

# ASSESSMENT & MANAGEMENT OF PAIN

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Have you heard ....

- "It's too early "
- " I can't give you anything else "
- " You shouldn't be having that much pain "
- " I am afraid you will become addicted "

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## What is Pain?

Pain is defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage."

(Federation of State Medical Boards of the United States, Inc. Model Guidelines for the use of Controlled Substances for the Treatment of Pain. Eules, TX: 1998)

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## Pain is Subjective

The gold standard for pain is:

- Whatever the patient says it is...
- Whenever the patient says it is.

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## Pain Categories

- Acute Pain
- Chronic Pain
- Episodic pain

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## Acute Pain

- Recent onset and expected to last no longer than days or weeks.
- Intensity is variable.
- Anxiety and pain behaviors (e.g., moaning, rubbing, splinting) are common when pain is severe or cause is unknown.
- Patient may show signs of sympathetic hyperactivity (i.e., tachycardia, hypertension, sweating, mydriasis) when pain is severe.
- Pain provides an essential warning and impels the patient to rest and avoid further harm.

(Portenoy RK Kanner RM in *Pain Management Theory and Practice*: Philadelphia:F.X. Davis Company; 1996)

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## Chronic Pain

- Remote, often ill-defined onset – duration unpredictable.
- Intensity is variable.
- Patient may display irritability or depression.
- Patients behavior (e.g., assuming a comfortable position) may or may not give indication of pain.
- Patient may or may not have vegetative signs (e.g., lassitude, anorexia, weight loss, insomnia, loss of libido)

(Portenoy RK Kanner RM in *Pain Management Theory and Practice*: Philadelphia:F.X. Davis Company; 1996)

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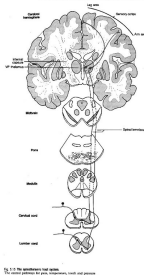
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## Pain-sensing System Malfunction in Chronic Pain



- Pain Sensing- in chronic pain, pain signals are generated without physiologic significance.
- Normal pain – Pain sensing signals are initiated in response to a stimulus, they elicit a pain relieving response.
- Chronic pain – pain signals are generated for no reason and may be intensified. Pain relieving mechanisms may be defective or deactivated.

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## What is Episodic Pain?

- Breakthrough – transient increase in pain; moderate – severe intensity; usually have an otherwise controlled stable pain syndrome; baseline pain well controlled.
- Incident – predictable and episodic, etiology may be physical or psychological
- End of dose failure – longer acting medication does not maintain effect for expected duration of time.

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## Classifications

- Nociceptive – arises from stimulation of nerve endings.
  - Somatic – skin, peripheral fibers, bone, joint, connective tissue, muscle - constant, well localized, aching, throbbing
  - Visceral – internal organs, GI tract, pancreas - deep, aching, squeezing, intermittent, cramping, poorly localized

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## Classifications – Cont'd

- Neuropathic
  - Injury, malfunction, nervous system dysfunction
  - Central or peripheral
  - Constant, intermittent, lancinating, burning, shooting, "on fire", tingling, ice cold
  - ? Resistant to opioid management.
  - Often requires use of adjuvant medications.

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## Pain in the Elderly

### Conditions Associated with the Development of Pain in the Elderly

- |                               |                         |
|-------------------------------|-------------------------|
| ■ Degenerative joint disease  | ■ Rheumatoid arthritis  |
| ■ Gastrointestinal causes     | ■ Post-stroke syndromes |
| ■ Fibromyalgia                | ■ Low back disorders    |
| ■ Peripheral vascular disease | ■ Improper positioning  |
- (AMDA)

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## What Are the Components of Pain Management?

- Pain Management is comprised of:
  - Initial and ongoing assessment of pain
  - Implementation of appropriate interventions to relieve pain
  - Measurement of outcomes

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## Assessment Is the First Step

- A standardized pain assessment tool should be used to help quantify and qualify a patient's pain.
- Stating a patient is experiencing severe pain is inadequate information for a physician to base treatment decisions on.
- Descriptors of pain quality can help the practitioner distinguish between somatic, visceral, and neuropathic pain.

