Do Opiates Affect the Clinical Evaluation of Patients With Acute Abdominal Pain?

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CLINICAL SCENARIO
A 28-year-old woman with no significant past medical history presents to the emergency department with rightsided abdominal pain, progressive over the past 3 days. She reports several episodes of vomitting greenish fluid within the last 24 hours but had no vomiting preceding the pain. She denies hematemesis, chills, dysuria, diarrhea, or vaginal discharge. The patient’s last menses ended 2 weeks prior without further menstrual cramping or vaginal bleeding.

The patient is febrile and appears uncomfortable, but other vital signs are normal. Her lungs are clear, and her cardiac examination findings are normal. She has lower right-sided abdominal tenderness with guarding but also has tenderness in the right upper quadrant without guarding. Examination for a psoas sign is positive. Pelvic and rectal examinations make her generally uncomfortable, but other specific findings are normal. Laboratory tests show a white blood cell count of 11,000 cells/µL. Levels of serum electrolytes, urea, creatinine, transaminases, bilirubin, and alkaline phosphatase are all within reference range. A pregnancy test result is negative.

The combination of right upper quadrant and lower abdominal pain suggests a problem in the right upper quadrant of the abdomen (RUQ), and the combination of lower abdominal pain and guarding suggest a problem in the lower abdomen (LA).

See also Patient Page.

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raises the possibility of pelvic inflammatory disease with pericholangitis (FitzHugh-Curtis syndrome), but the normal liver function test results and the lack of purulent endocervical discharge or cervical tenderness make this diagnosis less likely. You regard the combination of vomiting beginning after the onset of pain, fever, right lower quadrant pain, guarding, and a psoas sign as most suggestive of appendicitis. You request a consultation with the on-call general surgeon, who agrees that appendicitis is most likely. However, the surgeon would like to assess the presence of the right upper quadrant pain herself. She cannot come to the emergency department for approximately 1 hour and requests that you not administer opiates before she can examine the patient, since she does not want analgesia to mask important physical findings. When you return to the bedside, the patient is visibly uncomfortable, although her vital signs are unchanged. She requests “something for the pain.” You wonder if providing pain relief with opiate analgesics will affect the physical examination findings and/or result in either delays or unnecessary surgery.

**WHY IS THIS QUESTION IMPORTANT?**

Abdominal pain is the most common reason for emergency department visits in the United States, accounting for 7.6 million visits in 2003.\(^1\) Of these patients, 40% to 45% are eventually diagnosed with nonspecific abdominal pain, but 15% to 30% have conditions that require surgical treatment—pain, but 15% to 30% have conditions that require surgical treatment.\(^2\) There are many causes of acute abdominal pain, ranging from relatively minor conditions (e.g., gastritis) to major emergencies (e.g., perforated viscus). The diagnosis of an “acute abdomen” suggests symptoms and signs of an intra-abdominal disease that usually requires surgical treatment. Peritoneal signs, such as cough tenderness, ab-
Diagnosis Incorrect
Patient Observed
Diagnosis Correct

Surgery may be required to establish the final diagnosis. Opiates might alter the clinical findings and therefore affect the decision to proceed to surgery. Patients may be given opiates between the initial examination and final examination when a decision is made about surgery. Opiates might alter the clinical findings and therefore affect the decision to proceed to surgery. Surgery may be required to establish the final diagnosis.

**Figure 1. Diagnosis and Management Pathway in Patients With Acute Abdominal Pain**

Having Uncertain Diagnosis and Operative Decision After the Initial Examination

**Patient With Acute Abdominal Pain**

Initial Clinical Assessment by Nonsurgeon

Administer Opiates?

