

THE NEWSLETTER

for Attorneys and Paralegals



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ABOUT PAIN

- *Acute and Chronic Pain – What's the difference?*
- *Assessing Pain – How is it done?*
- *Managing Pain – What are the Interventions?*
- *Barriers to Pain Assessment and Intervention*

Did you know that PAIN is the most frequent reason a person seeks medical help? Pain – a significantly individual experience – differs not only among individuals but also from moment to moment. Whether it is associated with an illness or an injury it may be exaggerated or intensified by anxiety, or even by secondary gain...the attention of family members, health providers or, perhaps, attorneys.

Regardless of the cause, Pain Management, in addition to being a desired treatment goal, has also been identified by such regulating agencies as JCAHO as an expected part of care.

ACUTE AND CHRONIC PAIN – What's the difference?

Acute Pain is usually related to an identifiable source – a specific injury, illness or disease process. Typically it has a sudden onset, can be localized as it brings instant attention to the area that is injured or impacted by an illness (ex., appendicitis or a broken bone). Acute pain usually resolves within a comparatively short period of time - relative to the seriousness of the origin of the pain and the time and type of treatment involved.

A key point is ACUTE PAIN – INAPPROPRIATELY MANAGED – CAN BECOME CHRONIC PAIN.

Chronic Pain usually refers to discomfort lasting six months or, at least, longer than would be usual for the type or cause of the pain being treated. Chronic Pain

Pain Assessment Techniques

Using the pneumonic P-Q-R-S-T:

- **Provokes** – What brings on the pain?
- **Quality** – What does it feel like?
- **Region/Radiation** – Where is it? Where does it go?
- **Severity** – How bad is it? (Rated on a scale used consistently – such as '1 through 10...10 being the worst.')
- **Timing** – When did it start or stop? How long does it last? How long have you had it?

Objective "tools" Used By Healthcare Providers:

- **Facial Expression:** frowning, grimacing
- **Rapid Pulse:** faster than individual's normal pulse
- **Profuse Sweating:** usually not with chronic pain
- **Increased Blood Pressure:**
- **Increased Respiratory Rate**
- **Crying or a Sad Expression**
- **Type of movement:** slower than usual, guarded
- **Decreased level of Physical Activity**
- **Decreased Level of mobility:** gait changes
- **Groaning, Moaning, Grunting**
- **Restlessness**
- **Altered Sleep Patterns**
- **Irritability** – displays of temper, anger
- **Quiet/withdrawn**
- **Attention-seeking** - outbursts
- **Tapping or banging** –on bedrails

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has both physical and psychological components. It may exist without identifiable origin or onset; it may be diffuse or localized – or even change from one to the other; it may be difficult for the person to describe – or for an evaluator to “translate.” One person’s “prickly” pain may be another person’s “sharp” pain. “Constant” to one may be “all the time” to another – and either may, on investigation, turn out to be “whenever I bend over” or “eat spicy food.” There may be no observable signs or symptoms for the evaluator because the individual may have learned adaptive behaviors and physiological pain responses are absent. *(Consider the IME report which states “Mr. X demonstrates full range of motion of lower extremities; pain responses are absent. Flexion and Extension of the lumbar spine are slightly less than expected but elicit no pain responses.” A malingering? Or an individual who’s “chronic pain” has become his norm?)*

Chronic Pain can also be sub-divided to malignant or non-malignant – and this classification breakdown has – and still does – impact the kind or amount of medication an individual receives.

Breakthrough Pain occurs, usually within the context of chronic pain, when the medication prescribed for pain control is not effective for the period of time expected. The reasons are as varied as needing more or stronger medication to attempting an activity that exacerbates the pain causing condition. For instance, if Mr. X - with a complaint of chronic low back pain after a work related injury – spends an afternoon raking leaves and stacking wood his “breakthrough pain” is clearly self-inflicted. It may also be due to a lack of understanding – pain medication that seems to eliminate pain (such that Mr. X felt well enough to rake leaves) does not eliminate the condition or cause of the Chronic Pain.

