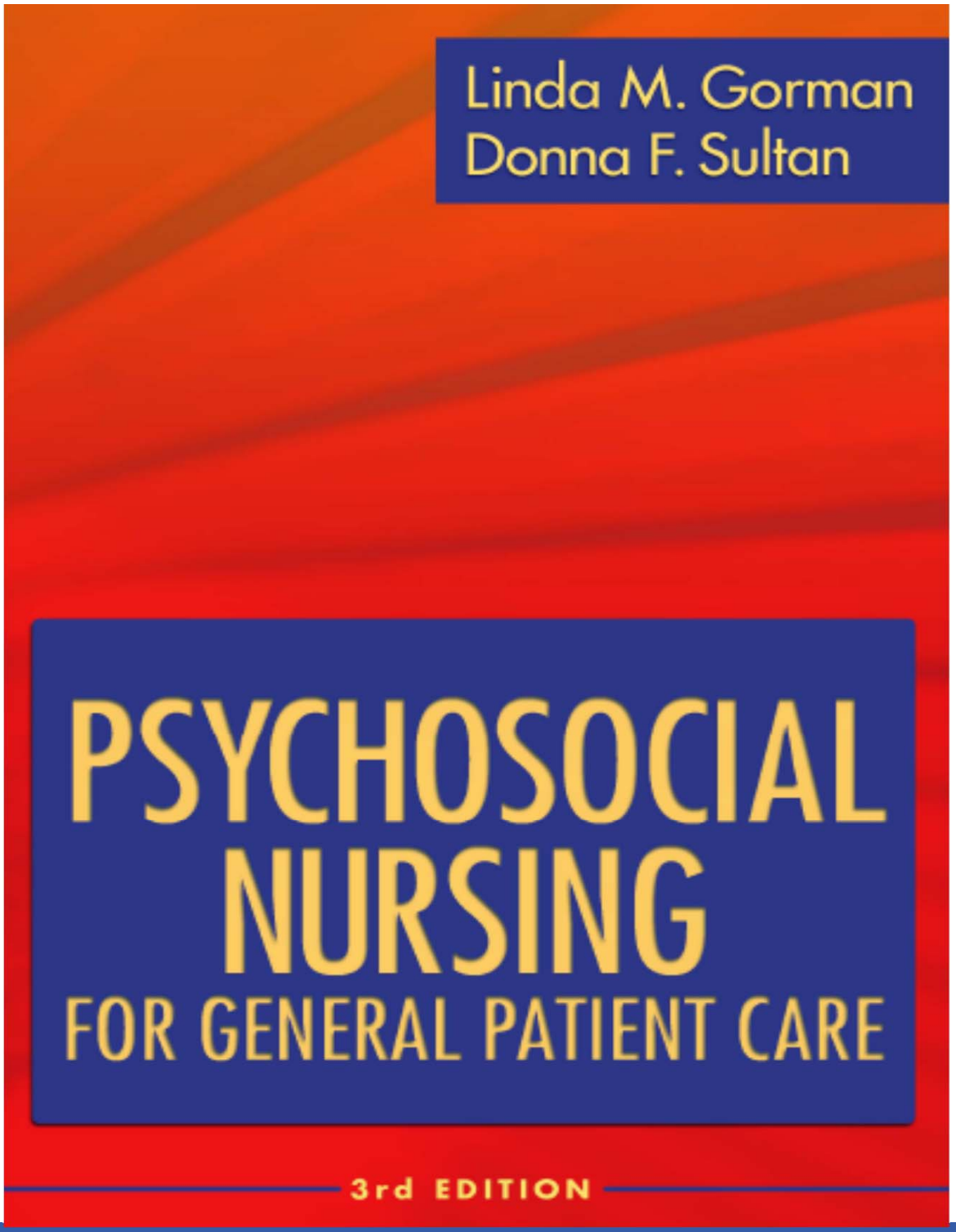

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Commonly Encountered Problems: Pain

The Patient with Pain

Learning Objectives

After the classroom discussion, the students will be able to:

1. **Differentiate between acute, recurrent, and chronic nonmalignant and malignant pain.**
2. **Examine the reasons for underassessment and under treatment of pain.**
3. **Describe important factors to be considered in the assessment of pain.**
4. **Describe the role and routes of opioid and non-opioid analgesics in pain management.**
5. **Discuss the importance of alternative (non-pharmacological) methods of pain relief.**

Useful Terminologies

1. *Acute pain* – Pain, usually of shorter duration, that acts as a warning and protective mechanism.

