

Pain Management Minimizing Abuse

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Pain Management

- Good pain management reduces likelihood of abuse.
- Goal of this discussion might be to enhance your pain management confidence, knowing that you are guarding against narcotic abuse and addiction.
- Questions from Internists are on the mark.

Questions About Opioids?

- What process to select the right opioid?
- Proper dosing for the level of pain?
- Assessing the “true” pain level?
- When do you change from short acting to long acting narcotics?
- Conversion from acute to chronic pain meds?

Pain Assessment

- Evaluate the Pain
 - History, Physical, Diagnostics
- Nociceptive Pain (tissue injury)
 - Visceral
 - Somatic
- Neuropathic Pain (abnormal nerves)
- Emotional Pain

Pain Assessment

- Pain is whatever the patient says it is.
- Pain Scale 1-10
- Wong Baker smiley faces
- World Health Organization (WHO)
 - Mild, level 1-3
 - Moderate, level 4-7
 - Severe, level 8-10

Pain Management

- Treat the cause of the pain
- Acute pain (usually less than two months)
 - Cause is often discoverable
 - Treatment can eliminate cause
- Chronic pain
 - Often multifactorial
 - Difficult to determine major component of pain

Pain Management

- WHO pain ladder
 - Mild, level 1-3
 - Acetaminophen, NSAIDs
 - Moderate, level 4-7
 - Codeine, Tramadol
 - Severe, level 8-10
 - Morphine and Opioids

Pain Management

- Adjunctive Rx
 - Antidepressants
 - Anxiolytics
- Complementary therapies
 - aka; Complementary Alternative Medicine
 - Acupuncture
 - Touch therapy
 - Music therapy

Pain Management

- Evaluate
- Prescribe
- Assess effectiveness
- Improve Rx, dose or schedule
- Document

Pain Management Protocol

- Start with short acting opioid q4hours prn
 - No range dosing
- After 24 hours calculate total dose
- Prescribe equivalent long acting (8, 12, 24 hour) dose
- Add short acting prn dose for breakthrough pain (about 10-15% of 24hour dose)

Pain Management Protocol

- Evaluate effectiveness (using prn continuously?)
- Pain persists
 - Mild, increase daily dose 25%
 - Moderate, increase daily dose 50%
 - Severe, increase daily dose 75-100%
- Adjust prn accordingly
- Add adjunctive Rx

Opioid Questions

- How do you manage sedation, and constipation?
- How about respiratory depression and OSA?

Managing Narcotic Side Effects

- Sedation
 - Unusual occurrence with therapeutic dosing
 - A patient without pain can rest and sleep
- Respiratory depression
 - Does not occur in an alert patient
 - Morphine is d.o.c. for dyspnea
- Constipation
 - “The hand that writes the opioid order shall also write the laxative order.”

Opioid Questions

- Cost?
- Financial issues? Poor Insurance coverage?

Narcotic Costs

- Very potent narcotics are not expensive
 - Morphine Sulfate
 - Methadone
- Hospice patients are covered
- Workers compensation and disability often cover related Rx
- Pharma has many indigent prescription plans

Medication Considerations

- Avoid Demerol
- Avoid Darvon/Darvocet
- Know the total daily Acetaminophen dose
- Benadryl is not a safe adjunct in the elderly
- With opioids, constipation is the only side effect that does not moderate over time

References

- Pain Scale; World Health Organization, 1990
- “The hand that writes....” Cicely Saunders
- Pain Protocol: EPEC, Module 4, 1999
- “Pain is whatever....” McCaffery and Beebe, “*Pain*” 1989.

Thank you

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