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## Scientific letters

# Analgesia and abdominal pain in the emergency room

## Analgesia y dolor abdominal en urgencias

Analgesia has traditionally been contraindicated in the emergency department for acute abdominal pain until a diagnosis and management decision has been made. However, it is becoming increasingly common in the ED to give opioid analgesia to patients with acute abdominal pain prior to the surgeon's visit and therapeutic decision. However, we have observed abdominal pain cases who have been given analgesia and discharged on improvement of their condition, only to return within hours or days with an obvious acute surgical abdomen. We wonder whether giving opioid analgesia in the ED masks acute abdomen, delays diagnosis, clouds prognosis, and worsens outcome.

We conducted a review of publications addressing this question. Three systematic reviews<sup>1-3</sup> and some original articles<sup>4,5</sup> analyse the problem. They compare the use of third-step analgesics on the WHO analgesic ladder (such as morphine and derivatives), used in patients with abdominal pain in the ED, with placebo. In most studies we found abundant evidence in favour of the early use of opioid analgesia in these cases. The major benefit, sometimes not appreciated under traditional thinking, is the patient's well-being and improvement in their general condition. This encourages the patient's participation in their process and, most of the time, even facilitates the clinical interview, the physical examination, and complementary examinations. It is also highlighted that opioid analgesia at least does not negatively affect the diagnostic process or the management and final outcome of these patients<sup>1-5</sup>. However, one review does note changes in exploratory findings<sup>3</sup>.

Details that should be considered are that the studies discussed do not use lower steps on the WHO ladder to compare the results, but they use a placebo<sup>1-5</sup>. Lower-level analgesia is used more often in clinical practice, at least in our hospital. This is not, however, a criticism of the value of these studies, given that if strong analgesia does not hinder or delay diagnosis, it is to be expected that lower analgesia will not do so either. On the other hand, although there is agreement that analgesia does not determine management or worsen prognosis or outcomes, only one study explores the parameter "diagnostic delay"<sup>1</sup>.

We believe that the belief, where it persists, that it is inappropriate to administer analgesia prior to diagnosis to patients presenting in the ED with acute abdominal pain should be challenged. However, this is an area where there are interesting questions yet to be clarified.

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