Pain Relief Connection

Issue #5 May 15, 2007

Preventing pain is easier than treating pain

Pain ... The 5th Vital Sign

In this issue:
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Journal Watch

- One of the many problems cause by pain is impairment of normal sleep pattern: Gevirtz C. Treating sleep disturbances in patients with chronic pain. *Nursing 2007 Apr; 37 (4) 26-7*
- Pain, according to the definition adopted by the International Society ofr the Study of Pain, is inherently emotional because it is unpleasant. Here is further evidence of the complex interplay of pain and emotion: Kulkarni B, et al Arthritic Pain Is Processes in Brain Areas Concerned with Emotions and Fear *Arthritis & Rheumatism April 2007;56(4):1345-54*
- In any clinical area, one of the major barriers to successful outcomes is patient adherence to the prescribed treatment regimen. This study compares the ability of patients to stick with one of two regimens; Giannopoulos S, et al Patient Compliance With SSRIs and Gabapentin in Painful Diabetic Neuropathy *Clinical Journal of Pain March/April 2007;23(3): 267-269*
- Buvanendran A. Useful adjuvants for postoperative pain management *Best Practice & Research Clinical Anaesthesiology* Mar 2007; 21 (1) 31-49
- "Oligoanalgesia". This study showed that implementation of guidelines, with accompanying education, improved practice and patient satisfaction. Decosterd I, et al Oligoanalgesia in the Emergency Department: Short-Term Beneficial Effects of an Education Program on Acute Pain. *Annals of Emergency Medicine 2007 Apr 17*
- There are an increasing number of long-term cancer survivor, but many of them have pain that persists long after definitive treatment ends. Persistent pain may be caused by the disease, but also by treatment. Is the pain of these cancer survivors more like "cancer pain" of more like "noncancer pain?" Burton AW et al. Chronic Pain in the Cancer Survivor: A New Frontier. Pain medicine *Mar 2007;8(2); 189-198 (10)*
- This study if the largest- and by far the longest term-prospective study to date of chronic opioid therapy for chronic pain. Portenoy RK et al Long-term Use of Controlled –release Oxycodone for Noncancer Pain: results of a 3-year Registry Study *Clinical Journal of Pain 2007; 23:287-299*

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Clinical Focus: Ten Guidelines for Assessing and Treating Pain

This is the 5th in a series on the principles an guidelines for pain management.

6. Prescribe and adequate opioid dose at correct intervals; include a breakthrough or rescue dose.
    - *Adequate dose*:

    ► For most opioids there is no ceiling dose; individualize the treatment; the adequate dose is the dose that relieves pain with acceptable side effects.

    ► When pain is inadequately relieved, escalate dose by 25-50% of the current dose.

- *Prescribe a correct dose interval:*

    ► In general, prescribe "by the clock": around the clock (ATC) at intervals determined by the pharmacokinetics of the drug and patient response. PRN dosing usually assures regular periods of recurrent pain.

    ► Reserve as-needed (PRN) dosing for breakthrough/rescue dosing, for intermittent pain states, and for incident pain (see below).

- *Provide a breakthrough or rescue dose:*

    ► People with either acute or chronic pan can be expected to have occasional acute exacerbations of their pain: a **rescue dose** of 15-20% of total daily opioid dosage should be available every 1-2 hours as needed for **breakthrough pain.**

    ► If the rescue dose is being used frequently, increase the basal 24 hour dose by an amount at least equal to the current dose plus all of the rescue doses in the past 24 hours. Depending on the opioid being used, decreasing the prescribed interval may be appropriate as in some SR preparations usually prescribed q12 hourly may be ordered q8h or q6h.

- Provide for pre-emptive doses when appropriate:

    ► Activities that can reasonably be predicted to cause exacerbation in pain (incident pain) should be scheduled to permit pre-emptive analgesic medication at a dose at least equal to the rescue dose or with a fast-acting short duration medication such as fentanyl/sufentanil administered sublingually 15 minutes prior to the activity. Common examples of precipitators of incident pain include: physical therapy, dressing changes, and disimpaction.

- *Provide for potential missed doses*

    ► When a patient is scheduled to be off the floor for a test or procedure that could potentially delay a scheduled analgesic, make arrangements for the dose to be given at the alternate site.

    ►Anticipate that a patient who normally takes PO meds may also need an alternate route.

If you have a question that you would like answered or a case study that you would like to see profiled here, please send the information to Bev More, Pain Management Resource Nurse, CS1-200 BRHC or email to: moreb@brandonrha.mb.ca

Feedback about this newsletter is welcome. Please send comments to moreb@brandonrha.mb.ca

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