Pain: Care & Management of the Patient with Chronic Malignant or Non-Malignant Pain

Site Applicability

VGH, UBCH

Background Information

Chronic pain is a subjective experience which involves physiological, psychosocial and spiritual components, each of which must be addressed. Management of chronic pain requires assessment, regular administration of analgesics and adjuvant medications, non-drug therapies, general comfort measures, and patient/family teaching. Good pain management requires the expertise of the whole interdisciplinary team.

Goal

1. The patient:
    1. will demonstrate that he/she is pain free or that the pain level is tolerable
    2. is able to participate at his/her optimal level in activities of daily living, rehabilitation, and medical treatment.
2. The patient and family will:
    1. demonstrate knowledge regarding the etiology of the pain (when known)
    2. demonstrate knowledge of the pain management plan
    3. implement pain management when appropriate
    4. demonstrate knowledge of measures to manage the side effects of treatment.

Patient Education

1. Teach patient and family about pain and its management according to their needs. Common areas which need to be addressed are:
    a. etiology of pain
    b. rationale of pain management regimen
    c. beliefs, myths, and concerns about pain and its management
    d. management of side effects
2. Utilize patient/family education pamphlets or other appropriate materials relevant to chosen interventions as reference for teaching.

Procedure / Recommendations / Assessment

A. UPON ADMISSION

1. Assess the physical characteristics of the pain(s):
    a. site - location of the pain(s)radiation - where the pain spreads quality - description of the pain in patient's own words
    b. intensity - use a pain scale to which the patient will best relate. A visual analogue scale which converts to 0 - 10 ratings is the most sensitive scale.
    c. aggravating and relieving factors - what makes the pain worse or better.
2. Obtain a pain history - when the pain began, how it has responded to treatment including medication.
3. Review physiological factors contributing to pain, (e.g. site of bone metastasis, site of previous injury).
4. Assess the psychosocial, cultural, and spiritual components of pain according to factors such as the meaning of the pain and the impact of pain on the patient's lifestyle, activities of daily living, family, sexuality, roles, etc.
5. Assess the patient's and family's educational needs in relation to pain according to:
    a. understanding of the etiology of pain (when known)
    b. understanding of principles of pain management
    c. myths, concerns and beliefs about pain and its management
    d. knowledge of the side effects of treatment.
    e. need to communicate with team re adequacy of interventions.
6. Assess the patient's and the family's expectations for pain control.
7. Assess the patient's level of pain in the absence of verbal data using non-verbal indicators and a pain history provided by family/significant others.

B. ONGOING ASSESSMENT

1. For **UNCONTROLLED** pain:
    a. Assess pain location and characteristic to determine if a new pain has developed.
    b. Assess the intensity of the pain and sedation level at a minimum of every four hours and at appropriate intervals prior to and following the administration of narcotic, non-narcotic, and non-pharmacologic interventions.
    c. For PCU only - assess dose totals q24h (dose totals are required when titration is needed)
    d. For palliative patients on PCA, assess PCA demands and PCA delivered doses q4h.
2. When **PAIN CONTROL IS ACHIEVED:**
    a. Assess the intensity of the pain and level of sedation every 24 hours.

b. For PCU only - when pain is controlled and dose is stable 24 hour dose totals are not necessary.

c. For palliative patients on PCA assess PCA demands and PCA delivered doses q8h.

3. Assess the effectiveness of break-through analgesia by assessing pain intensity and sedation within:
   a. 30-60 minutes of p.o./p.r. regular release15-60 minutes of S.C./I.M. administration
   b. 5-20 minutes of I.V. administration
   c. Sublingual - dependent upon medication, see PDTM.
4. When a patient reports pain which is different in character/location than previously described, a new form must be completed. (Initial Assessment: Click here for Complex Pain Assessment Form).
5. Monitor for the presence of nausea/vomiting, confusion and urinary retention; these may be transitory side-effects associated with the initiation of narcotic therapy.

Intervention

Pharmacological:

Opioid Analgesic Administration

1. **ROUTE:** Use oral route if available. If the p.o. route is not available, consider the rectal, sublingual transdermal patch or parenteral routes (especially subcutaneous).