Subsequent Assessment by Surgeon

Working Diagnosis Requires Surgery

Operation Performed

Diagnosis Correct

True Diagnosis Required Surgery

Necessary Surgery Performed Without Delay

Working Diagnosis Does Not Require Surgery

Patient Observed

Diagnosis Incorrect

True Diagnosis Did Not Require Surgery

Unnecessary Surgery

Diagnosis Correct

True Diagnosis Did Not Require Surgery

Surgery Was Appropriately Not Performed

Diagnosis Incorrect

True Diagnosis Required Surgery

Necessary Surgery Was Delayed or Not Performed

**Possible Impact of Opiates on the Physical Examination**

Synthetic opiates, primarily through interaction with µ receptors in the brain and spinal cord, produce analgesia by stimulating pain-inhibitory neurons and inhibiting pain-transmission neurons, thus blocking the pain cycle from afferent to central to efferent neurons. Blocking the somatic efferent fibers that conduct messages to the abdominal muscles and skin may alter peritoneal signs, but predicting how opiates may affect the sensitivity and specificity of the overall physical examination is challenging. Voluntary guarding—ie, contraction of the abdominal muscles in response to palpation—may decrease if opiates have diminished a patient’s overall pain level. However, involuntary guarding or rigidity is thought to be a reflex spasm of the abdominal wall and thus should not be affected by analgesia. The possible effect of opiates on rebound tenderness—ie, an increased pain response when abdominal pressure is removed suddenly during examination—is even more difficult to assess. If opiates help relax the patient without affecting the peritoneal signs, their administration could improve the reliability of results for some patients.

**METHODS**

We searched for studies that addressed 1 of 3 key questions: Does administration of opiates alter the history given by patients with acute abdominal pain? Does administration of opiates alter the physical examination of patients with acute abdominal pain? Does administration of opiates result in errors in the clinical manage-
ment of patients with acute abdominal pain?

We systematically searched MEDLINE by combining Medical Subject Headings title and text words targeting abdominal pain (eg, abdomen, acute, abdominal, appendicitis) with terms related to analgesia (eg, analgesics, opioid, analgesia) (full search strategy available from the authors on request). The MEDLINE search covered articles published through May 2006. We also searched EMBASE and scanned article bibliographies for potentially relevant studies. Two investigators (S.R.R., L.E.G.) independently reviewed each article and systematically abstracted the required data. A third investigator (K.G.S.) independently resolved discrepancies.

Inclusion Criteria and Outcomes

We included placebo-controlled trials of opiate analgesia in patients with acute abdominal pain that assigned treatment using a randomized or quasi-randomized design (eg, alternating patients). We included trials that provided data on changes in the history, physical examination, or clinical management of patients. We abstracted data on the incidence of all changes in the history and physical examination of the abdomen, including findings with the greatest relevance to diagnosing conditions requiring laparotomy, such as changes in the presence of peritoneal signs. Similarly, we abstracted data on the incidence of all management errors. When we abstracted the data, we made no assumptions about the presence of examination changes or management errors and used only the information provided by the authors of the original studies.

Delivering optimal surgical care necessitates performing a certain number of operations in patients who do not ultimately have surgical pathology. For instance, to avoid perforated appendicitis due to delaying surgery, a certain percentage of patients will undergo laparotomy in which the surgeon finds no pathology and removes a normal appendix. Our definitions of management errors do not take this into account and may include cases in which the purported error falls within the scope of acceptable surgical practice. However, by using a conservative definition of management error, any conclusions about the impact of administering opiates become more robust. If opiates do not increase management errors when a conservative definition of error is used, then one can more confidently conclude that opiates do not adversely affect patient outcomes.

Statistical Analysis

We constructed 2 × 2 tables from the raw data and calculated the risk ratios (RRs) for history or physical examination changes and risk differences for management accuracy. For calculations of RRs, 0.5 was added to each cell of the table when any single cell had zero events. We used a random-effects model to generate conservative summary RRs, risk differences, and confidence intervals (CIs) and calculated the I² statistic to assess for heterogeneity. All analyses were performed using Stata version 8.2 (StataCorp, College Station, Tex).

For history or physical examination changes, an RR with a point estimate greater than 1 and a lower 95% confidence limit excluding 1 suggests that opiates are more likely than placebo to affect the history or physical examination results. For management accuracy, the risk difference represents the absolute difference between management errors with opiates and with placebo. A risk difference with the point estimate and upper 95% confidence limit greater than 0 favors placebo and suggests that opiates might be harmful. We calculated the number needed to harm (NNH) as 1/(risk difference); the NNH represents the number of patients who would need to receive opiates to result in 1 management error in excess of the number associated with withholding opiates.

