Codeine - a national survey

Dannie Seddon, Ursula Dickson
Birmingham Children's Hospital, Birmingham, UK

Codeine is a weak opiate, which has been used in paediatrics for years. There has been increasing concern regarding its use because of the risk of severe respiratory depression in certain high risk groups in the population.

In July 2013, the MHRA issued a statement on its use. This recommended codeine be used in children over 12 only, with moderate pain and in whom paracetamol and ibuprofen is insufficient. Furthermore, it stated that it is contraindicated in children under 18 who are undergoing either tonsillectomy or adenotonsillectomy for obstructive sleep apnoea[1].This follows a review by the European Medicines Agency, after a number of codeine related fatalities were reported[2].

The APAGBI, following the MHRA statement issued a recommendation that codeine should be used with caution in children with symptoms of sleep disordered breathing.

Following these recommendations, we conducted a survey of APAGBI consultant members, to identify whether prior to the statement codeine had been in frequent use, whether practice had changed since the statement's release, and whether clinicians had experienced any problems with either codeine or its alternatives.

A total of 195 completed surveys were returned (with a denominator of 600 consultants, 32.5%). Of the 195, 145 (74.36%) consultants had used codeine prior to the MHRA guidelines being released.

The most frequent problem associated with codeine use was a complete failure of analgesic effect, but over 70% of the consultants who used codeine reported no problems at all. Following the guideline publication, 121 consultants stated that they had changed their practise (121/130, 93%).

Twenty consultants (16.5%),reported problems with the drug they had changed to, most often this was oral morphine. These problems were mostly related to reluctance to administer the drug, or problems with the pharmaceutical preparation of the take home formula.

Of the consultants that did not use codeine prior to the statement the majority used oral morphine (45/50, 88%). Five consultants reported problems with the alternative, again the majority related to reluctance to administer.

The results show that the majority of respondents followed the MHRA guidelines. The most frequently described problems with alternatives seem to be related to the logistics and familiarity of administration. There is potential to repeat this survey in a year's time to assess the practice and problems of administration, and whether with time these have been obviated.

References

1. Codeine for analgesia: restricted use in children because of reports of morphine toxicity. Drug Safety Update. Volume 6, Issue 12, July 2013.
2. More Codeine Fatalities After Tonsillectomy in North American Children. Kelly L, Rieder M, van der Anker J et al. Pediatrics, 2012; 129 (5) e1-e5.

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