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Benger, J. (2006) Brutacaine vanquished, but pain remains (commentary). *Emergency Medicine Journal*, 23 (11). p. 823. ISSN 1472-0205 Available from: <http://eprints.uwe.ac.uk/4834>

We recommend you cite the published version.

The publisher's URL is:

<http://dx.doi.org/10.1136/emj.2006.040980>

Refereed: No

(no note)

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Brutacaine

“Brutacaine” vanquished, but pain remains

J Benger

Has “brutacaine” find its rightful place in the history books?

At the age of 2 years, I was admitted to my local cottage hospital for a minor surgical procedure. In keeping with routine practice in the 1960s, my parents were allowed to visit only for a few hours each day, and they vividly recall my resulting distress. Furthermore, on returning to the hospital 10 days later, for removal of sutures, my reaction was so extreme that a normally even-tempered boy had to be dragged out from under a table and physically restrained by six adults to complete a simple procedure. Fortunately, I have no recollection of these events, but my parents speculate that this was the point I decided on a career in medicine, to ensure that I never found myself on the losing side again.

Much has changed over the past four decades, and conscious preschool children are now rarely separated from their parents in hospital. Just as important, but slower to gain widespread recognition, is the requirement for adequate analgesia and sedation during painful procedures.¹ It is entirely wrong to equate an inability to vocalise pain with an inability to perceive it, yet physical methods of restraint continue to be advocated.²

Emergency medicine has been a leader in ensuring adequate analgesia for children—for example, in the administration of morphine for abdominal pain³ and the introduction of nasal diamorphine.⁴ In this issue of the *Emergency Medicine Journal*, Loryman *et al*⁵ (page xx) from Leicester describe what has been

achieved in the UK to date, and also provide a clear indication of what more needs to be done.

This well-conducted postal survey is unusual in obtaining a tenacious 70% response rate from 283 major emergency departments in the UK that treat children, although there remains a distinct possibility that non-responders are different from the emergency departments described here, and perhaps less likely to use analgesia and sedation.

Encouragingly, however, 81% of emergency departments in UK report the use of procedural sedation in children, with two thirds opting for midazolam and one third for ketamine. It is, perhaps, surprising that ketamine is not used more often, as there is good evidence of its superiority to midazolam,⁶ and overall safety when used for sedation in paediatric emergency departments.⁷ More widespread use of ketamine may be inhibited by a prevailing view that it is an “anaesthetic” drug, and reluctance on the part of anaesthetists to support its use by other clinicians. This is disappointing, because there are powerful reasons to view ketamine as a unique dissociative drug, rather than a general anaesthetic,⁸ and because emergency doctors are rapidly becoming the experts in its use. A recent review of paediatric sedation and analgesia, published in *The Lancet*, states that “because of its unique preservation of airway reflexes, ketamine might be preferred over other agents for urgent or emergent procedures when fasting is not assured”.⁹

For analgesia, the findings are less encouraging. Only 55% and 41% of emergency departments in UK use intranasal diamorphine or topical local anaesthetic gel. Both are highly effective analgesics and, availability issues notwithstanding, should be a standard of paediatric emergency care. Loryman *et al*⁵ rightly highlight the currently poor compliance with our own association’s standard for acute pain control, and issue an unmistakable challenge for the future.

In summary, this survey shows good, but not universally excellent, practice. It is our task to make appropriate analgesia and sedation a routine part of all painful procedures in children, so that we can finally consign “brutacaine” to its rightful place in the history books.

Emerg Med J 2006;**23**:823.

doi: 10.1136/emj.2006.040980

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Accepted 4 September 2006

Competing interests: None declared.

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Emerg Med J 2006 23: 823

doi: 10.1136/emj.2006.040980

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