Pain Management

University of Hawaii
Geriatric Medicine

Objectives

- Understand the principles of pain
- Use validated tools to assess patient's pain
- Strategies to manage pain

Case

A 78 yo male with hx of Hypertension, Hyperlipidemia, and CKD stage III came to the clinic with complaining of chronic back pain.

He has been using 5% lidocaine patch and PRN Tylenol as needed but they are not helping him.

He statea he sometimes takes OTC Motrin.

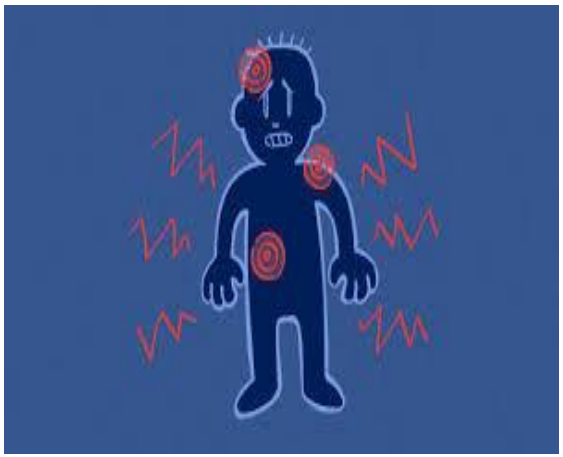
“Doc, can’t you do something for my back pain?”

What is pain?

- An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.
- Subjective
- Affected by cultural beliefs
- Common symptom at Nursing Home
- Controllable with proper

Pain and Suffering

- Suffering is more than the physical experience of pain
- Physical, Emotional, Social, Spiritual pain contribute to the experience of suffering



Things to ask

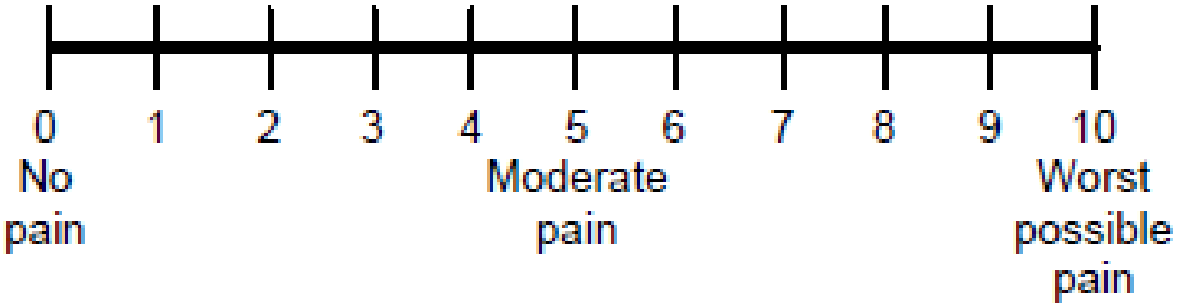
- **Location of the pain**
- **How bad is the pain**
- **Types of pain**
- **Duration of pain**
- **Alleviating factors**
- **Aggravating factors**
- **Current treatment (including medicines)**
- **Impacts on lifestyle (**Impact on sleep, mood, activity?)

Principles of Assessment

- Assess and reassess
- Use methods appropriate to cognitive status and context
- Assess intensity, relief, mood, and side effects
- Use verbal report whenever possible
- Document in a visible place
- Expect accountability
- Include the family

How do we assess the pain?

- **Ask the patient:**
- To describe their pain
- **Rate their pain** (use the faces scale)
- **Observe** the person's body language (how freely do they move).



Pain Assessment in Advanced Dementia Scale (PAINAD)

	0	1	2	Score
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations	
Negative Vocalization	None	Occasional moan or groan. Low level speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling, or inexpressive	Sad. Frightened. Frown	Facial grimacing	
Body Language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched, Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	

Type of physical pain

Nociceptive Pain

1) **Somatic:** Caused by activation of pain receptors (nociceptors) in the cutaneous or deep tissues (musculoskeletal)

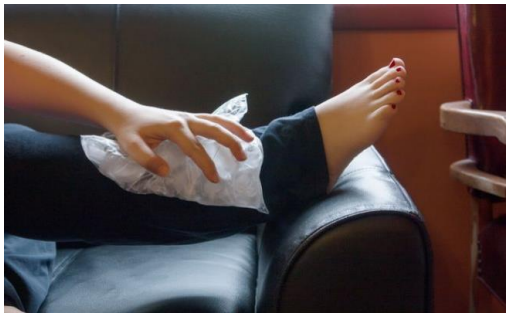
2) **Visceral Pain:** Poorly localized pain sensation from internal organs and structures (chest, abdomen, pelvis)

