UZ LEUVEN

Pain? Not only medication…

the role of the nurse in palliative care

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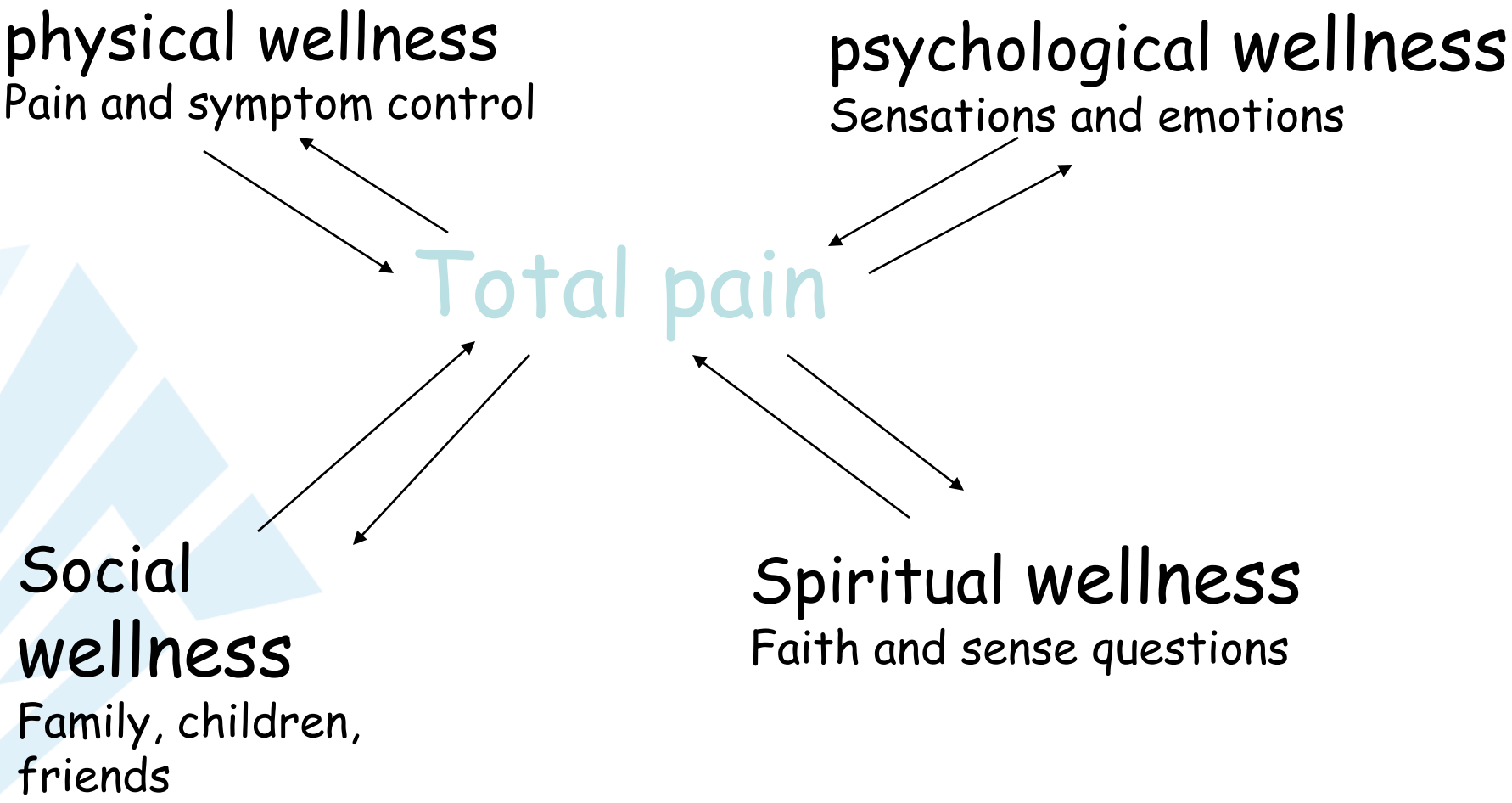
What is pain?

- "Pain is whatever the experiencing person says it is. Existing whenever he says it does" (1968, Mc Caffery).
- Pain is a subjective experience that differs from person to person. It is important to evaluate the experience in its subjectivity.

What is pain?

- Pain is a physical experience, accompanied with a psychological, emotional and spiritual effect.
- Pain influences much and a lot of things can influence pain!
- Examples?

Total pain


physical wellness
Pain and symptom control
psychological wellness
Sensations and emotions
Total pain
Social wellness
Family, children, friends
Spiritual wellness
Faith and sense questions

Pain tolerance is lowered by:

- Discomfort
- Insomnia
- Fatigue
- Anxiety
- Fear
- Anger
- Boredom
- Sadness
- Depression
- Introversion
- Social abandonment
- Mental isolation

Pain tolerance is raised by:

- Relief of symptoms
- Sleep
- Rest or physiotherapy
- Relaxation therapy
- Explanation/support
- Understanding/empathy
- Diversion
- Listening
- Elevation of mood
- Finding meaning and significance
- Social inclusion
- Support to express emotions

Total pain

- How can we manage it?