RESULTS

The search strategy yielded 492 citations, of which 11 met the above criteria. Review of the reference lists from these articles yielded 1 additional abstract. The 275 citations identified by the EMBASE search did not yield any additional trials. The final data set consisted of 12 studies reporting a total of 15 comparisons (Table 1 and Table 2). Nine studies enrolled adult patients, and 3 enrolled pediatric patients. Three studies enrolled only patients with right lower quadrant pain; all others enrolled patients with undifferentiated acute abdominal pain.

Three studies reported data from multiple examiners who evaluated the patients before and after administration of opiate or placebo (eg, an emergency medicine physician and a surgeon). In these studies, we used results only from the initial examiner, reasoning that the assessments of subsequent examiners would likely not be independent.

Effect of Opiates on Patient History

None of the included studies explicitly evaluated the effect of opiate administration on the patient history. Alteration of the history by provision of analgesia could potentially decrease its accuracy (by sedating the patient and minimizing previously concerning symptoms) or increase its accuracy (by calming the patient, allowing a clearer history). All studies assessed patients’ perceptions of changes in pain after receiving opiate or placebo. Analgesia was significantly greater in the opiate group compared with the placebo group in 11 of 15 comparisons. Five studies addressed the adequacy of blinding by having the examiner guess whether the patient had received opiate or placebo; in all cases, blinding was deemed adequate. Although the available evidence does not directly address the effects of opiates on the history, the adequacy of blinding in studies in which opiates provided significant pain relief provides some indication that administering opiates does not substantially alter the history.
Table 1. Adult Studies Used to Determine the Impact of Opiates on Accuracy of Clinical Evaluation of Patients With Acute Abdominal Pain