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## APS: "Pain: The 5<sup>th</sup> Vital Sign"

- Pain should be considered the 5<sup>th</sup> Vital Sign.
  - Assess patient for pain every time pulse, blood pressure, core temperature, and respiration are measured.
  - Record findings from pain assessment to ensure quality and continuity of care.
  - Recognize a report of unrelieved pain as a "red flag".

(APS 1995)

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## Assessment of Pain: Its Intensity and Character

- Onset and temporal pattern
  - When did the pain start?
  - How often does the pain occur?
  - Has pain intensity changed?
- Location
  - Where is the pain?
  - Is there more than one site of pain?
- Description
  - What does the pain feel like?
  - What words would you use to describe the pain?  
(AHCPR 1994)

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## Assessment of Pain: Its Intensity and Character

- Aggravating and relieving factors
  - What makes the pain better?
  - What makes the pain worse?
- Previous treatment
  - What types of treatments have you tried to relieve the pain?
  - Were these treatments effective?
- Effect
  - How does the pain affect physical and social function?
- Intensity
  - Using the pain assessment scale, rate the intensity of the pain.  
(AHCPR 1994)

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## Measuring Pain Intensity

- A pain scale can be useful for grading intensity of pain. It should:
  - Be easy for the patient to use.
  - Correlate with the patient's cognitive level.
  - Be used consistently across disciplines and at each examination.

(CAHO 1999)

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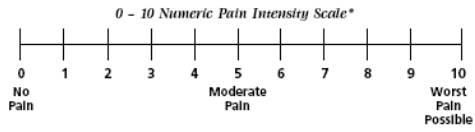
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## Numeric Pain Intensity Scale



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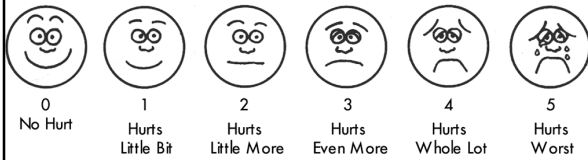
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## Wong-Baker FACES Pain Rating Scale



(Wong DL, Hockenberry-Eaton M, Wilson D, et al. *Whealey & Wong's Nursing Care of Infants and Children* 6<sup>th</sup> ed. St. Louis, MO: Mosby-Year Book, Inc. 1999)

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## Functional Pain Scale (FPS)

- 0 = No pain
- 1 = Tolerable (and does not prevent any activities)
- 2 = Tolerable (but does prevent some activities)
- 3 = Intolerable (but can use telephone, watch TV, or read)
- 4 = Intolerable (and can't use telephone, watch TV, or read)
- 5 = Intolerable (and unable to verbally communicate because of pain)

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## **Pain in the Elderly**

### **Consequences of untreated pain:**

- **Depression**
- **Suffering**
- **Sleep disturbance**
- **Behavioral disturbance**
- **Anorexia, weight loss**
- **Deconditioning, increased falls**

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## **Pain in the Elderly: Myths**

- **To acknowledge pain is a sign of personal weakness**
- **Chronic pain is an inevitable part of aging**
- **Pain is a punishment for past actions**
- **Chronic pain means death is near**
- **Chronic pain always indicates the presence of a serious disease**
- **Acknowledging pain will mean undergoing intrusive and possible painful tests.**

(AMDA)

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## **Pain in the Elderly: Myths**

- **Acknowledging pain will lead to loss of independence**
- **The elderly – especially cognitively impaired – have a higher pain tolerance**
- **The elderly and cognitively impaired cannot be accurately assessed for pain**
- **Patients in LTC say they are in pain to get attention**
- **Elderly patients are likely to become addicted to pain medications**

(AMDA)

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## Barriers to Pain Management

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## Barriers to Effective Pain Management

- Patient reluctance to report pain.
- Patient reluctance to use opioid analgesics.
- Fear of addiction.
- Inadequate physician education and training.
- Inadequate assessment by clinicians.
- Physician reluctance to prescribe opioids.
- Fear of opioid induced respiratory depression and death.
- Under treatment of specific patient populations.

