

Focus on Partnership

Pain Management

Pain has become the “fifth vital sign”, a term that was coined by the American Pain Society. This was done to invoke the seriousness of monitoring and controlling pain. The under-treatment of pain poses several ethical issues. Poor pain assessments lead to decreased quality of life, depression, reduced appetite, increased anxiety and gait impairment (Auret, K., et. al., 2005). Pain impacts the physical, emotional, social and spiritual dimensions of a person (Quality Insights). Approximately 45% to 80% of nursing home residents experience pain that decreases their quality of life (Ferrell, B.A., MD, 1995). Some of the indicators of pain include: increased blood pressure, increased heart rate, increased respiratory rate and restlessness (Weissman, D. E., et. al., 1999). Some caregivers also have misconceptions regarding pain in the elderly, a few examples include: pain in aging as “normal”; pain sensitivity and perception decreases with age; patients are unreliable when reporting pain (MacLean, MD, CMD, 2003). Often health care professionals experience “Opiophobia” which is the habitual underutilization of Opioid analgesia based on illogical and unfounded fear (Auret, K., 2005). In reality; addiction to Opioids in patients with acute pain or cancer pain is “extremely rare” (Auret, K., 2005). Opioids are the standard of care for moderate to severe pain; proper maintenance of the analgesic effect requires medication to be administered around the clock (ATC) (Vallernad,A.H.,2003).

Goals of Pain Management

Acute pain– provide residents with relief that allows them to rest comfortably and rehabilitate

Chronic pain– Restore the resident to the highest degree of function possible. Treatment may require prescribing multiple medications and/or medications for breakthrough pain

Cancer pain– To relieve the resident’s pain without disabling side effects. This requires prescribing long-acting medications in addition to medications needed for breakthrough pain.

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Classifications of Pain

Pain can be classified as *acute, chronic benign or malignant*.

Acute pain is caused by injury, illness or surgery and responds to medications. Once treated or healed this type of pain usually resolves.

Chronic benign pain exists beyond an expected time for healing, typically 3 to 6 months and is often associated with psychological effects caused by social isolation, depression and anxiety. Chronic pain is often not responsive to traditional pain medications.

Malignant pain may be acute, chronic or intermittent and is often related to cancer. and / or chemotherapy.



Diagnosis of Pain

1. The individual's self report of pain is the primary source of information.
2. Chronic pain assessment should include a detailed history of pain's intensity and characteristics, a physical exam emphasizing the neurological exam along with a psychological assessment.
3. Diagnostic tests, such as X-rays, CT or MRI scans are used to determine the disease progression and rule out new diseases.



Non-Opioid Analgesics

Drug Class	Generic Name	Brand Name
Salicylates	Acetylsalicylic acid	Aspirin
Para-Aminophenol	Acetaminophen	Tylenol
NSAIDs	Etolodac	Lodine
NSAIDs	Diclofenac	Voltaren
NSAIDs	Ibuprofen	Motrin
NSAIDs	Naproxen	Naprosyn
COX 2 Inhibitor	Celecoxib	Celebrex



Opioid Analgesics

Oxymorphone	Methadone
Morphine	Oxycodone
Codeine	Propoxyphyene
Hydrocodone	Fentanyl
Tramadol	Hydromorphone

“Pain upsets and destroys the nature of the person who feels it” Aristotle

Possible Opioid Side Effects

Mood Changes,
Drowsiness, lethargy,
inability to concentrate,
Nausea, vomiting,
Respiratory depression,
Constipation,
Tolerance,
Withdrawal symptoms if abruptly discontinued

Pain Management

Pain may also be classified according to its source. **Somatic pain** originates from the skin, muscles, tendons, ligaments, and bones. It is usually localized and described as sharp, stabbing, throbbing, or aching and responds to pain medications like Opioids. **Visceral pain** is pain in the body's internal organs (liver, stomach, intestines). Visceral pain is poorly localized and generates referred pain felt some distance away from the actual problem and does not respond to Opioids. **Nerve pain** occurs when the nerves themselves are damaged. Nerve pain is typically burning in nature, but may also present as a numb feeling, aching, or feel like an electric shock. Opioids alone may be ineffective in the treatment of nerve pain. Opioids can be effective in the treatment of neuropathic pain.

Pain management is a therapeutic strategy utilized in many forms of acute and chronic conditions. Pain is defined as any unpleasant sensory and emotional experience associated with actual or potential tissue damage. Pain and its respective treatment is often unrecognized and sub optimally treated in American society. Currently, approximately 75 million individuals suffer from chronic pain and between **1 in 5 people require daily medication**. Pain is what the resident says it is. Often health care providers under treat pain due to the myths and stigma of drug seeking behavior and addiction.

Principles of Opioid Use

Improving Your Facility Pain Management Program

Continuing education for health care professionals must include multiple strategies to focus on pain management. Nursing facilities need to implement quality assurance processes to address the under-treatment of pain.

Misconceptions regarding pain need to be addressed. Healthcare providers have a moral obligation to alleviate pain and suffering of their patients.

1. Opioids have **no ceiling** effect of pain relief, which means that as long as the dose is increased slowly to ensure little or no side effects there is no maximum dose for treatment of pain.
2. Oral medications should be used whenever possible.
3. When residents have constant or near constant pain, long-acting pain medication should be given around the clock.
4. Short-acting agents should be used for “breakthrough pain” as a rescue medication. The doses of rescue medications should range from 10-15% of the total daily dose of long-acting agents.

Effective Pain Management Requires Communication

Without proper education communication barriers exist in identifying pain levels leaving the patients to suffer in silence. The fact is often a patient will not express their pain unless they are asked if they are in pain (Ferrell, B.A., 1995). The expressions of pain in a patient, including those with cognitive impairment, are **typically dependable and legitimate** (Ferrell, B.A., 1995).

Pain Management and Treatment Strategies

Non-Opioid analgesics reduce prostaglandins produced by the pain pathway thereby decreasing the number of pain impulses received by the brain and spinal cord. Opioid analgesics reduce pain by mimicking the action of chemicals released by the brain that bind to and block Opioid pain receptors. Topically applied Capsaicin, tricyclic antidepressants, Lyrica, Cymbalta, anticonvulsants such as Gabapentin and NMDA receptor antagonists like Dextromethorphan can be used to treat nerve pain.

Non-drug strategies are used in combination with appropriate drug regimens and should not be a substitute for medication use when they are needed. Physical therapy is most commonly used to help restore physical strength and function after injury or surgery. Electrical nerve stimulation is used to interfere with the ability of the nerves to transmit pain to the spinal cord and brain. Biofeedback is a form of behavioral therapy where the resident learns to mentally control and change the pain signals. It is most commonly used to relax muscles and reduce stress. Distraction and relaxation are also used to assist the resident in refocusing attention on non-painful stimuli and improve mental health.



“We all must die. But if I can save someone from days of torture, that is what I feel is my great and ever new privilege. Pain is more terrible than lord of mankind than even death itself.”

Albert Schweitzer,
humanitarian, physician

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 **Partners-LTC**



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