<table>
<thead>
<tr>
<th>Source</th>
<th>No. of Participants</th>
<th>Inclusion Criteria</th>
<th>Examiner</th>
<th>Blinding</th>
<th>Analgesic Administered</th>
<th>Analgesia Greater in Opiates Group</th>
<th>Examination Outcome</th>
<th>Diagnosis Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zotie and Cust,25 1996</td>
<td>125</td>
<td>Age &gt; 16 y with acute abdominal pain (&lt;48 h) Excluded renal colic; “emergencies”</td>
<td>Same surgical resident before and after opiate administration</td>
<td>Examiner blinded to treatment group; unclear if outcomes assessors blinded</td>
<td>Sublingual buprenorphine (200 mg) vs placebo</td>
<td>No</td>
<td>Yes *</td>
<td>Yes *</td>
</tr>
<tr>
<td>Attard et al,21 1992</td>
<td>100</td>
<td>Age &gt; 16 y with acute abdominal pain (&lt;48 h) Excluded suspected AAA</td>
<td>Surgical resident before; surgical registrar after</td>
<td>Examiners blinded to treatment group; unclear if second examiner blinded to prior findings; unclear if outcomes assessors blinded</td>
<td>Intramuscular papaveretum (5-20 mg) vs placebo</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pace and Burke,22 1996</td>
<td>75</td>
<td>Age &gt; 18 y with acute abdominal pain (&lt;48 h) Excluded if SBP &lt;90 mm Hg or if judged to need opiates by treating physician</td>
<td>Same EM physician before and after</td>
<td>Examiners and outcomes assessors blinded</td>
<td>Intravenous morphine sulfate (up to 20 mg) vs placebo</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Garyfallou et al,23 1997 (abstract)</td>
<td>41</td>
<td>Age not specified Excluded “severe pain,” renal colic</td>
<td>Same physicians (EM physician and surgeon) before and after</td>
<td>Unclear if examiners or outcomes assessors blinded</td>
<td>Intravenous fentanyl (1.5 µg/kg) vs placebo</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>LoVecchio et al,24 1997</td>
<td>29</td>
<td>Age &gt; 18 y with acute pain, peritoneal signs Excluded renal colic, suspected AAA</td>
<td>Same EM physician (attending or senior resident) before and after</td>
<td>Unclear if examiners or outcomes assessors blinded to treatment groups</td>
<td>Intravenous morphine sulfate (5 mg) vs placebo</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes *</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>As above</td>
<td>As above</td>
<td>As above</td>
<td>Intra-venous morphine sulfate (10 mg) vs placebo</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes *</td>
</tr>
<tr>
<td>Vermeulen et al,25 1999</td>
<td>350</td>
<td>Age &gt; 16 y with RLQ pain Excluded renal colic, patients with “symptoms not suggestive of appendicitis”</td>
<td>EM physician before; surgeon after</td>
<td>Unclear if examiners or outcomes assessors blinded to treatment group or prior findings</td>
<td>Intravenous morphine sulfate (0.1 mg/kg) vs placebo</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Mahadevan and Graff,26 2000</td>
<td>68</td>
<td>Age &gt; 11 y with RLQ pain &lt;1 wk</td>
<td>Same EM resident before and after</td>
<td>Examiner blinded to treatment group; unclear if outcomes assessors blinded</td>
<td>Intravenous tramadol (1 mg/kg) vs placebo</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Thomas et al,27 2003</td>
<td>74</td>
<td>Age &gt; 18 y with “severe” pain &lt;72 h Excluded biliary/renal colic, hypotensive, suspected AAA</td>
<td>Same before and after (unclear if surgical resident, EM resident, or attending)</td>
<td>Examiners and outcomes assessors blinded</td>
<td>Intravenous morphine sulfate (up to 15 mg) vs placebo</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Wolfe et al,28 2004</td>
<td>22</td>
<td>Age &gt; 16 y with suspected appendicitis scheduled for operation</td>
<td>Same EM physician and surgical resident before and after</td>
<td>Examiners blinded; unclear if outcomes assessors blinded</td>
<td>Intravenous morphine sulfate (0.075 mg/kg) vs placebo (crossover design)</td>
<td>Yes</td>
<td>Yes *</td>
<td>No</td>
</tr>
</tbody>
</table>

Abbreviations: AAA, abdominal aortic aneurysm; EM, emergency medicine; RLQ, right lower quadrant; SBP, systolic blood pressure.

*Outcome reported, but insufficient information provided for quantitative analysis.
Effect of Opiates on the Physical Examination

Fourteen comparisons (from 11 studies20-23,25-29,31) reported data on changes in the physical examination, of which 11 comparisons (from 9 studies20-23,25,27-29,31) provided data in a format amenable to quantitative synthesis (Tables 1 and 2). The 9 comparisons conducted in adult patients20-23,25,27,29 showed a trend toward changes in the physical examination with opiate administration, with a summary RR of 1.51 (95% CI, 0.85 to 2.69) (Figure 2). The 2 pediatric studies that provided quantitative data26,31 showed a similar trend toward changes in physical examination with administration of opiates (RR, 2.11; 95% CI, 0.60 to 7.35) (Figure 2). Across both pediatric and adult studies, the summary RR was 1.55 (95% CI, 1.02 to 2.36.)

These results exhibited significant heterogeneity (I²=62.1%; P=.003), indicating that the variation in individual studies’ estimates of the effect of opiates on the examination was greater than would be expected by chance alone. One source of such nonrandom variation may have been the adequacy of analgesia for patients in the opiate group. In 3 comparisons,20,25 pain relief reported by the opiate group did not differ significantly from that reported by the placebo group. Restricting the analysis to the studies with adequate analgesia resulted in the risk for examination changes with opiate administration becoming statistically significant (RR, 2.13; 95% CI, 1.14 to 3.98) (Figure 2), but significant heterogeneity remained (I²=68.6%; P=.002).

Another potential source of heterogeneity may be that studies generally did not distinguish between potentially beneficial changes (such as improved localization of tenderness) and potentially harmful changes (such as changes in peritoneal signs). Only 2 studies27,28 specified changes in peritoneal signs as an outcome; loss of peritoneal signs after drug administration occurred in 5.6% to 18.7% of patients in the group receiving opiates and in 2.6% to 7.7% of those in the control group.