   NOTE: When converting the analgesic from one route to another route, refer to the VHHSC Equianalgesia Chart for Chronic Pain (p.o. = p.r. = S.L. and I.V. = S.C. = I.M.)
2. **REGULAR DOSING:** Opioid analgesics should be ordered regularly, not prn, for chronic pain. Administer regular analgesics on time, round the clock, even when the patient is sleeping. For patients on q4h oral dosing patterns who have well controlled pain, the hs oral dose (2200) may be doubled and 0200 dose omitted. A doctor's order is required.
3. **BREAKTHROUGH ANALGESIA:** A p.r.n. breakthrough dose should be ordered when a patient is on a regular opioid. It is always a short-acting medication. The route is generally the same as the regularly scheduled dose and the breakthrough dose is obtained by dividing the regular dose by the time interval between doses. Administer the breakthrough analgesia promptly when a patient experiences "breakthrough" pain. Breakthroughs can be safely administered anytime immediately up to the next regularly scheduled dose.

   Examples:

   #1: Short Acting Narcotic:

   Regular Dose: MOS 60 mg q4h

   To obtain prn dose divide regular dose by 4.

   Breakthrough Dose: MOS 15-30 mg q1h prn

#2: Sustained Release Narcotic:

Regular Dose: M-Eslon 120 mg q12h (long-acting morphine)

The prn dose is 120 mg divided by 12 hours = 10mg/hr

Breakthrough Dose: MOS 10mg q1h prn (short acting morphine)

#3: Parenteral Infusion:

Regular Dose: Morphine 20 mg/hr via continuous I.V. infusion

The prn dose is equivalent to the hourly continuous infusion dose.

Breakthrough Dose: Morphine 20 mg I.V. q1h prn.

4. **EFFECTIVENESS:** Assess effectiveness and report lack of effectiveness of the pain management plan to the physician.
5. **CONVERSION TO SUSTAINED RELEASE OPIOID:**
   i. Convert to a sustained-release preparation (e.g. Fentanyl patch, M-Eslon, Hydromorph Contin) when pain is well controlled on a short acting preparation.
   ii. Determine the appropriate dose by adding up the patient's daily oral opioid requirements and converting to sustained release.
   iii. Administer on the appropriate dosing schedule, for example q12h.
   iv. Obtain an order for a short-acting opioid on a q1h prn basis for breakthrough pain.
   v. NEVER CRUSH M.S. CONTIN OR OXYCONTIN
   vi. M-Eslon and Hydromorph Contin are long-acting morphine preparations in capsule form - the granules within the capsule are sustained release and can therefore be sprinkled or administered via feeding tube.
6. **TITRATION OF OPIOID ANALGESICS:**

General Considerations:

- Recognize that respiratory depression and psychological dependence (a craving for drug's psychic effects or addiction) are rare in patients receiving opioids for malignant pain. A need to increase analgesic doses often means an increase in pain and not tolerance.

Titrate when:

- Patient's pain is poorly controlled (>1 on pain scale or by patient's definition)three or more breakthrough doses are required in a 24 hr period (patient can receive up to two breakthroughs per day with no titration required)
- Analgesics for respiratory distress should not be included in 24 hour dose totals without consultation with the physician.

How to Titrate Opioid Analgesic*Short-Acting Opioid:

- assess titration needs after 24 hours of regular opioid administration

NOTE: use breakthrough doses to manage pain in the interim period

- at 0800 hours total the amount of regular and breakthrough analgesia used in the 24 hour period. Divide the total by the number of doses of regular analgesia to be administered per 24 hours period.

Example:

Doctor's Orders - MOS 40 mg q4h and MOS 10 mg q1h prnIn last 24 hour period patient received 40mg q4h and 6 x 10 mg breakthrough doses.

Calculations are:

(6 x 40) + (6 x 10) = 300 mg (24 hour total)

300 divided by 6 = 50 (new regular dose)

Thus, new dose should be:

MOS 50 mg q4h (regular dose)

MOS 12.5 mg q1h prn (breakthrough dose)

Obtain an order and administer the newly calculated dose at 1000.