  - Interdisciplinarity
  - Medication treatment
  - Complementary modes of treatment

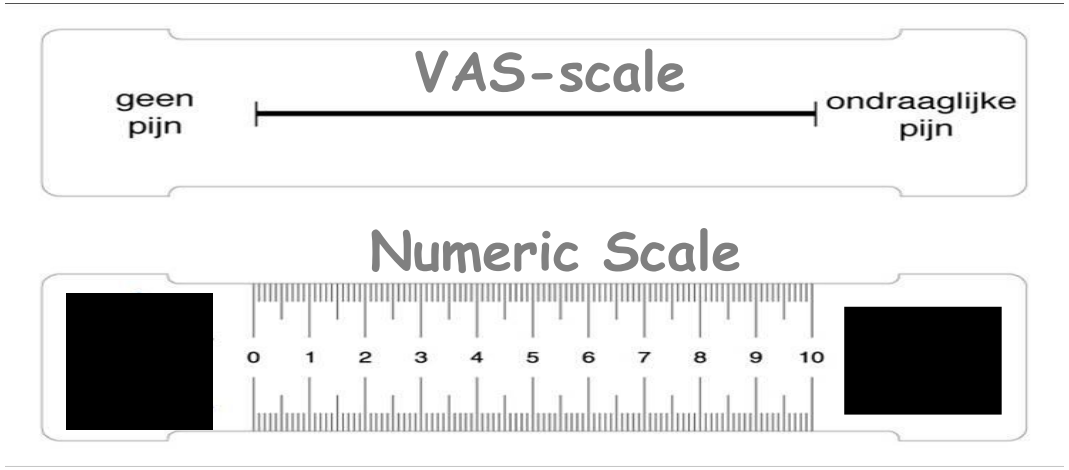
What can be the cause of pain in cancer?

- Cancer itself (61 %)
- Cause of the cancer or impact of the cancer (12%):
  - Bone pain
- Cause of the treatment (5%):
  - Mucositis, constipation
- Other illness (22 %): arthritis, migraine

What can we ask, when someone has pain?

Pain assessment: pain is a signal

- Don't ask do you have pain?
- But ask how much pain do you have?
- Measure the pain
  - Visual analogue scale (VAS)
  - Numeric scale



Painassessment: pain is a signal

- Where do you have pain?
- How is the evolution of your pain?

  ongoing or intermittent
- How is your pain?

  - gnawing, stinging, shooting, burning, colics
- What is worsening your pain?
- What is helpful for your pain?
- What is the meaning of your pain?

How can we do a painassessment?

- With a form
- With the patient and his family
- It takes time,

  but the time rewards…

Hospice Initial Pain Assessment

No pain reported _____ Person reporting pain: Patient _____ Patient's caregiver _____ Other _____

Intensity of the patient's pain. Using the assessment tool below, document the patient's pain for each site in the chart below. For reference, mark each pain site by letter (A, B, C, D) on the drawings in the lower right portion of the form.

0 1 2 3 4 5 6 7 8 9 10
No pain — Moderate pain — Severe pain

Description	Site A	Site B	Site C	Site D
Intensity at present				
Worst pain				
Best pain				
Tolerable level				
Duration: 0, 1, 2, 3*				
When did pain start?				
Any patterns to the pain?				
Patient's description of the pain	1 Sharp 1 Dull 1 Stabbing 1 Throbbing 1 Aching 1 Burning 1 Other	1 Sharp 1 Dull 1 Stabbing 1 Throbbing 1 Aching 1 Burning 1 Other	1 Sharp 1 Dull 1 Stabbing 1 Throbbing 1 Aching 1 Burning 1 Other	1 Sharp 1 Dull 1 Stabbing 1 Throbbing 1 Aching 1 Burning 1 Other
Acute pain, chronic pain, or both				
Somatic, visceral or neuropathic				
Other type of pain				
Effects of pain	Appetite, physical activity	Appetite, physical activity	Appetite, physical activity	Appetite, physical activity
	Emotions, relationships	Emotions, relationships	Emotions, relationships	Emotions, relationships
	Sleep disturbance	Sleep disturbance	Sleep disturbance	Sleep disturbance
Decreased quality of life				

*—Duration scale: 0 = no pain; 1 = pain less often than daily; 2 = pain daily, not constantly, controlled with interventions; 3 = pain all the time.

Manner in which the patient expresses pain: _____

Patient's goal for pain control: _____

Physical examination of pain site: _____

Current pain medications: _____

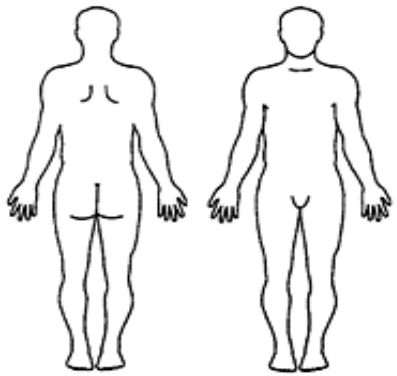
Venous access line present? _____

Problem: _____

Teaching/intervention(s): _____

Goal/outcome: _____

Pain site identification



Patient's name: _____ Patient's ID number: _____

What if the patient can't say it himself?

- No complaints = no pain??
- Observation!! if there is a change in
  - body language
  - voice sound
  - mimicry

Pain?