Effect of Opiates on Potential Management Errors

Twelve comparisons (from 9 studies20,24-26,28,31) supplied quantitative data on diagnostic accuracy (Tables 1 and 2), though definitions of diagnostic errors varied across studies. We focused our analysis on the subset of studies that supplied sufficient information to apply our definition of potential management errors. Possible cases of delayed or unnecessary surgeries could be identified in 7 studies, 4 adult21,22,24,27 and

<table>
<thead>
<tr>
<th>Source</th>
<th>No. of Participants</th>
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<th>Examiner</th>
<th>Blinding</th>
<th>Analgesic Administered</th>
<th>Analgesia Greater in Opiates Group</th>
<th>Examination Outcome</th>
<th>Diagnosis Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kim et al.26 2002</td>
<td>60</td>
<td>Age 5-18 y with pain &lt;5 d or SBP &lt;90, suspected biliary or pancreatic disease, IBD, sickle cell anemia</td>
<td>Pediatric EM attending before and after</td>
<td>Examiner blinded; unclear if outcomes assessors blinded</td>
<td>Intravenous morphine sulfate (0.1 mg/kg) vs placebo</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Comparison 1</td>
<td></td>
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<tr>
<td>Green et al.,31 2005</td>
<td>108</td>
<td>Age 5-16 y with abdominal pain of &lt;48 h duration who required surgical consultation</td>
<td>Pediatric EM physician before and after</td>
<td>Examiners blinded; unclear if outcomes assessors blinded</td>
<td>Intravenous morphine sulfate (0.05 mg/kg)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<td>Comparison 2</td>
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<tr>
<td>Kokki et al.26 2005</td>
<td>63</td>
<td>Age 4-15 y with abdominal pain of &lt;7 d duration and &gt;3 cm on VAS</td>
<td>Same surgeon before and after</td>
<td>Examiners and outcomes assessors blinded</td>
<td>Buccal oxycodone (0.1 mg/kg)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Abbreviations: AAA, abdominal aortic aneurysm; ED, emergency department; EM, emergency medicine; IBD, inflammatory bowel disease; RLQ, right lower quadrant; SBP, systolic blood pressure; VAS, visual analog scale.

*Outcome reported, but insufficient information provided for quantitative analysis.
3 pediatric,26,28,31 (Table 3). The specific management errors identified in each study are detailed in Table 4.

In adult studies,21,22,24,27 meta-analysis indicated no significant change in the rate of incorrect management decisions among patients who received opiates (+0.3% absolute increase; 95% CI, −4.1% to +4.7%) (Figure 3). Analgesia was adequate in all these studies, and no significant heterogeneity was present ($I^2 = 8.7%$; $P = .35$). The magnitude of this nonsignificant increase in incorrect decisions is very small. To illustrate, if it had been significant, 333 patients would need to receive opiates to result in 1 management error attributable to analgesia. These data are also compatible with fewer management errors among patients receiving opiates, as the range of the 95% CI suggests that there may be no true underlying difference in effect between opiates and placebo. Moreover, these results reflect the conservative assumption that the 2 patients with missing data in 1 study24 would have contributed to management errors in the opiate group. Excluding those 2 patients from the analysis results in a pooled risk difference of 0% (95% CI, −4.2% to +4.2%).

Meta-analysis of the 3 pediatric studies26,28,31 indicated a nonsignificant absolute decrease in incorrect management decisions (−0.8%; 95% CI, −8.6% to +6.9%; $I^2 = 0.0%$; $P = .71$). Across all studies (adult and pediatric), there was virtually no change in the management error rate for those who received opiates (+0.1% absolute increase; 95% CI, −3.6% to +3.8%) (Figure 3), which translates to an NNH of 909. Analgesia was inadequate in 1 trial,26 though eliminating this trial from the analysis had minimal impact on the estimated error rate (−0.2% absolute decrease in potential management errors with opiates; 95% CI, −4.0% to +3.6%).

