PAIN MANAGEMENT: A LOOK BEYOND THE BASICS

Presented by:

PURPOSE

- The participant of this activity will enhance their direct care and leadership skills, increase knowledge on how to manage pain, how to assess pain and pain symptoms, understand the guidelines for pain management, and identify treatment options for managing pain.

OBJECTIVES

- Describe a systematic approach to pain assessment
- Identify treatment options for pain
- Explain patient/resident and caregiver education
Of all the symptoms experienced by those at the end of life, pain is one of the most common and most feared.

**End of Life Pain**

**Establish a Procedure for Pain Assessment**

- Attempt first to elicit a self-report from patient and, if unable, document why self-report cannot be used.
- Identify pathologic conditions or procedures that may cause pain.
- List patient behaviors that may indicate pain.
  - A behavioral assessment tool may be used.
- Identify behaviors that caregivers and others knowledgeable about the patient think may indicate pain.
- Attempt an analgesic trial.

(Pasero & McCaffery, 2011)

**Agency for Healthcare Policy and Research (AHCPR)**

**ABCDE of Pain Management**

- **A**sk about Pain Regularly. Assess Pain Systematically
- **B**elieve the patient and family in their reports of Pain and What Relieves the pain
- **C**hoose pain control options Appropriate for the patient, family and the setting
- **D**eliver interventions in a timely, logical and coordinated fashion
- **E**mpower patients and families, Enable them to control their course to the greatest extent possible
DEFINITION OF PAIN

- "Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage."
- "Pain is whatever the person says it is, experienced whenever they say they are experiencing it."

PAIN IMPAIRS THE INDIVIDUAL'S QUALITY OF LIFE

Inadequate pain relief hastens death by
- Increasing physiological stress
- Potentially diminishing immuno-competency
- Decreasing mobility
- Worsening risk of pneumonia & thromboembolism
- Increasing the effort of breathing & myocardial oxygen requirements

MAKING PAIN AS THE FIFTH VITAL SIGN

- An institution that includes the pain intensity ratings as a routine part of the assessment, increases the quality of life and improves patient outcomes
BARRIERS TO PAIN RELIEF

Lack of education, misconceptions, and attitudinal issues by:
- Healthcare providers
- Healthcare system
- Caregivers/families
- Patients

BARRIERS RELATED TO HEALTHCARE PROFESSIONALS
- Inadequate knowledge
- Poor assessment skills
- Regulation concerns
- Fears
  - Patient addiction
  - Adverse effects
  - Tolerance to analgesics
  - Cause the patient's demise
  - Not wanting to give the last dose

BARRIERS RELATED TO THE HEALTHCARE SYSTEM
- Low priority given to pain treatment
- Inadequate reimbursement
- Restrictive regulations
- Problems with availability of or access to treatments
- Pseudo Addiction
BARRIERS RELATED TO THE CAREGIVER AND FAMILIES

- Lack of knowledge
- Fear of the Stigma
- Fear of addiction
- Fear of the word Morphine, believe morphine is only used at the end of life

BARRIERS RELATED TO PATIENTS

- Reluctance to report pain
- Concern about not being a good patient
- Reluctance to take medications
- Fear
  - Addiction
  - Adverse effects
  - Disease getting worse
- Fear of symptom management without a definitive diagnosis
- Fear of stigma
- Cost
- Tolerance to pain medications

ADDICTION

- A primary persistent neurobiological disease with genetic psychosocial and environmental factors influencing its development
- Characterized by specific behaviors that relate to craving, obsession, and out of control usage
PSEUDO-ADDICTION

- **Signs**
  - Focused on pain med schedule
  - Asking for pain meds around shift changes
  - Requesting specific pain medications

- **Causes**
  - Patient has pain, it remains under-recognized and undertreated
  - Fear of uncontrolled pain, NOT desire, is the driving force
  - Patients clock-watch and request medications with caregivers who have responded in the past

DEBUNKING MYTHS ABOUT PAIN

*Even today, myths about pain and its management flourish among both patients and health care providers.*

**MYTH:**

Pain is a natural part of aging or illness and people have to live with it

- **Fact:** There is almost always a reason why a person is experiencing pain and in most cases physical pain can be managed.
- **Fact:** When someone is in pain, it can be impossible to think about anything else. Pain can make it difficult for you to work, sleep, maintain relationships with friends and loved ones and participate in simple activities.
MYTH:

The goal of pain management is to use as little pain medications as possible.