2. *Addiction* – A psychological process, in contrast to drug tolerance, that involves the repeated use of a drug or drugs for psychological, not medical, reasons.

3. *Cancer pain* – Usually placed in a category of its own. Even if it lasts for more than 6 months, it is often treated like acute pain because of its progressive nature.

4. *Chronic pain* – Pain that lasts beyond the ordinary duration of time that an insult or injury to the body needs to heal.

Useful Terminologies

5. *Drug tolerance* – A physiological response of the body, not under the person's control, in which the drug loses its effectiveness after repeated use.

6. *Pain* – An unpleasant sensory and emotional experience arising from actual or potential tissue damage caused by a noxious stimulus.

7. *Pain tolerance* – Duration and intensity of pain that an individual is willing to tolerate at any one time.

8. *Placebo* – Any medical or nursing measure that works because of its implicit or explicit therapeutic intent rather than its chemical or physical properties.

Useful Terminologies

9. *Pseudo-addiction* – Patient behaviors that may mimic drug-seeking behaviors and occur when pain in undertreated.

10. *Referred pain* – Pain felt at a site other than the injured or diseased organ or body part. The pain of coronary artery insufficiency, for example, is often referred to the left shoulder, arm, or jaw, and pancreatic pain may be referred to the middle back.

Introduction

- Pain is what the person experiencing it says it is, exists when and where he or she says it does. The patient is the authority about his/her own pain. (McCaffery, 1968)

- Pain is a universal experience occurring in all age groups and is the most frequent reason why people seek health care.

- Recent research indicates that nurses and physicians continue to undertreat pain in patients because they do not understand pain management principles, they fear causing the patients' dependence on opioids, and they have poor knowledge of opioids, adjuvant therapies, and the components of pain assessment (McCaffery & Ferrell, 1997).

Pain Management Principles

1. Pain intensity and relief must be assessed and reassessed at regular intervals in a consistent manner
2. Patient preferences must be respected when selecting methods of pain management.
3. Each institution must develop an organized program to evaluate the effectiveness of pain assessment and management.
4. Establishing positive relationships between patients and health-care professionals is an important part of successful pain control.
5. Unrelieved pain has severe negative physical and psychological consequences.
6. Prevention is better than treatment. Pain that is established is more difficult to control.

ETIOLOGY

The Gate Control theory, originally proposed in 1965 by Melzack and Wall, suggests that pain occurs when smaller diameter type A nerve fibers and very small diameter type C fibers are stimulated.

A number of neurotransmitters have been discovered that are found to contribute to the carrying of the pain impulse.

These include glutamate and substance P. A number of drugs are being investigated that inhibit binding of excitatory amino acids such as glutamate that normally binds to N-methyl-Daspartate (NMDA).

ETIOLOGY

- The *multiple opioid receptor theory* recognizes that not all opioids work the same way and some cannot be switched back and forth without adverse consequences.
- There are at least three types of opioid receptor sites in the spinal column.
- Each type binds somewhat differently with different types of opioids. For example, opioids like butorphanol tartrate (Stadol) or nalbuphine (Nubain) (agonist antagonist drugs) antagonize the effects of other narcotics like morphine and can contribute to withdrawal rather than pain relief. Knowledge of this theory enhances appropriate selection of analgesics (Ripamonti, Zecca, & Bruera, 1997).

ETIOLOGY

- *Gender and social and cultural factors* also affect the pain response by influencing how the individual interprets pain and how he or she responds emotionally. Through family, social, and cultural values and attitudes, the patient learns which types of pain responses are appropriate within his or her group. Of course, family and social influences change as a child matures.