Sustained-Release Opioid:

For BID dosing, titrate on a q48h basisFor Qd dosing, titrate on a q 4 days basis

For q72h dosing (eg. Patch) titrate on a q 3 days basis

Opioid Infusion:

Consider titration of I.V./S.C. infusions after a 4-hour period. This includes PCA.

After each 4 hour period total the amount of regular and breakthrough analgesia given. This total is then divided by 4 to give the new hourly infusion rate.

Example:

Doctor's orders: Morphine 40 mg/hr. S.C. via continuous infusion and Morphine 40 mg S.C. q1h prn

In a 4 hour period the patient receives: 40 mg q1h + 2 x 40 mg breakthrough doses

Calculations are:

(40 x 4) + (2 x 40) = 240mg

240mg divided by 4 = 60 mg

Thus, new dose should be:

Morphine 60 mg/hr. S.C. via continuous infusion and

Morphine 60 mg S.C. q1h prn

Prevention and Management of Opioid Analgesic Side Effects:

1. Implement the Bowel Protocol for Opioid-induced Constipation.
2. *Administer an anti-emetic for nausea and/or vomiting.
3. *Provide non-invasive measures to promote voiding.
4. Notify physician if patient's bladder is distended and obtain intermittent catheterization order as needed.
5. Contact the physician if the patient's respiratory rate unexpectedly drops below eight breaths per minute.
6. For the Palliative patient, six breaths per minute is acceptable as long as the patient can be aroused.
7. Observe for muscle spasms, change in cognition, drowsiness.
8. Assess mouth every day and provide q4h mouth care prn.

*** Requires Physician Order**

Adjuvant Medications

- Consideration to the involvement of adjuvant medications (e.g. NSAID) is integral to adequate pain management (consider the etiology of the pain).

Non-Pharmacological Measures:

1. Implement strategies to treat the psychosocial and spiritual realms of pain such as providing the patient with time to explore feelings about the pain, impact of pain on lifestyle and meaning of the pain. Assist palliative patients to chronicle stories/values, etc. for future generations.
2. Use measures to promote general patient comfort such as pressure - reducing mattresses, correct positioning/alignment and ice packs.
3. Use measures to promote relaxation (e.g. relaxation tape or massage), diversion (activities or music), or increase the patient's sense of mastery/control over his/her pain.
4. Assist patient/family to resume hobbies/activities which they may have stopped during periods of intense pain levels.

Documentation

1. Pain assessment on the Patient Admission Assessment form (including patient's desired goal for pain intensity) and when applicable complete the Complex Pain Assessment Pain form (Click here for Complex Pain Assessment Form).
2. On-going pain assessments on Pain Flow Sheets including pain intensity, sedation and side-effects.
3. Regular (black ink) and prn/breakthrough (red ink) opioid analgesics given on Pain Flow Sheets.
4. Pain management plan in the Patient Care Plan.
5. The effectiveness of the pain management plan and the patient/family satisfaction with the plan including both pharmacologic and non-pharmacologic interventions in the Nurses' Notes:
    1. Specific teaching with regard to pain and its management in Nurse's Notes.
    2. PCA documentation as per assessment guidelines on Pain Flow Sheets.
    3. When breakthroughs are administered for incident pain document "incident pain" in black (vertical print) beneath dose documented on Pain Flow Sheet.
6. **For PCU only: Document analgesia dose totals in red on the Pain Flow Sheet. Indicate entry as a dose total by drawing a vertical red line on both sides of the number.**

Associated Guidelines

- Neuropathic Pain Assessment and Management - Acute Care [D-00-07-30262]
- Medications: Sublingual Administration of [D-00-12-30282]

Forms

- Pain Flow Sheet
- Complex Pain Assessment

Educational Material

- Module: Basic Pain, 2000
- Module: Management of Chronic Cancer Pain, 1994
- Module: Use of Patient Controlled Analgesia for Chronic Malignant and Chronic Non-Malignant Pain, 2001.