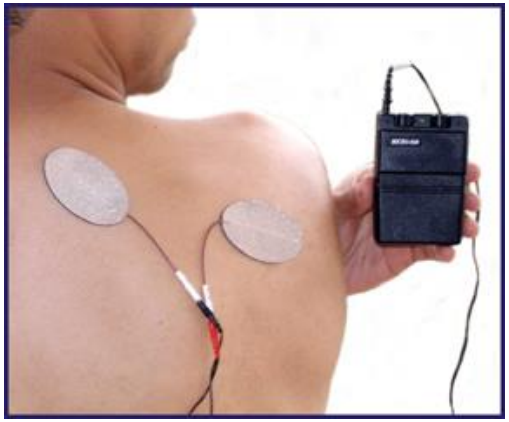
Neuropathic Pain:

Results from injury to nervous system (burning or tingling)

Non-pharmacologic pain management

- Examples of non-pharmacologic therapies include:
  - Hot-cold treatments
  - Positioning
  - Movement restriction-resting
  - Acupuncture
  - Hydrotherapy
  - TENS (Transcutaneous Electrical Nerve Stimulation)
  - Massage
  - Therapeutic touch

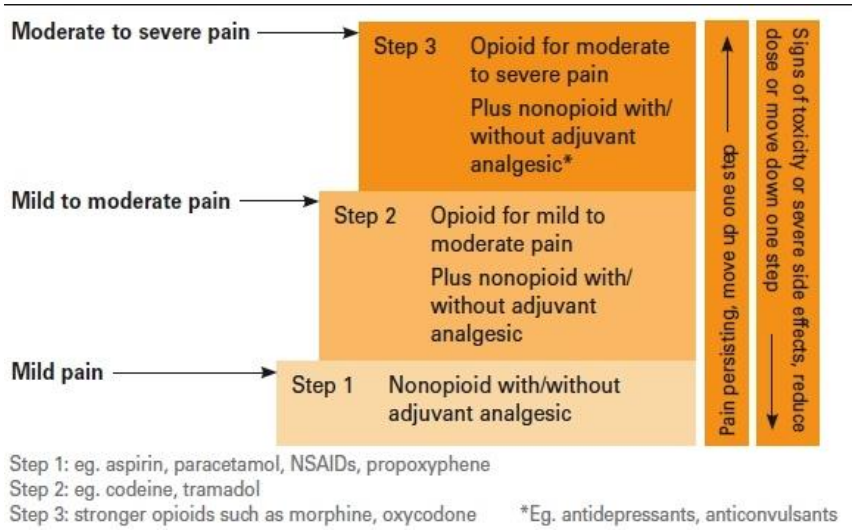




Medication Management

Key points:

- Use a step-wise approach to introduce pain medicines (analgesics)
- Prescribe regular doses of analgesics
- Plan a trial period with clear and specific instructions
- Review the effects on regular basis eg may need more frequent review for new medicines or when dose changes



