

# Pain Assessment and Management – beginnings



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# Pain – beginnings

The Appetizer Platter:

- to tantalize and entice you to sample more in learning about Pain

# Disclosures:

None

No any affiliation with any company other than the Fraser Health Authority

# Topics everyone wants to hear about

- Pain:
  - types,
  - Pathophysiology
  - Assessment
  - Pharmacological management
  - Non-pharmacological interventions

# The Plan:

- an overview of the types of pain
- pain commonly experienced
- assessment and management of pain
- overall philosophy of the importance of pain assessment
- the role of the nurse in helping patients manage pain
- Pharmacology 101 – medications used in pain management and what is safest in renal population

# Comments about pain

1. Pain is good for you. It builds strength and character.
2. Pain always means that some part of your body is physically damaged.
3. Addiction to opioid medications — such as oxycodone or morphine — is very common.
4. People should wait until their pain is bad to take medication like morphine so it will be effective when it's really needed.
5. Women are much better than men when it comes to dealing with pain.
6. All pain is curable.

# What is Pain?

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

*American Pain Society, 1992*

# What is Pain?

- personal, private and unique to each person
- an experience
- cannot be separated from the person's mental state, environment and cultural background.
- Subjective:
  - is whatever a person says it is and it exists whenever a person says it does

— McCaffery, M., & Pasero, C. Pain: Clinical Manual, 2nd ed. St Louis: Mosby.1999

# Types of Pain

## Acute Pain:

( usually time limited)

Nociceptive (somatic and visceral)

Neuropathic

\*\*\*\*\*

## Chronic Pain

( a bit of everything)

Neuropathic

Nociceptive (somatic and visceral)

# Other methods of classification

- Location ( abdominal, shoulder...)
- Intensity ( moderate, severe .....)
- Quality ( lancinating, dull ....)
- Aggravating factors ( stress induced, sports related....)

# Acute Pain

- results from the activation of nociceptors (free nerve endings)
- Warning of injury or disease
- Protective
- Usually easy diagnosed and obvious pathophysiology
- Potential to be treated effectively
- Usually time-limited /short duration
- If undertreated ► may go on to become chronic pain

# Nociceptive

- caused by or from responding to a painful stimulus.
- Nociceptive pain is usually time limited, meaning when the tissue damage heals, the pain typically resolves.
- Examples include sprains, bone fractures, bumps, bruises, inflammation
  - Two Types: Somatic and Visceral

# SOMATIC

- caused by the activation of pain receptors in either the cutaneous (body surface) or deep tissues (musculoskeletal tissues)..

*well localized, aching, throbbing, deep, dull, gnawing or sharp, muscle/bone pain*

# VISCERAL

- caused by activation of pain receptors resulting from infiltration, compression, extension, or stretching of the thoracic, abdominal, or pelvic viscera.
- *not well localized, pressure-like, deep, aching, crampy squeezing.*
- Can be referred pain

# NEUROPATHIC

- the nerve fibers themselves may be damaged, dysfunctional or injured
- Can be as a result of damage to a nerve or the spinal cord such as injury, chemotherapy, radiation, surgery.
- Examples: phantom limb syndrome, diabetic neuropathy, trigeminal neuralgia, Post herpetic neuropathy
  - *burning, shooting, numb, tingling, stabbing, touch sensitive*

# Pain Quality Descriptors

The descriptors patients use are helpful to identify what type of pain they are experiencing

Nociceptive		Descriptors	Examples
	Somatic	Throbbing, aching, sharp, gnawing, constant	Surgical pain, sprained ankle, burns, bone metastases
	Visceral	Dull, cramping, squeezing, deep aching	Pancreatitis, bowel obstruction, menstrual pain
Neuropathic		Burning, shooting, tingling, electric or shock like, pins & needles, tingling	Diabetic Neuropathy Trigeminal Neuralgia Guillian Barre-Syndrome

# Chronic Pain:

- persists beyond the course of injury or may not be related to a specific injury
- may spread beyond the original site of injury
- may have NO identifiable cause
- Serves no biological purpose.

# Chronic Pain

- has a cognitive, emotional and psychological impact
- The longer pain persists the more resistant it becomes to treatment
- Chronic pain requires complex treatment strategies
- Complete relief is generally not possible.

# One pain at one time or all at once?

Somatic, visceral, and neuropathic pain can all be felt at the same time or singly and at different times.

## Acute on Chronic Pain

different types of pain respond differently to the various pain management therapies.

# Other terminology

- Baseline Pain – generally constant and last through at least 50% of the day. Usual or normal level
- Breakthrough Pain – pain that increases over baseline and is of a higher intensity than usual
- Incident Pain – pain over baseline and breakthrough that is usually related to an activity.

# Impact and Effects of Pain

# Unrelieved Pain:

- Is harmful
- Expensive
- Thought to enhance tumor growth
- Can contribute to atelectasis ( esp. surgical/ stationary )
- Inhibits the immune system
- Increases oxygen demand
- Causes respiratory dysfunction
- Decreased GI motility
- Confusion

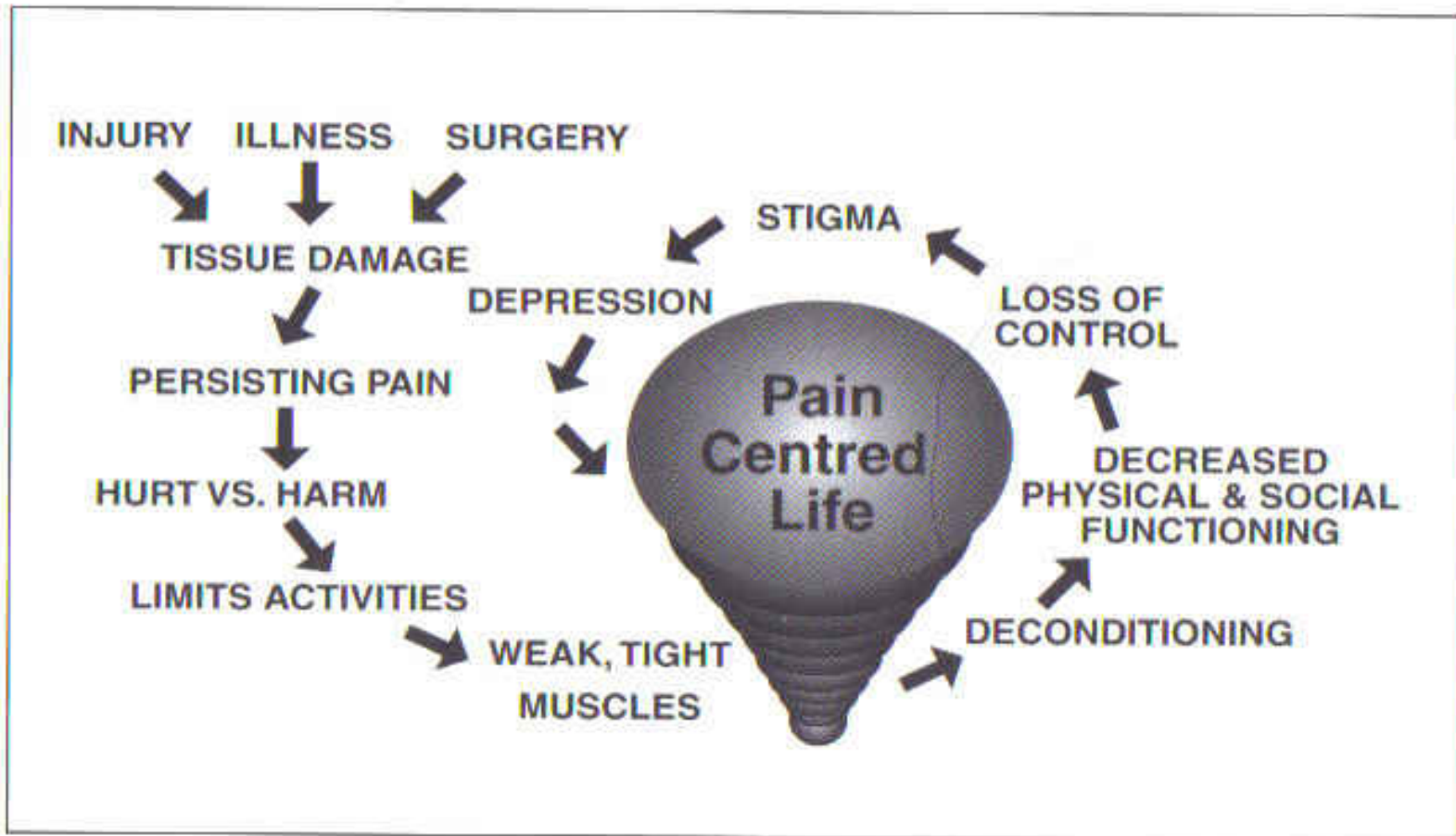
# Impact of Pain

- Interferes with:
  - sleep
  - rest
  - appetite
  - activity
  - mood
  - enjoyment
  - concentration
  - work
- Unrelieved Pain can lead to psychological discomfort: frustration, anxiety, irritability.