Assessing and Managing Pain

Many pain assessment and management tools have been developed including numbered scales (such as the 0-10 previously noted), word descriptions, and visual scales with pictures, facial expressions, and colors. Regardless of which tool is selected, it is important to maintain consistency - *all* care providers should use the same scale with the individual (an example of incompatible evaluation: doctors assessing pain as “mild/moderate /severe”, nurses assessing by

a facial expression scale, and physical therapy assessing by a numeric scale).

The best way to describe pain is in an individual’s own words. While subjective measurements (things the healthcare provider can observe and document) can help document the presence of pain, nothing is better than an individual’s own description of what they are feeling, recorded in the record as a quote - “I have a prickly feeling in my backside” or “my hand feels cold”.

The Wong-Baker “FACES” Pain Rating Scale is an excellent pain rating tool to use with children and adults alike.¹ The individual having pain is asked to select a facial expression (from smiling to frowning) that matches their professed level of pain. Numeric scales allow a person to rate their pain, usually numbered 0-10 or 0-5. Word scales offer a selection of descriptions placed on a scale, usually from no pain to the worst possible pain.

Ignorance of pain management techniques also contributes to inadequate pain management - both on the part of the prescribing professional and the person evaluating the interventions used. Often, the symptom of pain is treated instead of the problem causing the pain...a classic example is the use of strong pain killers (like oxycodone/acetaminophen (Percocet) or meperidine (Demerol)) for migraine pain, when other drugs such as tryptans like sumatriptan (Imitrex) can be used to reverse the cause of the migraine.

Frame of mind, memories, cultural belief or conditioning all shape not only an individual’s perception of pain, but may also influence the opinion and interventions of individuals managing the pain of others.

To understand the management pain, one must comprehend the:

- different types of pain
- barriers to pain management
- different pain management interventions
- drug therapy available
- alternative and complementary therapies available for pain
- treating of pain among different groups of individuals: the elderly, the nonverbal individual, the confused individual, the individual with a history of addiction, the depressed individual.

PAIN MANAGEMENT INTERVENTIONS

The World Health organization (WHO) recognizes pain management as a universal health concern and has devised an "analgesic ladder" as tool for stepped therapy for pain management.² Therapy with suggested medications for mild/moderate pain and progresses to the strongest medications available for severe pain:

Step 1: mild to moderate pain - non-opioids such as NSAIDs, aspirin or acetaminophen (Tylenol)

Step 2: Moderate to severe pain not relieved by maximum doses of NSAIDs - add a weak opioid or an adjuvant

Step 3: Add strong opioid such as morphine (MS Contin, Roxanol) or fentanyl (Duragesic) and titrate. Continue NSAIDs and adjuvants

MEDICATION USAGE TERMINOLOGY

Addiction Abnormal, compulsive use of a substance despite psychological, physical, medical, social, and/or vocational adverse effects.

Physical Dependence Development of a withdrawal syndrome when the drug is stopped. May develop with any individual; not a sign of drug addiction

Tolerance Need to increase the dose of a medication in order to have the same effect

Pseudoaddiction Behaviors symptomatic of addiction; observed among individuals in inadequately managed pain

Withdrawal range of symptoms experienced with discontinuation of opioids - may consist of abdominal cramping, muscle twitching, excessive sweating, nausea/vomiting, confusion and possibly convulsions - signs/symptoms can be lessened by slowly tapering off the drug.

PAIN MANAGEMENT APPROACHES - ALL PAIN IS NOT TREATED EQUALLY – A SUMMARY :

Different kinds of pain require different approaches for optimal relief:

Acute Pain

For management of acute pain, the therapeutic goal is typically rapid relief given either orally or parenterally using a standard dosage that lasts an average of 4 hours with a sedative effect often desired to encourage the individual to rest and heal. The use of adjuvant medications is uncommon.