RELATED CLINICAL CONCERNS

- Chronic pain is a significant health problem. For example, 10% to 15% of adults in the United States are estimated to have some form of disability from back pain (Borsook, McPeek, & Lebel 1996). One in five Americans suffer from chronic pain (Sternberg, 2005). In addition to disrupting employment, chronic pain can contribute to family problems and social isolation.

- Chronic pain patients are also at higher risk for dependence and abuse of medication because their pain is often not relieved and they begin taking larger doses in hopes of obtaining relief and treating their depression.

Factors Influencing Pain Tolerance

Factors that may increase or decrease tolerance:

1. Past experiences with painful stimuli (e.g., surgery, trauma, illness)

2. Knowledge about cause of pain, its treatment, and probable outcome

3. Personal meaning of pain (e.g., recurrence of cancer, day off from school or work)

4. Knowledge and experience in coping with pain, willingness to try new techniques

5. Stress, fatigue, energy levels

Factors Influencing Pain Tolerance

6. How others treat person when he or she has pain (e.g., secondary gains)

7. Available resources (e.g., money for treatment)

8. Interactions with healthcare providers (e.g., preventive approach: pain is treated early or patient has to prove that pain is “real” before anything is done to help relieve it)

9. Cultural background: some cultures encourage the expression of even mild discomfort, whereas others expect stoic, quiet tolerance of even very severe pain

Factors Influencing Pain Tolerance

Factors that usually decrease pain tolerance:

1. Disbelief on the part of others
2. Lack of knowledge about pain, pain-relief measures
3. Fears about addiction, loss of control over pain
4. Poor experiences with past pain-relief efforts
5. Disability, increasing or long-term
6. Fatigue and monotony

LIFE SPAN ISSUES

Children

- As with adults, pain is one of the most feared symptoms in children (Collins & Walker, 2006).
- Research indicates that younger children, including neonates, may experience some pain more intensely than older children.
- For children who cannot communicate verbally about their pain, one needs to assess pain by observing physiologic changes, nonverbal behavior, and vocalizations, such as crying or groaning..

