WORKSHOP: COMPLEX PAIN MANAGEMENT

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WOUND PAIN

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WHAT IS PAIN?

• “An unpleasant sensory and emotional experience which we primarily associate with tissue damage or describe in terms of tissue damage, or both” (International Association for the Study of Pain 1999)

• Provides information about noxious stimuli causing actual or potential tissue injury
WOUND PAIN – WHAT IS NOT WORKING

- Inappropriate or non-existent pain assessment
- Inefficient prescribing of analgesia
- Lack of knowledge about pain
- Inappropriate beliefs and attitudes
- Inappropriate wound care practices
LIVING WITH A CHRONIC WOUND

- Pain
- Exudate and malodour
- Anxiety, depression, self-neglect
- Loss of self-esteem/ Loss of control
- Social isolation
- Poor sleep
- Role functioning (work, financial, mobility)
- Inconvenience (dressings, clinic etc)
LIVING WITH A CHRONIC WOUND

- Body image - presence of an unsightly (possibly unnecessary) leaky, malodorous, painful wound
- Withdrawal and social isolation
- Relationship problems
- Emotional distress:
  - Anger
  - Embarrassment
  - Depression
  - Anxiety
  - Guilt
  - Disgust
  - Shame
  - Denial
  - Fear
TYPES OF WOUND PAIN

Cyclic Acute Pain
Non-Cyclic Acute Pain

Chronic Pain

Pain level

Time
CAUSES OF WOUND PAIN

• Superficial somatic pain
  • Tissue injury
  • Stimulation of nociceptors
  • Injury to skin - ‘cutting’ or ‘burning’ pain
  • Injury to blood vessels - ‘throbbing’ pain
CAUSES OF WOUND PAIN

- Superficial somatic pain
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- Peripheral neuropathic pain
  - Nerve damage due to disease process – e.g. diabetes
  - Secondary to nerve damage such as trauma, surgery, or locally invasive malignancy
  - Spontaneous ‘burning’ pain with intermittent ‘sharp stabbing’ pains
  - ‘itching’, ‘tingling’, ‘smarting’ or ‘stinging’ pain
PAIN ASSESSMENT

• Location
• Nature
• Severity
• Onset / frequency
• Duration
• Aggravating factors
• Alleviating factors

• Current analgesia
• Effectiveness of treatments
• Impact on activities of daily living
PAIN ASSESSMENT

No pain

Worst pain imaginable

Please mark the line at a point that best reflects your pain
PAIN ASSESSMENT

Wong-Baker FACES® Pain Rating Scale

0  2  4  6  8  10
No Hurt  Hurts Little Bit  Hurts Little More  Hurts Even More  Hurts Whole Lot  Hurts Worst

Originally created with children for children to help them communicate about their pain. Now the scale is used around the world with people ages 3 and older, facilitating communication and improving assessment so pain management can be addressed.
REDUCING ACUTE WOUND PAIN

• Irrigate gently with warm 0.9% sodium chloride or water
• Use a sterile gloved hand
• Use modern dressing products
REDUCING ACUTE WOUND PAIN

• Irrigate gently with warm 0.9% sodium chloride or water
• Use a sterile gloved hand
• Use modern dressing products
• Maintain moist wound environment
• “Adhesive dressings” - use with caution
• Protect surrounding skin
Complex pain management

Rod MacLeod MNZM

New Zealand Wound Care Society 8th National Conference 2017
"Clearing the Air – Dispelling Myths and Misconceptions in Wound Care"
Pain management

Ensure people have the time and space to express their concerns and receive validation from your team – they are going to need to trust you.

Give a consistent message about pain etiology and pain management – why do they have the pain they have.

People should be treated in a holistic way by a multidisciplinary approach.

