

Pearls and Perils of Inpatient Pain Care

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Objectives

- Understand the impact of chronic pain and barriers to effective treatment
- Briefly review a few basic pain mgt. principles
- Learn some useful pearls and important perils of pain treatment for the acutely ill hospitalized patient
- Identify a management approach to opiate unresponsive pain

IASP Definition

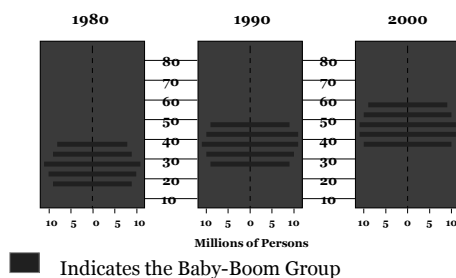
- Pain is an unpleasant sensory or emotional experience associated with actual or potential tissue damage or described in terms of such damage

Prevalence and Impact of Chronic Pain on Society

- Chronic pain is one of the most common conditions for which people seek medical treatment
- 35% of Americans suffer from chronic pain
- >50 million Americans are partially or totally disabled by chronic pain
- 50 million workdays are lost per year
- \$100 billion is the estimated annual cost in lost productivity, medical costs, and lost income

(al, 2001)

The proportion of older Americans is increasing rapidly ...



Common Barriers to Treatment of Chronic Pain...

Patient-Related

- Exaggerated fear of addiction, tolerance, side effects
- Reluctance to report pain: stoicism, desire to “please” physician
- Concerns about “meaning” of pain (associate increased pain with worsening disease)

Common Barriers to Treatment of Chronic Pain

- Physician-Related**
 - Limited knowledge of pain pathophysiology and assessment skills
 - Biases against opioid therapy and overestimation of risks
 - Fear of regulatory scrutiny/action
- System-Related**
 - Low priority given to pain and symptom control
 - Limits on number of R_xs filled per month & number of refills allowed
 - Reimbursement policies

(American Pain Society, 2001; Gleichen, 2001; Lister, 1996; Portenoy RK, 1996; Weinstein et al, 2000)

Pain pathophysiology

- **Acute pain**
 - identified event, resolves days–weeks
 - usually nociceptive
- **Chronic pain**
 - cause often not easily identified, multifactorial
 - indeterminate duration
 - nociceptive and / or neuropathic

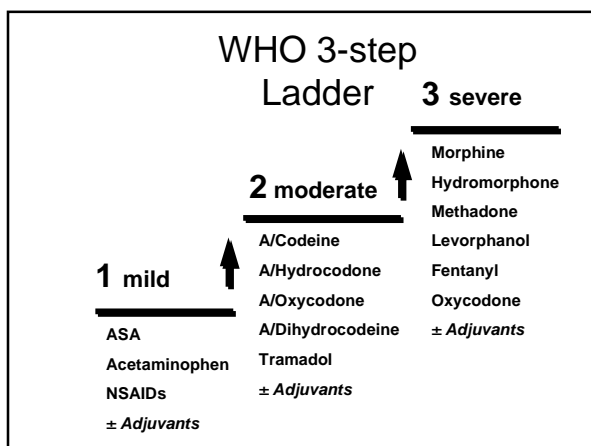
Pain Assessment

- **OPQRST**
- **Barriers to treatment**
- **Tolerance and Addiction***
- **Side effects**
- **Previous treatment experiences**
- **Meaning of the pain**
- **Types of pain - nociceptive x 2, neuropathic**

*The National Federation of State Medical Boards has defined addiction as psychological dependence on the use of substances for their psychic effects characterized by compulsive use despite harm

Assess for Co-morbid Factors

- **Presence of Depression**
 - depressed mood
 - anhedonia
 - emotional lability
- **Anxiety disorder or other psychiatric illness**
- **Psychosocial and spiritual issues**
 - fear of the dying process
 - unresolved sources of suffering
 - **Poor social support or abusive relationship**



Adjuvant analgesics (co-analgesics) ...

- **Medications that supplement primary analgesics**
 - may themselves be primary analgesics
 - use at any step of WHO ladder
- **SSRIs usually useful as treatment for common comorbid cofactors**
 - Depression
 - Anxiety

...Adjuvant analgesics
(co-analgesics)

- Tricyclic antidepressants
- Anticonvulsants
- SNRI's
- Antispasmodics
- Anesthetics and other topicals
- NSAID's

Non-pharmacologic
interventions

- Availability in the acute hospital setting?
- Cognitive therapies
 - Hypnosis, biofeedback, guided imagery, Reiki, therapeutic touch, etc.
- Supportive psychotherapy
- Music Therapy
- Acupuncture
- Manipulation
 - PT, OT
 - massage

2 Key Concepts in Pain
Management

- **Wind-Up phenomenon**
 - CNS neuronal remodeling resulting from the chronic pain
 - Characterized by a state of sensitization of neurons
- **Gate Control Theory**
 - Descending inhibition through intrinsic antinociceptive systems (endorphinergic, serotonergic, GABAergic)
 - Modulation by 2nd order neurons (WDRN's)

Pearls to Remember

- **Chronic or persistent pain means the pain is present most of the time**
 - Scheduled dosing is the cornerstone of effective relief
 - Titration begins with a fixed dose of an immediate release opiate
 - Rescue dosing should be offered as often as every 1-2 hours
 - Upward titration should be a percentage increase (e.g. 25-100% dose escalation)