- Fact: The goal of pain management is to keep the patient as comfortable as possible. Help the patient choose a target pain rating that will reduce his discomfort to a tolerable level and let him participate comfortably in self-care and activities. Regularly assess and document his pain intensity using an appropriate pain rating scale (0-10).

MYTH:

If the patient doesn't seem to be in pain, he isn't in pain.

- Fact: Pain is subjective—it is whatever the patient says it is, occurring whenever he says it does. Don’t expect to find physiologic markers of pain, such as vital sign changes, grimacing, or diaphoresis, in a patient with chronic pain. Chances are his body has adapted to the pain.

MYTH:

A patient who is sleeping isn't in severe pain.

- Fact: Patients can fall asleep despite severe pain. Some patients even use sleep as a way to control pain.
**MYTH:**

If the patient is joking with others, he can't be in severe pain.

- **Fact:** Joking with others can be a form of distraction that the patient uses to cope with pain. The best indicator of pain is the patient's own report of pain.

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**PAIN ASSESSMENT**

Accurate pain assessment is the basis of pain treatment; it is a continuous process.

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**COMPONENTS OF PAIN**

- Quality
- Locations
- Intensity
- Pattern
- Aggravating/alleviating factors
QUALITY
- Nociceptive pain
  - Somatic Pain
    - Aching, throbbing
  - Visceral Pain
    - Squeezing, cramping
- Neuropathic pain
  - Burning, tingling, shooting

LOCATIONS
Determining the location and distribution of pain will:
  - Help determine etiology of the pain
  - Provide clues to appropriate treatments to palliate or relieve the pain

INTENSITY
- Quality pain – use of intensity scale
- Scale 0-10
- Individualize the pain assessment tool
- Determine the appropriate pain assessment tool
- Use the individualized tool consistently
**PATTERN**

- Acute pain
- Persistent pain
- Chronic pain
- Breakthrough pain

**AGGRAVATING/ALLEVIATING FACTORS**

- This information can help determine etiology and appropriate treatment

**COMPARING ACUTE AND CHRONIC PAIN**

<table>
<thead>
<tr>
<th>Acute</th>
<th>Chronic</th>
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<tbody>
<tr>
<td>Comes on Suddenly</td>
<td>Evolves over years</td>
</tr>
<tr>
<td>Lasts a few days to a few</td>
<td>Interferes with quality of</td>
</tr>
<tr>
<td>weeks</td>
<td>life</td>
</tr>
<tr>
<td>Constant, intermittent, or</td>
<td>Pain that has lasted more</td>
</tr>
<tr>
<td>both</td>
<td>than 6 months</td>
</tr>
<tr>
<td>Usually resolves</td>
<td></td>
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**PQRST: THE ALPHABET OF PAIN**

A Mnemonic Device to Obtain More Information About the Patient’s Pain.

**ASSESSMENT TOOL ADAPTED FROM HOSPICE PHARMACIA**

- History: the story
- Location
- Pattern
- Quality
- Radiation/Refers to another area
- Symptoms associated with pain
- Treatment: medication history, what’s being used
- Understanding:
  - Meaning of Pain: what does the individual attribute the pain to?

**COMPONENTS OF PAIN ASSESSMENT**

- Pain history
- Medication history
- Meaning of pain
PAIN HISTORY

- Pain self-report is most valid measure of pain
- Involve family/caregivers
- Unable to use the word “pain”
- Cultural biases

MEDICATION HISTORY

Questions to ask:
- “What meds have they already tried?”
- “What meds were effective?”
- “Any adverse effects resulted?”
- “What meds are they taking now?”
- “When was your last dose?”
- “How often are you taking the medication?”

MEDICATION HISTORY (CONT.)

Questions to ask:
- “Are you on a scheduled dose?”
- “How long do you wait prior to taking a breakthrough pain medication dose?”
- “What is the Pain score when you take the breakthrough pain medication dose?”
- “After taking a pain medication how long does the medication take to eliminate the pain?”
MEANING OF PAIN

- Evaluating the patients knowledge and beliefs about pain
  - Punishment for something they have done
  - Cultural beliefs- hesitate to complain of unrelieved pain
  - Suffering is part of life’s journey

PHYSICAL ASSESSMENT

- Nonverbal cues
  - Withdraw
  - Fatigue
  - Grimaces
  - Moans
  - Irritability
- Assess sites of pain- trauma, skin breakdown, changes in bony structures
- Palpate for Tenderness
- Assess lung sounds and bowel sounds
- Percuss area for fluid or gas
- Neurological assessment