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## Facility Barriers to Pain Management

- Availability of on-call physicians off hours.
- Availability of medication supply for newly prescribed medications:
  - Offsite pharmacy
  - Emergency Kit contents
- Requirement for physician signature for Schedule II narcotics.
  - 7-day emergency supply from pharmacy

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# Pharmacologic Treatment of Pain

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- ## Goals of Pain Management
- PREVENT pain
  - MINIMIZE side effects
  - SIMPLIFY for the patient

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- ## Pain Management KISS Approach
- K EEP
  - I T
  - S IMPLE
  - S TUPID

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## Follow the KISS Rules

- 3 "BY" S
- 2 "ONE" S

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### "BY" S

- By the Clock
- By the Mouth
- By the Ladder

### "ONE" S

- One drug
- One route

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### By the Clock

- RTC dosing – not PRN
- PRN = Make them get on their knees and beg
- Dose adequately, with breakthroughs
- Appropriate dose = enough

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## By the Mouth

- Controls 95% of pain.
- Oral dosing give adequate blood levels
  - Sustained release opioid products
  - Plus breakthrough doses
  - Allow patient to control analgesia
- Other routes reverted to for special cases
  - Buccal and sublingual
  - Transdermal
  - Rectal
  - IV
  - Subcutaneous

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## By the WHO Ladder

- Patients enter the ladder where appropriate.
- Can ascend or descend the ladder as needed.
- Add opioids in addition to non-opioid medications.

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## Goal of "ONE" S

- Find one drug that optimally manages pain with minimal side effects
- Use the same drug for routine and breakthrough dosing.

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## Avoid

- Duragesic 50 mcg  
+
- MS Contin 60 mg BID  
+
- Percocet 1 – 2 q 4 hours PRN  
+
- Vicodin 5 – 10 mg q 4 hours PRN

Polypharmacy = Poor Pain Protocol

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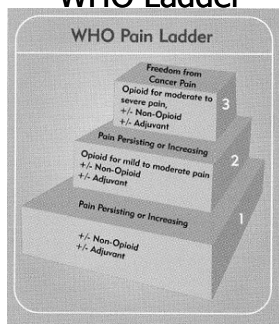
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## Pain Management – WHO Ladder



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## Pharmacologic Management

- First Step of Ladder – Pain rated 1 - 3
  - NSAIDs and acetaminophen ± adjuvant medication
- Second Step of Ladder – Pain rated 4 - 6
  - Weak Opioids ± adjuvant medication
- Third Step of Ladder – Pain rated 7 - 10
  - Opioids ± adjuvant medication

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### STEP ONE PAIN:MILD

- Acetaminophen
- NSAIDs
- Tramadol (Ultram)
- Dexamethasone

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### Acetaminophen

- Effective, not anti-inflammatory
- Dose limited – daily maximum 4,000 mg per day. Use caution when administering acetaminophen with combination drugs also containing acetaminophen
- Major Hepatotoxin

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### NSAIDS

- Many options
- Useful in inflammation
- Dose limited
- Nephrotoxins, GI Upset

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## Tramadol (Ultram)

- Non-opioid with dual action
- Binds weakly to the Mu opioid agonist receptor
- Similar efficacy as codeine 30 mg

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## Dexamethasone

- Multi-use drug
  - Bone pain
  - Blastic metastases
  - Increased intracranial pressure
  - Bowel obstruction
  - Mood/appetite stimulation

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## STEP TWO PAIN: MODERATE

- Escalate to opioids
- Traditionally weak opioids include:
  - Codeine
  - Vicodin, Lorcet (Hydrocodone and acetaminophen)
  - Percocet (Oxycodone and acetaminophen)
  - Darvocet (Propoxyphene)

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## Codeine

- Usually compounded with acetaminophen
- Dose 15 – 30 mg. Max = 60 mg.
- Poor side effect profile: nausea
- Avoid codeine in the elderly

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## Hydrocodone

- Always compounded with acetaminophen
- High usage
- Dose: 5 – 10 mg

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## Propoxyphene

- High usage rate
- Mild opioid effects
- Question efficacy vs acetaminophen
- Is on the "Beers" list

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## STEP TWO "PROBLEM"

- Drugs have ceiling effect
- Leads to polypharmacy
- Solution: use strong opioids in lower doses.

