PAIN MANAGEMENT 101

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Objectives

• Identify a step-wise approach to pain management.
• Identify the WHO Pain Ladder.
• Identify non-pharmacological pain control measures.
• Identify adjuvant treatment measures.
• Identify common myths and truths
• Identify common side effects and treatment options.
Pain Management Principles

• Use Multi-Treatment and Multi-Discipline Approach
  • Combine opioids with non-opioid medications
  • Non-pharmaceutical approaches
  • Include family and caregiver in planning
  • Include the patient!
  • Coordinate with facility
  • Coordinate with all providers-
    • Primary Care Provider
    • Nursing Home Physician
    • Hospice IDG Members
Utilize the WHO Ladder

World Health Organization

• (WHO) “analgesic ladder”

• Follow the steps as indicated.

• Determine if adjuvants are necessary.
WHO Pain Ladder

**STEP 1**
Non-opioid
+ / - adjuvant

**STEP 2**
“Mild” opioid for mild-moderate pain +/− non-opioid
+/- adjuvant

**STEP 3**
“Strong” opioid for severe pain
+/- non-opioid
+/- adjuvant
Step 1-Mild Pain

NON-OPIOID MEDICATION OPTIONS

- **Acetaminophen**  
  (Tylenol)-(Paracetamol)-(Panadol)

- **Non-steroidal anti-inflammatory drugs (NSAIDs)**
  
  **Traditional NSAIDS**
  
  Ibuprofen-(Motrin) Aspirin-(Bayer) Naproxen-(Aleve)  
  Nabumetone-(Relafen)

  **Cox-2 Inhibitors**
  
  Celecoxib-(Celebrex) Rofecoxib-(Vioxx)  
  Valdecoxib-(Bextra)
Adjuvants

- **Antidepressants**
  - amitriptyline- (Elavil)
  - nortriptyline- (Pamelor)

- **Anticonvulsants**
  - gabapentin-(Neurontin)
  - carbamazepine-(Tegretol)

- **Antispasmodics**
  - dicycloverine-(Bentyl)
  - scopolamine-(Transderm Scop)

- **Steroids**
  - prednisone-(Deltasone)
  - methylprednisolone-(Medrol)
Non-Pharmacological Measures

• **Environmental controls**
  Room Temperature  Osulating Fan

• **Conservation of Energy**
  Frequent rest periods

• **Aromatherapy**
  vanilla, peppermint, jasmine, citrus

• **Massage Therapy**
  simple back massage to deep muscle massages
Non-Pharmacological Measures

- Physical therapy
- Frequent position changes
- Heat, and cold
- Relaxation, imagery, hypnosis
- Music therapy
- Distraction
Step 2-Moderate Pain

- Hydrocodone-(Lortab)
- Oxycodone-(Percocet)
- Ultram-(Tramadol)
Adjuvants

- **Antidepressants**
  - amitriptyline-(Elavil)  nortriptyline- (Pamelor)

- **Anticonvulsants**
  - gabapentin-(Neurontin)  carbamazepine- (Tegretol)

- **Antispasmodics**
  - dicycloverine-(Bentyl)  scopolamine- (Transderm Scop)

- **Steroids**
  - prednisone-(Deltasone)  methylprednisolone- (Medrol)
Step 3-Severe Pain

- **Morphine**-(MS Contin, MSIR)
- **Hydromorphone**-(Dilaudid)
- **Methadone**-(Methadose)
- **Fentanyl**-(Duragesic, Actiq)
Adjuvants

- **Antidepressants**
  - amitriptyline-(Elavil)
  - nortriptyline- (Pamelor)

- **Anticonvulsants**
  - gabapentin-(Neurontin)
  - carbamazepine-(Tegretol)

- **Antispasmodics**
  - dicycloverine-(Bentyl)
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- **Steroids**
  - prednisone-(Deltasone)
  - methylprednisolone-(Medrol)
Common Myths

“I will become addicted to pain medication”

“Use of opioid will shorten length of life”

“Taking pain medication will mask pain and delay diagnosis”

“Starting pain medication in early stage of disease will lead to lack of options in future”
Common Myths

“Patients can not drive or carry out normal activity”

“These might make me drugged out”

“They will cause the patient to stop breathing”
The Truth

• In advanced disease patients do not become addicted to opioids.

• Will not shorten life if used properly and if doses are titrated—controlling pain may even lengthen life.

• Opioid use at an earlier stage of disease does not mean that options later in the disease progression will be “used up”
The Truth

- Respiratory depression is one of the last symptoms with titration.

- Sedation can be transient or managed.

- During chronic use and slow titration normal activity can be maintained and even improved.
Common Side Effects & Statistics

- **Constipation** up to 80%  
  - Not transient
- **Nausea or vomiting** 15–30%  
  - Often transient lasting 2–3 days
- **Sedation** 20–60%  
  - Often transient at initiation or dose increase
- **Confusion or hallucinations** - No figures available  
  - May herald toxicity
- **Myoclonic jerks** - Up to 60% (at higher doses)  
  - May herald toxicity, check for renal failure  
  - (Hall and Sykes 2004)
Common Side Effects & Statistics

- **Respiratory depression** - *Rare* in chronic dosing.
  - Stop opioid for a few hours, restart at 30%–50% of dose,
  - use naloxone in 100–200 mg increments only if respiratory rate < 8–10/min
- **Xerostomia** *Common*
  - Exclude candidiasis and other drugs; offer ice, Artificial salivas or pilocarpine may help
- **Urinary retention** *Rare*
  - cholinergic agonists may help
- **Pruritus** 2–10 %
Treatment for Side Effects

- **Urticaria, pruritus**
  - fexofenadine, 60 mg po bid; diphenhydramine, loratadine, or doxepin, 10–30 mg po q hs

- **Constipation**
  - All patients on routine opioids should be started on bowel program unless contraindicated.

    Start with routine Senna or bisacodyl. Add stool softener

    If no BM in two days add MOM or lactulose
Treatment for Side Effects

• Nausea/Vomiting

Promethazine or Reglan.

Difficult to treat symptoms may respond to Haldol or Benadryl or "Nausea Blocker" compounded medication.
Treatment for Side Effects

• Sedation

Opioid-induced sedation usually disappears over a few days as tolerance develops.

Ritalin was effective in reducing sedation in 90% of cancer patients.

If undesired sedation persists, a different opioid or an alternate route of administration may provide relief.
Treatment for Side Effects

**Delirium (rare)**
Try reducing dose or changing opioid agent

• **Respiratory depression (rare)**
Try reducing dose or changing opioid agent

Narcan only in severe cases as it can cause withdrawal symptoms in long term opioid users.
Tips for Effective Pain Management

• First choice for severe pain is Morphine

• Follow the WHO pain ladder

• Consider NSAIDs and other non-opioids

• Identify and dispel “myths”
  • (Hall and Sykes 2004)
Pain Management Tips 101

• Use one long acting medication and one short acting for breakthrough pain.

• Increase the long acting medication if ineffective.

• Do not crush long acting medications

• Avoid “mixing” narcotics

• Start at the lowest possible dose first.
Pain Management Tips 101

- Don’t wait until pain is severe before starting patient on pain management regimen.
- Consider ATC dosing.
- ALWAYS perform a detailed pain assessment!
- Determine the TYPE of pain before implementing a treatment plan.
Pain Management Tips 101

• All patients should be started on bowel program immediately on initiation.

• Change agent for severe side effects or inadequate control.

• Oral route is the most effective!
Questions?

Q & A
References


References


References

Chappell, Mary Margaret “Aromatherapy for Pain Relief” Arthritis Today 2003 Arthritis Foundation.