PATIENT'S AT RISK FOR POOR PAIN ASSESSMENT AND TREATMENT

- Children
- Elderly
- Cognitively impaired
- Unconscious patients
- Patient who deny pain
- Non-English speaking patients
- Persons of different cultures than healthcare professionals
- Persons with a history of substance abuse
SPECIAL POPULATIONS

- Unrelieved pain greater in patients who cannot express their discomfort
- In the assessment and management of pain, there are issues specific to special populations that play a role in determining a plan of care for end of life.
  - Focus on Elderly

FOCUSING ON THE ELDERLY PATIENTS' ASSESSMENT

- Health history of all prescriptions
  - over-the-counter medications
  - herbal preparations
- Surgical procedures
- The patient’s response to pain
- Physical examination of neuromuscular and musculoskeletal systems
- Functional abilities
  - Mobility
  - Gait
  - Balance
  - Self-care proficiency
  - Activity tolerance
  - Any pain-related disabilities
- Psychosocial skills and cultural and spiritual beliefs (with a focus on pain coping skills and strategies)
- Cognitive ability (note impairment or depression)
- Sensory deficits (auditory, visual, verbal)
- Family support systems and social networks
THE PAIN-DEPRESSION CONNECTION

Elderly patients with diagnosis of depression typically report more incidences of pain and pain greater intensity than patients without depression.

FAMILY MEMBERS CAN HELP

- Ask about patient's normal behavior patterns and functional abilities
- Subtle changes in routine behaviors patterns can be a key to assessing and treating pain
- Some signs to watch for:
  - A drop in the patient's normal level of activity
  - Loss of appetite
  - The sudden onset of agitation or difficulty sleeping
  - A reduction in social interaction

PHARMOKINETICS AND AGING

- Absorption
- Distribution
- Metabolism
- Elimination
**ABSORPTION**

- Gastric pH increases as the stomach secretes less hydrochloric acid (an acid environment speeds the absorption of some drugs)
- The stomach takes longer to empty
- Contents of the GI tract move slowly
- Blood flow to the intestines is reduced
- Structural changes in the villi that line the small intestines slow their function

**DISTRIBUTION**

- More body fat
- Less muscle mass
- Lower level of water in body
- Redistribution of subcutaneous tissue

**METABOLISM**

- Liver mass and function declines with age- slow the metabolism of drugs- leads to higher blood levels and potential for exaggerated effects.
- Liver's capacity to metabolize drugs doesn't decline consistently for all drugs
ELIMINATION

- Renal function begins to decline around age 30; function change not significant until age 50 or 60
- By age 80 renal function can be 50% of what it once was
- As excretion slows, the half-life of administered drugs—and the risk of toxicity—increases.

REASSESS

- Regularly
- Teach patient to report any changes in pain
- Assessing pain relief

PAIN VERSUS SUFFERING AT THE END OF LIFE

The Presence of Pain compounds suffering and results in spiritual distress
COMMUNICATING ASSESSMENT FINDINGS

- Clear objective communication (both verbally and in writing) of the pain assessment findings will ultimately improve pain management.

  *Pain should be considered “the Fifth Vital Sign.”*

PHARMACOLOGICAL THERAPIES

- Nonopioids
- Opioids
- Adjuvant analgesics

NONOPIOID ANALGESICS

- Acetaminophen
- Nonsteroidal anti-inflammatory drugs
- Ceiling effects
- Adverse Effects
OPIOIDS

- Agonists
- Adverse Effects
- Mixed agonist-antagonist

AGONISTS

- Codeine
- Morphine
- Hydrocodone
- Hydromorphone
- Fentanyl
- Methadone
- Oxycodone
- Meperidine

ADVERSE EFFECTS

- Allergic reactions- extremely rare
- Respiratory depression
- Constipation
- Sedation
- Urinary retention
- Nausea and Vomiting
- Pruritus (Itching)
MIXED AGONIST-ANTAGONIST
- Stadol, Nubain, Talwin
- Not recommended in use for chronic pain
- Concerns

ADJUVANT ANALGESICS
- Primary indication other than pain but are analgesic in certain pain states
- Used to enhance the effects of the opioid drugs or to allow dose reduction because of adverse opioid side effects
  - Tricyclic Antidepressants as Analgesics
  - Anticonvulsants as Analgesics
  - Local Anesthetics
  - Corticosteroids
  - Baclofen
  - Capsaicin

TRICYCLIC ANTIDEPRESSANTS AS ANALGESICS
- Cymbalta
- Elavil
- Pamelor
- Nortriptyline
- Side effects
- Contraindications
BENZODIAZEPINE

