PAIN MANAGEMENT (ESSAY)

→ An unpleasant sensory and emotional experience associated with actual or potential tissue damage

→ Pain may / may not be directly proportional to amount of tissue injury

→ highly subjective.

→ In cancer, the prevalence of pain in advanced disease is 70–90%.

In HIV, pain prevalence is 50%.

Other illness → no clear data.

Classification

- Acute
- chronic
  - Non malignant
  - malignant

Acute pain

Injury, trauma, spasm/disease to skin, muscle, somatic structures or viscera.

perceived and communicated via peripheral mechanisms.

Usually associated with autonomic response as well (tachycardia — bp, diaphoresis, pallor, mydriasis (pupil dilation))

→ subsides quickly as pain producing stimuli + ass with anxiety.

Chronic

Non malignant

→ pain persists beyond the precipitating injury

→ rarely associated with autonomic symptoms.

→ sufferers often fail to demonstrate objective evidence of underlying pathology.

Malignant

→ chronic & symptoms of acute pain

→ definable cause eg. tumor recurrence.

→ In treatment, narcotic hallucination is generally not a concern.

Types of pain.

→ Somatic
→ Visceral
→ Bone.
→ Neuropathic
→ Emotional / spiritual.

Somatic Pain (skin, muscle, joint)

Aching, often constant dull or sharp

worse with movement

well localized.
Eg: Bone & soft tissue.
chest wall

Visceral
constant / crampy
aching / burning
poorly localized.
Referred.
Organs of thorax & abdominal cavity
Usually as a result of stretching, infiltration and compression.
Eg: Bowel obstruction.
Liver capsule distention.

→ Both somatic & visceral pain travel along same pathway.
So, pain should arising from the viscera is perceived as somatic in origin.
This can be confused by the brain and is often described as REFERRED PAIN.

Bone Pain
→ Poorly localized, aching, deep, burning
common with malignancy of breast, lung, prostate
lead to fracture

Neuropathic pain
→ lesion, trauma, infection, compression / tumour.
→ burning, shooting, tingling
→ not respond well to standard analgesics
→ caused by disturbance of function / pathological change in a nerve.

Categories of Pain.
↓ Nociceptive pain.
↓ Neuropathic pain.

Effects of pain.
Sympathetic responses.
pallor, ↑ BP, ↑ pulse, ↑ resp, sweating, diaphoresis

parasym
↓ BP, ↓ pulse, weakness
pallor, nausea, vomiting.

Pain History
→ site of pain
→ Type of pain.
→ Exacerbating & relieving
→ factors.
→ How frequently.
→ Impact on daily life

Pain Assessment tools

→ Verbal analogue scale
→ Visual " "
→ The Faces scale

Numeric Pain rating scale.

→ Score 0 – 10 ask patient.
(no pain) (worst possible pain).

Wong - Baker Faces pain rating scale.

Colorado pain Rating scale

Severity assessed.

Managent

→ Non - pharmacological treatment
→ Pharmacological
  - Analgesics
  - Adjuvants
→ Others

Non Pharmacological treatment

→ exercise
→ weight reduction
→ Counselling
→ Smoking cessation
→ Massage, relaxation therapy
→ heat & cold application

Analgesia

→ Non opioid
eg: diclofen, paracetamol.
→ Opioids
eg: codeine, morphine.
→ Adjuvant.
eg: muscle relaxant, anti depressant, anti-epileptic.
→ NSAIDS.

Choosing appropriate analgesic

WHO has a 3-step model.

Step 1 → NSAIDS ± adjuvants
Step 2 → NSAIDS + mild opioids ± adjuvant.
Step 3 → Strong opioids + NSAIDS ± adjuvants.

Non opioids

→ Salicylates
→ NSAIDS

Weak opioids → codeine.
Strong → fentanyl, morphine.

Opioid side effects

→ constipation : need proactive laxatives.
→ Nausea / vomiting
→ Urinary retention
→ Rash / Itch
→ Dry mouth.
→ Resp depression.
→ Neurotoxicity.

Adjuvants for Neuropathic pain

→ cyclic antidepressants

Amitriptyline

→ Anticonvulsants.

→ Local anesthetics.

Other modalities.

→ Nerve blocks, epidural, blocks & ablative neurosurgical procedures may be effective.

Such procedures may be associated with return of pain after a no. of months & that timing of procedures may be important.