- Ask for a pain-killer, if effective, start it round the clock

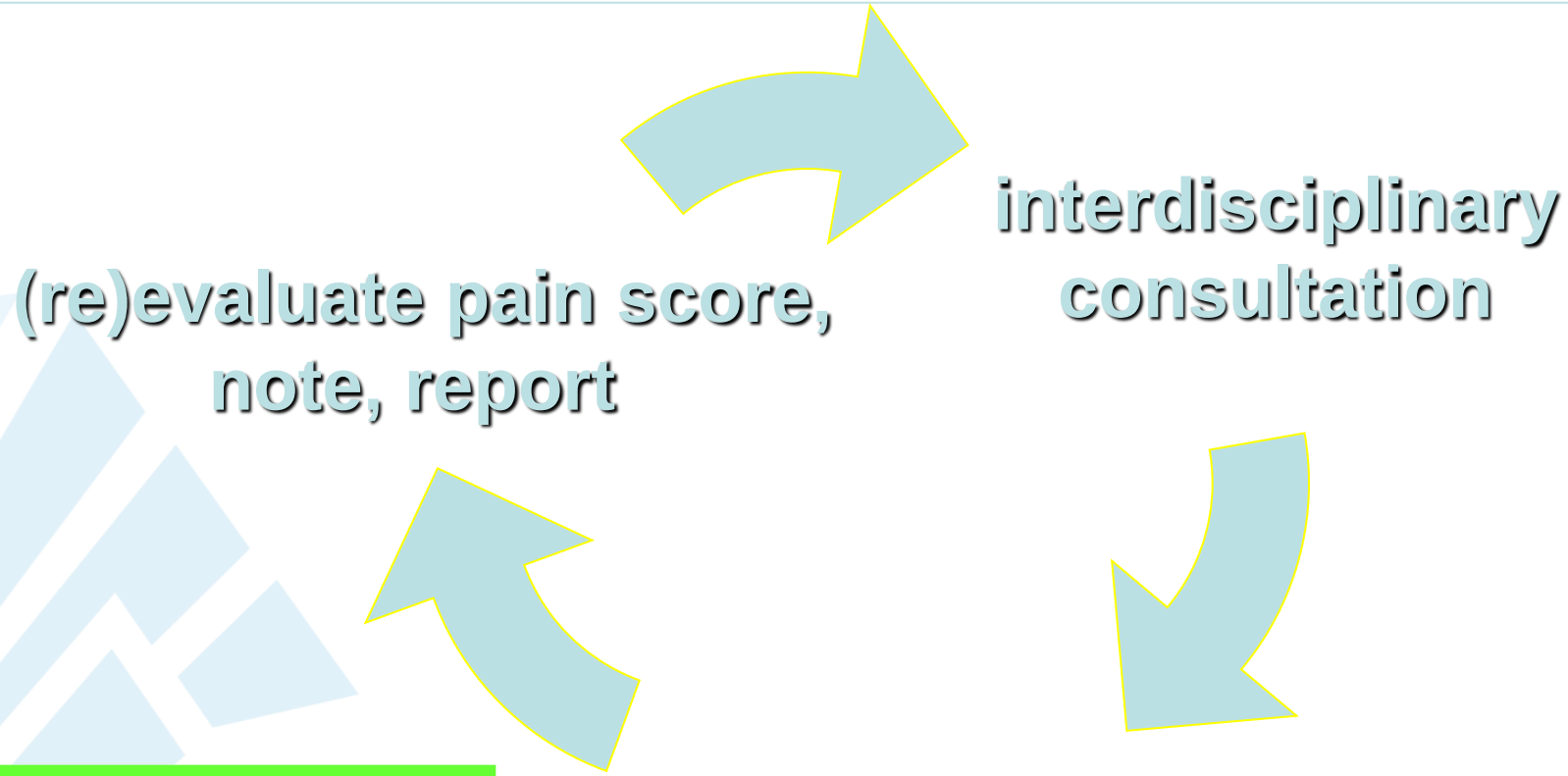
The painad scale, Pain Assessment in Advanced dementia

The Pain Assessment in Advanced Dementia (PAINAD) Scale*

Items	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad. Frightened. Frown.	Facial grimacing.	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
			Total	

**Warden V, Hurley Ac, Volicer L. Development and psychometric evaluation of the pain assessment in advanced dementia (PAINAD) scale. J Am Med Dir Assoc. 2003; 4:9-15.*

