

4 reasons why codeine should not be sold without prescription.

Written by The Conversation

The TGA has called for submissions on the idea of [deleting codeine from Schedule 3](#) (pharmacy only) availability and moving it to Schedule 4 (prescription only). From my point of view this is a good thing, though I realise that not everyone will agree at first blush.

There will be a huge backlash to the proposal from the OTC medicines industry as well as pharmacists, since both these groups have financial and business incentives to preserve the status quo. The scientific and clinical arguments against continuing to make codeine readily available are compelling, and have been becoming stronger as time goes by. It's time to put principle ahead of profits once again.

OTC doses of codeine aren't really more effective than the drugs they are added to

Codeine is a poor analgesic in its own right. The codeine molecule is essentially morphine with a methyl group added. A group of enzymes in the liver called Cytochrome P450 2D6 removes the methyl group from around 10% of any given dose of codeine which renders it into active morphine. This smaller dose of morphine is the bit that relieves your pain. Genetic variability means it's a lottery whether you will be a responder or not. Common drugs such as SSRI antidepressants interfere with this conversion.

The amount of codeine added to OTC preparations such as Nurofen Plus or Panadeine does not seem high enough to add any benefit to that of the ibuprofen or paracetamol respectively. According to a [Cochrane review](#) you need to treat 12 people with 60mg of codeine alone to get one who has a 50% reduction in acute pain. Adding lower doses of codeine to more effective drugs achieves nothing but more side effects.

There are better alternatives to codeine-containing OTC formulations

For instance, a combination dose of 200mg ibuprofen/500mg paracetamol won handsomely in terms of both effectiveness and tolerability [in a head-to-head trial](#) against paracetamol 500mg/codeine 15mg tablets.

For people with pain that responds well to low doses of opioids, there are low-dose patches and

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'non-strong' opioid drugs such as tramadol and tapentadol. So both with and without prescriptions, there are excellent alternatives to the relatively inefficient and old-school approach of using codeine for acute and sometimes persistent pain.

Unsupervised dose escalation can have serious risks with no prospect of benefit

If you don't realise that most of the codeine you are taking isn't giving you pain relief, but you are constantly told it's 'heavy duty' and for 'strong pain only' it makes sense to escalate the dose if your pain doesn't get better. There would be few GPs or hospital doctors who wouldn't have seen some cases of liver damage from high paracetamol doses. Ditto for gastrointestinal or kidney injury from ibuprofen doses taken in response to undermanaged pain. The record I have seen personally was someone taking 45 tablets a day of OTC paracetamol/codeine.

Addictive behaviour can potentially be triggered by opioids of all strengths, and is difficult to recognise until out of control. There have been clearly and abundantly documented harms from addiction and non-addictive dose escalation to set against the very marginal (if any) benefit. Regular codeine use even at moderate doses can cause chronic rebound headaches which worsen when attempts are made to reduce or discontinue it.

This is an opportunity to improve the care of acute pain in the community

Codeine is old hat. It's a constipating cough suppressant which gives some people pain relief as a side effect. GPs are roughly split between those who prescribe it out of longstanding habit and those who won't prescribe it at all. Most are unaware of the inefficiency of codeine metabolism and underestimate the side effects. This regulatory change will force a whole new approach to acute pain treatment which will have to be informed by up to date and more comprehensive pain education of the community and primary care health practitioners.

Cleverly implemented, the move of codeine to prescription-only status will be a good thing. It has already happened in the US, Sweden and Germany to name three countries comparable to us. Our current arrangements are not serving the public good, by perpetuating last-century prescribing habits and providing drugs freely which are neither particularly safe or particularly effective. Pharmacy staff cannot reliably spot abusers, particularly if they don't fit the common social stereotype of a drug abuser. In any case, they can only deny service so the shopper goes elsewhere. Severe pain demands a diagnosis and skilled assessment. Persistent pain even more so. It's time to acknowledge that codeine, like dextropropoxyphene before it, has been

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overtaken by better, safer options.

*I'd like to thank Prof Stephan Schug from the University of Western Australia for helpful guidance with this article.

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