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## STEP THREE PAIN: SEVERE

Strong Opioids

- Morphine
- Oxycodone
- Hydromorphone
- Fentanyl
- Methadone
- Meperidine

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## MORPHINE

- Gold standard for pain management
- Available in any route needed
- Starting dose: 2.5 - 5 mg.
- Escalate dose by 30 – 50%
- No ceiling effect
- Convert from IR to SR at steady state.

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## OXYCODONE

- Available as pills (Oxycontin)
- Combined with APAP (Percocet)
- Available as IR, ER, and as IR elixir
- Side effect profile similar to MS.
- Starting dose: 2.5 - 5 mg q 4 hours
- Escalate by 30%
- No ceiling effect

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## HYDROMORPHONE (DILAUDID)

- 4x more potent than MS
- Benefit in high tech infusions, smaller volume.
- Needs dosing q 3 hours.
- Side effects, nausea, CNS
- Starting dose: .5-2.0 mg.
- No ceiling effect, dose not usually pushed (side effects?)
- Preferred opioid in patients with renal failure

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## FENTANYL

- Patch not "easy"
- High use, often inappropriate
- Best reserved for steady state pain
- **Very expensive**
- Slow onset
- Many variables
  - Body fat
  - Temperature
  - Hydration

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## METHADONE

- Effective
- Inexpensive
- Analgesic effect 6 hours
- Metabolite half-life 120 hours
- Starting dose 10 – 20 mg/day in divided doses
- Escalate slowly

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## Indications for Methadone

- Long acting opioid therapy required
- Intolerable side effects from another opioid
- Inadequate pain control from other opioid
- Need for treatment of neuropathic pain

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## Methadone Elimination

- Biphasic pattern of elimination
  - Alpha-elimination phase
    - Lasts 8 – 12 hours
    - Correlates with its analgesic period
  - Beta-elimination phase
    - Ranges from 30 – 60 hours
    - During this phase methadone can accumulate and produce drug levels that can cause toxicity

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## Methadone Review

- Methadone has the same action as morphine, but is morphine +
- Can be used to treat neuropathic pain instead of Neurontin or Tricyclics
- Effective without the side effects of other opioids
- Is associated with less neurotoxicity
- Slower onset but more stable steady state
  - Very lipophilic, thus less breakthrough pain
- Drug "hangs around forever"
- Excellent cost/benefit ratio
- Not used for breakthrough pain

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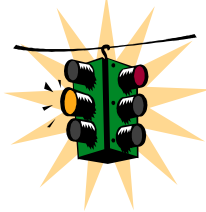
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## MEPERIDINE

- Do not use in elderly



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## Principles of Opioid Therapy for Effective Pain Management

- Treat persistent pain with around-the-clock scheduled administration of long-acting agents.
- Treat breakthrough pain with short-acting agents as "rescue" therapy.
- Titrate dose to achieve maximum desired level of pain relief.
- Use least invasive route of administration first (oral).
- Anticipate and treat opioid-induced side effects.

(AHICPR 1994) (WHO 1996) (aps 1999)

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## Controlled-Release Opioids: Pain Control Around-the-Clock

- Controlled-release opioid preparations – among the most important recent innovations in analgesic treatments – helps patients to:
  - Achieve a steady level of satisfactory analgesia throughout the day.
  - Sleep through the night.
  - Enhance compliance.

(APS 1999) (Pappagallo, M, Henberg, L.J. *Semin Neurol* 1997)

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## Goals of Opioid Titration

- Dose titration over time is critical to successful opioid therapy.
- Gradually increase dose until pain relief is adequate or until unacceptable side effects occur.
- A "correct" dose is one that best controls the pain without unacceptable side effects.
- Responsiveness of an individual patient to a specific drug varies.

(J. Portenoy 1997, 2; Mercadante, 2001)

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## Goals of Titration – cont'd

- There is no ceiling dose for opioids. Titrate the dose upward to obtain maximum pain relief without unacceptable side effects. Always prescribe rescue medication for breakthrough pain.
- If a patient does not respond well to one opioid, it is important to try another.
- Set the patients goals and expectations at the outset of therapy.