Interdisciplinarity

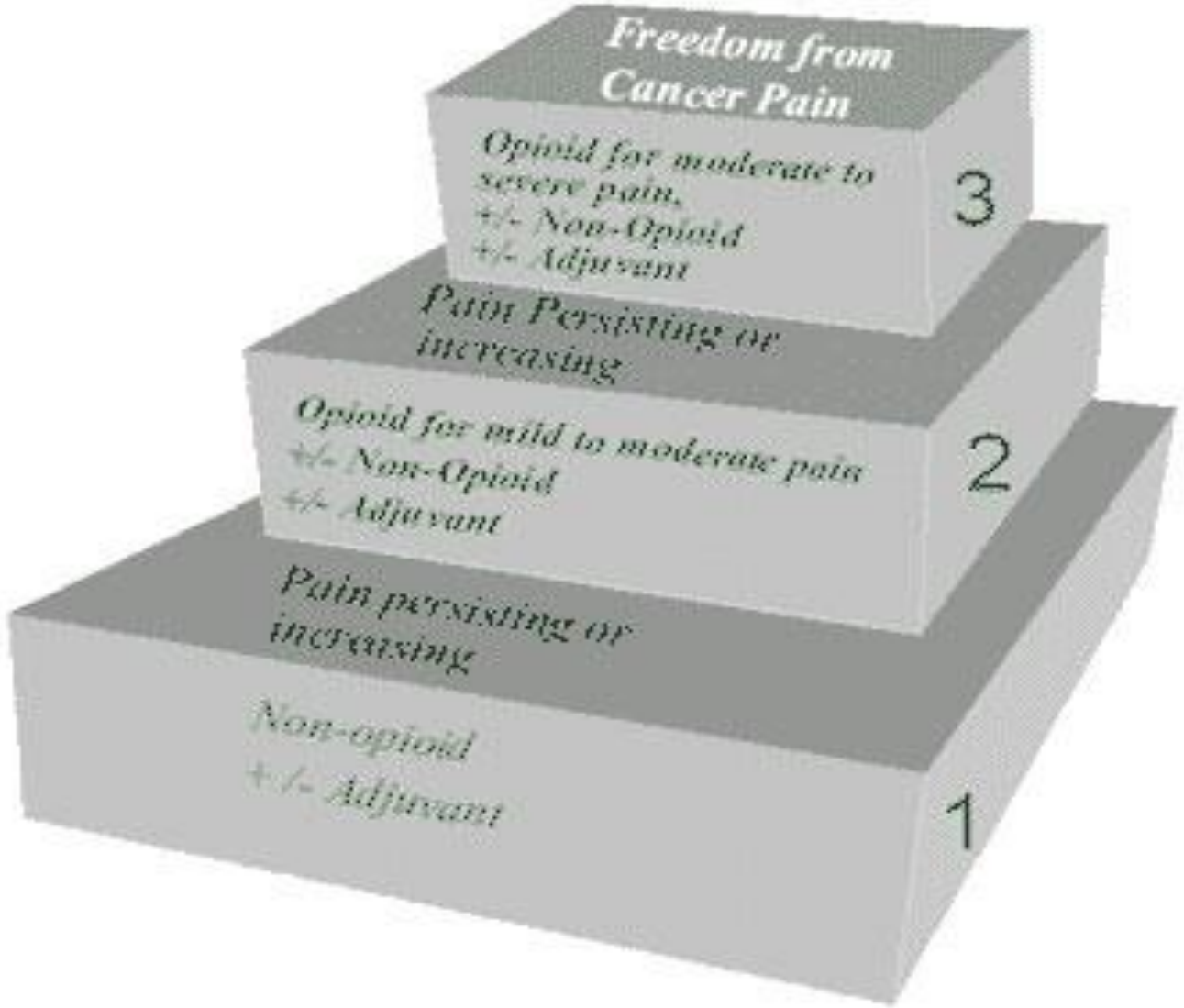


= our task!

causal pain treatment?

- Examine each situation as new consider all possibilities!
  - Surgery
  - Radiotherapy
  - Chemo- hormonotherapy, immunotherapy
  - nerve block-system, or other … pain specialist
- + Symptomatic pain treatment

WHO's Pain Relief Ladder



Mild pain	moderate pain	severe pain
1	2	3

3

Methadone
Morphine: MS Contin®, MS Direct®, Morphiphar®
Hydromorphone: **Palladone®** Oxycodone **Oxycontin®** **Oxynorm®**
Fentanyl : **Durogesic®**

? Buprenorphine: Temgesic®, **Transtec®**

2

Codeine: Codicontin
Tramadol: Contramal®, Tradonal®, Dolzam®
Tilidine: Valtran®
Combination:paracetamol-codeine

1

salicylates
paracetamol
NSAID: Brufen®, Indocid ®, Voltaren®, Tilcotil®

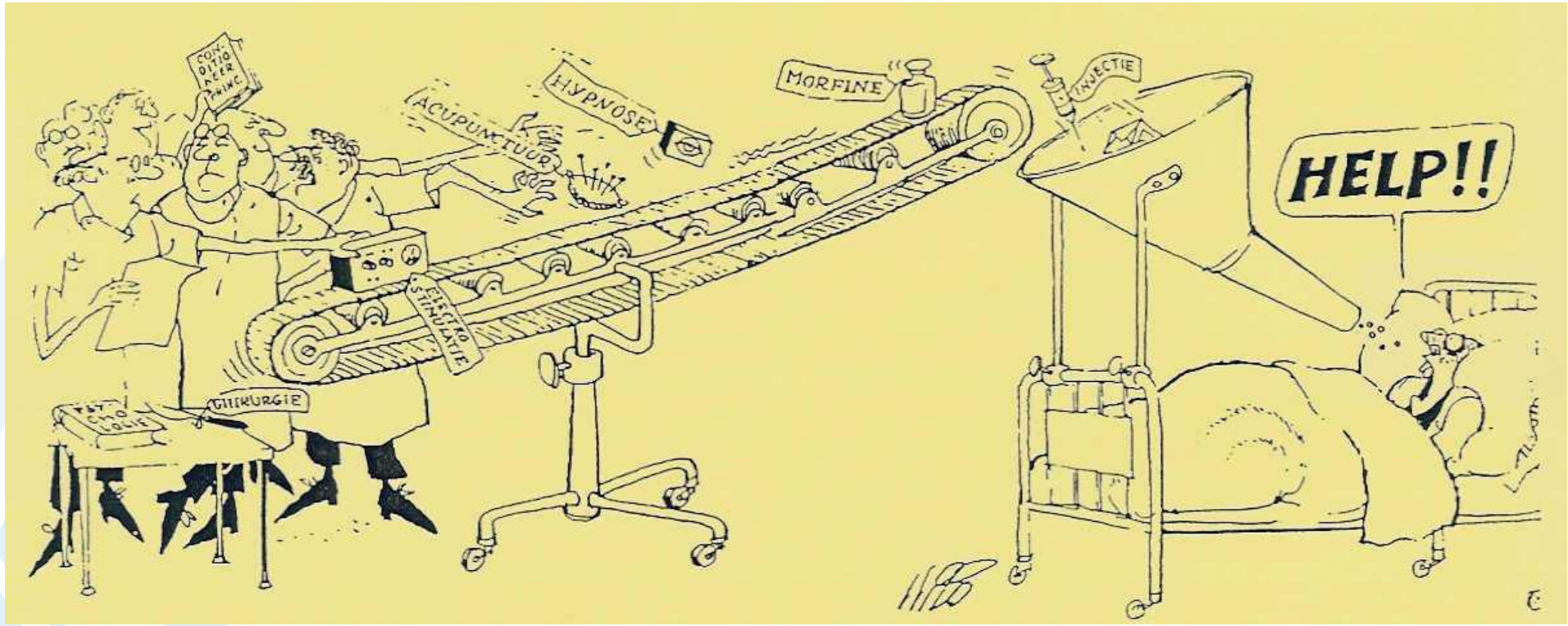
How can we give pain medication?

