How we care for the dying must surely be an indicator of how we care for all our sick and vulnerable patients. Care of the dying is urgent care; with only one opportunity to get it right to create a potential lasting memory for relatives and carers’
Professor Mike Richards
Chair, End of Life Care Strategy Advisory Board, UK

Never underestimate your role as a nurse or other health professional to influence the care of the patient

PAIN

Causes
Perception
Interventions
Physiology
Assessment
Types of cancer pain
Principles of pain therapy
Principles of morphine use

PREVALENCE OF CANCER PAIN

30-40% in early disease
70-90% in advanced disease
(Foley 2004)

PREVALENCE OF BREAKTHROUGH PAIN

19-95%, depending on the definition (Zeppetella & Ribeiro 2003)


PAIN

1. is what the patient says hurts
2. is what the patient describes, not what others think it ought to be

PAIN – PRINCIPLES OF THERAPY

• Principles of Pain Therapy
  1. Keep the person in control
  2. Encourage them to be honest and realistic about their pain
  3. Use language the patient and family will understand
  4. Acknowledge pain may cause feelings of hopelessness/loss of control

CASE STUDY

77yo man with prostate cancer. Bone scan showed widespread bony metastases. He experienced no pain at all.

NOCICEPTIVE PAIN

Nociceptive pain – produced in response to stimulus of free nerve endings
Impulses carried along peripheral nerve to spinal cord
Then carried up spinal cord, through brain stem to thalamus
From thalamus, impulses are delivered to various areas of cerebral cortex, allowing perception of and reaction to pain

NEUROPATHIC PAIN

Neuropathic pain results from damage to nerves or neural tissue. Characteristics:
1. Altered sensation in area infiltrated by damaged nerve
2. Pain results from damage to nerve pathways in peripheral and central nervous systems
3. Due to tumour infiltration, compression, treatment
NEUROPATHIC PAIN

1. treatment of neuropathic pain is difficult; surgery not an option
2. drugs of choice: tricyclic antidepressants (TCAs), and antiepileptic drugs e.g. gabapentin, pregabalin, sodium valproate (Epilim)
3. amitriptyline most commonly used TCA

INCIDENT PAIN

Incident pain occurs only in particular circumstances, such as pain which occurs after a particular movement or on standing.

(Woodruff 1999)

INCIDENT PAIN

Use short acting medication such as fentanyl
- give as injection, lozenge, or sublingual tablet (Abstral)

Duration of fentanyl:
- 30-60min post IV/lozenge
- 1-2 hours post IM/SC


PAIN PERCEPTION

 lowered threshold

1. Discomfort
2. Insomnia
3. Fatigue
4. Anxiety/Fear
5. Anger
6. Sadness
7. Depression
8. Boredom

PAIN PERCEPTION

 lowered threshold

1. Mental isolation
2. Social abandonment
3. Helplessness
4. Loss of control
5. Loss of independence
6. Uncertainty
7. Hopelessness

CASE STUDY

35yo man with HIV/AIDS – excruciating pain related to degloving – extensive area of skin loss in lumbar and inguinal regions related to skin infection. Opioids ineffective. Prescribed ketamine gel applied topically – very effective analgesia, however produced side effects of hallucination and out of body experience due to absorption of drug by the body.
**PAIN PERCEPTION**

Raised threshold

1. Relief of symptoms
2. Sleep
3. Rest
4. Empathy
5. Understanding
6. Companionship
7. Diversional activities
8. Decreased anxiety

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**PAIN PERCEPTION**

Raised threshold

1. Improved mood
2. Analgesics
3. Anxiolytics
4. Antidepressants
5. Sense of control
6. Hope
7. Positive outlook

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**THE ROLE OF THE NURSE IN PAIN MANAGEMENT**

1. Assessment
2. Knowledge and appropriate use of pharmacological agents
3. Patient advocacy
4. Education
5. Collaboration, team approach
6. Individualised holistic independent practice
7. Accurate documentation
8. Reassessment

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**PAIN ASSESSMENT**

1. Where is the pain?
2. What does it feel like?
3. What makes it worse/better?
4. Does it stop you from doing anything?
5. Is it the only pain you have?
6. Does it wake you/stop you from sleeping?

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**PAIN ASSESSMENT**

Where is the pain?
Use a figure drawing
Can the patient point to the pain on the body

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Description of pain
1. E.g. aching, dull, sharp, throbbing
2. Duration – how long it lasts
3. Variations/rhythms e.g. on waking
4. Intensity e.g. on scale of 1-10
BARRIERS TO GOOD PAIN CONTROL

Clinical factors include:
1. lack of pain assessment skills
2. lack of knowledge of current therapeutic approaches
3. uncertainty about role of opioid treatment
4. insufficient knowledge of opioid treatment
5. overestimation of risks of addiction
6. concern about tolerance
7. concern about management of adverse effects

Patient factors include:
1. fear of addiction
2. fear of becoming tolerant
3. fear of adverse effects
4. inability to comply with complicated programs
5. inability to understand dosing guidelines
6. communication difficulties (language differences, cultural issues, intellectual disability)

PAIN – RISK FACTORS

Risk factors for refractory pain
1. Neuropathic pain
2. Incident pain
3. Multiple pains and pain mechanisms
4. Longstanding pain or history of pain resistant to medication
5. Poor response to analgesics in the past
6. Refractory adverse effects from analgesics
7. History of drug or alcohol dependency
PAIN INTERVENTIONS

Effective intervention requires:
1. Accurate and detailed assessment
2. Knowledge of types of pain
3. Knowledge of different therapeutic approaches to pain

Centre for Palliative Care Research and Education

Questions?