suppress prostaglandins in menstrual fluid
  - Best given 48 hours before menstruation is expected, or with onset of pain
  - Treatment continued for first 48 to 72 hours of menses when prostaglandin release is maximal
  - Insufficient evidence to favour one NSAID over another
- Secondary dysmenorrhea should be referred for further investigation

Primary dysmenorrhea

- Other options
  - Local heat
  - Transcutaneous electrical nerve stimulation (TENS)
  - Acupressure
  - Acupuncture
  - Spinal manipulation
  - Herbal and dietary preparations (e.g. vitamin E, thiamine, pyridoxine, magnesium, fish oil)
- Pain reduction was demonstrated but the studies were limited in size and quality.
- Chinese herbal medication, exercise and psychological behavioural interventions have shown benefit in small trials

Musculoskeletal injury

- RICER
- Analgesia
  - First-line treatment is paracetamol.
  - Nonsteroidal anti-inflammatory drugs (NSAIDs) may be used in combination with paracetamol.
    - There is theoretical risk of NSAIDs inhibiting muscle repair
    - NSAIDs should not be used for more than 48 hours for acute muscle injury
    - No single NSAID shown to be more effective than any other, but some patients may respond better to one NSAID than to others
      - If a patient does not respond to the first NSAID trialled, generally one or two other NSAIDs should be trialled before confirming nonresponse to NSAIDs
- Physiotherapy
  - Exercise is important for rehabilitation of the injured muscle to prevent recurrence of injury
- Heat and massage are contraindicated in the first 48 hours following injury.

Dental pain

- Avoid foods that provoke pain
- Analgesics especially nonsteroidal anti-inflammatory drugs (NSAIDs) if the patient can use them
- Cover any obvious cavity with an inert material (e.g. chewing gum)
- Topical anaesthetics
- Referral to dentist ASAP

Cold & flu

- Provide medication according to symptoms
- Combination products should only be given if meet symptom requirements i.e. if no pain, products with analgesia shouldn't be given

Chronic pain

- The role of opioids in chronic non-cancer pain management is limited
  - Experience suggests that opioids work in only one in three patients and that they reduce pain intensity by 30% to 50% at best
  - In patients taking opioids for chronic non-malignant pain, about 80% have at least one adverse effect.

Chronic pain

- Educate patient about the role of medications in chronic non-cancer pain
- Discuss lifestyle modifications including diet and exercise
- Discuss non-pharmacological options including heat, massage, psychotherapies, physio, osteo etc.

Pain management plan

- Developing a pain management plan with the patient may be appropriate

https://www.guild.org.au/__data/assets/pdf_file/0017/6209/patient-resource-my-pain-management-plan-nps-medicines-wise4e0a9a33c06d6d6b9691ff000026bd16.pdf

Professional Services

- MedsCheck
- Home Medication Review
- Pharmacy Pain Management Programs e.g. Pain Wise

Support groups and patient information

- MOVE – Arthritis Victoria
- NPS
- Pain Australia
- Local pain management programs

Complementary medicines for pain

- Fish oil
- Turmeric – limited evidence
- Glucosamine & chondroitin – limited evidence in OA of the knee

Key messages

- Validate pain
- Remember non-pharmacological options and lifestyle factors
- Give realistic expectations as to what to expect from pain management, especially medications
  - Onset of action
  - Duration of relief
  - Level of relief
- Get them to come back or go to GP if adequate relief not obtained