Opiates

Dosing Table for Opioids						
Drug	Oral to Parenteral (IM, SQ, IV) Ratio	Approximate equianalgesic dose	ADULTS Recommended starting dose (adults more than 50 kg body weight)		PEDIATRICS Recommended starting dose (children and adults less than 50 kg body weight)[1] NOTE: when assessing doses in larger children, note usual initial adult dose	
			oral	parenteral	oral	parenteral
Opioid Agonist						
Morphine	3 mg oral to 1 mg parenteral	10 mg PARENTERAL	10-20 mg every 4 hours	3-5 mg every 4 hours	0.3-0.5 mg/kg/dose every 6 hours	0.05-0.2 mg/kg/dose every 4 hours (MAX 2-4 mg)
Codeine[2,3] (as Tylenol #3: 30 mg codeine/300 mg APAP)	1.7 mg oral to 1 mg parenteral	Use of parenteral codeine is not recommended.	30-60 mg Every 4 hours	N/A	0.5-1.5 mg/kg/dose every 6 hours	N/A
Fentanyl	N/A	Fentanyl 100 mcg (0.1 mg) PARENTERAL = Morphine 10 mg PARENTERAL (see next Table for conversion from fentanyl patches to parenteral morphine)	Actiq™, Fentora™ are not available at UNC.	50 mcg every 2 hours	N/A	1 – 2 mcg/kg/dose every 4 hours
Hydrocodone[3] (as Norco: 5 mg hydrocodone/325 mg APAP)	N/A	Hydrocodone 1 mg ORAL is equal to Morphine 1 mg ORAL	5-10 mg every 4 hours	N/A	0.05-0.2 mg/kg/dose every 4 hours	N/A
Hydromorphone (Dilaudid)	5 mg oral to 1 mg parenteral	Hydromorphone 2 mg PARENTERAL is equal to Morphine 10 mg PARENTERAL	2 mg every 4 hours	1 mg every 4 hours	0.03-0.08 mg/kg/dose every 4 hours	0.015 mg/kg/dose every 4 hours
Meperidine	4 mg oral to 1 mg parenteral	Meperidine 75 mg PARENTERAL is equal to Morphine 10 mg PARENTERAL	NOT RECOMMENDED AS AN ANALGESIC (FOR TREATMENT OF RIGORS ONLY)			
Methadone[4]	Caution is advised when converting to methadone due to variability in patient response and delayed peak effects. Reliable equianalgesic conversion for repeated dosing is not available. Parenteral methadone is not available at UNC.		5 mg every 8 hours	N/A	0.1 mg/kg/dose every 8 hours	N/A
Oxycodone[3] (as Percocet: 5 mg oxycodone/325 mg APAP)	N/A	Oxycodone 1 mg ORAL is equal to Morphine 1.5 mg ORAL	5 -10 mg every 4 hours	N/A	0.05-0.2 mg/kg/dose every 6 hrs	N/A
Opioid Agonist-Antagonist and Partial Agonist						
Butorphanol	N/A	Butorphanol 2 mg PARENTERAL is equal to Morphine 10 mg PARENTERAL	N/A	2 mg every 4 hours	N/A	10-20 mcg/kg/dose every 4hours
Nalbuphine	N/A	Nalbuphine 10 mg PARENTERAL is equal to Morphine 10 mg PARENTERAL	N/A	10 mg every 4 hours	N/A	0.1 mg/kg/dose every 4 hours

http://pharmacy.intranet.unchealthcare.org/clinresources/clinguidelines/pain.pdf

Opioid side effects

- Sedation or drowsiness
- Constipation – patient should begin a bowel regimen simultaneously with opioid
- Itching
- Nausea
- Confusion
- Myoclonus -irregular involuntary contraction of a muscle

Co Analgesics Commonly Used For Pain

- NSAIDS
- Acetaminophen
- Antidepressants
- Anticonvulsants
- Corticosteroids
- Neuroleptics
- Antihistamines
- Analeptics
- Benzodiazepines
- Antispasmodics
- Muscle relaxants
- Systemic local anesthetics

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Emotional Pain

He lost his wife about 2 years ago. Since then, he has been feeling down.

PHQ-2: 2/2 positive

GDS: 8/15

Social Pain

Financial burden

5 % lidocaine is expensive.

Spiritual Pain

N/A

Physical Pain

Next Slide

Case-Physical Pain

- **Location of the pain :** Mid lower back, radiates to Right lower legs
- **How bad is the pain :**6/10, after Tylenol or Motrin →3/10
- **Types of pain :**Dull pain in mid back, Aching pain in legs
- **Duration of pain:** all the time
- **Alleviating factors:** Warm compress, lying down
- **Aggravating factors:** Bending, sitting long time
- **Current treatment (including medicines)**

5 % lidoderm patch, Tylenol, Motrin

- **Impacts on lifestyle (**Impact on sleep, mood, activity?)

Feels depressed, stopped going to the church

Case

- Interventions:
  D/C Motrin given his CKD stage III
  D/C 5% lidoderm patch
  PT/OT
  Start Venlafaxine ER 37.5 mg po daily
  Start Scheduled Tylenol 650 mg po TID
  Non-pharmacologic pain managements

Tramadol for breakthrough pain, however need to be careful for possible Serotonin syndrome.

Take Home Message

- Perform a thorough **assessment**.
- **Discuss options** for managing pain with the patients or their families
- Recommend **opioid** only as **part of** an pain **management plan**