We further analyzed the 7 trials21,22,24,26,28,31 by post hoc classification of errors into surgeries that were possibly delayed or unnecessary. Among a total of 816 patients, 7 in the opiate group and 4 in the control group may have experienced a clinically important delay in surgery (Table 3). Meta-analysis of the difference between groups was not informative, as the small number of outcomes produced wide CIs. On the other hand, the rate of delayed surgeries overall was only 1.3% (95% CI, 0.7% to 2.4%).

The frequency of possible unnecessary surgeries was 7.6% (95% CI, 5.2% to 10.6%) among patients who received opiates, compared with 7.9% (95% CI, 5.4% to 10.9%) among patients who received placebo. Meta-analysis showed a trend toward fewer unnecessary surgeries among patients who received opiates for both adults (−0.3%; 95% CI, −7.5% to +6.8%) and children (−2.6%; 95% CI, −9.1% to +3.8%). Among all patients, there was a nonsignificant decrease in the risk of unnecessary surgeries for patients receiving opiates (−0.8%; 95% CI, −5.6% to +4.1%).

**Methodological Limitations of the Studies**

The majority of included studies exhibited important methodological problems. Only 1 study28 indicated adequate concealment of allocation of patients to treatment group, and the outcomes assessors were blinded to treatment assignment in only 4 comparisons.22,27,28 (Tables 1 and 2). Two methodological issues related specifically to the study questions at hand: the use of the same examiner before and after treatment and the adequacy of opiate analgesia.
In all but 2 studies,21,24 the same physician examined the patient before and after the study medication was administered. Physical examination results and differential diagnoses produced by the same examiner will likely be significantly correlated. This creates bias toward the null hypothesis, making it less likely that a significant difference would be found between opiates and placebo for any aspect of the clinical examination. Using the same examiner in a before-after study design requires that clinicians consider whether the results generalize to the examination by a consultant after their patient receives opiates, especially since interrater agreement on the presence of a “surgical abdomen” is only moderate.32 Blinding to study medication was adequate in the 5 studies13,18-20,28 in which it was assessed, providing some support for generalizing the results.

Analogic agents varied across the studies and included opiates not routinely administered to treat acute pain in the emergency department setting. Seven studies22-24,26,27,30,31 used intravenous morphine, but intravenous fentanyl,29 intravenous tramadol,25 intramuscular papaveretum,21 buccal oxycodone,28 and sublingual buprenor-

<table>
<thead>
<tr>
<th>Table 3. Cases of Possible Management Errors, Defined As Delayed Surgery or Unnecessary Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Study</td>
</tr>
<tr>
<td>------------------</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Attard et al,21</td>
</tr>
<tr>
<td>Pace and Burke,22</td>
</tr>
<tr>
<td>Vermeulen et al,24</td>
</tr>
<tr>
<td>Thomas et al,27</td>
</tr>
<tr>
<td>Kim et al,26</td>
</tr>
<tr>
<td>Kokki et al,32</td>
</tr>
</tbody>
</table>

Abbreviation: NR, not reported.
*The presenting complaint was undifferentiated abdominal pain for all studies except Vermeulen et al24 (right lower quadrant pain).
†Refers to a variety of conditions, which occurred in ≤2 patients in each study.
‡Only 71 patients completed the study (4 excluded for protocol violations).
§Only 340 patients completed the study (8 excluded for protocol violations, 2 lost to follow-up [included in sensitivity analysis herein]).
Table 4. Examples of Delayed and Unnecessary Surgeries

