



Medication Policy

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General Considerations

Storage and Security protocols are to be followed to ensure that all medication is secured and access to the medication is restricted to approved personnel only. This particularly applies to Schedule 8 medications. Such medications require two witnesses for all handling, administration, stocktaking and destruction of expired stock.

An induction protocol will be followed to ensure that any new individuals coming to the organisation are systematically taken through policies and protocols relating to the storage and supply of medication, including Australian Sports Anti-doping Authority (ASADA) Education Modules.

Stock-takes of medication are conducted monthly. A printed report of the stock take report is provided to the CMO.

TUE Medications

Bright alert labels are placed on any medications which are restricted for use by athletes under the World Anti-Doping Agency (WADA) Code. Athletes prescribed such medications must be given written instructions regarding appropriate use to avoid the possibility of an anti-doping rule violation.

Provision of medication to athletes by non-medical practitioners

Medications are provided to athletes on the specific instruction of a medical practitioner. In instances where in a medical practitioner is unavailable, the following medications may be issued by a registered nurse;

- Paracetamol
- Vitamin C and Zinc
- Povidone-Iodine throat gargle

Team travel

When travelling internationally with a team, doctors should follow the procedure outlined below:

- Obtain Licence and Permission to Export and/or Import Controlled Drug Substances via www.tga.gov.au/import-and-export.
- Create a detailed inventory of medications carried
- Maintain comprehensive records of all medications dispensed
- Prepare appropriately including an understanding of regulations pertaining to carriage/import of medications in country of destination
- Reconciliation of medication usage on completion of tour

Teams travelling without a doctor

Where possible, it is preferable that a doctor travels with athletes on tour. This is particularly important when travelling to destinations where;

- Access to quality medical care is tenuous
- The environment increases the likelihood of significant medical issues
- The nature of the sport (contact, collision) increases the likelihood of significant medical issues

Where there is no doctor accompanying a travelling team, it is the athlete's responsibility to make an appointment with a doctor, prior to the commencement of the tour. At this appointment, the athlete can be provided with an appropriate personal supply of medications and relevant advice for prevention of illness and/or treatment of conditions which may be reasonably anticipated.



The relevant sporting organisation should assess medical resources at the tour destination(s) and have such resources documented and provided to the therapist prior to departure, to minimise time and energy expended by the therapist in sourcing medical assistance on tour.

Athletes, coaches, managers and therapists should receive education on the role of the therapist in the absence of a doctor. In particular, such education should remind staff that the team therapist;

- Is not a doctor and should not be put in the position of having to behave as a 'pseudo-doctor'
- Will not carry or supply medication for athletes
- Should communicate with appropriate medical staff (AIS medical staff or sporting organisation's Chief Medical Officer (CMO)), should medical matters of a more serious nature arise.
- Will keep all relevant parties informed, e.g. if communicating primarily with sporting organisation CMO, copy in AIS CMO and Lead Physical Therapist, as responsible officers for Sport Australia staff.
- Should source medical treatment from local medical providers, where access to AIS medical staff is not possible.
- Should source prescription medication from local medical providers, in collaboration with NSO/AIS medical staff, in situations where prescription medications are unexpectedly required.
- When sourcing treatment from a local medical practitioner, the athlete must ensure the local medical practitioner is aware of the requirement for adherence to the WADA Code.

