PAIN IN MEDICAL CARE

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Pain is an important entity, firstly in understanding, secondly in diagnosis, and thirdly in management of the patient. It has been called the fifth vital sign.

UNDERSTANDING PAIN

Pain may be defined as an unpleasant sensory or emotional experience. This broad divide of physical and emotional pain is of importance because the management of emotional pain is different from physical pain. The two is also often intertwined. What is remarkable is scientists have now confirmed that physical pain and emotional pain is carried by the same pathways so that the emotional pain of rejection is like "a kick in the guts". And this connection has survival value because the ability to sense rejection as a pain helps one to reappraise the safety of the emotional milieu of one's survival (Vastag, 2003).

PAIN IN DIAGNOSIS

Various descriptors have been given to the pain that we experience by clinicians. This kind of categorisation of pain helps the attending physician to pin-point the cause of pain and this is important as the first step towards the understanding and control of that pain.

Acute pain is short lived and usually lasts 3 months; it can be stopped by removal of cause and treatment with pain medication. Its clinical importance lies in the cue that something has just gone wrong. It is a red flag that some attention is needed immediately within the small window of opportunity to halt the damage that is ongoing. The best examples of this kind of situation is the acute appendicitis and the ectopic pregnancy.

Chronic pain is pain that is still present after three months despite sensible treatment. It is more complex requiring other forms of treatment beside conventional medications. It may be due to a condition that is not easily reversible. Endometriosis is a good example of the perpetuator of such pain.

Somatic pain is pain pertaining to the body – muscles, bones, usually localised, worsens with movement. It is dull, aching, throbbing in character. **Visceral pain** is pertaining to the organs. It is diffused or generalised, gnawing cramping in character. **Referred pain**, or transferred pain, is pain felt superficially in the dermatome of an affected viscus or other deep structure innervated by that root. An example is pain felt in the left arm because of cardiac disease. Together, they help us locate the seat of disease.

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Radicular pain is pain in the distribution of a nerve root, so that pain is felt in an area corresponding to one of the dermatomes down the arm or leg or round the trunk. It is typically caused by compression. **Central pain** is spontaneous pain caused by damage to the central nervous system, often accompanied by dysaesthesia. An example is the pain which can occur on the side of the body affected by a stroke, the thalamic or post-stroke syndrome. **Phantom pain** is pain felt in the missing limb or stump. **Neuropathic pain** are numbness, tingling, burning type of pain experience in the legs feet and hands as a result of damage to the peripheral nerves such as in diabetes mellitus. Such pains are usually troublesome to bear if the cause cannot be easily reversed.

The intensity of pain varies with the underlying condition and its need for relief. To help clinicians understanding this aspect of pain, various pain scales have been developed so that the patient's intensity of pain can be quantified. The numeric Rating scale uses a 0-10 scale to assess the degree of pain. Simple descriptive intensity scale, uses such words as "mild", "moderate", and "severe" to describe the patient's pain intensity. Visual Analog Scale requires patients to mark a point on a 10 cm horizontal or vertical line to indicate their pain intensity, with 0 indicating "no pain" and 10 indicating "the worst possible pain".

Patient may have pain at more than one site and should be encouraged to report as many sites that are relevant. Physicians may need to utilize more than one pain intensity scale based on the needs of its various patients. Adults should be encouraged to use those 0-10 numeric scales. If they are unable to understand or unwilling to use this scale, the Wong-Baker Faces Pain Rating Scale can be used.

MANAGING PAIN

Management of pain has to be holistic to be effective. It often extends beyond analgesics, it also includes the person's quality of life and his ability to function.

Approach to pain management

The agency for health care policy and research (AHCPR) recommended the ABCs of pain management. The ABCs stand for:

A – Ask about pain regularly. Assess pain systematically.
B – Believe the patient and family in their reports of pain and what relieves it.
C – Choose pain control options appropriate for the patient, family, and setting.
D – Deliver interventions in a timely, logical, coordinated fashion.
E – Empower patients and their families. Enable patients to control their course to the greatest extent possible.

The management of pain starts with a comprehensive assessment. The initial assessment should focus on identifying the cause and developing a plan of care to manage the pain. Pain should be assessed and documented for intensity and character.

1. Onset – when did it start? How often does it occur? Has its intensity changed?
2. Location – where is the pain? Is it more than one location?
3. Description – what does your pain feel like? What words would you used to describe your pain?
4. Intensity – how much does your pain hurt right now? How much does it hurt at its worst? How much does it hurt at its best?
5. Aggravating and relieving factors – what makes your pain better? What makes your pain worse?
6. Previous treatment – what types of treatments have you tried to relieve your pain? Were they effective?
7. Effect – how does the pain affect physical and social functions?
8. Type and frequency – is the pain constant? Does it change over time or comes and goes? If intermittent how frequent and what is the duration?

Treatment Modalities

The scope of treatment of pain can be pharmacological and non-pharmacological treatment and often both are used simultaneously. Relying on one modality of treatment alone such as drugs is unlikely to be effective in the long term. Other dimensions should be explored such as social, emotional, and spiritual aspects.

Often than not by offering comfort care and concern to the patient can have quite a reliving effect to the patient. In the case of patient with terminal illness prayers by his parish priest or his pastor can provide solace to the patient and help to numb the physical pain.

The patient with pain should be reviewed regularly and frequently. His medication requirements may increase or decrease depending on other pre-existing condition and progression of disease or other conditions that may develop.

Non-Pharmacological approaches may include the following:

1. Physical modalities: simple touch, heat/cold (alternating), massage/body rub, vibration
2. Occupational therapy: immobilization of joints, strength and endurance training, transcutaneous electrical nerve stimulation (TENS).
3. Relaxation techniques: individual or group activities, music and conversation.

These are important as they augment the efficacy of medications and have minimal side effects. It gives the patient a sense of control and participation. It addresses functional decline, mood and social isolation.

Alternative and complementary therapies can also play an important role. Physicians may consider the various alternatives as relevant: acupuncture, chiropraxis, massage and related techniques, aromatherapy, biofeedback, hypnosis, meditation and even music therapy. So long as they do no harm, the patient should be given a chance to try the alternatives for themselves.

Pharmacological treatment should relate the type of drug to the type of pain. The treatment of neuropathic pain is different from the treatment of tissue-damage (nociceptive) pain. Even within nociceptive pain, some types responds better to NSAIDs, examples are dysmenorrhoea, dental pain and arthritic pain. The WHO step-ladder approach to pain is a good roadmap for dealing with pain that needs palliation.

Understanding the barriers to effective pain management

The problems may be related to the physician, patient and the healthcare organization.

Physician related barriers include the following:

- Inadequate knowledge of pain management and pharmacology of pain medication
- Poor assessment skills
- Concern of medication side effects and fear of using addictive drugs
- Problems related to storage and usage of controlled drugs.

Problems related to the patients:

- Reluctance and inability to verbalized pain
- Fear of becoming addicted to the drugs or becoming a drug addict
- Worries about side effect of the medication

These will lead to inadequate treatment and compliance to medication prescribed. A drug is only as effective if the patient takes it.

Problems related to organization:

- Restrictive regulation about drug usage and storage of controlled drugs
- Problems of assess and availability of treatment
- Problems of Government or Managed care subvention and reimbursement.

CONCLUSIONS

The effective management of pain begins with the ability to understand the patient description of the modality. Time spent getting a correct description is never wasted. Effective management depends on the correct diagnosis, understanding of the patient, and the modalities that can be used to cure, relieve and comfort the patient and lessen his suffering.

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