

## **The Essentials of Pain Management**

**Presenter**  
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## **TO EASE PAIN AND SUFFERING IS SIMPLY DIVINE**

Joanne Skillman FNP-C,MSN,RN

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### **Objectives**

- Describe the classifications of pain.
- Perform initial and ongoing pain assessment.
- Describe WHO organization standards by selecting step one, two and three agents for different patient conditions.
- Assess and recognize the potential for somatic, visceral, and neuropathic pain.
- Understand the difference between addiction and tolerance.

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**Pain management is comprised of initial and ongoing assessment of pain, implementation of appropriate interventions to relieve pain, and measurement of outcomes.**

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**What is Pain?**

**Pain is described as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.”**

Federation of State Medical Boards of the United States, Inc. Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. Eules, TX: 1998)

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**What is Pain?**

- **Pain is “Whatever the experiencing person says it is, existing whenever he says it does.”**
- **There is only one pain that is easy to bear: it is the pain of others. (Leriche, 1939,p.24)**
- **Pain is a nursing diagnosis.**

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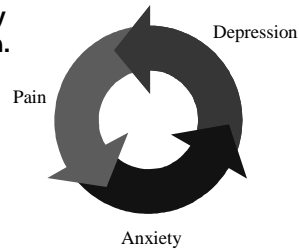
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## A Vicious Cycle

- Unrelieved pain leads to anxiety and depression.



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## The Gold Standard

- The clinician must accept the patient's report of pain.
- The single most reliable indicator of the existence and intensity of pain, and any resultant distress, is the patient's self report.



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## JACHO Says . . .

“The management of pain is appropriate for all patients, not just the dying patient. Pain management is considered a Patient's right.”



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## The Goals of Pain Management

Comfort vs. Function



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## Types of Pain

Visceral  
(Nociceptive)



Somatic  
(Nociceptive)

Neuropathic



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## Character and Quality

**Visceral pain** is usually described as:

- Squeezing
- Deep pressing crushing
- Cramping
- Bloating
- Nausea and vomiting

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**Character and Quality**  
**Somatic Pain**  
**Bone and skin pain** is usually described as:  
Worse with movement  
Muscle aching  
Dull  
Steady  
Tender to pressure

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**Character and Quality**  
**Nerve Pain**  
**Nerve pain** is usually described as:  
Burning                      Tingling  
Sharp shooting              Throbbing  
Numbness              Light touch is painful  
Itching

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**Why Manage Pain?**  
Stress hormone response  
Flight or fight alarm response  
Promotes breakdown of body tissue  
Increases metabolic rate  
Increases blood clotting  
Increases water retention

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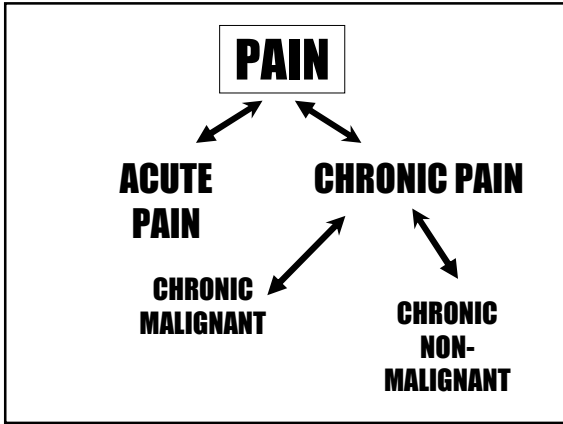
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**What is Acute Pain?**

“Acute pain is the normal predicted physiological response to an adverse chemical, thermal, or mechanical stimulus and is associated with surgery, trauma, and acute illness. It is generally time-limited and is responsive to opioid therapy, among other therapies.”

Federation of State Medical Boards of the United States, Inc. Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. Euless, TX: 1998)

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**Acute Pain**

- \* Increased heart rate
- \* Pallor and perspiration
- \* Crying, moaning, frowning
- \* Immobilizing, withdrawing, rubbing painful body part, muscle tension, clenching fist
- \* Disturbed amount and quality of sleep
- \* Anxiety

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### Examples of Acute Pain

- \* Post-surgical pain
- \* Post-trauma pain, fractures
- \* Infection
- \* Myocardial infarction
- \* Bowel obstruction
- \* Torn muscles, ligaments

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### What is Chronic Pain?

Chronic pain is “a pain state which is persistent and in which the cause of the pain cannot be removed or otherwise treated. Chronic pain may be associated with a long-term incurable or intractable medical condition or disease.”