<table>
<thead>
<tr>
<th>Study</th>
<th>Delayed Surgeries</th>
<th>Unnecessary Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attard et al,21 1992</td>
<td>Two patients with appendicitis who had delayed appendectomies; initial working</td>
<td>Preoperative diagnoses were appendicitis (5 patients) and perforated peptic ulcer (1 patient); postoperative diagnosis was nonspecific abdominal pain in all patients</td>
</tr>
<tr>
<td></td>
<td>diagnoses not provided</td>
<td></td>
</tr>
<tr>
<td>Pace and Burke,22 1996</td>
<td>None</td>
<td>Preoperative diagnosis was appendicitis; postoperative diagnosis was nonspecific abdominal pain in both patients</td>
</tr>
<tr>
<td>Vermeulen et al,24 1999</td>
<td>Two patients lost to follow-up; in the main analysis, we treated these patients as</td>
<td>Preoperative diagnosis was appendicitis; postoperative diagnosis was nonspecific abdominal pain in all patients</td>
</tr>
<tr>
<td>Thomas et al,27 2003</td>
<td>Delayed cholecystectomy; treating clinicians had noted “borderline evidence for</td>
<td>Two patients with preoperative diagnosis of acute cholecystitis underwent cholecystectomy with no pathological findings; postoperative diagnosis presumed to be nonspecific abdominal pain in both cases</td>
</tr>
<tr>
<td></td>
<td>cholecystitis” but discharged patient for outpatient follow-up, which resulted</td>
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<td></td>
<td>in cholecystectomy. Per study protocol, an independent surgeon unaware of study</td>
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<td></td>
<td>group assignment judged the patient’s presentation as warranting</td>
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<tr>
<td></td>
<td>cholecystectomy during hospitalization</td>
<td></td>
</tr>
<tr>
<td>Kim et al,26 2002 (</td>
<td>None</td>
<td>Preoperative diagnoses not clear; indication for surgery listed as “exploratory laparotomy.” Opiate group included 2 negative appendectomies, 1 patient with pelvic inflammatory disease</td>
</tr>
<tr>
<td>Pediatric Studies</td>
<td>Preoperative diagnosis was nonspecific abdominal pain in all patients</td>
<td></td>
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<tr>
<td>Green et al,31 2005</td>
<td>Three patients in the opiate group and 1 in the placebo group were admitted for</td>
<td>Preoperative diagnoses not stated; in all cases, normal appendix found at laparotomy and no other surgical diagnosis identified</td>
</tr>
<tr>
<td></td>
<td>observation and found to have perforated appendices at laparotomy; 1 additional</td>
<td></td>
</tr>
<tr>
<td></td>
<td>patient in the placebo group was discharged from the ED and readmitted 5 d later</td>
<td></td>
</tr>
<tr>
<td></td>
<td>with acute appendicitis</td>
<td></td>
</tr>
<tr>
<td>Kokki et al,28 2005</td>
<td>Delayed appendectomy; patient admitted for observation and at laparotomy was</td>
<td>Preoperative diagnosis was appendicitis and postoperative diagnosis was nonspecific abdominal pain in all patients</td>
</tr>
<tr>
<td></td>
<td>found to have perforated appendicitis with peritonitis</td>
<td></td>
</tr>
</tbody>
</table>

Abbreviation: ED, emergency department.

Figure 3. Absolute Change in Risk of Incorrect Management Decisions With Opiates

The forest plot shows the trials that provided data on potential errors in clinical management, defined as possible delays in necessary surgery or the performance of possibly unnecessary surgery. The overall random-effects estimate shows almost no difference in the risk of incorrect management decisions (+0.1% absolute increase with opiates; 95% confidence interval [CI], −3.6% to +3.8%). The trials did not exhibit significant heterogeneity ($I^2 = 0.0\%$, $P = 0.67$). Size of data markers is proportional to the weight of the individual studies in the meta-analysis.

The results from the analysis suggest that opiates might change the physical examination findings, you decide to administer intravenous morphine sulfate. When examined by the surgical consultant, your patient is more comfortable.
pared with when you evaluated her. The surgeon finds right lower quadrant tenderness on deep palpation without peritoneal signs. A computed tomography (CT) scan confirms the clinical impression of acute appendicitis. The patient undergoes an uncomplicated laparoscopic appendectomy and recovers uneventfully.