- …With the most respect for the patient!

How can we give pain medication?

- oral
- sublingual
- transdermal
- Rectal
- subcutaneous
- intra-venous
- (intra-muscular)
- epidural of intra-thecal

How can we give pain medication?



What do you need to know about opioids?

- Medication round the clock!!
  - Learn your patient to take his medication regularly
- What is breakthrough pain ?
- What is incidental pain?

What you need to know about opioids…

- What is breakthrough pain ?
  - Pain that is breaking through the medication round the clock, you need to give a bolus, when you need 3 or more boluses a day you augment the daily dose.
- What is incidental pain?
  - Pain that is occurring on a particular moment, p.e. by daily care or wound care

What you need to know about opioids: bolusdoses

- In violent pain more than VAS 5/10:
  - 1/6th of the total day amount

repeat the bolusdoses as much as necessary!

But when 3 or more bolusdoses/d => augment the daily dose

Oral morphine (longacting)

Hydromorphone (Palladone ® SR), Oxycodone hydrochloride SR (Oxycontin ®) morphinehydrochlorid (MS Contin ®),

- indications: maintenance amount at pain;
- advantages: works during 12 hours
- regulation: different regulations possible
- period of operation:

  1 mg hydromorphone = 8 mg morphinehydrochlorid

  1 mg oxycodone = 2 mg morphinehydrochlorid

Shortacting oral morphine, liquid or Hydromorphone IR, oxycodone IR, morphine HCl Sc

- indications: breakthrough pain or incidental pain, start up
- advantages: quick working
- regulation:
  - morfinehydrochloride/H_2O: 1mg/ml: liquid
  - Oxycodone instant: 5, 10 en 20mg
  - hydromorphone HCl for SC or IV (2, 10, 20mg)
- period of operation: 4h, but if pain → repeat the product

sublingual

- Advantages
  - when vomiting, problems to swallow
  - quick functioning
- Disadvantage
  - when dry mouth - > bad resorption
- Medication
  - Lorazepam (Temesta®),
  - buprenorphine (Temgesic®),
  - piroxicam (Feldene® liotabs),
  - domperidone (Motilium ®)

rectal

- Only short episods
- Emergency treatment
- Medication:
  - NSAID pe. diclofenac (Voltaren ® 100 mg 2 X per dag)
  - Diazepam ® (Valium®)
  - Morphine suppo made in the pharmacy (Morphine hydrochlorid can be introduced in the rectum)

transdermal

- Fentanyl in a patch (Durogesic ®), buprenorphine (Transtec ®)
- alternative in case of vomiting, problems with swallowing
- 4 times stronger than total oral day amount of morphine over 24 hours

Fentanyl patch

- 25 µg fentanyl ≈ 100 mg morphine
- Breakthrough medication: 1/6 of the total morphine day amount
- By 25 µg fentanyl:
  - 10-15 mg morphine orally or
  - 5-8 mg subcutaneous or intravenous
- What are the possible disadvantages of the patch?

Disadvantages of the patch

- Seems banal medicament
- Do not use for breakthrough or acute pain
- Slow start in working the first time
- Don't start in terminal stage, if patient have a patch, continue him and give morphine SC
- Works 3 days, do not forget to change the patch