# Chronic Pain Spiral

<http://www.paincare.ca/Professional/Resources/PainManagementTools.aspx>

## The Chronic Pain Spiral – A Patient Teaching Aid



# Interpretation, Tolerance and Response to pain is affected by:

Emotional and psychological state

Upbringing

Beliefs & Values

Age

Sex

Social and Cultural Influences

Attitude

Memories of past pain experiences

Expectations

# Pain Statistics

In 2000-01:

- 12.0% of Canadians over age 12 had pain or discomfort that prevented at least a few of their activities.

In 2004-05

- 25 -30% of the adult population suffers from chronic pain

# Did You Know?

- 4/10 people with moderate to severe chronic pain report inadequate relief
- 70% of people with cancer report inadequate pain relief
- 25 – 45% of older adults (>65) live with chronic pain (45 – 85% in institutions)

## **Acute Pain**

- 50-80% of patients report that they experience inadequate pain relief following surgery

Reference: M Mcaffery

# Pain Pathways

- Understanding of pain mechanisms & pathways is the basis for improved pain management
- Various targets for pain treatment based on the pathophysiology of pain:
  - » Pharmacological (multimodal concept)
  - » Regional anesthesia (nerve blocks, epidurals, spinals)
  - » Complementary therapies
  - » Surgical Interventions

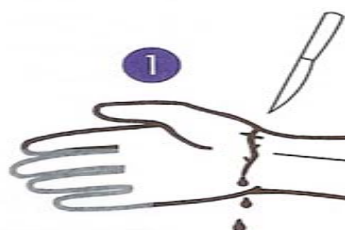
# 1 Transduction

A. Cell damage releases sensitizing substances: PG, BK, 5-HT, SP, H

B. Action potential



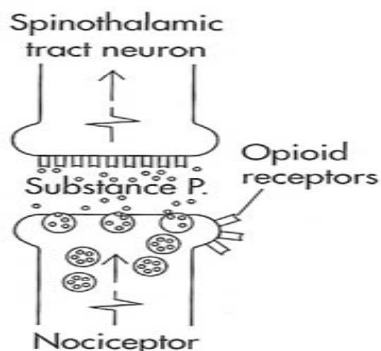
Example of noxious stimuli that damage cells and stimulate nociceptors, initiating the sensation of pain.



Transmission

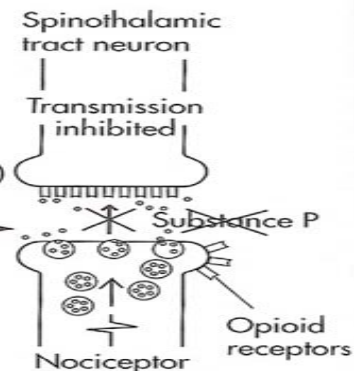
# 2 Transmission

This phase of transmission occurs in the dorsal horn of the spinal cord.



# 4 Modulation

Neurons from the brainstem release 5-HT, NE, endogenous opioids



# 3 Perception of pain

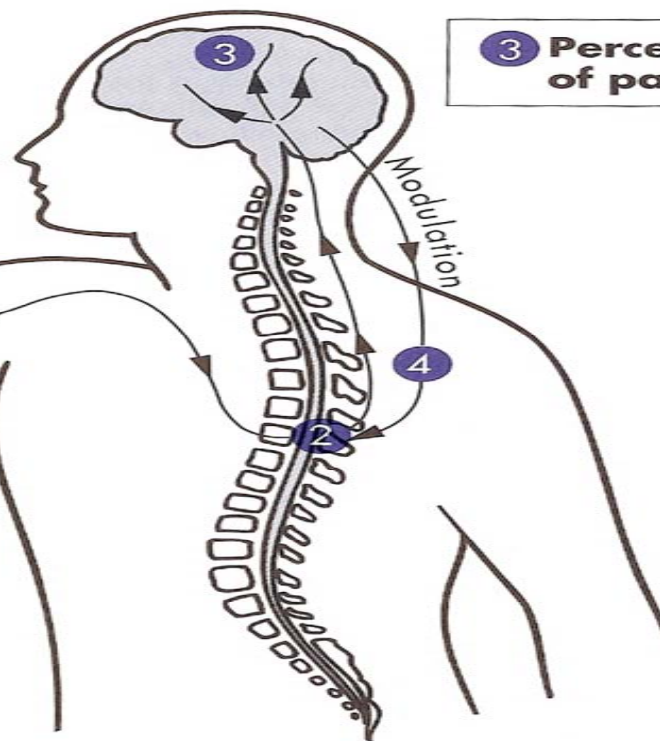
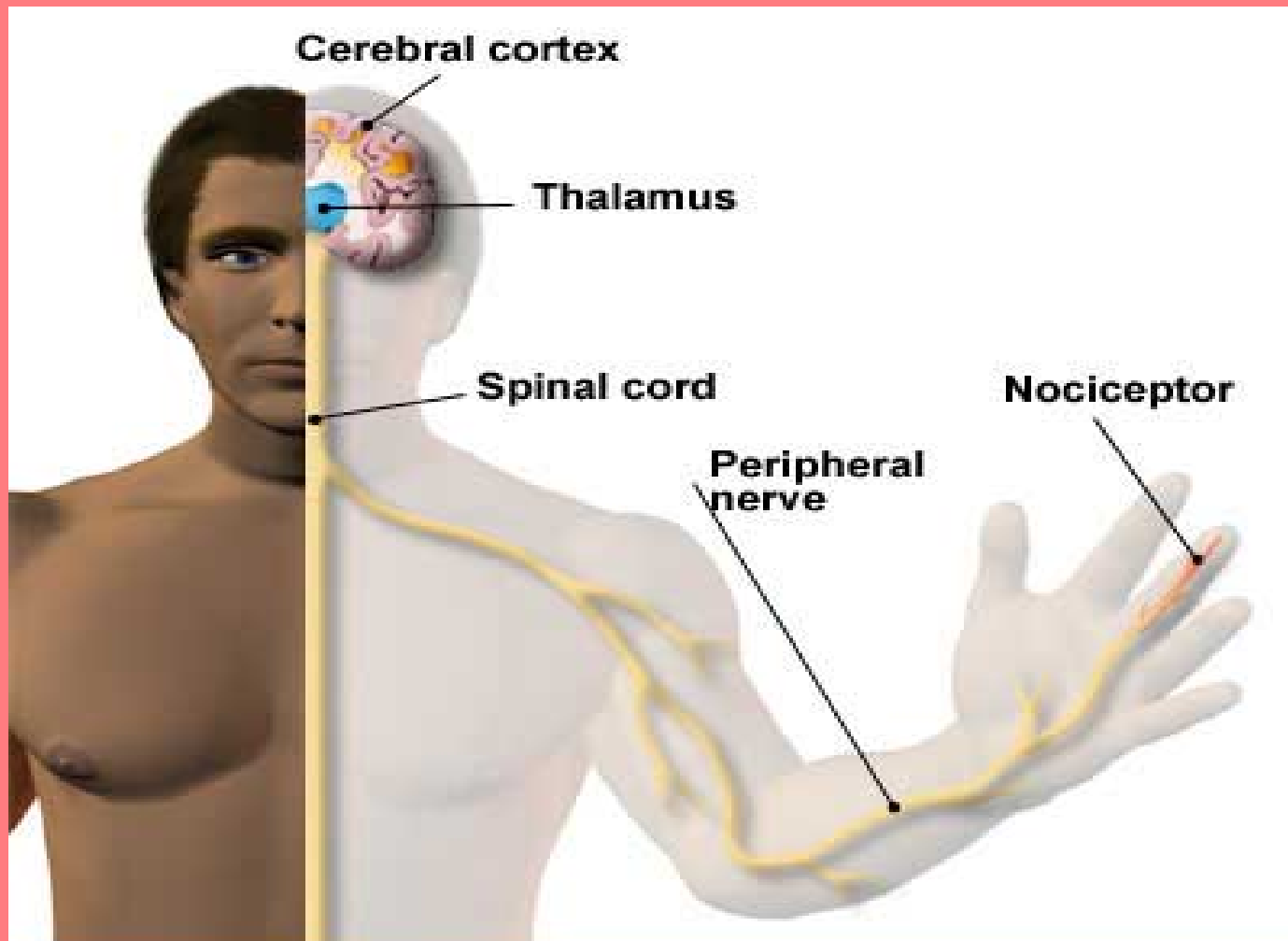
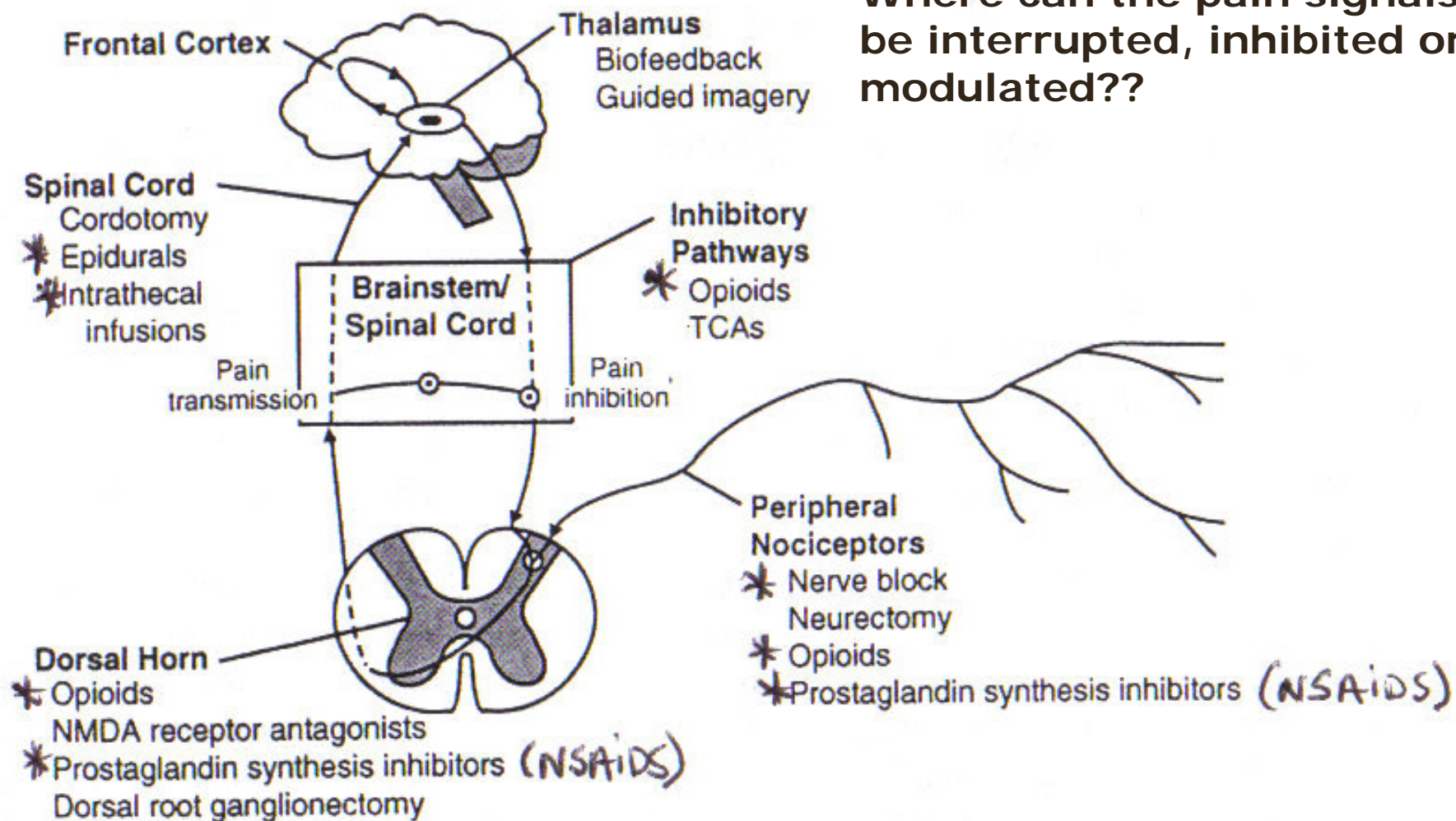