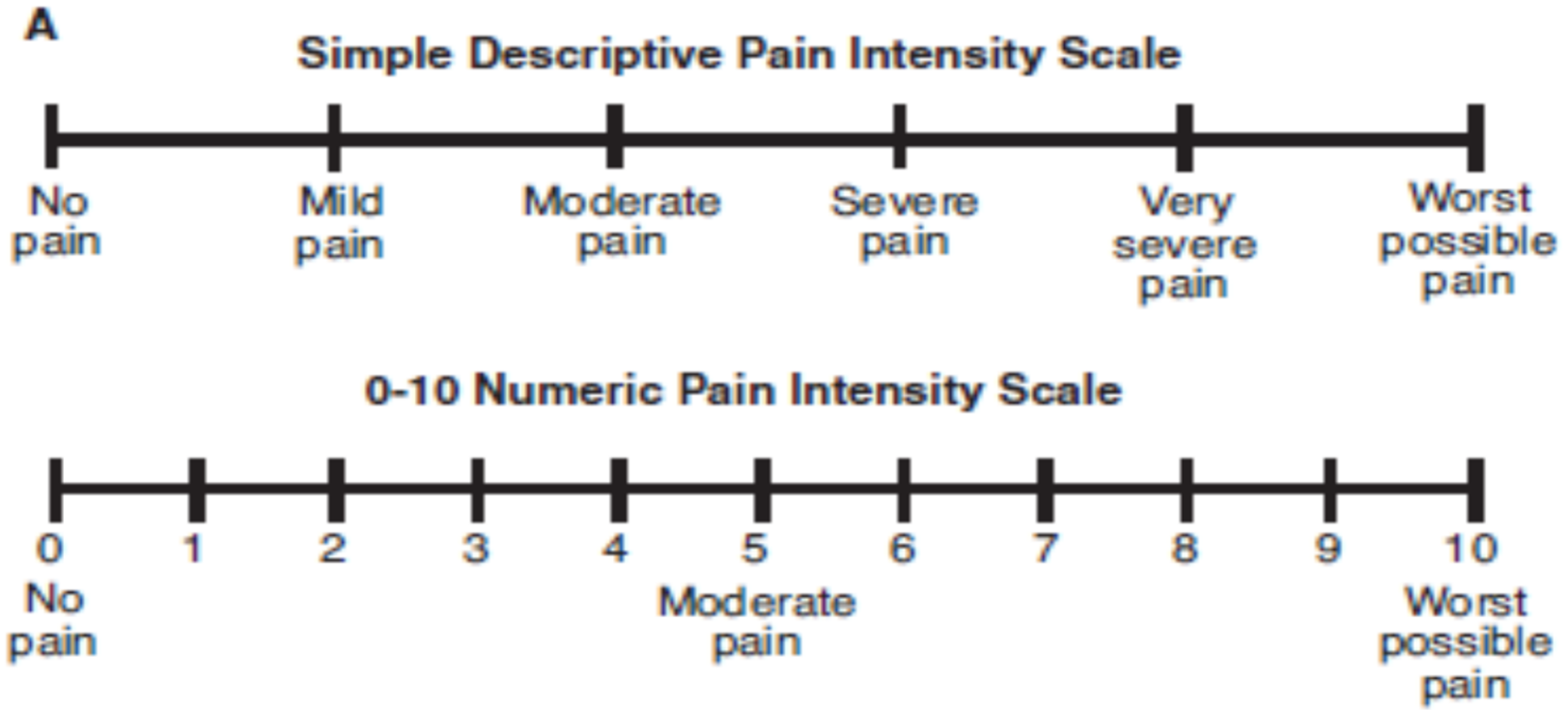
LIFE SPAN ISSUES

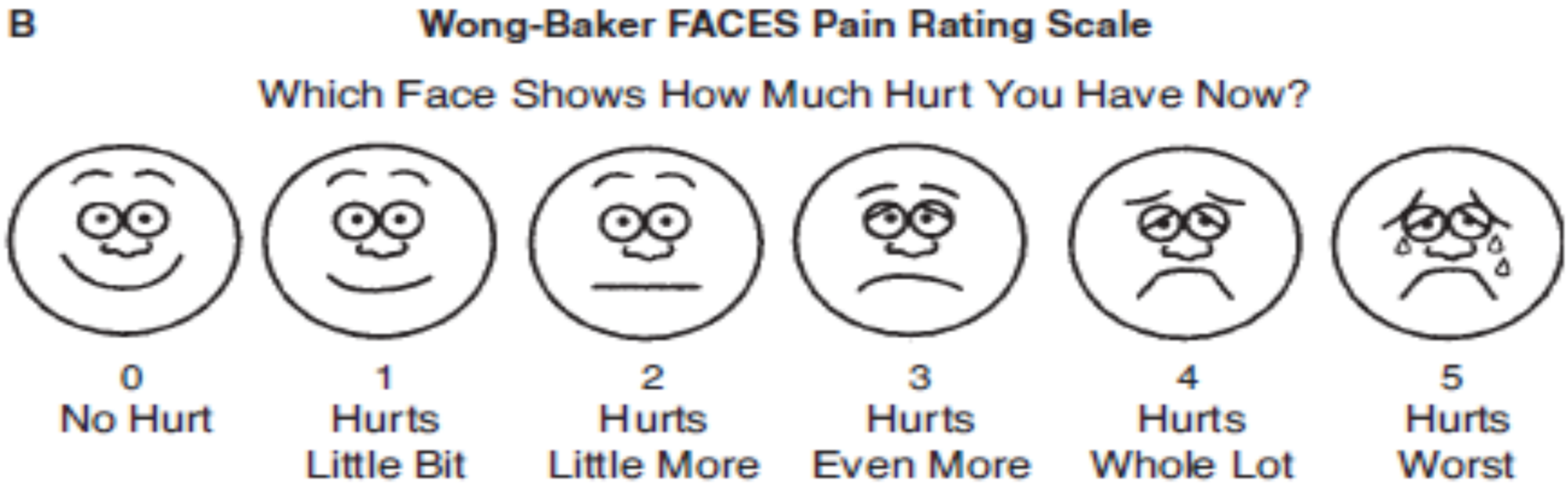
Older Adults

- Pain is not an inevitable part of aging; however, elderly people are at greater risk for many disorders that may result in pain, such as arthritis, cardiovascular disease, osteoporosis, falls, hip fractures, and cancer (Horgas & Elliot, 2004; Barkin, Barkin & Barkin, 2005).