**THE BOTTOM LINE**

Despite methodological limitations, we conclude that opiate analgesics do alter the physical examination in patients with acute abdominal pain. Few studies specifically reported on examination changes that could alter the decision to operate (such as altered peritoneal signs), making it difficult to assess the significance of these changes. However, opiate administration seems to have negligible impact on clinical management. Despite using a definition in our analyses that would favor withholding opiate analgesia, 909 patients would have to receive opiate analgesia to result in 1 potential management error. The CI around this estimate includes the possibility that more liberal use of opiate analgesia reduces management errors, but it also includes the possibility of a 3.6% absolute increase in management errors. This error rate (associated with an NNH of 28) reflects a conservative definition in which surgeries labeled as either delayed or unnecessary may have met appropriate standards of care. As shown in Table 4, some of the cases termed management errors may fall within the scope of acceptable surgical practice. An exploratory laparotomy that reveals a nonsurgical condition, or even no specific diagnosis, is not necessarily a management error. Labeling such practices as potential errors reflects the conservative nature of our analysis. None of the patients defined as having experienced a management error experienced significant morbidity or mortality.

Clinicians incorporate a complex series of inputs to arrive at a management decision, including the patient’s history, physical examination, and laboratory and radiological data. The debate in the literature has centered on the effects of opiates on physical examination findings. This focus runs counter to the generally accepted view that the history by itself provides the crucial information necessary for a diagnosis in many patients. However, no study specifically addressed the effect of opiates on the accuracy of a patient’s history. Thus, we do not know whether analgesic doses of opiates cloud a patient’s memory or instead calm the patient so that he or she can provide a more coherent and accurate history.

Improvements in imaging have led to changes in practice patterns, whereby surgical diagnosis is increasingly predicated on the results of imaging (particularly CT scan). Use of abdominal imaging may have decreased the emphasis in practice on the physical examination as a decision-making tool for patients with acute abdominal pain. Our results primarily pertain to patients in whom the initial clinical examination does not yield a specific diagnosis, necessitating reexamination, imaging studies, or both. Within this group, the subset of patients who have surgical problems but nondiagnostic imaging studies may be most susceptible to management errors caused by altered clinical examination findings. The size of this group of patients is not clear, nor is it known which diagnoses are likely to present in this fashion.

Greater reliance on imaging also raises the question of how opiate use affects the requests for, and interpretation of, abdominal ultrasound or CT scans. Two studies have evaluated the effects of opiate analgesia on the accuracy of ultrasound. One study included in our analysis examined the influence of opiates on the accuracy of ultrasound in diagnosing acute appendicitis; administering opiates increased the specificity of ultrasound, while sensitivity decreased. Another study found no change in the accuracy of the sonographic Murphy sign for diagnosing acute cholecystitis if patients had received opiates. No study has yet investigated the influence of analgesia on the use or interpretation of CT scanning in evaluation of abdominal pain.

What are the implications for clinical practice? While the theoretical possibility of harm from liberal administration of opiates exists, few empirical data document the extent of this harm. One retrospective study found an increased incidence of significant morbidity in patients with an acute abdomen who were given opiates, but causality is difficult to determine, as the opiate effect may have been confounded by pain severity. The rate of perforated appendicitis is often used as an indicator of delayed surgery. This rate appears to have remained stable at 15% to 20% of appendicitis cases over the last 3 decades, despite some change in physicians’ attitudes toward opiate use over that time. Two retrospective analyses of patients with proven appendicitis did not find any difference in the rate of perforated appendicitis between patients who received or did not receive analgesia. Reports of analgesia administration leading to adverse consequences remain limited to case reports.

While giving opiates to patients with acute abdominal pain appears to alter the physical examination, the use of opiates leads to virtually no increase in incorrect management decisions. Given the humane duty of physicians to relieve pain and the totality of the available evidence, clinicians should administer analgesia unless further studies document adverse events to patients directly attributable to opiates. Further studies should also clearly define and measure beneficial and harmful changes (both accuracy and delays) in the history, physical examination, and patient management. In addition, investigators should attempt to define the patient population in which physical examination changes are likely to influence management as well as consider whether opiates affect the need for CT scanning and if analgesia might im-
prove (or worsen) the accuracy of imaging studies.

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