Fig. 17-1 Basic mechanisms underlying the causes of pain and effects of pain. PG, Prostaglandin; BK, bradykinin, 5-HT, 5-hydroxytryptamine; SP, substance P; H, histamine;  $\text{Na}^+$ , sodium;  $\text{K}^+$ , potassium; NE, norepinephrine. (From McCaffery M, Pasero C: *Pain: clinical manual*, ed 2, St Louis, 1999, Mosby.)

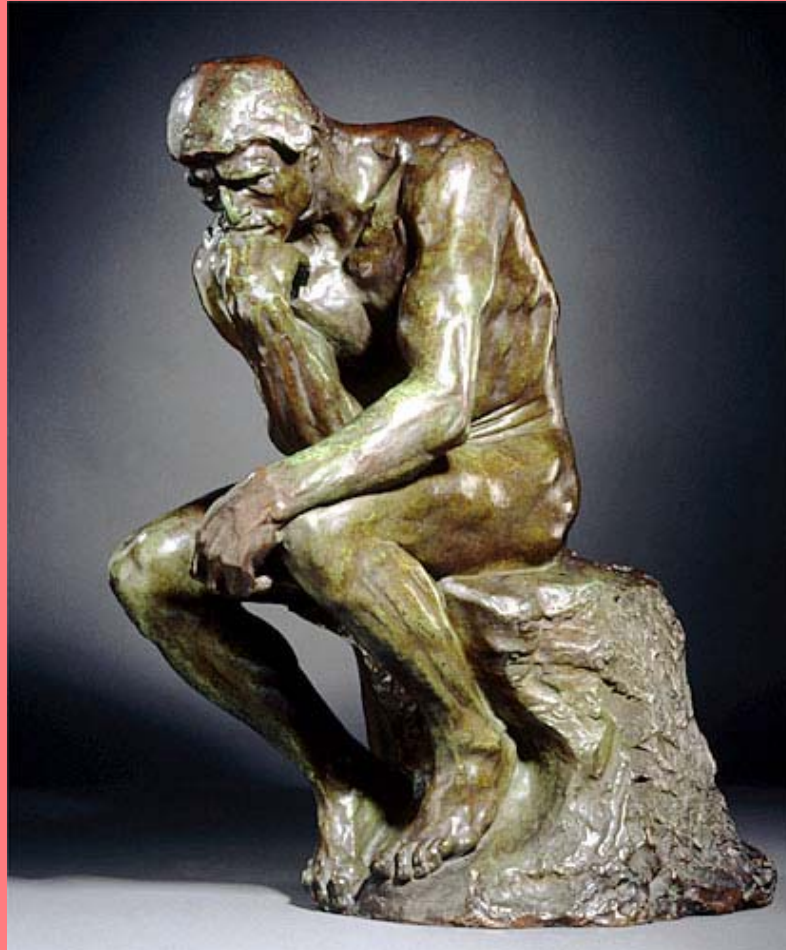
# How pain messages travel?



# Pain Pathway & Targets for Pain Treatment



# Something to think about



**What can we do?**

pain commonly experienced by renal patients

- restless legs syndrome (RLS)
- hypoesthesia (reduced sense of touch )
- pruritus (itch)
- Musculoskeletal pain ( arthritis, spasms, cramps,
- Peripheral neuropathies
- Peripheral vascular disease ( ischemia)

- Many of which can be attributed to a nervous system disorder due to kidney dysfunction or even to coexistent diseases.
- these symptoms are difficult to manage and they respond poorly to conventional treatment

# Barriers to effective pain management

- **Lack of recognition of pain being a problem**
- **Poor communication regarding pain**
- **Lack of understanding of pain and its effects**
- **Altered pharmacokinetics, pharmacodynamics and adverse effects---** especially in renal clients
- **Lack of assessment**

# Pain Assessment

- **Patients have the right to the best pain relief possible**
  - this begins with an comprehensive assessment
- Additional value of the assessment is that it improves communication between the nurse and the patient and facilitates the development of a therapeutic and trusting relationship.