- Older patients may deny pain more frequently than other age groups because they fear the consequences of admitting pain, such as longer hospitalization or more tests, or they have the mistaken belief that pain

Pain Rating Scales





POSSIBLE NURSES REACTIONS

- May rely more on physiological changes or signs such as vital signs, body movement, facial gestures, and other nonverbal behavior than on patients' own verbal reports to assess patient's pain.
- May become insensitive to patient's expressions of pain.
- May have difficulty accurately assessing the patient's pain. Varying opinions among staff members over interpretation of behaviors suggesting pain and selected pain control modalities can lead to very divisive conflicts among staff members.
- May feel extremely frustrated over what can be done to help the patient.
- May fear causing a patient's addiction if the patient requires narcotics for an extended period of time.
- May think that the need for greater pain control is more acceptable for certain types of pain, such as cancer pain.
- May believe that patients will always accurately report pain when they have it.
- May become frustrated over what to do when a patient denies having pain to the physician but continues to request pain medication from nursing staff.
- May feel manipulated by patients who staff members believe are faking pain for the purpose of obtaining more medication.

ASSESSMENT

1. Behavior and Appearance
2. Mood and Emotions
3. Thoughts, Beliefs, and Perceptions
4. Relationships and Interactions
5. Physical Responses
6. Pertinent History

COLLABORATIVE MANAGEMENT

1. *Pharmacological*

- Several types of drugs are available to treat pain. Selection is based on the cause of the pain, its intensity and duration, and the patient's response. Mild intermittent pain may be treated with salicylate analgesics, acetaminophen, or nonsteroidal anti-inflammatory agents (NSAIDS).

- These drugs have specific upper dose limits due to their side effects. More severe, acute pain may need opioid analgesics such as morphine or oxycodone.

NURSING MANAGEMENT

PAIN, ACUTE evidenced by report of moderate pain, changes in autonomic nervous system (increased heart rate and blood pressure), and reduced ability to perform ADLs related to surgery, injury, or illness

Patient Outcomes

- Reports decreased pain levels
- Identifies previously successful pain-relief techniques to use now to decrease pain
- Identifies and minimizes factors that precipitate or aggravate pain
- Participates in assessment of pain and effectiveness of pain-relief methods
- Demonstrates increased mobility and activity

NURSING MANAGEMENT

Interventions

- Look directly at patient when speaking. Call patient by name frequently. Identify yourself by name before each conversation and refer to others by their names rather than “he” or “she.”
- Keep interactions simple. Use short words and simple sentences that express one thought or question at a time.
- Ask specific questions such as “Does your stomach hurt?” rather than general ones like “How are you?”
- Reinforce speech with nonverbal techniques. For example, point, touch, or demonstrate an action while talking about it. For instance, if the patient is trying to tell you about his or her body, point as well as ask “Is this where it hurts?”

NURSING MANAGEMENT

- Perform a thorough pain assessment. Ask patient to rate pain on a consistent scale such as 0 to 10, with 0 being no pain and 10 being the worst possible pain. Determine if the patient can relate more to a visual pain scale.
- Use the same tool each time you assess that patient's pain.
- Be sure to determine the patient's perception of his or her pain, previous effective pain methods used, and any misperceptions the patient has about effective pain-relief methods.
- To reduce the patient's anxiety, explain the causes of pain, if known.
- Teach the patient and family about factors that may increase or decrease pain. Try to minimize factors that increase pain perception..