References

- Guidelines for Management of Chronic Non-Malignant Pain. February 1993, College of Physician & Surgeons of Alberta.
- Librach, Larry. And Squires Bruce. (1997) The Pain Manual: Principles and Issues in Cancer Pain Management. Canadian Cancer Society, Pegasus Healthcare International.
- Portenoy, R.K. (1990). Chronic opioid therapy in nonmalignant pain. Journal of Pain and Symptom Management, 5(1), pp. 546-562.
- US Department of Health and Human Services (1994). Management of Cancer Pain: Clinical Practice Guidelines.

- Watt-Watson, Clark, A. John, Finley, G. Allen, Watson, C. Peter. (1999). Position Statement: Canadian Pain Society Position Statement on Pain Relief. Pain Research & Management 4(2): 75-78

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Alternate Search Terms

- chronic malignant
- pain

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VANCOUVER HOSPITAL & HEALTH SCIENCES CENTRE

COMPLICATED PAIN ASSESSMENT FORM

This form is to be used for all patients admitted to VHHSC who have a problem with pain requiring comprehensive assessment and multimodality interventions eg: chronic pain, complex acute pain. This form is a permanent part of the health record and is filed in the medical history.

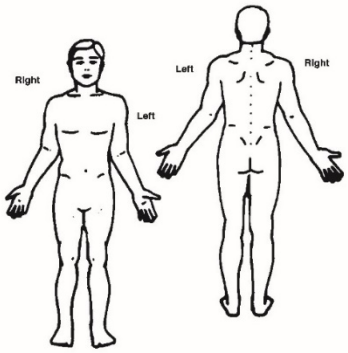
DATE NURSING UNIT

MR. MISS. MRS UNIT NUMBER

SURNAME GIVEN NAME

DOCTOR (PLEASE USE BLOCK CAPITALS)

SEX AGE

A. LOCATION	VERBAL RESPONSE	
Where is the pain? Show where the pain(s) are on your body. Is the pain inside or on the surface? Does the pain spread? Where does it start and where does it go?		 OBSERVATIONS OF PAIN LOCATION

B. QUALITY	VERBAL RESPONSE	NON VERBAL RESPONSE
What words describe how your pain feels? Does it ever differ or vary?		

C. INTENSITY	VERBAL RESPONSE	PAIN SCALE
How severe/strong/bad is your pain? Can you show me on this scale how much pain you have?		Scale Used: _____ Pain Now: _____ Worst: _____ Best: _____

D. TIMING	VERBAL RESPONSE	
When does your pain begin? How long does it last? Does it ever go away? Is it better or worse at certain times of the day?		12 am 8 am 12 noon 6 pm

E. PAIN HISTORY	VERBAL RESPONSE
When did the pain first begin?	
What was your understanding of the cause of the pain then and has that changed?	
Has the pain changed in any way since it first began?	
What things have you done in the past to try to decrease the pain?	
How much help have they been?	

F. AGGRAVATING AND RELIEVING FACTORS	VERBAL RESPONSE	OBSERVED PAIN BEHAVIOUR
What brings the pain on?		
What makes it worse?		
What makes it better?		
What are you currently doing to relieve the pain?		
If using medication, describe how you are currently using it?		

G. IMPACT OF PAIN	VERBAL RESPONSE OF PATIENT AND FAMILY
How has the pain affected you life? eg: sleep pattern.	
How does the pain make you feel?	
What are you able to do each day?	
What are you prevented from doing?	

H. EXPECTATIONS	VERBAL RESPONSE OF PATIENT AND FAMILY
What are your expectations for managing the pain?	
What are your expectations of us?	
Using the pain scale identify what intensity rating the patient selects as "satisfactory pain management"?	
	Pain Scale Rating:

Date: _____ SECTIONS: _____ Completed By: _____ Source: ☐ Patient: ☐ Other: _____

Date: _____ SECTIONS: _____ Completed By: _____ Source: ☐ Patient: ☐ Other: _____

Date: _____ SECTIONS: _____ Completed By: _____ Source: ☐ Patient: ☐ Other: _____