

Pain Overview

Principles:

- Pain mgmt should rarely be adversarial but should usually be collaborative between us and the pt. Good communication is critical to making this happen.
- **We should review the pain brochure during rounds** (although this shouldn't need to be an extra step but rather should support a discussion that is already happening)
- Use whiteboard for daily pain plan
- Use frequent and clear communication with patients about pain meds (frequency, IV to PO, dose, discharge plan, overnight plan, etc.) before implementing the plan or making changes
- Continue chronic pain meds inpt unless safety is a concern (encephalopathy, sedation, AKI)
- When changing chronic meds on admission, dose reduction will sometimes be more appropriate than abrupt cessation, and communication with the patient is key
- Maximize non-med options (music, hot/cold, SW - relaxation techniques, chaplain - guided imagery)
- Non-opioid meds: Tylenol, NSAIDs, IV ketorolac, gabapentin, nortriptyline, SNRIs, topical lidocaine, benzodiazepine, cyclobenzaprine, tramadol

Opioids:

- "Titration period" – first 6 hours of treatment. Frequently assess pain and change dosing as needed
 - o Initial dose should usually be 50-100% of individual doses required in ED
 - o IV opioids reach effect in 15mins. Re-dose as needed
 - o Oral opioids take 1-2 hours to reach peak
- IV opioids should often be q2 hrs prn and oral short-acting opioids should often be q4 hrs prn
- Can consider long-acting opioids in patients requiring frequent dosing
- Opioids are less helpful in fibromyalgia, poorly-defined pain syndromes, daily headache, chronic LBP
- Change to PO when possible. Indications for IV opioids: 1) NPO, 2) malabsorption concerns including ileus or partial bowel obstruction, 3) active nausea/vomiting, 4) first 24 hours of a pain crisis
 - o When transitioning to PO, calculate equivalent dose and consider 50-100% total daily dose
 - o May have IV doses available for breakthrough during first 24 hrs after transition to oral
- Schedule a bowel regimen with opioids with goal of BM q 48 hrs or less
 - o senna 8.6mg + docusate 50mg – 1 tab PO daily or b.i.d. – "hold for diarrhea"
 - o polyethylene glycol 3350/miralax 17g PO daily or b.i.d. prn
- Controlled substance database search (DOPL) if any concern for misuse/abuse of opioids
 - o Risk factors for abuse include: 1) past/current substance abuse, 2) family hx of substance abuse, 3) psych dz, 4) younger age
- Discharge plan for new/increased opioids should include: direct communication with outpt provider, timely f/u appt (usually ≤ 1 week), documentation of # pills prescribed at d/c
- Naloxone should only be used if needed (main goal is stable respiratory status) and with caution
 - o In non-emergent settings, 0.08 mg is generally a reasonable starting dose (1 amp is 0.4 mg which can be diluted in 10cc NS). Can be re-dosed in several minutes prn. Starting with a higher dose can lead to a dangerous pain/sympathetic crisis

Key Messages to Patients:

- We cannot make the pain go away, but we will do our best to make your pain manageable so you can function
- Your safety is our #1 concern, but your comfort is a close second
- Oral meds are just as strong as IV but they last longer
- It is important for us to make sure you are tolerating oral pain meds and they are working for you so that we can feel confident when you leave the hospital that you will be safe and have good pain control
- When you leave the hospital you will not have the same level of monitoring so we need to be cautious with how we prescribe pain medications for after discharge.
 - o In some cases, it may not be safe to give as high of a dose or to give the dose as frequently
 - o We need to have a close f/u plan so your outpt provider can help closely manage your pain and your pain medications

Pain Overview

MYTH:	FACT:
Pts at risk for delirium need to tolerate a higher level of pain because opioids cause delirium	Undertreating pain increases the risk of delirium
Patients who request a particular pain med are “drug seekers”	Some patients do better on one opioid or class of medication compared to another
Patients who consistently ask for medication the moment it is available are “drug seekers”	Sometimes this is a sign that the dose or frequency is inadequate. It also may be a sign that the pt is using opioids maladaptively (as a coping mechanism)
Sleeping, having normal VS, or “looking comfortable” are reliable signs that a patient’s pain is well controlled.	Even patients in pain sleep sometimes. It is possible to have significant pain without looking uncomfortable or having abnormal VS.
Experiencing opioid withdrawal or becoming angry when opioids are withheld proves that a patient is a “drug seeker” or has opioid addiction	Any patient who takes opioids chronically may experience withdrawal if they are dramatically decreased. Physical dependence on opioids is different from addiction (which is associated with impaired control, compulsive use, continued use despite harm, etc).
Aggressive use of opioids for acute pain in the hospital will lead to or feed opioid addiction.	Addiction is rarely caused or exacerbated by appropriate acute pain treatment in the hospital.
Since we should minimize opioid use, a patient who is not frequently complaining of pain does not need an adjustment in their pain regimen.	Many patients are slow to mention pain due to fear of addiction, fear of looking like an addict, fear of being labeled a complainer, fear of looking weak, fear of med side effects, unwillingness to acknowledge worsening disease, etc. Undertreating pain (like overtreating) is harmful

When to consult: APS (Acute Pain Service), PCS (Palliative Care Service)

1. Pain issues in the setting of serious concern regarding opioid abuse or addiction
2. New requirement of large doses of opioids for pain control (total daily dose > equivalent of 150mg of oral morphine = 100mg oxycodone)
3. Requirement for methadone dose adjustments
4. Need for PCA or interventional pain strategies
5. Difficulty transitioning to oral but not meeting criteria for IV opioids

Who to consult:

-APS: complicated med mgmt., need for PCA, ketamine, or interventional procedure

-PCS: less complicated med mgmt issues, pts who are challenging from social/communication standpoint, limited prognosis, difficulty transitioning to PO

OPIOID EQUIANALGESIC CONVERSION TABLE*

OPIOID	ORAL	IV/IM
Morphine (MSIR, MS Contin, Kadian, Avinza, etc.)	30mg	10mg
Oxycodone (Percocet, Oxycontin, etc.)	20mg	N/A
Hydromorphone (Dilaudid)	7.5mg	1.5mg
Hydrocodone (Lortab)	30mg	N/A
Fentanyl	N/A	100mcg

**These conversions are only estimates. Incomplete cross-tolerance, pharmacokinetics, etc., must be considered when changing between opioid agents. A well-controlled patient may require a 25% or greater dose reduction of the new agent.*