NURSING MANAGEMENT

- Teach about any necessary painful procedures before they occur to reduce stress over anticipating the procedure. Patient teaching should include:

- Provide accurate information about analgesics to reduce fear or misconceptions about addiction, tolerance, and physical dependence. Recognize that the patient or family may become anxious when medications are changed. Discuss any changes in medication, dose, or frequency with physician, and plan how to inform the patient about the pain control goals and parameters.

- Provide relief measures at regular intervals rather than on an as-needed basis, even when the pain is still tolerable. Do not expect the patient to wait until pain is unbearable to administer the next dose

NURSING MANAGEMENT

- Check with patient 30 minutes after administering a pain medication to assess its effectiveness. Include patient in rating level of pain before and after medication or other pain-relief method used.
- Encourage patient's participation in using alternative pain-relief methods such as relaxation exercises or use of heat or cold
- Instruct the patient about rigid body position, which can increase pain, and techniques to reduce muscle tension.
- Discuss effects of stress, monotony, fatigue, and distraction on pain perception.
- Provide for privacy for pain expressions if the patient desires.
- Try to limit the number of caregivers interacting with patient and making decisions about pain management.

NURSING MANAGEMENT

PAIN, CHRONIC evidenced by ongoing episodes of pain, difficulty performing usual activities, and other effects of chronic pain, such as sleep disturbance or poor nutrition related to effects of illness, surgery, or injury more that lasts beyond the ordinary duration of time that body needs to heal.

Patient Outcomes

- Participates in assessment of pain
- Uses one or more alternative measures to manage pain
- Demonstrates reduced intensity of depression
- Increases participation in activities
- Decreases use of pain behaviors for secondary gain
- Decreases dependence on analgesics when pain controlled

NURSING MANAGEMENT

Interventions

- Assess patient's previous and current pain behaviors.
- Encourage the patient to learn and use noninvasive pain-relief methods, such as muscle relaxation, deep breathing, guided imagery, distraction, TENS, and application of heat or cold.
- Incorporate family or caregivers in alternative pain-relief measures.
- Use analgesic medications in conjunction with alternative pain-relief measures to effectively control pain.
- Discuss with physician or pharmacist plan for weaning patient off opioids and onto non-narcotics.
- Teach patient and family that oral medication, when prescribed in appropriate dose and frequency, can be as effective as parenteral.

NURSING MANAGEMENT

- Administer a loading dose and then maintain a therapeutic drug level of oral medications when first switching to gain the patient's confidence in new treatment.
- Ask patient to participate in evaluation of pain-relief methods by keeping his or her own pain diary.
- Help family or caregiver to recognize and decrease pain behaviors for secondary gain.
- Promote optimal mobility and meaningful activity in patient.
- Assess patient's nutrition and elimination functions related to use of medications and decreased mobility or activity.
- Assess patient's sleep pattern, levels of depression, or other psychological reactions to prolonged pain. Consider use of adjuvant treatments, as indicated.

NURSING MANAGEMENT

ALTERNATE NURSING DIAGNOSES

1. *Anxiety*
2. *Comfort, Impaired*
3. *Coping, Ineffective*
4. *Fear*
5. *Powerlessness*
6. *Self-Concept, Disturbed*
7. *Sleep Pattern, Disturbed*
8. *Spiritual Distress*
9. *Thought Processes, Disturbed*

WHEN TO CALL FOR HELP

- Pain-relief measures are ineffective.
- Pain levels increase.
- Patient or family is unwilling to learn about alternative methods of pain relief.
- Psychiatric problems are interfering with patient's use of prescribed pain-relief methods.
- There is increased frustration from dealing with the patient's or family's pain behaviors.
- Analgesics ordered are ineffective and physician refuses to make changes.
- Patient continues or increases use of pain behaviors for secondary gain.
- There are concerns over patient's or family's ability to manage pain after discharge.
- Evidence of abuse of opioids.

WHO TO CALL FOR HELP

- Pain team
- Addiction specialists
- Social Worker
- Palliative Care Team/Hospice
- Attending Physician

End of Chapter