...Pearls to Remember

- **The breakthrough pain rescue dose is approximately 10% of the 24 hour dose**
 - Frequent source of error is using a rescue dose that is inadequate relative to the ER drug
 - Try to keep it pure and simple, using the same IR as your ER preparation
 - The ideal chronic or persistent pain regimen is one where rescue dosing is only needed 1-3 times daily
 - Not everyone can be titrated to an ideal regimen

...Pearls to Remember

- **Event pain or incident pain should be anticipated**
 - Preemptive analgesia reduces severe pain flares associated with provocative events
 - Time of administration should consider pharmacokinetics of the drug
 - Anticipatory anxiety may also require pretreatment
 - Lavage and wound care

...Pearls to Remember

- **Limit IV dosing at every opportunity**
 - Rapid tolerance
 - More likely to result in cognitive side effects*
 - Increased risk for line sepsis
 - Shorter duration of effect
- **Convert to P.O. regimen after initial titration**
 - Use ER preparations if daily analgesic requirement exceeds 30 mg/day (in oral morphine equivalents)
 - Equianalgesic tables

*especially if opiate naive

...Pearls to Remember

- **Triad for Pain Orders**
 - Scheduled dose
 - Rescue dose
 - Nurse discretionary dose (parenteral)*
 - For rapid relief of pain when patient is in extremis
 - *Recommend SQ route
 - In those patients with consistently high pain scores, but able to move about comfortably then make it contingent upon using the oral rescue dose first
 - May need to focus on function vs reported pain scores

Perils to prepare for...

- **“Chemical Copers” vs Addicts**
- **Aberrant behavior and limiting dosing**
 - communicate goals of therapy
 - Intractable Pain Treatment Act
 - assess often
 - long-acting drugs with no rescue doses
 - observed administration
 - addiction-medicine specialist

The Terminology of Abuse

- **Addiction**
 - Drug-related Disease with pharmacologic, genetic, psychosocial elements
 - Fundamental features: loss of control, compulsive use, use despite harm
 - Diagnosed by observation of aberrant behavior
 - Predictors of addiction may include
 - history of substance abuse
 - Age
 - personality factors
 - family dynamics and social factors
 - **Must be able to verify the given history**

(AAPMAPS, 1996; NIDA, 2001; Paasik et al., 2000; Portenoy, 1996)

Tolerance

- Diminished drug effect from drug exposure
- Tolerance to analgesia is seldom a problem in the clinical setting:
 - Tolerance rarely “drives” dose escalation
 - Tolerance does not cause addiction
 - Abrupt withdrawal will precipitate abstinence symptoms

Pseudo-addiction

- Aberrant drug-related behaviors driven by uncontrolled pain
 - Clock-watching
 - Conflict with staff over dosing regimen or delays in dosing
 - Histrionic responses in expressing pain
 - “earn your morphine”
- Reduced by improved pain control

Chemical Coping

- Usually chronically ill or chronically hospitalized
- Fixation on the drug, dose, route, and sequence
- Failure to acquiesce will cause patient to decompensate
- Comorbid factors play a role
- Focus is on functional outcomes

... Perils to prepare for

- Acute Renal Failure and OSA/Lung Dz
 - If high risk then mainly rely on PCA or nurse discretionary dosing for initial titration
 - Limit other sedating meds as much as possible
- Sepsis/change of LOC
 - You can always safely make a 50% dose reduction
 - Never say that opiates are not a factor

... Perils to prepare for

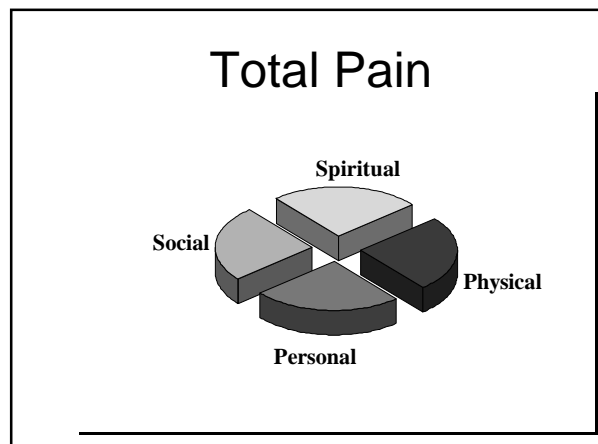
- Little old ladies
- Remember the bowels!!!
- Don't ever slam an amp of Narcan
- Pain poorly responsive to opiates

Pain poorly responsive to opiates

- If dose escalation → adverse effects
 - more sophisticated therapy to counteract adverse effect
 - alternative
 - route of administration
 - opioid (“opioid rotation”)
 - Coanalgesics: “ramp up the adjuvants”
 - add a nonpharmacologic approach
 - Limit the dosing

...Pain poorly responsive to opiates

- Consider total pain (Cicely Saunders)
 - Welk model
- Take time to deal with the experience of the illness
 - Palliative care consultation
 - Therapeutic effects of presence
- “Total Pain” is an indication for palliative care (or hospice)



Palliative care: expanding the options

- Anytime during illness
- Whenever high symptom burden, disabling disease, or psychosocial needs
- May be combined with curative therapies
- May be sole focus of care
- Earlier symptom management expertise
- Improving the experience of chronic illness for families and patients who are suffering with the high stress and care requirements of disabling disease

Summary

- Chronic pain is a major cause of disability and is often undertreated
- Following basic principles of pain management can provide effective treatment strategies for the majority of patients
- Complications from opiate therapy can be avoided if you are aware of the perils
- “Total Pain” is an indication for palliative care (or hospice)

“It is a very limited concept of medicine that strives to understand disease, but not the needs of sick people.”

Henry Miller