Alternative/Complementary Therapy

Studies have shown that drug therapy is most effective when combined with non-pharmacological pain relief strategies.^{3,4,5} The importance of the mind-body connection has been established and there is growing interest in non-pharmaceutical interventions for pain. A sampling of these interventions include.:

- chiropractic
- acupuncture / acupressure
- massage
- transcutaneous or percutaneous electrical
- nerve stimulation (TENS/PENS)
- aromatherapy
- homeopathic remedies
- naturopathic remedies
- nutritional supplements
- music therapy / humor therapy
- magnetic therapy
- application of heat / cold
- biofeedback / meditation
- psychotherapy
- spiritual healing
- hypnosis (dates back to 1770!)
- physical therapy / exercise / yoga
- occupational therapy if appropriate
- spinal cord nerve stimulators

Individuals experiencing pain, particularly chronic pain, are among the largest groups of individuals that seek alternative forms of pain relief. It is important to obtain a detailed history of how an individual has managed their pain. Especially important is obtaining information about use of over-the-counter medications (OTC) and herbal supplements or remedies. Many of these contain substances that may interact with prescribed medications. Many OTC agents used for pain or discomfort contain acetaminophen, aspirin, or NSAIDs. Their use combined with other prescribed or alternative medications may result in adverse reactions or levels.

TENS/PENS works to "block" nociceptive and neuropathic pain messages in the sensory nerves. TENS/PENS is contraindicated in individuals with pacemakers or implanted defibrillator devices. It also cannot be used on the neck near the carotid arteries.

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Chronic Pain

The therapeutic goal of chronic pain management is focused more on the prevention of pain using an around-the-clock dosage mechanism either orally or via skin patches (transdermal), or by infusion pump to deliver an individually titrated dosage that will last as long as possible. Sedation is often undesirable to encourage maximal functioning. The use of adjuvant medications is very common.

Nocioceptive Pain

The type of pain healthcare providers are typically most familiar with is nociceptive pain - that is pain caused by stimuli sent directly to the brain.

Nocioceptive pain can be from joints (Gout, rheumatoid arthritis, osteoarthritis), muscles (myalgias, strains and sprains, myofascial pain syndromes), skin (ulcerations, lacerations, abrasions, insect bites), inflammatory disorders (polymyalgia rheumatica), autoimmune disorders (lupus, AIDS), ischemic disorders (MI), vascular disorders (Raynaud's or Beurgers disease, some migraines), or it can be visceral (from the internal organs – such as pain from stones in the gallbladder, appendicitis pain or kidney stone pain).

Neuropathic Pain

This pain, often described as burning or stabbing, may follow acute injury or occur after illness that affects the nerves. Neuropathic pain can be present on the face from trigeminal neuralgia, can follow amputation or injury, may be present with multiple sclerosis, can be present with alcoholism or diabetes, and can radiate from nerves off the spinal cord. Various pain control strategies are used for neuropathic pain including nonopioids and opioids, adjuvant medications, electrical nerve stimulation, behavioral modification, and most recently, for post-herpetic neuralgia, topically applied patches containing lidocaine. These patches are cut to the appropriate size and applied directly over the painful area. They are usually left in place on the skin for several hours and removed for skin care to avoid irritation or rash. Individuals given these patches will need instruction on use, skin care, and keeping a pain diary to share with their prescribing professional to evaluate and adjust their pain management treatment plan.

TENS/PENS is particularly useful for:

- musculoskeletal pain
- head and face pain
- neuropathic pain
- postoperative pain
- vascular pain
- abdominal pain
- pelvic pain
- cancer pain
- pain associated with Multiple Sclerosis
- reflex sympathetic dystrophy

Transdermal patches are rapidly gaining popularity as an effective tool for chronic pain management for a variety of indications. There are advantages and concerns an individual must be aware of when using transdermal patches for pain management (refer to enclosed chart)

Metastatic Pain

Cancer pain may be confined to the area of the tumor, radiate to areas far from the tumor or be present in areas where the cancer has spread to. Metastatic pain (pain from areas where cancer has spread to) is especially difficult to control and requires intensive pain management. The level of pain may vary greatly with location, rate of tumor growth, and what structures affected or compressed by the tumor.

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Adequate pain management is not only a desired outcome, but an expected one. Pain must be taken more seriously by all healthcare providers - assessed and responded to with the same level of urgency that a change in pulse or an elevation in temperature would require. When acute pain is effectively managed, individuals recover faster, suffer less, have better psychological outcomes, and are less likely to develop chronic pain. When chronic pain is managed effectively, individuals can lead more enjoyable and productive lives or experience the end of life with less suffering. Inadequate pain management can destroy self-esteem, autonomy, happiness, and even the will to live. All healthcare providers share the responsibility for educating individuals, adequately assessing, reassessing, and changing the plan of care as needed to assure appropriate pain management.