Federation of State Medical Boards of the United States, Inc. Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. Eules, TX: 1998)

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### Chronic Pain

- \* May be absence of verbal indications of pain; may be increasingly withdrawn or attempt to talk about other things
- \* Physical inactivity in response to pain, exhibited by more frequent sleep time, decrease in ADL function, decreased participation in activities and interpersonal relationships
- \* Weight gain and perpetual fatigue
- \* Depression

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### Examples of Chronic Pain

- **Chronic malignant**
  - Cancer related
    - Advanced and progressive
- **Chronic non-malignant**
  - Arthropathies
    - Myalgias
    - Skin and mucosal ulcerations
    - Ischemic disorders
    - Neuropathic pain and headaches

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### Breakthrough Pain

- Occurs between scheduled doses of analgesia
  - \* Immediate release analgesics are needed to control these occurrences

### Incidental Pain

- Pain on movement or caused by procedures such as dressing changes, therapies
  - \* Immediate release analgesics

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### Prevalence of Pain

*Pain is a major, yet largely avoidable public health problem.*

- Over 30 million Americans suffer from chronic non-malignant pain.
- Acute and chronic pain are serious problems for 20-30% of the U.S. population.
- Over 70% of patients with advanced cancer report having moderate to severe pain.

(JACHO 1999) (Holmquist GL. *Pharmacy Times*, 1999) (AAMC 1999) (APF 1999)

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## Patients Dying in Pain

*Too many dying people suffer preventable pain*

- Pain treatment is inadequate in 84% of patients with aids
- 73% of advanced cancer patients admitted for palliative care receive inadequate pain relief

(Field, MR, Cassel CK, eds. *Approaching Death: Improving Care at the end of Life*. Washington, D.C. National Academy Press: 1997) (Briebart W, Rosenfeld BD, Passik SD, et al. *Pain*, 1996) (Brescia F. J, Portenoy RK, Ryan M, et al. *J Clin Oncol*, 1992)

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## Under Medication of Patients with Pain

86% of physicians reported that the majority of patients with pain were under medicated.

(Von Roenn JH, Cleeland CS, Gonin R, et al. *Ann Intern Med*, 1993)

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## Unrelieved Pain

- Chronic pain patients
  - 40% report that their pain in out of control
- General public
  - 71% avoid calling the doctor when in pain
  - 46% avoid medication until the pain “gets bad”
  - 35% avoid medication until the pain in unbearable

(APS 1999) (Bostram M. *J Pain Symptom Manage*, 1996)

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### **Patient Barriers to Effective Pain Management**

- **Reluctance to report pain**
  - Many patients silently tolerate unrelieved pain
- **Reluctance to take pain medications**
- **Lack of adequate education regarding available pain remedies**

(AHCPR 1994) (APS 1999)

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### **Healthcare Professional Barriers to Effective Pain Management**

- **Inadequate training in pain management**
  - 52% of oncologist surveyed considered their training to be poor
- **Poor assessment of pain**
- **Concern about:**
  - Regulation of controlled substances
  - Tolerance
  - Side effect management
- **Fear of addiction**

(AHCPR 1994) (VonRoenn JH, Cleeland CS, Gonin R, et al. *Ann Intern Med.* 1993) (AAPM & APS 1997)

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### **Healthcare System Barriers to Effective Pain Management**

- **Low priority given to pain treatment**
- **Inadequate reimbursement**
- **Restrictive regulation of controlled substances**
- **Problems with availability of or access to treatment**

(AHCPR 1994) (APS 1997)

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### Barriers to Effective Pain Management: Cancer and Non-Cancer

- Failure of:
  - Patients to comply with medication regimens
  - Healthcare professionals to adhere to guidelines and standards
  - Institutions to adopt and enforce guidelines and standards

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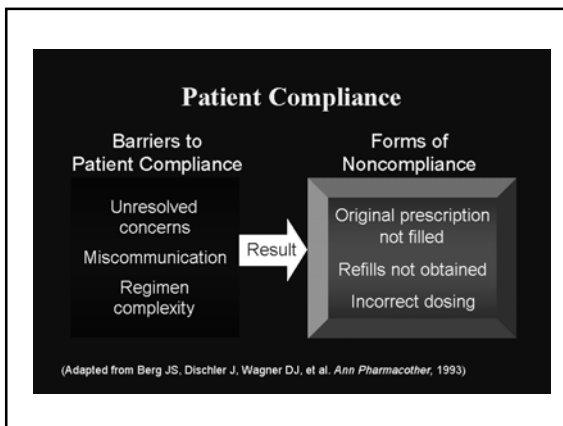
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### Guidelines and Consensus Statements for Improving Pain Management

- 1999 Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- 1999 American Pain Society (APS)
- 1997 American Academy of Pain Medicine (AAPM) and APS
- 1996 World Health Organization (WHO)
- 1994 Agency for Health Care Policy and Research (AHCPR)

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**JCAHO Revised Standards for Pain Management**

- Patients have the right to appropriate assessment and management of pain.
- Patients are involved in all aspects of their care, including making care decisions about managing pain effectively.
- The goal of the care of patients is to provide individualized care in settings responsive to specific patient needs.

