

Pain

Notes from a talk given at the Wheel of Life *Living & Dying* 2013 workshop on 16 February 2013

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Pain is:

- an unpleasant sensory and emotional experience
- a sensation that is a useful warning signal that actual or potential damage is occurring to the body's tissues
- the most common symptom in patients with advanced cancer
- often poorly treated, resulting in unnecessary suffering

The frequency and intensity of pain varies depending on:

- what disease they have
- how advanced their disease is
- what other health problems they are experiencing

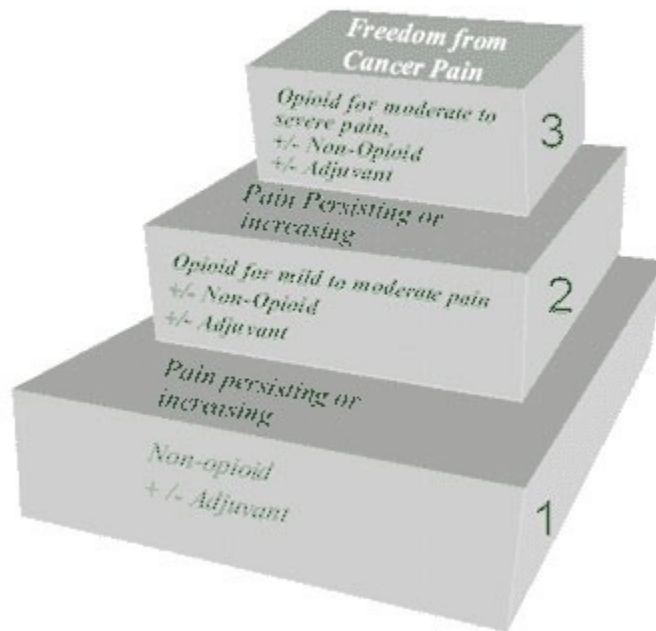
The pain experience is unique to an individual.

It can be magnified by psychosocial stressors, and modified through psychological and emotional support.

It is what the person describes and not what others think it ought to be.

The WHO Analgesic Ladder for Cancer Pain relief

WHO's Pain Relief Ladder



Step 1 : Non-opioids (aspirin, paracetamol, anti-inflammatories). If inadequate relief from regular administration of these then move to:

Step 2 : Mild opioids (codeine). If inadequate relief from regular administration of these then move to:

Step 3 Strong opioids (morphine, oxycodone, hydromorphone, fentanyl, methadone).

Adjuvants are medications where the primary role is not pain relief but they supplement the benefit of analgesics and improve pain control. eg. Ketamine; Antiepileptics (sodium valproate; gabapentin; pregabalin); Antidepressants (amitriptyline)

Opioids are medications that bind to opioid receptors resulting in analgesia. Many opioids are synthetic eg oxycodone, hydromorphone. Opiates are opioids that are derived from the opium poppy.

Choice of which opioid to use dependent on:

- Effectiveness – if its working and not causing problems don't change it
- Adverse effects – if these are too troublesome then change it
- Client choice – daily; twice daily; third daily; weekly
- Onset of tolerance – change it
- What is available
- Formulations – liquid, tablet
- Dose required – higher concentrations

Opiophobia is indicated by the following:

- thinking that it is only used when patient is dying
- Morphine hastens death
- causes respiratory depression
- causes unacceptable side effects
- Morphine doesn't work
 - incorrect administration
 - opioid insensitive pain
 - ignoring psychosocial aspects
- fear of tolerance physical and psychological dependence

Managing cancer pain

Take regular, slow release – constant low dose provides better overall control of pain

Use breakthrough as required

Anticipate needs – take before effort required

Report dissatisfaction – there are alternative options

Use non-pharmacological methods

Assessing pain

Facial signs – furrowed brow, grimace, eyes closed tight, clenched teeth, taut lips.

Body posture signs – very still, stiff, can only get comfortable in one position

Take note of what happens if they move, or you move them

Are they happy, content or are they irritable and withdrawn?

Do they have an appetite?

Helping pain

Find out what helps or makes it worse – movement, massage, support on a pillow, distraction (music, company, television/radio).

Find out the most comfortable position for them – document, and if they are unable to communicate easily use a photograph or diagram.

Reference

Therapeutic Guidelines of Palliative Care, Version 3 (2010) Therapeutic Guidelines Limited, Melbourne

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