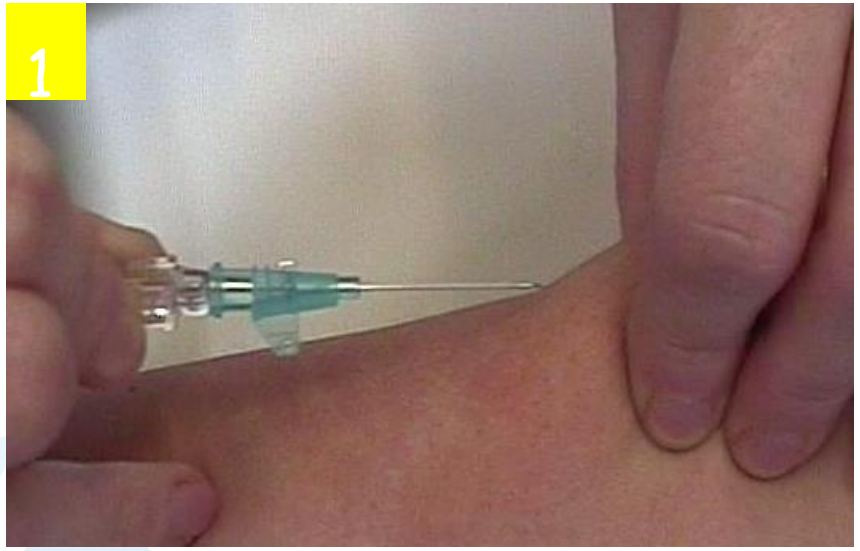
Subcutaneous

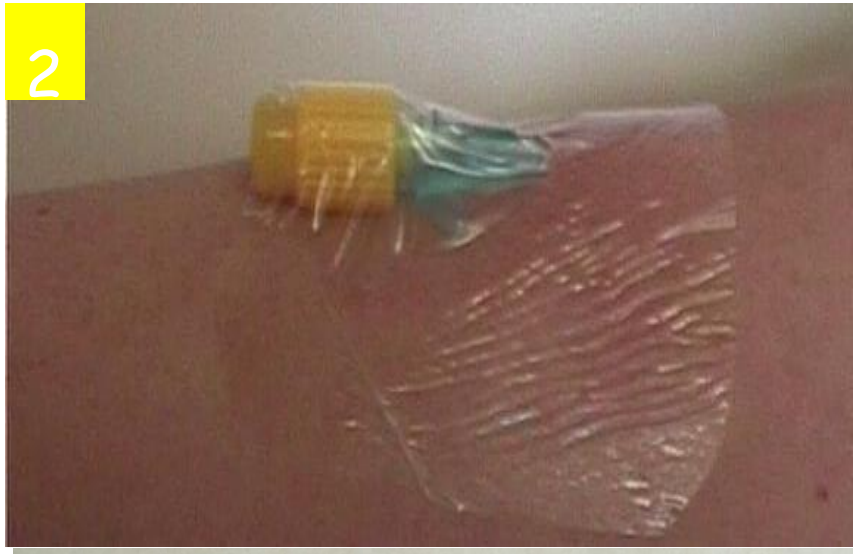
- Indications:
  - when vomiting, problems in swallowing, coma
  - home situation (no intravenous access necessarily)
- Advantages
  - Quick symptom control possible