(JCAHO 1999)

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**JCAHO Revised Standards for Pain Management (cont.)**

- Policies and procedures support safe medication prescription or ordering
- Patient is monitored during the post procedure period
- Patients are taught that pain management is part of treatment
- The discharge process provides for continuing care based on the patient's assessed needs at the time of discharge
- The organization collects data to monitor performance

(JCAHO 1999)

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**APS Guidelines: Treatment of Acute Pain and Cancer Pain**

1. Individualize therapy
2. Administer analgesics regularly
3. Know your opioids
4. Give infants and children adequate doses
5. Follow patients closely
6. Use equianalgesic doses when switching opioids
7. Recognize and treat side effects

(JCAHO 1999)

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**APS Guidelines: Treatment of Acute Pain and Cancer Pain** (cont.)

- 8. Be aware of hazards of meperidine and mixed agonist-antagonists
- 9. Do not use placebos to assess pain
- 10. Treat tolerance
- 11. Be aware of the development of physical dependence and prevent withdrawal
- 12. Do not confuse addiction with physical dependence or tolerance
- 13. Be alert to the psychological state of patients

(JCAHO 1999)

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**AAPM and APS Consensus Statement**

*Principles of good medical practice should guide the prescribing of opioids*

- Evaluation of the patient
- Treatment plan tailored to the patient's needs and problems
- Consultation, as needed, with appropriate specialists (e.g., Pain medicine, psychology)
- Periodic review of treatment efficacy
- Documentation to support the pain management treatment plan

(AAPM & APS 1997)

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**WHO Recommendations for Treatment of Cancer Pain**

- By the mouth
- By the clock
- By the ladder
- For the individual
- With attention to detail

(WHO 1996)

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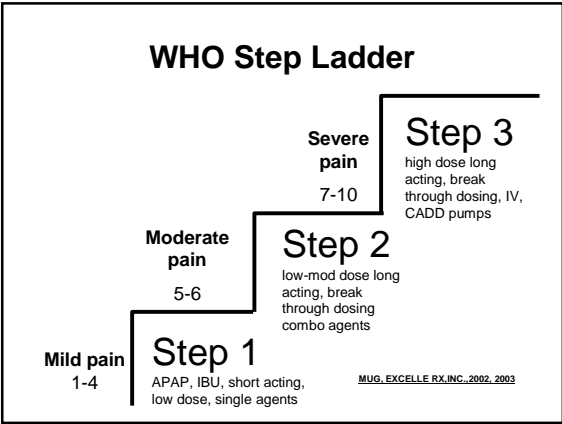
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- ### AHCP R Guidelines
- **Clinicians should:**
    - Reassure patients and families that most pain can be relieved safely and effectively.
    - Assess patients, and if pain is present, provide optimal relief throughout the course of illness.
    - Collaborate with patients and families taking costs of drugs and technologies into account in selecting pain management strategies.
    - Educate patients and families about pain and its management in the treatment plan.
    - Encourage patients to be active participants in pain management.
- (AHCP R 1994)

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- ### APS: “Pain: The Fifth Vital Sign”
- Consider pain “the fifth vital sign.”
  - Assess patient for pain every time pulse, blood pressure, core temperature, and respiration are measured.
  - Recognize a report of unrelieved pain as a “red flag” and address it appropriately.
- (APS 1996) APSQCC JAMA, 1995)

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### **Pain Assessment by “ABCDE” Mnemonic**

- **A**sk about pain regularly; **A**ssess pain systematically.
- **B**elieve the patient and family in their reports of pain and what it relieves.
- **C**hoose pain control options appropriate for the patient, family, and setting.
- **D**eliver interventions in a timely, logical, and coordinated fashion.
- **E**mpower patients and their families; **E**nable them to control their course to the greatest extent possible.

(AHCPR 1994)

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### **Initial Pain Assessment**

- Intensity of pain
- Location of pain
- Quality, patterns of radiation, if any, and character of pain (in patient’s own words when possible)
- Onset, duration, variation, and patterns of pain
- Alleviating and aggravating factors
- Effects of pain on daily life (e.g., function, sleep, appetite, relationships with others, emotions, concentration)

(JCAHO 1999)

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### **Initial Pain Assessment** (cont.)