- Valium
- Ativan
- Side effects
- Contraindications

ANTICONVULSANTS AS ANALGESICS

- Lyrica
- Tegretol
- Neurontin
- Useful with neuropathic pain described as “shooting”
- Adverse effects

LOCAL ANESTHETICS

- Useful with neuropathic pain
- Topical Treatment
- Lidocaine
CORTICOSTEROIDS

- Useful for neuropathic, pain, bone pain, and visceral pain
- Decreases edema surrounding many types of tissues
- Dexamethasone (Decadron)- often preferred at end of life

BACLOFEN

- Useful for relief of spasm-associated pain
- Weakness and confusion occur with higher doses

CAPSAICIN

- Given topically
- First causes pain, burning, then relieves pain
- Useful in relieving pain associated with post-mastectomy syndrome, postherpetic neuralgia, and post-surgical neuropathy pain in cancer
- Wash hands immediately after application- use gloves-
PRINCIPLES REGARDING THE USE OF ANALGESICS

The World Health Organization (WHO)

3-Step Analgesic Ladder

Step 1:
- Present mild pain
- (1-3 on 0-10 scale)
- non-opioid with an adjuvant if the patient has neuropathic pain
- if pain persisting or increasing proceed to Step 2

Step 2:
- Moderate pain
- (4-6 on 0-10 scale)
- add opioids. The non-opioid and adjuvants may also be continued.
- if pain is increases proceed to Step 3
PRINCIPLES REGARDING THE USE OF ANALGESICS

The World Health Organization (WHO)
3-Step Analgesic Ladder

**Step 3:**
- Severe pain
- (7-10 on 0-10 scale)
- Add higher doses of opioids. The non-opioid and adjuvants may be continued.

PREVENTION & TREATMENT OF ADVERSE EFFECTS

- Treat predictable adverse effects
- Place on laxative/stool softener combination
  - Do not use if patient has condition that causes diarrhea

USE OF LONG-ACTING AND BREAKTHROUGH MEDICATIONS

- Immediate-release formulations – convert to long-acting formulation
- Sustained-release & around-the-clock dosing
- Breakthrough medications- use of immediate-release medications
OPIOID ROTATION

- A systematic attempt at using various opioids
  - Ineffective after adequate upward titration of the dose
  - Produces adverse effects

NON-PHARMACOLOGICAL TECHNIQUES FOR PAIN MANAGEMENT

Other approaches to manage pain:
- Cognitive-behavioral therapies
- Physical measures
- Complementary therapies
- Other pain relieving therapies

These types of interventions can give the patient:
- An increased sense of control
- Decrease anxiety
- Improve mood
- Improve sleep

PAIN DURING THE LAST HOURS OF LIFE

- Patient may present with a diminished level of consciousness
  - This makes pain assessment complicated
  - Caregivers need to look for behavioral cues of pain

- Intractable Pain at the End of Life
  - Pain may become intractable even with aggressive titration of standard opioid and other therapies
  - There may be a need to produce sedation to provide end of life comfort
PATIENT EDUCATION

- Pain control is every patient’s right
- Good pain management will improve their quality of life
- Patients and families should be given permission to discuss concerns and fears

PATIENT EDUCATION

- Medication action, dosage, route, time, side effects, contraindications
- Drug to be taken on time or at the first onset of symptoms, before pain becomes severe
- Explain peak effect time
- Schedule difficult tasks 1/2 hour after taking medication

PATIENT EDUCATION (CONT.)

- Assure patient taking narcotics, less likely to become addicted if he takes it a short time
- Provide reading material on medications
- Teach about the pain scale
  - 0 to 10
  - Faces
  - Pain AD
  - Activity Tolerance Scale
- To call if any questions or concerns about the medications
HEALTH CARE PROVIDERS’ CHALLENGE

Health care providers can be guilty of lapses in knowledge that pose barriers to effective treatment. It’s critical to regularly update your knowledge of guidelines for elder care, pain assessment techniques, and treatment options.

- Some examples of common yet erroneous beliefs that affect pain management include:
  - Older patients are susceptible to addiction
  - Adverse reactions to opioids are particularly dangerous for elderly patients
  - Patients with cognitive impairments don’t have pain

HEALTH CARE PROVIDERS’ CHALLENGE

- Pain sensitivity decreases with age
- Pain management is a lower priority in the treatment plan

To meet the growing challenge of managing pain in elderly patients, all health care providers need a clear understanding of the unique physiologic, social, and psychological make-up of this population of patients.

Effective pain management can only occur when we shed common misconceptions about pain in elderly patients and overcome the barriers to treatment.

QUESTIONS & DISCUSSION

THANK YOU FOR ATTENDING