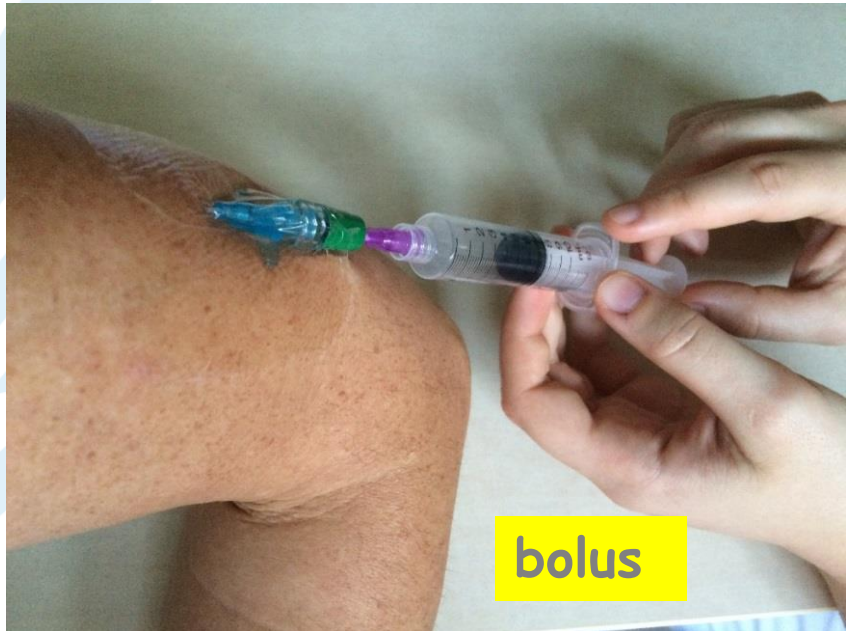
subcutaneous

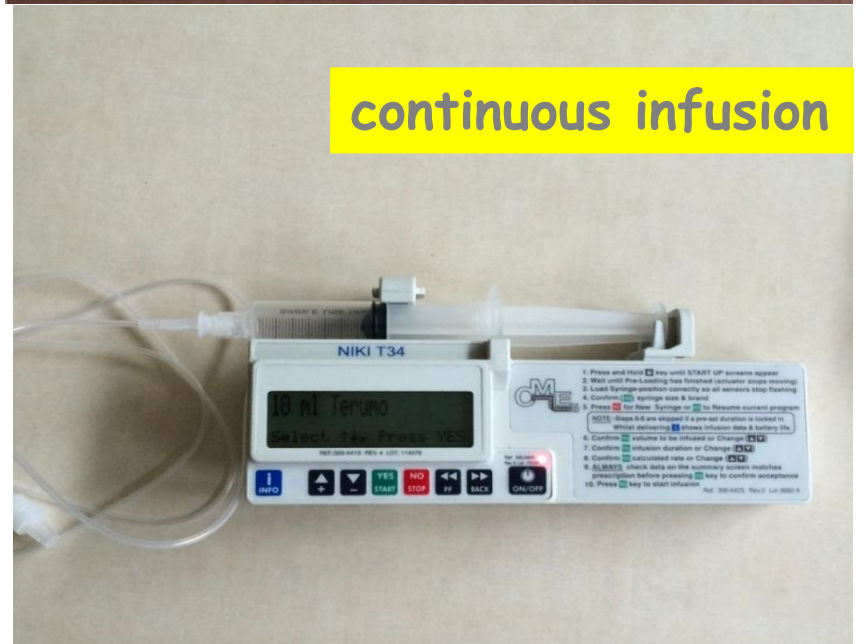
- With a subcutaneous catheter
  - bolus
  - continuous with a syringe driver
- mono or combination-therapy
- How can you place a subcutaneous catheter?

Subcutaneous









What do you look for in a subcutaneous infusion?

What do you look for in a subcutaneous infusion?

- Replace if redness, hardness, pain, swelling, flow back of medication
- Preferably to be placed in
  - The upper arm
  - thigh leg
  - Abdomen

Which product can you give SC?

• Alizapride	Litican®
• Amitryptiline	Redomex ®
• Clonazepam	Rivotril®
• Dexamethasone	Aacidexam®
• Diclofenac	Voltaren®
• Furosemide	Lasix®
• Haloperidol	Haldol®
• Hyoscine Hydrobromide	Scopolamine®
• Hyoscine Butylbromide	Buscopan®
• Lorazepam	temesta ®

Which product can you give SC?

• Levomepromazine	Nozinan ®
• Metoclopramide	Primperan ®
• Midazolam	Dormicum ®
• Morfine	morfine
• Natriummetamizol	Novalgine ®
• Octreotide	Sandostatine ®
• Ondansetron	Zofran ®
• Ranitidine	Zantac ®
• Tramadol	Contramal ®
• And even more…	

What you need to know about opioids: Conversion

- oral morphine /3= intravenous or subcutaneous:
- Oral morphine/2= oxycodone oral daily dose

What are the most important side effects of the opioids?

What are the side effects of the opioids?

- constipation (90%)
- dry mouth (40%)
- nausea and vomiting (28%)
- sedation (20%)
- delirium (<5%)
- urine retention (< 5%)
- Toxic myoclonus
- breathing depression
- sweating, tingling

What can you do for it?

- Laxatives (constipation)
  - Lactulose, Macrogol Movicol°, Forlax°, Laxoberon°, glycerinesuppo
- Anti-emetics (in nausea and vomiting)
  - Haloperidol Haldol°, domperidon, alizapride
- Narcoleptics (in delier)
  - Haloperidol

What is a co-analgesic?

What is a co-analgesic?

- medication whose primary indication is for a purpose other than pain relief, but it can demonstrate some analgesic effects. Antidepressants, anticonvulsants, corticosteroids, and other drugs may be used as co-analgesics. They may be used in addition to other analgesics or alone as primary treatment for specific painful conditions.

Co-analgesics for neuropathical pain

- Tramadol and strong opioids, oxycodone
- antidepressants

  bv. amitriptyline (Redomex°), duloxetine (Cymbalta°)
- anticonvulsants

  bv. Gabapentin (Neurontin°), Pregabaline (Lyrica°),

Co-analgesics for bone pain

- **NSAID's**

  non-steroidal anti-inflammatory drugs :

  bv. Ibuprofen, diclofenac, indomethacin

!!! Gastro-intestinal bleeding

- **bifosphonates :**

  bv. Pamidronate, Clodronate

psychopharmaca

- anxiolytics:
  - pe. Alprazolam Xanax°, lorazepam Temesta°, Midazolam Dormicum°,…
- Antidepressants :
  - pe. Amitryptiline Redomex°, duloxetine (Cymbalta°)

- neuroleptics :
  - pe. haloperidol Haldol°,…
  - Midazolam Dormicum°

- But give also information to the patient and his family
- Be there!!

Co-analgesics and adjuvants

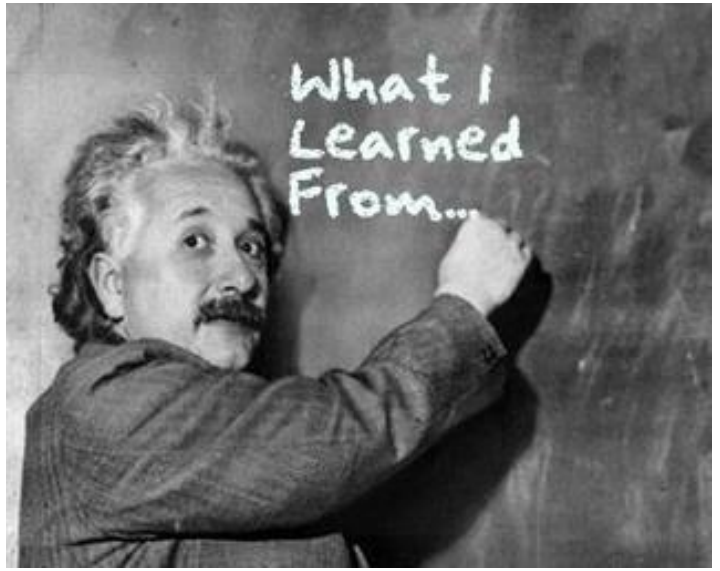
- cortico-steroïds ->
  - analgesic, stimulates the apetite, anti-emetic, arousing effect e.g. Aacidexam°, Medrol°
- neuroleptics ->
  - restlessness, delirium: haloperidol Haldol°,
  - vomiting, e.g. chloorpromazine Largactil°,
- benzodiazepines ->
  - fear, restlessness, Alprazolam Xanax°, lorazepam Temesta°, Midazolam Dormicum°,...
  - Muscle spasms, Diazepam Valium°

Triple regulation!!