(Passik 1990)

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## Titration of Immediate Release Opioids

- For treatment of uncontrolled pain
- 1. Provide immediate-release (IR) analgesia around the clock
- 2. Provide as needed, additional doses of 50% of starting dose every 2 hours.
- 3. If pain is almost controlled by present regime, but still discomfort, may increase by 10 – 20%.
- 4. If pain partially controlled, increase dose by 25 – 50%
- 5. If pain severe and little or no pain relief with current dose, increase of 100% may be appropriate.
- 6. Upward titration should continue until pain relief is achieved or until unacceptable side effects intervene.

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## Rescue dosing

### Guidelines

- If > 3-4 episodes breakthrough pain/day may increase ATC and evaluate PRN dosing

### Ideal medication for rescue

- Rapid onset, short duration of action, minimal side effects, ease of use, cost effective
- 10% - 15% of 24 hour dose

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## Opioid Conversions

- Always convert "via" morphine
- Morphine is common link
- Convert on total 24 hour dose, then divide according to schedule
- Dose reduction for cross tolerance

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### Opioid Equianalgesic Conversion Table

- 30 mg Morphine (10 mg IV/IM/SQ)
- 7.5 mg Hydromorphone (2 mg IV/IM/SQ)
- 20 mg Oxycodone
- 4 tabs Oxycodone 5 mg/APAP 325 mg (Percocet)
- 6 tabs Hydrocodone 5 mg/APAP 500 mg (Lortab)
- 6 tabs codeine 30/APAP (Tylenol #3)

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### Opioid Equianalgesic Conversion Table – cont'd

Fentanyl patch conversion:

25 mcg/hour topically exchanged every 72 hours equivalent to:

- Morphine 15 mg IV or 45 mg po per day
- Hydromorphone 3 mg IV or 12 mg po/day
- Percocet/Lortab5/Tylenol #3 9 tablets/day

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### Opioid Equianalgesic Conversion Table – cont'd

Methadone conversion: One way rotation from PO Morphine (MS) to PO Methadone (ME)

4:1 for up to 100 mg MS	15:1 for 501-1000 mg MS
8:1 for 101 – 300 mg MS	20:1 for > 1000 mg MS
12:1 for 301 – 500 mg MS	

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## Scenario 1

Hypothetical patient receiving:

Fentanyl 50 mcg = MS 100 mg  
+ MS Contin 60 mg = MS 120 mg  
+ Percocet (2) x 3 doses = MS 45 mg  
+ Vicodin (2) x 3 doses = MS 30 mg

Converts to: Total MS 295 mg per 24 hours  
MS-IR 50 mg q 4 or MS Contin 150 mg BID or  
Kadian 300 mg daily(altho consider 1/3 decrease  
for cross tolerance if pain is controlled)

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## Scenario 2

77-year old female admitted to your TCU post  
knee replacement.

Pain medication orders are:

1. Tylenol 650 mg q 4 hours prn
2. Vicodin 1 – 2 q 4 – 6 hours PRN pain
3. Percocet 1 – 2 q 4 – 6 hours PRN pain

What is wrong with this picture?

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## What's Wrong?

- What medication do you use first? There is no priority established.
- How do you know whether to use 1 or 2 tablets? Not specific.
- Potential to exceed daily limit for acetaminophen.
- Survey citation.

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## How to Fix?

- Assess patients pain level.
- Determine how much narcotic is required?
- Start with Tylenol ES 2 tablets QID.
- Add dose of narcotic without acetaminophen.

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## PRN Orders

- PRN
  - Range orders without an indication are medication safety issues and can be subject to interpretation. Must have a protocol for interpretation and specify parameters – indications for which the drug is to be given.
- IR for breakthrough pain – rapid onset, ease of use, short duration, cost effective.

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## Adjuvant Therapy

- Adjuvant therapy may be used at all steps of the WHO ladder to:
  - Enhance the analgesic effects of opioids
  - Treat concurrent symptoms that may worsen pain.
  - Provide independent analgesia for specific types of pain.