# Pain Assessment



- How do you know someone has pain?
  - Ask them
    - Make it part of your routine assessment “the 5<sup>th</sup> vital sign”
  - Pain is subjective
    - Variety of tools for assessing
    - Variety of mnemonics to help ( LOTARP PQRST for example)

# Assessment

- **Location** — where is the pain? Ask about all areas of discomfort.
- **Onset**— when did it start. Constant or intermittent. Any precipitating factors
- **Type** — what does it feel like to them- descriptive words (burn, ache, sharp stabbing)
- **Timing**- It is constant or intermittent, worse in the am or pm.
- **Aggravating**-What makes it worse
- **Alleviating** – what makes it better
- **Radiation**- Does it radiate to any other area
- **Rating**- Rate pain on scale of 0-10
- **Pain Scale** 0-10
- **Patient perception** — how is the pain affecting them
- **Patient Goal** – what is their pain goal ( ie 3/10)

# Assessment

- O = onset
- P = provoking/palliating
- Q = quality
- R = region/radiation
- S = severity
- T = treatment
- U = understanding/impact
- V = values

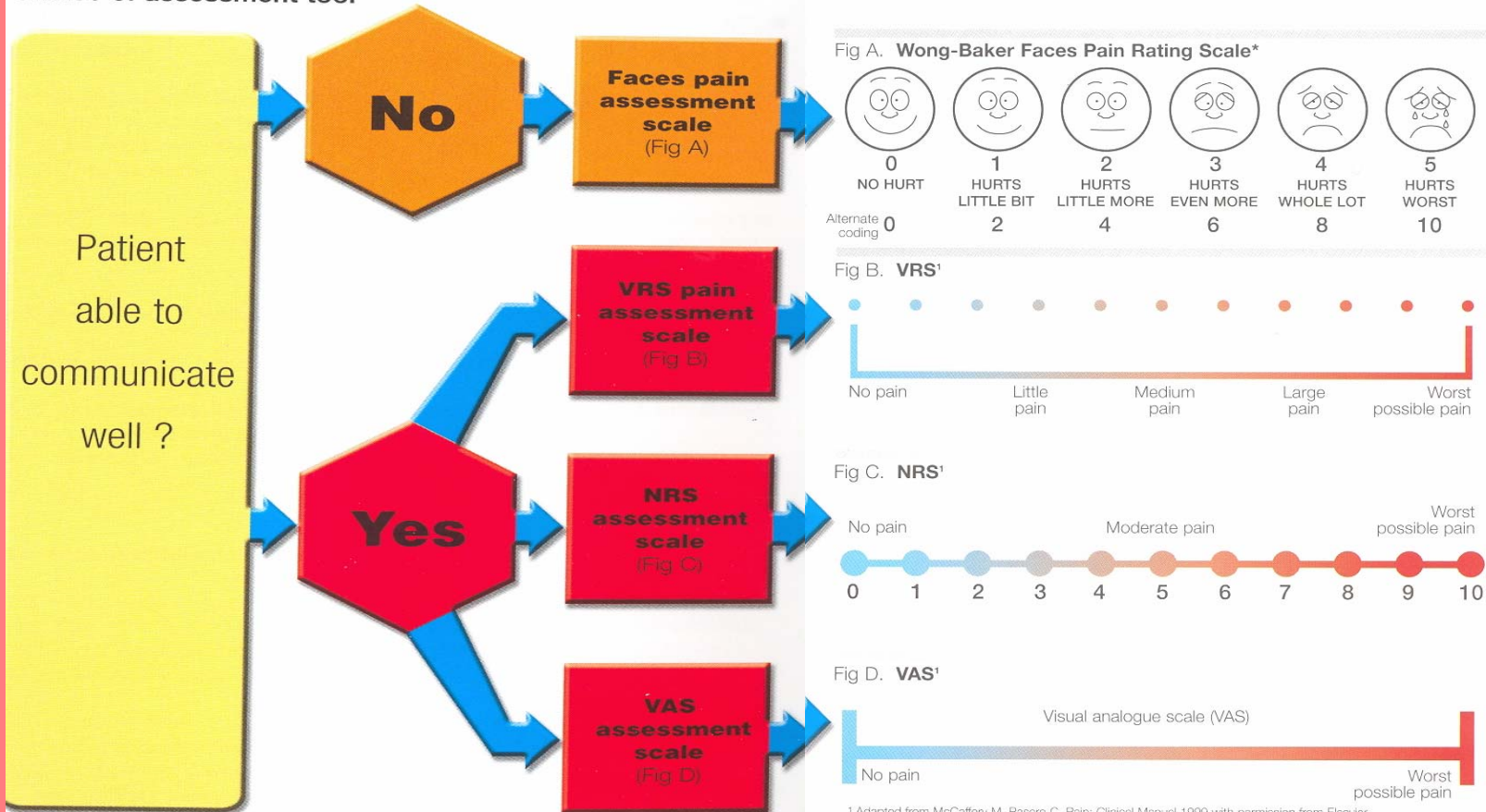
# How intense is the pain?

- Always use a pain scale:
  - 1 to 3: Mild pain – does not functionally bother the patient – Needs no Rx usually
  - 4 to 6: Moderate pain – does functionally bother the patient – Needs Rx
  - 7 to 10: Severe pain – severe distress, needs Rx as an emergency

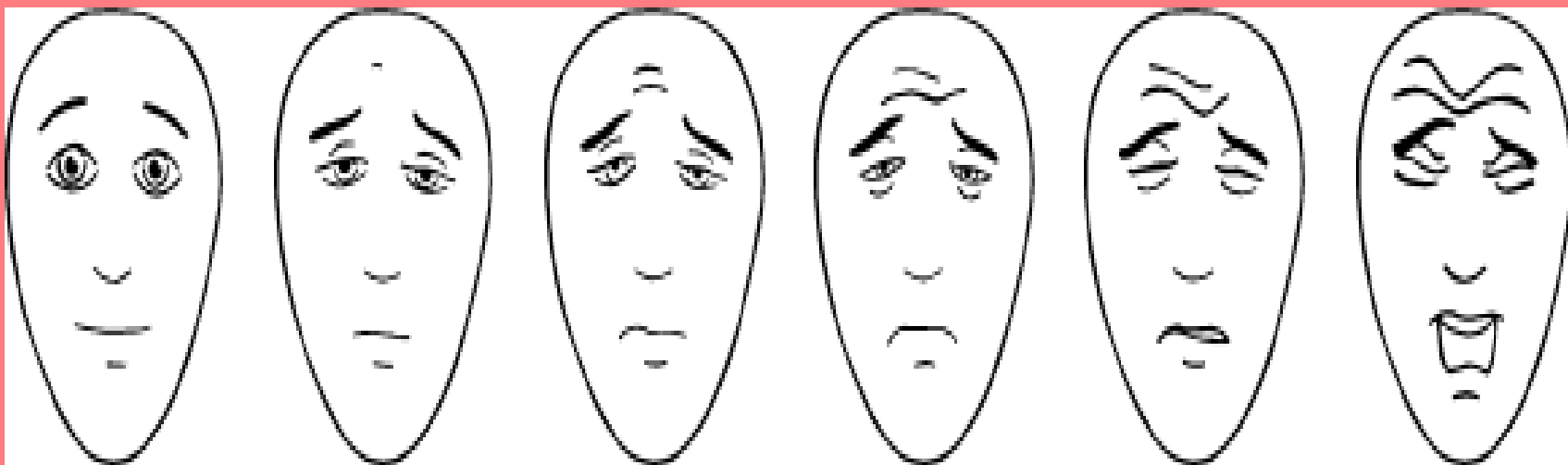
# Choice of Assessment Tool

\*adapted from McCaffery, M. Pasero C. Pain : clinical manual with permission from Elsevier  
Page 10-11 Postoperative Pain Management- Good Clinical Practice

Figure 1.  
Choice of assessment tool



<sup>1</sup> Adapted from McCaffery M, Pasero C. Pain: Clinical Manual 1999 with permission from Elsevier.  
\* With permission from Elsevier.



