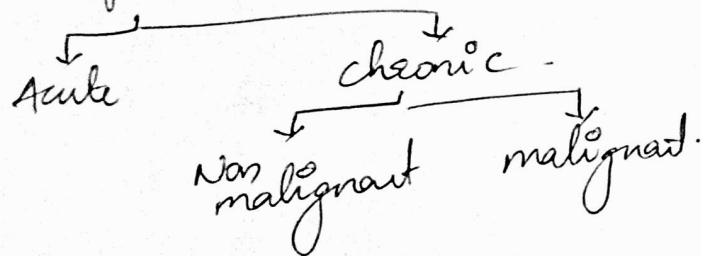


PAIN MANAGEMENT. (ESSAY)

- 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 illnesses → no clear data.

Classification



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 to are 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 e.g. tumor recurrence.
- In treatment, narcotic habituation 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 / laceration.

→ burning, shooting, tingling.

→ not respond well to standard analgesics

→ caused by disturbance of function / pathological changes in a nerve.

Categories of Pain

↓
Nociceptive pain

↓
Neuropathic pain

Effects of pain

Sympathetic responses -

pallor, ↑ BP, ↑ pulse, ↑ resp, sweating, diaphoresis

parasymp

↓ 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 FACS scale

Numeric Pain rating scale

- From 0 - 10 ask patient.
(no pain) (worst possible pain)

Wong - Baker Faces pain rating scale

Colour pain rating scale
Severity assessed.

Management

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

Non Pharmacological treatment

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

Analgesics

- Non opioid
eg: aspirin, 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 prokinetic laxatives
- nausea/vomiting
- Urinary retention
- Rash / Itch
- Dry mouth
- Resp depression
- Neurotoxicity

Adjuvants for neuropathic pain

- cyclic antidepressant

Amikopy

→ Anticonvulsant.

→ 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.