Besides pethidine and butorphanol, no reference could be found regarding the use of any other opioids in the management of biliary colic pain. These drugs were compared to an NSAID, and since these do not have any advantage over NSAIDs, it is not recommended but may be used in patients in whom NSAIDs are contraindicated.

Regarding the influence of opioids on the tone of the sphincter of Oddi: pethidine may decrease the tone, morphine may increase the tone, and tilidine does not affect the tone and may be used. The increase in tone caused by morphine is reversed by naloxone. The efficacy of the smooth muscle relaxant *hyoscine bromide* is inferior to that of NSAIDs.

Dysmenorrhoea

Primary dysmenorrhoea is explained by an overproduction of prostanoids in the endometrium when progesterone levels decline. A non-selective NSAID is the first-line treatment in the management of pain of dysmenorrhoea. Several of these agents are effective and are better than paracetamol. No reference regarding the use of opioids could be found.

Posttraumatic pain

Everybody, including babies, children, fit athletes and the frail elderly, is vulnerable to trauma. Trauma patients do not only differ in age, but also with regards to the type of trauma, comorbid conditions and medications – including analgesics. These factors must be considered when treating their pain.

Initial therapy for significant trauma pain is best achieved by the titration of IV opioids. Morphine sulphate remains the most widely-used agent, but adverse effects such as nausea and vomiting, hypotension, respiratory depression and oversedation occur commonly. The dose is 50 µg/kg every 5 minutes until the VAS is $\leq$ 3/10.

NSAIDs are effective analgesics in the trauma setting. These should preferably be administered IV, but IMI administration may be necessary if IV access is not available. NSAIDs (non-selective and selective COX-2 inhibitors) are generally safe, but should not be used in patients at risk of haemorrhage; that is CNS injury, head and neck injury, vascular injury, patients with premorbid diseases such as GI ulcers and bleeding diathesis (e.g. liver disease), antiplatelet agents, and anticoagulants. These should not be used in patients at risk of renal failure (hypovolaemia, the elderly, use of ACEIs, ARAs and diuretics) and IV paracetamol is preferable in these patients.

NSAIDs are usually continued after hospital discharge in an oral formulation either alone or in combination with an opioid derivative, such as codeine. *Topical NSAIDs* in gel or patch form are useful and decrease systemic analgesic requirements.