0 1 2 3 4 5 6 7 8 9 10

# Additional components of Assessment

- **Analgesic History**- what have they tried in the past, what do they take at home? Response to past and current medications, side effects, DOSAGES.
- **Opioid risk assessment**
- **Impact of Pain**- how is this pain affecting their functioning and quality of life ( sleep, appetite, mood, ability to move)? Is it delaying their recovery???
- **Personal perceptions about pain/analgesia**
  - Fears, myths, anxiety, stereotypes
  - What does pain mean to this person
  - What is the goal of pain management for the person

# Addiction

Example of 1 risk assessment tool

Item	Mark each box that applies	Item score if female	Item score if male
1. Family history of substance abuse:			
Alcohol	<input type="radio"/>	1	3
Illegal drugs	<input type="radio"/>	2	3
Prescription drugs	<input type="radio"/>	4	4
2. Personal history of substance abuse:			
Alcohol	<input type="radio"/>	3	3
Illegal drugs	<input type="radio"/>	4	4
Prescription drugs	<input type="radio"/>	5	5
3. Age (mark box if 16-45)	<input type="radio"/>	1	1
4. History of preadolescent sexual abuse	<input type="radio"/>	3	0
5. Psychological disease			
Attention-deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia	<input type="radio"/>	2	2
Depression	<input type="radio"/>	1	1
Total		—	—
Total Score Risk Category:			
Low Risk: 0 to 3			
Moderate Risk: 4 to 7			
High Risk: 8 and above			

# Pain Assessment Tool

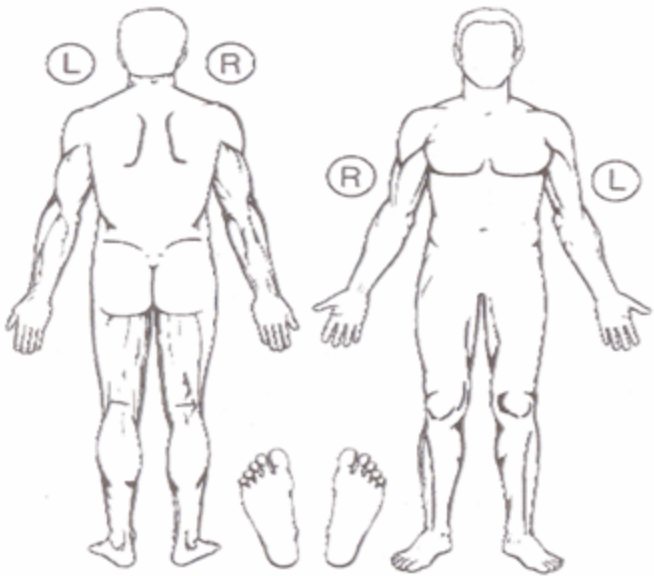
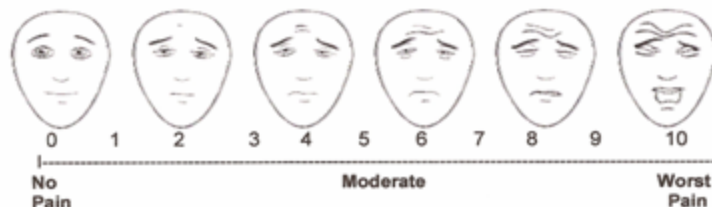
Date: \_\_\_\_\_ Time: \_\_\_\_\_

Information Source: ☐ Patient ☐ Spouse ☐ Child ☐ Interpreter ☐ Other \_\_\_\_\_

Form Completed by: \_\_\_\_\_

On the diagram below mark using colours listed OR using the letters/symbols shaded in grey to show where your pain is and the best word that would describe it.

Letter	Description	Colour
S	Sharp stabbing	Purple
N	Numbness	Blue
P	Pins & Needles	Green
A	Aching	Orange
B	Burning	Red
X	_____	Black
Y	_____	Yellow

Use numbers on the above diagram or write the name of the pain area below		Please rate your <b>pain level</b> for the last 2-3 days		
		Worst	Best	Average
Site 1				
Site 2				
Site 3				

# NEUROPATHIC PAIN SCREENING

WOULD ANY OF THE PAIN YOU ARE HAVING BE DESCRIBED AS:

	YES	NO
BURNING	<input type="checkbox"/>	<input type="checkbox"/>
PAINFUL COLD	<input type="checkbox"/>	<input type="checkbox"/>
ELECTRIC SHOCKS	<input type="checkbox"/>	<input type="checkbox"/>

DOES THE PAIN EVER FEEL LIKE:

	YES	NO
TINGLING	<input type="checkbox"/>	<input type="checkbox"/>
PINS & NEEDLES	<input type="checkbox"/>	<input type="checkbox"/>
NUMBNESS	<input type="checkbox"/>	<input type="checkbox"/>
ITCHY	<input type="checkbox"/>	<input type="checkbox"/>

DOES THE PAIN INCREASE WHEN THE AREA IS LIGHTLY TOUCHED OR BRUSHED AGAINST?

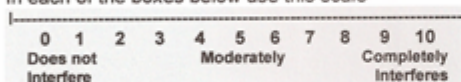
☐ YES ☐ NO

DOES THE AREA WITH PAIN HAVE LESS FEELING OR SENSATION?

☐ YES ☐ NO

STAFF SECTION: Neuropathic Pain Indicated (Positive)  
by 4 or more Yes ✓ in above section.

In each of the boxes below use this scale



and put in the number that describes how PAIN HAS INTERFERED in the last 2-3 days with your:

Quality of Life	Number out of 10
General Activity	
Mood	
Walking ability	
Normal work (includes both work outside the home and housework)	
Relations with other people	
Sleep	
Enjoyment of life	

/70

What makes your pain better?

- ☐ Heat
 ☐ Cold
 ☐ Massage  
☐ Distraction
 ☐ Lying down  
☐ Changing positions  
☐ Chiropractor
 ☐ Physiotherapy

What makes your pain worse?

What medications have you tried in the past and how did they affect your pain?

What PAIN medications are you currently taking?

Please include: Prescription, Non-Prescription or Herbal

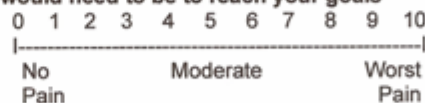
Does the current pain medication or pain treatment decrease your level of pain?

YES ☐
 SOMETIMES ☐
 NO ☐

Rate the 3 most important goals for you if you had less pain

- \_\_\_ Sleep comfortably  
 \_\_\_ Comfort at rest  
 \_\_\_ Comfort with movement  
 \_\_\_ Stay alert  
 \_\_\_ Perform activity: \_\_\_\_\_  
 \_\_\_ Other: \_\_\_\_\_

Circle where you think your pain level would need to be to reach your goals



Is there anything else you would like to say about your pain?

Staff Section – Please complete

POSITIVE Neuropathic Pain Screen YES/NO (circle)  
 Quality of Life Score (total number out of 70) /70

# What to do after you have assessed their Pain

- Document your assessment findings
- Plan your course of action
- Apply your interventions



Pain Management has already begun !

# Assessment and REASSESSMENT

Assess the effectiveness of your interventions, and include what patient coping strategies have been incorporated

**REASSESS** their pain  
and your interventions – **critical**

Document ( this is the start of a continuing plan of action)



# Pain Management

- Comprehensive assessment of the patients understanding and experience of pain
- Consistent use of assessment tools
- Continuous reassessment & evaluation
- Customization (multimodal approach) & collaboration (involving interdisciplinary team).

# Goal of Pain Management

- to eliminate or decrease the pain to a level that is acceptable to the patient.

# What is an acceptable level?

- Subjective.....

But for example:

- An acceptable level is one that allows the post operative patient to move, deep breath and cough.
- For a patient with chronic or cancer related pain an acceptable level of pain allows them to continue with their daily activities and have an acceptable quality of life.

# Ask the patient what is their acceptable pain level.

- Establish a baseline –
  - What is their pain like as you start your shift assessment.
  - Use the pain scale with the patient,
    - this will ensure the consistent measure of pain intensity for both the patient and any staff caring for them.
    - Using the pain scale identifies when medication or intervention is effective and when these measures are not providing adequate pain relief.

# Pain Management

- Multimodal:
  - Self management
  - Psychological
  - Medications: Opioids, NSAIDS & Adjuvants, nerve blockade
  - Cognitive Behavioural : distraction, music, biofeedback
  - Physical: heat/cold massage, TENS

# Pain Management

## Multi-modal

### Non-Pharmacological

- Heat/Cold
- Massage
- Distraction
- Self Management
- Psychology

### Pharmacological



# Pain Management

Select an intervention:

Monitor

Tylenol

Opioids

NSAIDS

antispasmodics

adjuvant medications

? intervention

heat/cold

Distraction

???

# Pain Management

- Evaluate the patient's response to the intervention
  - Usually 20-40 minutes depending on intervention
    - » A flow sheet or a pain diary is helpful



# Why does the evaluation and time matter?

- Pain is no different than any other VS we evaluate
  - Temp 40 C
  - P 140 bpm
  - RR 32
  - O2 Sat 90%
  - BP 83/50
- If interventions are ineffective, we need to be patient advocates for alternate interventions
  - ( other options, medications, doses) which may prove more effective.