- Present pain management regimen and effectiveness, if appropriate
- Pain management history, including history of pharmacotherapy, interventions, and response
- Presence of common barriers to reporting pain and using analgesics
- The patient’s pain goal, including pain intensity and goals related to function, activities, and quality of life

(JCAHO 1999)

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## Pain Assessment Scales

The more accurate the assessment of pain, the more effective the treatment

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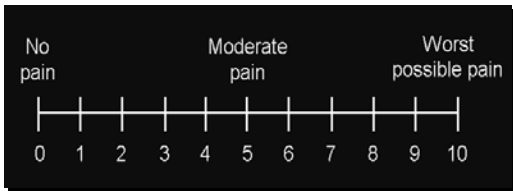
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## Numeric Pain Intensity Scale



(AHCPR 1994)

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## Visual Analogue Scale (VAS)



(AHCPR 1994)

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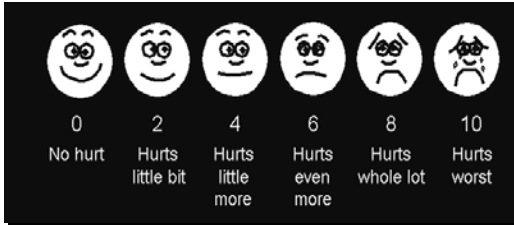
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## Wong-Baker FACES Pain Rating Scale



Adapted from Wong DL, Hockenberry-Eaton M, Wilson D, et al. *Whaley & Wong's Nursing Care of Infants and Children*, 6<sup>th</sup> ed. St. Louis MO. Mosby Year Book, Inc. 1999 @Mosby. Reprinted with permission

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## Pharmacologic Therapy for Pain Management

- It has been suggested that physicians may not be treating pain effectively due to fear of:
  - Addition to pain medications
  - Societal and regulatory censure
  - Diversion of drugs to the street

(Pain management: are patients suffering because of strict regulations? Editor's Summary (Medscape Website). 1997. Available at <http://www.medscape.com/medscape/features/spotlight/sep/0997-spotlight.html>.

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## Physical Dependence

**“Physical dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered.”**

**Physical dependence is an expected result of opioid use and, by itself, does not equate with addition.**

(Federation of State Medical Boards of the United States, Inc. *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*, Eulless, TX, 1998)

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## Tolerance

**“Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect, or a reduced effect is observed with a constant dose.”**

**Tolerance does not usually develop to the pain-relieving effects of opioids.**

(Federation of State Medical Boards of the United States, Inc. Model Guidelines for the Use of Controlled Substances for the Treatment of Pain, Eules, TX, 1998)  
(Schneider JP. J Care Manage, 1998)

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## Pseudotolerance

***Pseudotolerance is the need to increase dosage that is not due to tolerance, but due to factors such as:***

- Disease progression
- New disease
- Increased physical activity
- Lack of compliance
- Change in medication
- Drug interaction
- Addiction
- Diversion

(Pappagallo M. J. Pharm Care Pain Symptom Control, 1998)

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## Defining Addiction

- Addiction is a psychological and behavioral disorder
- Addiction has nothing to do with physical dependence. It is characterized by:
  - Loss of control (compulsive use)
  - Continuation of drug use despite adverse consequences
  - Preoccupation with obtaining and using the drug despite the presence of adequate analgesia

(Schneider JP. J. Care Manage 1998)

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## Misunderstanding Addiction

- **Misunderstanding addiction may result in unnecessary withholding of opioid medications**
- **Patient may be mislabeled as an addict – real problem may be that pain is being inadequately treated**

(Schneider JP. *J. Care Manage* 1998)

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## Opioids and Addiction

- **Risk of addiction is rare in patients with no history of addiction who are prescribed opioids for the management of pain**
  - **Exposure to an opioid, even for prolonged periods, does not produce the aberrant behaviors consistent with addiction**

(Porter J, Jick H. *N Engl J. Med*, 1980)

(Portenoy RK, Kanner RM. In: *Pain Management: Theory and Practice*. Philadelphia, PA: F.A. Davis Company, 1996)

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## Summary: What is Pain Management

- **“The systematic study of clinical and basic science and its application for the reduction of pain and suffering” (AAPM)**
- **“A newly emerging discipline emphasizing an interdisciplinary approach with a goal of reduction of pain and suffering” (AAPM)**
- **A team approach that includes patient and family (JCAHO)**

(AAPM 1996) (JCAHO 1999)

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