(AHCPR 1994)

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## Ongoing Pain Assessment

- Pain should be assessed and documented
  - At regular intervals after initiation of a treatment plan
  - With each new report of pain
  - At a suitable interval after each pharmacologic or nonpharmacologic intervention (i.e., 15-30 minutes after parenteral drug therapy and one hour after oral administration)

(AHCPR 1994)

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## Documentation

- Remember if it is not documented, then one must assume it has not been done...
  - Pre and post intervention
  - Vital signs - BP, Pulse, Respirations
  - LOC - Sedation
  - Pain scale individualized to meet pt. needs
  - Pt. response - efficacy and/or adverse effects

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## Remember...

"If you don't measure it,  
you can't improve it."

(Field M, Cassel CK, eds *Approaching Death: Improving Care at the End of Life* Washington DC National Academy Press, 1997)

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## Side Effects

- Anticipate and Educate
- Nausea, vomiting, sedation – tolerance usually develops within short time.
- Constipation – tolerance does not develop – initiate prophylactic bowel regime.
- Consider dose reduction or alternative therapy if side effects intolerable.

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## Fear of Addiction - Terminology

- Dependence
- Tolerance
- Addiction
- Pseudo addiction



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## Physical Dependence

- "Physical Dependence on a controlled substance is a physiologic state of neuro-adaptation which is characterized by the emergence of a withdrawal syndrome if drug use is stopped or decreased abruptly, or if an antagonist is administered".
- Physical dependence is an expected result of opioid use and, but itself, does not equate with addiction.

(Federation of State Medical Boards of the United States, Inc. Model Guidelines for the Use of Controlled Substances for the Treatment of Pain. Eules, TX: 1998)

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## Tolerance

- "Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce the same effect or a reduced effect is observed with a constant dose."
- Tolerance does not usually develop to the pain-relieving effects of opioids.

(Federation of State Medical Boards of the United States, Inc. *Model Guidelines for the Use of Controlled Substances for the Treatment of Pain*. Eulless, TX: 1998) (Schneider, JP *J Care Manage* 1998)

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## Pseudotolerance

Pseudotolerance is the need to increase dosage that is not due to tolerance, but due to factors such as:

- Disease progression
- New disease
- Increased physical activity
- Lack of compliance
- Change in medication
- Drug interaction
- Addiction
- Diversion

Pappagallo, M. *J Pharm Care Pain Symptom Control*, 1998)

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## Opioids and Addiction

- Risk of addiction is rare in patients with no history of addiction who are prescribed opioids for the management of pain.
  - Exposure to an opioid, even for prolonged periods does not produce the aberrant behaviors consistent with addiction.

(Porter, J, Jick, H, *N Engl J Med*, 1980) (Portenoy RK, Kanner, RM, IN: *Pain Management Theory and Practice*, Philadelphia, PA: F.A. Davis Company, 1996)

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## Defining Addiction

- Addiction is a psychological and behavioral disorder.
- Addiction has nothing to do with physical dependence. It is characterized by:
  - Loss of control (compulsive use)
  - Continuation of the drug use despite adverse consequences
  - Preoccupation with obtaining and using the drug despite the presence of adequate analgesia

(Schneider, JP. J Care Manage 1998)

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## Misunderstanding Addiction

- Misunderstanding addiction may result in unnecessary withholding of opioid medications.
- Patient may be mislabeled as an addict – real problem may be that pain is being inadequately treated.

(Schneider, JP. J Care Manage 1998)

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## Fear of Hastening Demise

- Minnesota Nurses Association Statement: Pain Management.
  - "Nurses have a primary obligation and moral imperative to relieve pain and provide comfort for patients."

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## Summary

- Identify and assess source of pain
- Individualize analgesic and/or adjuvant treatment according to level of pain
- Start with low dose and slowly titrate to lowest effective dose
- Adjust route of administration to meet patient needs
- For chronic pain use analgesic around the clock
- For breakthrough pain use fast onset ,short acting analgesic
- Recognize and minimize side effects; avoid over sedation
- Reassess pain and response to treatment regularly
- Clinical endpoints; decreased pain,increased function, improvement in mood and sleep

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