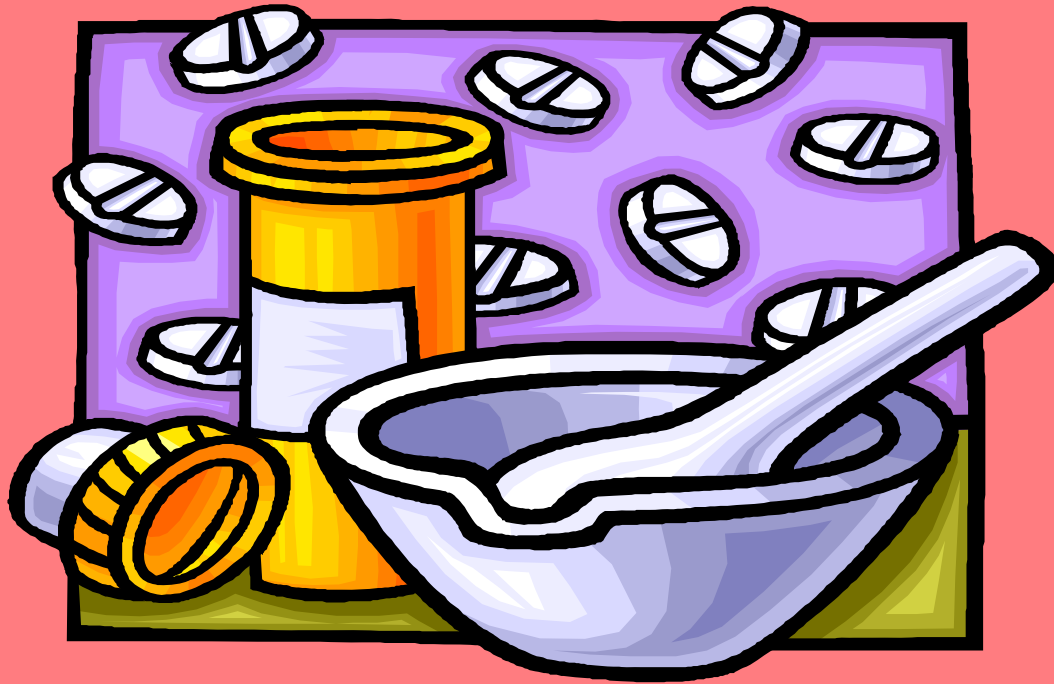


The assumption being made is that:

the patient's source and reason for pain has been or is being investigated.

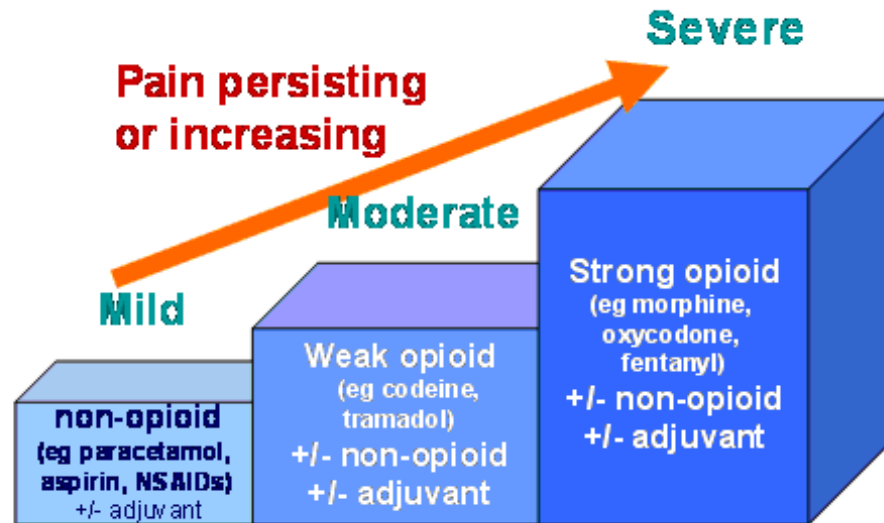


# Medications



# WHO Ladder

created for cancer pain but has been used for all pain



# Principles of Analgesic Use for the WHO Ladder

- By the mouth-use the simplest route
- By the clock-give scheduled doses
- By the ladder- select level by pain intensity
- Individualize treatment
- Monitor response
- Use adjuvant drugs as needed
- Prevent and treat side-effects

# Adverse Effects can be common in certain classes

Delirium – Opioids esp. Demerol,

Seizures – Demerol,

Nausea – Codeine (P450 system)

Esophagitis, gastritis - NSAIDS

Organ Toxicity can be common with certain classes

Renal, GI, Hepatic – NSAIDs

CNS- Demerol, Darvon, MORphine

Hepatic -- Tylenol



# Analgesic compounds

- Tylenol
- Opioids ( Morphine, HYDROmorphine, oxycodone, meperidine, codeine)
- Cannabinoids ( Sativex, Marinol, Nabilone)
- NMDA inhibitors ( Methadone, Ketamine)

# Adjuvant Analgesics

NSAIDs – Motrin, Naprosyn, Indocin, celebrex, voltaren

Steroids – prednisone, Decadron, depomedrol

Anti-depressants – Elavil, Desyrel, Celexa, Effexor

Anti-neuroleptics – Neurontin/Gabapentin, Tegretol, Lyrica

Anxiolytics – Valium, Ativan, Xanax

» May be used in combination with each other

# MSK pain

## ⌚ **Acetaminophen**

- ⌚ Analgesic without anti-inflammatory propriety
- ⌚ As effective as NSAIDs in relieving mild-moderate osteoarthritis pain if taken 4 times/day, with less ADRs
- ⌚ Tylenol arthritis pain → 8 hours duration

## ⌚ **Topical NSAIDs**

- ⌚ Localized osteoarthritis pain of superficial joints
- ⌚ For mild to moderate pain (score < 4/10)
- ⌚ Can also be used as co-analgesic / adjuvant

# Neuropathic pain

## ⌚ Anticonvulsants

- ⌚ Gabapentin, pregabalin
- ⌚ Act on GABA receptors to modulate nerve influx
- ⌚ ADRs: somnolence, dizziness, and ataxia

## ⌚ Capsaicin cream

- ⌚ Stimulates the nerves, to then desensitizes them (depletion of substance P)
- ⌚ Also use in osteoarthritic pain
- ⌚ Causes erythema and feeling of warmth at application (lidocaine x 2 weeks)
- ⌚ Wash hands after using it
- ⌚ Can take up to 2-4 weeks before onset of action
- ⌚ Maximum response after 4-6 weeks of regular use

# Neuropathic pain

## @ Antidepressants

- @ Good choice if concomitant depression or insomnia

## @ Tricyclic antidepressant (TCAs)

- @ Desipramine and nortriptyline preferred agent
  - @ Less anticholinergic effects
- @ ADRs: **Cardiac toxicities**, orthostatic hypotension, constipation, dry mouth

## @ Venlafaxine

- @ Less efficacy/safety data available
- @ ADRs: HTN, nausea

# Neuropathic pain

## ⌚ **Nabilone**

- ⌚ Cannabinoid class
- ⌚ Good choice if concomitant malnutrition, nausea
- ⌚ ADRs: drowsiness, vertigo, dry mouth, euphoria, hallucination, disorientation, anxiety, tachycardia

# Opioids



describe drugs with “Morphine like effects”

Morphine, fentanyl, codeine, oxycodone, demerol  
& hydromorphone

--ceiling dose individualized & dependent on pain  
control vs manageable side effects

# Approximate Equivalency to Morphine

Approximate Equivalency to <b>10mg</b> IV Morphine					Approximate Equivalency <b>1mg</b> IV Morphine		
Drug	Route	Dose			Drug	route	dose
<b>Morphine</b>	<b>PO</b>	<b>20-30mg</b>			<b>Morphine</b>	<b>PO</b>	2-3 mg
Hydromorphone	PO	7.5mg			Hydromorphone	PO	0.75 mg
Hydromorphone	IV	1.5mg			Hydromorphone	IV	0.15 mg
Fentanyl	IV	100mcg			Fentanyl	IV	10 mcg
Oxycodone	PO	15-30mg			Oxycodone	PO	1.5-3 mg
Codeine	IM	120mg			Codeine	IM	12 mg
Codeine	PO	200mg			Codeine	PO	20 mg
Methadone	PO	10-20mg			Methadone	PO	1-2mg

•Reference McCaffery, M., Pasero,C. Pain :Clinical Manual

# Opioids

- ✓ Efficacy in MSK and neuropathic pain
- ✓ Usually use in conjunction with other analgesics  $\Rightarrow$  ↓ dose of opioid
- ✓ Opioids have similar efficacy if appropriate dosage conversion
- ✓ Routes (PO/IV/SC/IM) have similar efficacy if appropriate dosage conversion

