CPER digest September 2015

You are called for a 32 year old male patient complaining of severe right flank pain for several hours. He describes the pain as "coming in waves". He denies any lower urinary tract symptoms such as dysuria, urgency or frequency and has not had a fever. He is pale, clammy and complains of nausea. The patient has not taken anything to relieve the pain. He is otherwise healthy except for a history of previous renal colic and has no known drug allergies.

Initial vitals are as follows:

HR – 110bpm, regular; RR – 16/min, regular; A/E equal bilaterally, no adventitious sounds; BP – 118/72; O2 sat – 99% on RA; Rhythm interpretation – Sinus tachycardia @ 110bpm, Pain – 8 out of 10

Based on your assessment findings, you believe the patient to be having an episode of renal colic (colicky, ie. intermittent, wave-like pain usually in the flank area from stones that are caught in the ureter**.** As the stones move lower in the ureter towards the bladder, the pain may move into the lower abdomen, groin area or perineum). Associated symptoms can include hematuria, diaphoresis, nausea and vomiting.

Before this patient receives pain management, alternative diagnoses should be considered. Upper urinary tract infections may have similar features (ache in the flank and urinary symptoms). A ruptured abdominal aortic aneurysm (AAA) has a very high mortality rate and often presents with similar pain as renal colic, making it difficult to differentiate in the field. Always have a high suspicion of AAA in patients (especially those > 50 years of age) who present with flank pain and/or back pain, and be sure to elicit if the patient has had an episode of syncope, is hypotensive or has poor acute distal circulation. It is very important to relay these important details to the ED staff.

As per the Adult Analgesia Medical Directive (PCP Medical Directives, Version 3.3, orange section, pages 78-80 and ACP Medical Directives, Version 3.3, brown section, pages 120-123), suspected renal colic in a patient with a prior history meets the inclusion criteria, whereas urinary infections and suspected AAA would not. For this patient, consider ketorolac 10-15mg IM/IV (PCP and ACP) and adding morphine 2-5mg SC/IV, q 5 mins x 4 doses (ACP) for pain management.

If the patient's nausea becomes worse or he begins to vomit, consider dimenhydrinate 50mg IV/IM as per the Auxillary Nausea/Vomiting Medical Directive (PCP Medical Directives, Version 3.3, orange section pages 76-77 and ACP Medical Directives, Version 3.3, brown section, pages128-129).

*****Please be reminded that to receive analgesia for pain management for suspected renal colic, the patient must have a prior history of renal colic.*****

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