- Morphine
- Breakthrough medication
- Laxatives

We have to ask it…

to the doctor



Put the correct treatment at the correct type of pain

- Burning nerve pain
- Bone pain
- Visceral pain
- nerve pain
- Spiritual pain
- Pain due to stretching of liver capsule,
- head pain

- Corticosteroïds
- Tender love and care
- Tramadol, Anti epileptics, buprenorfine patch
- Corticosteroïds , opioids
- amitryptiline
- NSAID or radiotherapy
- Paracetamol
- Opioids

Put the correct treatment at the correct type of pain

• Burning nerve pain	• amitryptiline
• Bone pain	• NSAID or radiotherapy
• Visceral pain	• Opioids
• nerve pain	• Tramadol, Anti epileptics, buprenorfine patch
• Spiritual pain	• Tender love and care
• Pain due to stretching of liver capsule,	• Corticosteroïds , opioids
• head pain	• paracetamol • Corticosteroïds

What is the bolusdoses, that the patient needs at the moment of breakthrough pain for Mrs Icks if she takes 2 times a day 30mg oxycodone PO?

What is the bolusdoses, or amount at breakthrough pain for Mrs Icks if she takes 2 times a day 30mg oxycodone PO?

- 2 times 30mg oxycodone = 60 mg by 24h by mouth
- bolusdoses : 10 mg oxycodone (instant) orally in violent pain (VAS more than 5)

Ms Peeters needs 600 mg morphine by ox per day. By nausea and vomiting it's difficult to take the medication further orally. Which alternatives can you present?

Ms Peeters needs 600 mg morphine by ox per day. By nausea and vomiting it is difficult to take the medication further by orally. Which alternatives can you present?

- Subcutaneous: 200 mg ongoing concerning 24h in a syringe driver or 30 mg every 4 hours subcutaneous in a bolus.
- fentanyl: 150-175 Ug/h and as bolus 100mg morphine by ox or 35 mg morphine subcutaneous
- Intravenously: 200 mg ongoing concerning 24 u.

Ms White describes a burning pain, you suspect a nerve pain. The doctor confirms this and presents an antidepressant. The patient refuses this, how can you try to motivate this?

Ms White describes a burning pain, you suspects a nerve pain. The doctor confirms this and presents an antidepressant. The patient refuses this, how you try to motivate this?

-The antidepressant has a positive impact on this type of pain.

-Impact within the week, the anti-depressant impact lasts longer.

-Can be stopped if no advantage

The doctor has started with strong opioids. You can see: morphine: 2x 30mg, at 20h: corticosteroid 32mg, sleep medication. What do you ask the doctor?

The doctor has started with strong opioids. You can see: morphine: 2x 30mg, at 20h: corticosteroid 32mg, sleep medication. What do you ask the doctor?

- What can be given for breakthrough pain? 10mg morphine syrup, 5mg oxycodone QR or 1, 3mg hydromorphone
- What can I give for constipation?
- Can I give the corticosteroid in the morning?

You can see that Ms Jones has a lot of pain, but she does not take her extra amount of morphine. To the doctor she says that she has no pain.

How can you manage this?

You can see that Ms Jones has a lot of pain, but she does not take her extra amount of morphine. To the doctor she says that she has no pain. How can you manage this?

- WHY??

Try to convince her but take to account her motivation. E.g.: Fear for addiction, fear for somnolence, but this is only the first days

A patient has pain, problems to swallow, death rattle and is dying. He has:

fentanyl patch of 150µg/h.
oral medication:
-corticosteroid 32mg,
-anxiolyticum 0,5mg 3 times a day,
-morphine 20mg for breakthrough pain (3 or 4 times a day), ---
-Metoclopramide before eating,
-Ranitidine (to protect the stomach) 300mg,
-heartmedication 1co/d,
-diuretics 1 co/d,
-antibiotics 3 x 500mg per dag.

What can you suggest?

A patient has pain, problems to swallow, death rattle and is dying. What can you suggest?

- Give all the medication subcutaneous
- Ask to stop all the useless medication, always continue the painkillers or change them
- Corticosteroid 5mg/d via subcutaneous way,
- morphine 20 tot 30mg/d, continue the patch
- Haloperidol 5mg in stead of the anxiolyticum and the metoclopramide,
- For the death rattle ask to start hyoscine hydrobromide or butylbromide.

What is our responsibility against pain?

1. pain prevention e.g. prevention of pressure sores, good attitude, avoid complications
2. recognise the pain
3. give meaning to what is happening
4. co-responsibility of the patient and his family
5. information!!
6. comfort (small resources)

Heal, sometimes

Ease, often

Comfort, always ...