# Opioids

- Administer on a regular schedule with interval corresponding to duration of action
  - SR formulation use when daily dosage established
  - Appropriate breakthrough dose equal to 10% of daily dosage Q2Hrs PRN
- Opioids of choice: hydromorphone, oxycodone, fentanyl
  - Avoid morphine since risk of neurotoxicity (eg. seizure, myoclonia, hallucination, etc.) related to metabolites.
- ADRs : Sedation, nausea, constipation, hallucinations, hyperalgesia, respiratory depression, cognitive impairment, gait disturbances

# Opioids in Renal



- Increased ADR /Toxicity with:
  - Morphine (M3G/M6G)
  - Meperidine ☒
  - Codeine
- Use with caution:
  - HYDROmorphine \*
  - Oxycodone
- Safest with:
  - Fentanyl \* has to be titrated from another
  - Methadone

# Opioid Neurotoxicity

- Myoclonus-uncontrollable twitching and jerking of muscles or muscle groups, usually occurs in the extremities.
- Hyperalgesia-increased sensitivity to noxious stimuli or even light touch
- Delirium with hallucinations
- Grand mal seizures-late

# Transdermal Fentanyl

- Good choice for patients with stable level of pain
- Good choice for dysphagic patients
- Do not use in the opioid-naïve

# Methadone

- Opioid analgesic with an antagonist effect on NMDA (N-methyl-D-aspartate) receptors (responsible of constant and exaggeration of pain)
- Option if pain refractory to usual opioids
- Long half-life
- High inter-patient variability, multiple drug interaction
- Physician needs special privilege to prescribe it
- ADRs: Bradycardia, hypotension, general weakness, sedation, nausea, constipation, respiratory depression, dysphoria, insomnia, anxiety

# Indications for Opioid Rotation

- Intolerance to side-effects of drug
- Pain not satisfactorily controlled
- Loss of oral route
- Cost issues
- Convenience/compliance issues
- Drug abuse concerns

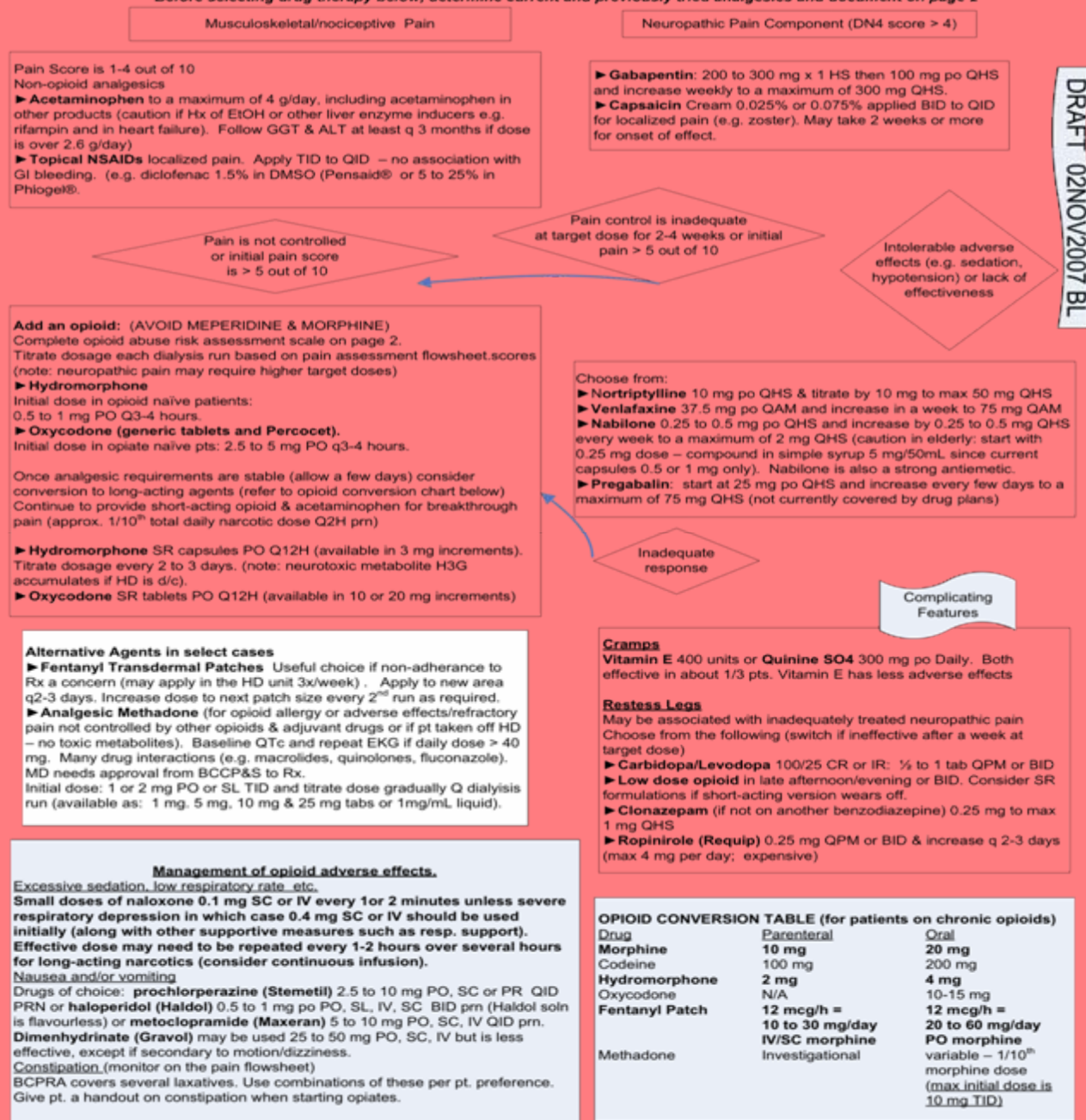
Can not just substitute due to variances in molecular structure

# Cautionary Notes:

- Short Acting Medications
  - Must be given at q2-3h (sometimes are given q1h in certain cases)
  - Use Oral preparations when possible
  - Never use 2 short acting preparations together
- Long Acting
  - NEVER use 2 long acting opioids together
  - May have Q8H or Q12 H dosing rarely more frequent
  - Never to be used as breakthrough

# Clinical Pathway and Drug Choices for Chronic Pain in Patients on Dialysis – FHA Renal Program

Before selecting drug therapy below, determine current and previously tried analgesics and document on page 2



DRAFT 02NOV2007 BL

# Management of ADRs



# Management of ADRs

- **Nausea/vomiting**
  - Usually tolerance after 5-7 days
  - GI stasis and impact on chemoreceptive zone
    - Domperidone/metoclopramide
    - Or/and
    - Prochlorperazine/ Haloperidol
  - Re-evaluation Q2-3 days

# Management of ADRs

- ◆ **Constipation – start a bowel protocol at same time as starting opioid therapy**
  - ◆ Proportional to opioid dosage
  - ◆ Stool softener (docusate) and GI stimulant (sennosides) for all patients on opioids
  - ◆ Lactulose, PEGLyte, glycerin supp., bisacodyl supp. are other options
  - ◆ To be avoided: fleet phosphate, Milk of Magnesia, mineral oil

# Management of ADRs

- **Excessive sedation/ ↓ RR**
  - Naloxone 0.1-0.4 mg sc or IV initially
  - Effective dose can be repeated every 1-2 hours if SR opioid formulation

# Monitoring parameters

- **Pain control**
  - Evaluation for every site
  - Non-pharmacological methods
  - In relation with initial pain score and pain score goal
- **ADRs**
  - Nausea/vomiting
  - Constipation
  - Dizziness, sedation
  - Itchiness
  - Tremors
  - Diaphoresis

# Non-Pharmacologic Interventions

- Ask the patient what helps them manage their pain.
  - Repositioning
  - Application of warmth or cool compresses
  - Diversion/distraction activities (e.g. massage, meditation, imagery, music, muscle relaxation, etc.)

# Non-Pharmacologic Interventions

Involve interdisciplinary team (PT, OT, Pastoral Care, Social Worker, etc.)

- Prepare the patient and family in advance for painful procedures/ progress (amount of pain, duration)

# Documentation

- Use progress note and/or a flow sheet to document initial and continued assessment of interventions.
- Document the administration of medications as ordered (route, continuous, single, prn, in notes, on pain management flow sheet & MAR).

# Evaluate

- Assess the patient for:
  - Psychosocial / Comfort – acceptable relief
  - Respiratory – RR, LOC,
  - Cardiovascular – hypotension, bradycardia
  - GI – nausea, vomiting, BM, constipation
  - Mental Status: acute delirium, sedation
  - GU – presence of urinary retention
  - Musculoskeletal / Skin integrity – diaphoresis, pruritis

# Ongoing Care and Assessment

- Assessment of the patients pain / comfort levels should be checked and documented at each encounter or q8h if admitted.
  - Use pain management flow sheets to document patients self report of pain  
and /or
  - Document patient behaviors that indicate pain if the patient is unable to self report. (frequently calling out, resistance to position changes, restlessness, agitation, moaning).