Patients should be involved in the development and review of a plan for their pain management.
Pain management

Patient education: information about the pain, aggravating and alleviating factors, management strategies, lifestyle factors that may influence the pain (e.g. use of nicotine, alcohol)

Physical rehabilitative approaches: physiotherapy for reconditioning (e.g., walking, stretching, etc)

Other physical approaches: application of heat or cold, TENS, massage, acupuncture

Occupational therapy: attention to proper body mechanics, resumption of normal levels of activities of daily living
Step 1  
Mild pain  
Non-opioid ± adjuvants

Step 2  
Mild to moderate pain  
Strong opioids ± non-opioid ± adjuvants

Step 3  
Moderate to severe pain  
Strong opioids ± non-opioid ± adjuvants

Step 4  
Severe to very severe pain  
Analgesic side-effects  
Interventional treatment  
± non-opioid ± adjuvants

Review, review, review…
Pain management

Pharmaceuticals: simple analgesics, opioids, antidepressants, anticonvulsant drugs – by mouth, by the clock, for the individual

Regional anesthesia: nerve blocks and/or intraspinal analgesia (e.g. opioids, clonidine, baclofen, local anesthetics)

Psychological approaches: relaxation training, biofeedback, counselling, behavior modification, psychotherapy, visualisation, guided imagery, hypnosis, music therapy/engagement

Surgery: neuroablation, neurolysis etc
Once the pain is no longer managed by step 2 analgesics, (in combination with NSAIDs), it may be time to initiate morphine, oxycodone or fentanyl.

Avoid morphine in renally impaired patients. Morphine is metabolised by glucuronidation to morphine-3 and morphine-6 glucuronide. Both are active metabolites and morphine-6 is renally excreted.

Some pain may not respond completely to opioids - remember the non-physical elements of pain. Co-analgesics may be useful when response to opioids is poor.

Review, review, review…
Neuropathic pain management

Medication needs to be tailored to the patient

- Opioid analgesics (now first line for neuropathic pain) should be trialed, but doses may increase rapidly - some opioids may be more useful than others, eg, methadone, which has intrinsic NMDA blocking activity. (NMDA receptor antagonists are a class of anaesthetics that work to antagonise, or inhibit the action of, the N-methyl d-aspartate receptor) – **don’t forget laxatives**

- Tricyclic antidepressants, eg, nortriptyline and SSRIs, eg, escitalopram, paroxetine - are recommended as second-line therapy, but may be of limited efficacy in palliative care
Neuropathic pain management

- Anticonvulsants, e.g., valproate, (carbamazepine), gabapentin and pregabalin (not currently funded)

- Benzodiazepines, e.g., clonazepam

- Combining an antidepressant with an anticonvulsant may be more effective than either alone, e.g., nortriptyline + gabapentin

Other medications may be useful, e.g., ketamine and methadone - discussion with local specialists is recommended

Review, review, review…
Pain management

When we are not getting it right

- Repeated complaints of pain
- Runs out of medication ahead of schedule
- Frequent calls for help
- Non-compliance?
- Diminished hygiene, nutrition, social contacts
Always think about healing

- **D**iabetes – diminished sensation
- **I**nfection
- **D**rugs – steroids, antimetabolites
- **N**utritional problems – malnutrition and/or vitamin deficiency
- **T**issue necrosis – local or systemic ischemia or radiation therapy
Always think about healing

- **H**ypoxia
- **E**xcessive tension on wound edges
- **A**nother wound (competing for substrates required for healing)
- **L**ow temperature
Don’t forget about you

You won’t always get it right

That doesn’t mean a failure
Don’t forget about you

You won’t always get it right

That doesn’t mean a failure

Look after yourself
CASE REVIEWS
CASE 1: JEAN

- 79, widowed 6 months
- Lives in ARC
- Diabetes, neuropathy, PVD, IHD
- Lost 15kg in last 4 mths
- Complaining of worsening pain in leg
- Does not want anything touching it, makes pain +++ worse
CASE 2: ALAN

- 56, married with adult children
- Cutaneous lymphoma
- Hospitalised 5 months
- Misdiagnosed
- Multiple surgical interventions
- Severe pain, especially at dressing change
- Exudate leaking onto clothing
- Undergoing chemotherapy