No Needles Policy

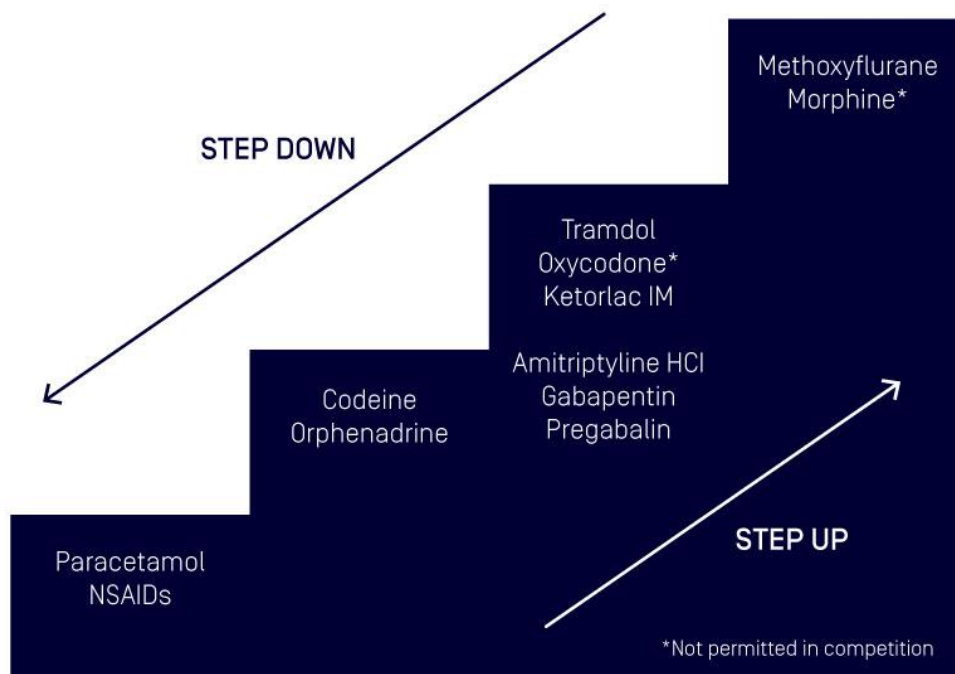
The AIS has a No Needles Policy which complements the AIS Medication Policy. It covers matters to do with the administration of injection therapy and the carriage of injection equipment.



Analgesic Policy

Athletes should be asked to rate pain out of 10 at all pain presentations.

The AIS has adapted the World Health Organisation Analgesic Ladder to guide a step up, step down approach to treatment of pain.



The analgesic ladder is based on the principle that medical practitioners should use the lowest dose and the safest medication to achieve pain relief. Where the medication is not efficacious, the medical practitioner should 'step up' the analgesic intervention. As soon as the symptoms begin to abate, the medical practitioner should 'step down' the analgesic intervention.

1. For mild to moderate pain the use of regular paracetamol without opiates is the treatment of first choice.
2. If there is clinical evidence of inflammation at the first presentation, a nonsteroidal anti-inflammatory drug (NSAID) may be preferred over paracetamol.
3. NSAIDs should be used for the shortest duration possible with a view to switching across to paracetamol.
4. Where paracetamol alone or an NSAID alone fails to control pain, paracetamol and codeine is an appropriate next option.
5. Where there is severe inflammatory pain, it may be appropriate to combine an NSAID with codeine.
6. Where the pain is strongly associated with muscle spasm, orphenadrine is an appropriate first drug of choice.
7. Tramadol must be used with caution. The analgesic effect of tramadol is unlikely to be superior to paracetamol/codeine but the side effect profile is significantly worse. Tramadol should only be used in those who are intolerant of codeine.
8. Where there is strong evidence of significant neuropathic contribution to the pain, use of amitriptyline HCl, gabapentin or pregabalin should be considered.
9. Amitriptyline HCl can be efficacious in situations of chronic pain and / or where there is evidence of pain centralisation.
10. Oxycodone can be used for severe pain, often in the post-operative period. **OXYCODONE IS NOT PERMITTED DURING COMPETITION.**
11. Where strong analgesics are required (oxycodone, tramadol, high-dose codeine), that medication should be used for the shortest possible duration required to control the pain, before changing to a less strong analgesic (paracetamol, low-dose codeine).
12. Doctors working with athletes need to be aware that athletes discharged from hospital or acquiring medications from sources external to the athlete's sporting organisation are sometimes provided with quantities of strong analgesics in excess of clinical requirements.
13. Intramuscular ketorolac can be used in acute severe pain (fractures, acute spinal pain) where there is need for immediate strong pain relief.
14. Methoxyflurane and/or morphine can be used in situations of emergency analgesia for severe pain where the athlete requires relief for transportation to hospital. **MORPHINE IS NOT PERMITTED IN COMPETITION.**



NSAID Policy

1. Regular paracetamol should be the primary baseline treatment for most musculoskeletal injuries. NSAID medication should be used when there is good clinical evidence of an inflammatory component to the pain aetiology.
2. Medical practitioners should take a detailed history of previous adverse drug reactions, history of gastrointestinal symptoms, hypertension, renal disease, asthma and urticarial reactions.
3. Athletes should be asked about their prior experience of NSAIDs in terms of efficacy and side effects.
4. Athletes at high risk for gastrointestinal complications from NSAIDs should be offered:
 - a. Regular paracetamol before an NSAID
 - b. Celecoxib as the preferred NSAID
 - c. Ibuprofen as the preferred non-selective NSAID, where Cox 2 coverage is deemed not appropriate
 - d. PPI cover while taking an NSAID
5. Athletes considered at high risk for cardiovascular complications should be offered ibuprofen or naproxen.
6. Prolonged ingestion of NSAIDs should be avoided.
7. NSAIDs should be prescribed at the minimal efficacious dose.
8. Where it is deemed appropriate to treat an acute injury with NSAIDs, medical practitioners should aim to use the NSAIDs for about five days before switching to regular paracetamol.