**Neuropathic Pain Screening**  
(See Pain Assessment Tool)  
POSITIVE \_\_\_ YES \_\_\_ NO

**PATIENT'S PAIN CONTROL GOAL**

- ☐ Sleep comfortably
- ☐ Comfort at rest
- ☐ Comfort with movement
- ☐ Stay alert
- ☐ Perform activity: \_\_\_\_\_
- ☐ Other: \_\_\_\_\_

Date: \_\_\_\_\_ Current Medications for Pain Management \_\_\_\_\_  
Drug/Dose/ Frequency \_\_\_\_\_ Drug/Dose/ Frequency \_\_\_\_\_  
Drug/Dose/ Frequency \_\_\_\_\_ Drug/Dose/ Frequency \_\_\_\_\_

DATE:		Site 1 _____	Site 2 _____	Site 3 _____
Patient's Rating of Pain				
Scale used	Present:			
<input type="checkbox"/> 0 -10	At Worst:			
<input type="checkbox"/> Faces	At Best:			
<input type="checkbox"/> Verbal				
Side-effects / Treatment / Changes in Pain Medications or Comments				
				Initials
PRN / Breakthrough Analgesic given				Initials

DATE:		Site 1 _____	Site 2 _____	Site 3 _____
Patient's Rating of Pain				
Scale used	Present:			
<input type="checkbox"/> 0 -10	At Worst:			
<input type="checkbox"/> Faces	At Best:			
<input type="checkbox"/> Verbal				
Side-effects / Treatment / Changes in Pain Medications or Comments				
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PRN / Breakthrough Analgesic given				Initials

DATE:		Site 1 _____	Site 2 _____	Site 3 _____
Patient's Rating of Pain				
Scale used	Present:			
<input type="checkbox"/> 0 -10	At Worst:			
<input type="checkbox"/> Faces	At Best:			
<input type="checkbox"/> Verbal				
Side-effects / Treatment / Changes in Pain Medications or Comments				
				Initials
PRN / Breakthrough Analgesic given				Initials

# Ongoing Assessment

- Identify & Monitor emotional & behavioral coping patterns to pain:
  - Stoicism, denial, anxiety, confusion, anger, withdrawal
- Identify environmental factors that can increase or decrease pain:
  - Minimize noxious stimuli, noise, music, weather, lights, smells if possible

# Pain Management

- PATIENT TEACHING



# Patient Teaching

- Include family if possible
- Use of pain scale
- Encourage patient to report pain
- Discuss misconceptions as needed:
  - such as fear of addiction, dependence, or being judged in a variety of ways

# Patient Teaching

- Emphasize the need to use/request medication to intercept pain before it becomes severe
- Use of comfort measures (repositioning, splinting area, relaxation techniques, activity modification)
- Safety measures: depend on situation: may include no machinery, driving restrictions, side-rails etc

# URGENT NEED

- Better professional education programs and resources
- Further dedicated research to help guide clinical practice
- Better pain management strategies that specifically target the special needs of various populations such as older persons, renal patients for example

# Conclusion

- Estimated that 50-75% of ESRD patients experience chronic pain
  - 82% patients reporting pain as moderate to severe
- Impact on QOL, mental and physical symptoms
  - Insomnia, depression, nausea, anorexia

# *What did we do?*



FHA renal program pain initiative:

WHO? = Interdisciplinary team working together



GOALS:

--Improve recognition of patients with pain

--Improve pain evaluation and management in our population

Long process to find "beginning" viable solutions

Numerous changes and re-inventions but ....

On the road to success



# FHA TOOLS

- 2007 meetings to develop tools to standardized pain assessment and ensure pain was incorporated in regular assessment
- Tools went into practice 2008
  - Initial assessment tool
  - Ongoing flow sheet
  - Algorithm for medication management \*

# ABC's of Pain Care:

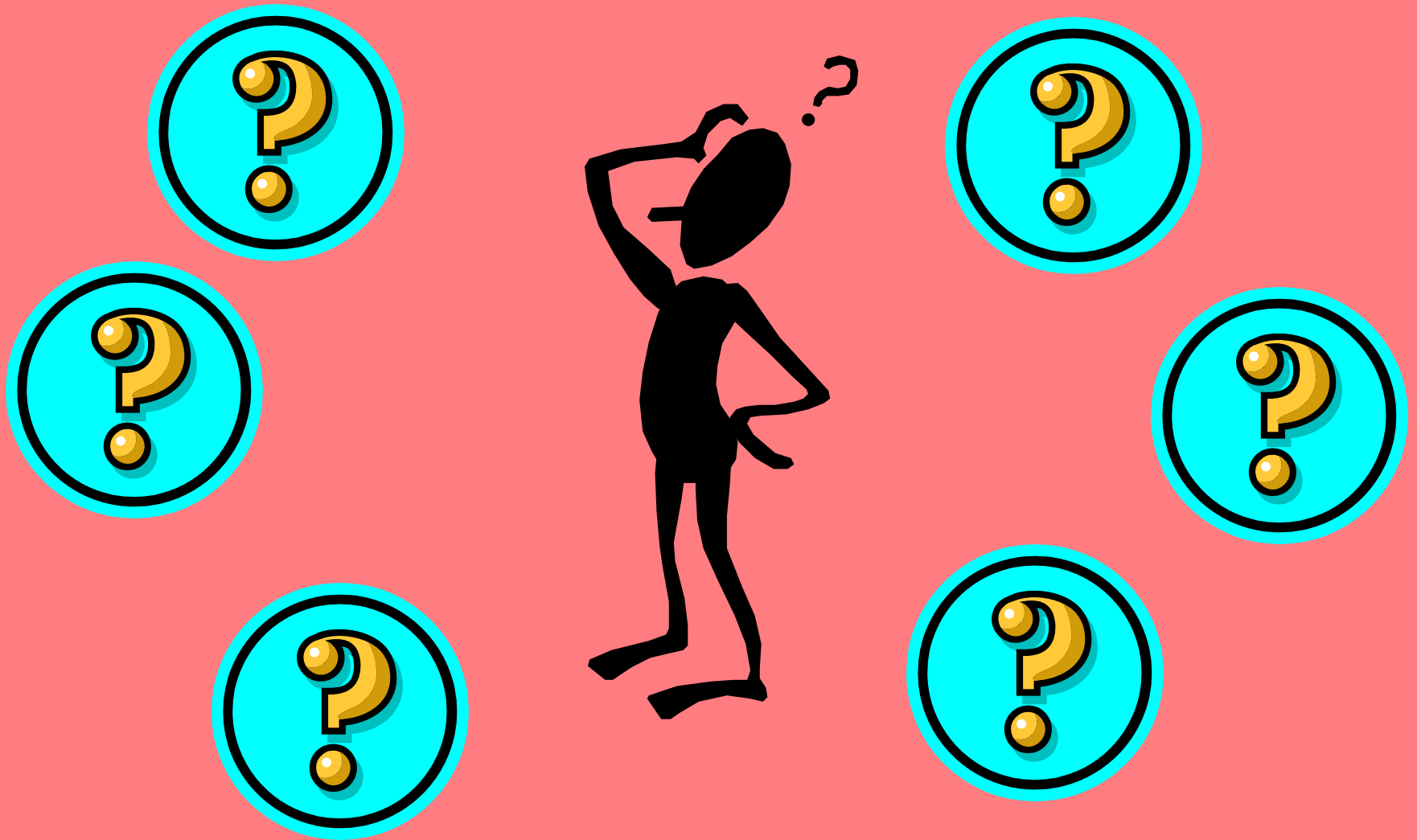
- **A**sk the patient
- **A**ssess regularly
- **B**elieve the patient
- **B**e proactive and be an advocate
- **C**hoose pain-control options
- **D**eliver interventions
- **E**mpower patients
- **E**nable them to control their course as much as possible

# Pain Management



- © Patient centered
- © Team approach

# Questions



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<http://www.jr2.ox.ac.uk/bandolier/booth/painpag/index2.html>

<http://www.medicinenet.com/script/main/art.asp?articlekey=20502&pf=3&page=1>

<http://www.painclinic.org/>

<http://www.canadianpainsociety.ca/indexenglish.html>

[http://www.ama-cmeonline.com/pain\\_mgmt/module01/02intro/index.htm#](http://www.ama-cmeonline.com/pain_mgmt/module01/02intro/index.htm#)

<http://www.stoppain.org>