Sleeping Medication Policy

Medical practitioners should not assume that all travelling athletes require sleeping medication. Many individuals will cope with travelling and performing at the destination without any requirement for sleeping medication. Medical practitioners need to be aware of this when discussing medication with or in front of athletes. Indicating that a particular medication will 'work wonders' for one athlete could be construed as 'promotion' of the medication, by other athletes observing the interaction.

Sleeping medication may be appropriate to assist some athletes adjust to variation in time zones, associated with travel. Sleeping medication can also be used in the short term, to assist athletes who are having difficulty with sleeping for non-travel related reasons. Sleeping medication is not a long-term solution for insomnia.

When athlete presents with difficulty sleeping, the medical practitioner should discuss sleep hygiene with the athlete and provide the athlete with written material regarding appropriate sleep hygiene strategies. Depending on the causation of the sleep difficulty, a referral to Performance Psychology may be appropriate.

The options for use of sleep medication include melatonin, benzodiazepines (temazepam, diazepam), Z-drugs (e.g. zolpidem) and low dose tricyclic antidepressants such as amitriptyline hydrochloride. Benzodiazepines and Z-drugs have addictive qualities and can lead to dependence.

There have been reports in the media and in medical literature of individuals having hallucinations, amnesia, unusual behaviour and/or inappropriate behaviour after taking Z-drugs. The cases officially reported are relatively few in number and did not indicate a significant difference in the risk profile between Z-drugs and benzodiazepines. However, doctors must keep in mind the potential for such reactions.

Melatonin, benzodiazepines and Z-drugs should not be used for long periods of time and certainly not for more than a couple of weeks in extreme circumstances. The usual procedure for provision of sleeping medication associated with travel should be one dose to assist with sleep while travelling and two doses to assist with sleep on arrival at destination. Similarly, one dose can be provided on the return trip and two doses to assist with sleep when arriving back at home base. This should mean that for a standard travel trip, athletes will be provided with not more than six doses of a sleeping medication.

Low dose tricyclic antidepressants can be used to assist with attaining stable sleep patterns over a more prolonged period of time. However, the use of such medication should not replace advice regarding sleep hygiene strategies.



Athletes will be provided with the following information in writing, at time of supply of sleeping medication.

- Sleeping tablets are not a long-term solution to sleep difficulty
- Good sleep hygiene is the basis for ensuring healthy sleeping patterns
- Sleeping tablets are addictive and some individuals will experience withdrawal effects, after using sleeping tablets regularly for as little as one week
- Sleeping tablets should only be taken for short periods of time to assist with sleeping difficulty. Ideally this would not be for more than a few days in succession.
- Sleeping tablets should only be taken once you are in bed, not on your way to bed
- Sleeping tablets should not be taken in conjunction with other sedative medication such as other sleep medication, strong pain-killing or antidepressant medication.
- Sleeping medication should not be taken in conjunction with alcohol, caffeine drinks or any other psychoactive substances.

Stilnox and the AOC

While there is debate about the scientific evidence of increased adverse side-effects from the Z-drugs as opposed to using benzodiazepines, medical practitioners need to be aware of the Australian Olympic Committee ruling regarding Stilnox. The position of the AOC is that Stilnox will not be permitted at any Olympic events. Given that the Olympics represent the peak performance goal for many athletes, it is questionable whether athletes who are planning to attend the Olympics should be using a medication for sleep adjustment purposes which they will be unable to use at their peak event.


Policy Summary

1. Sleep hygiene will be promoted as the basis for obtaining normal sleep patterns.
2. Sleeping medication will be prescribed for short duration use, not longer than three days in succession.
3. Melatonin or temazepam will be utilised as the first line treatment.
4. Z-drugs will be the second line treatment, where temazepam is deemed not appropriate by the medical practitioner.
5. Where appropriate, amitriptyline hydrochloride may be utilised where the medical practitioner believes this is the most appropriate treatment. This medication may be utilised for longer periods of time where medical conditions other than insomnia warrant such treatment.
6. Doctors will warn the athlete of potential adverse effects and provide written information on sleeping medication at each episode of prescription





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