

PAIN IN PEOPLE WITH SERIOUS ILLNESS

Comprehensive Assessment of Pain 1

- History
 - Pain assessment location - intensity, description, duration, alleviating and aggravating factors
 - Medication use – past and current, include OTC and herbal products
 - Functional assessment - effect of pain on ADLs and QOL
 - Risk assessment for Substance Use Disorder (SUD)
 - Past, present use of tobacco, alcohol, cannabis, Illicit agents and prescription drugs
 - Family history of SUD
 - History of abuse (physical, emotional, sexual), PTSD
- Physical Assessment
- Imaging, Labs – if contribute to the treatment plan

Assessment Guides Pharmacologic Therapy 2

Type of Pain	Pharmacologic Interventions
Somatic (nociceptive) <ul style="list-style-type: none"> “Aching”, “throbbing” Bone metastases, arthritis 	Non opioids <ul style="list-style-type: none"> Acetaminophen NSAIDs Opioids
Neuropathic <ul style="list-style-type: none"> “Tingling”, “burning”, “electrical” Chemotherapy-induced peripheral neuropathy, post herpetic neuropathy, nerve root compression by tumor 	Opioids (may require higher doses) Adjuvant analgesics <ul style="list-style-type: none"> Antiepileptics Antidepressants Corticosteroids Local anesthetics
Visceral <ul style="list-style-type: none"> “Squeezing”, “cramping” – diffuse, may be referred RUQ pain due to liver metastases with pain in upper right shoulder 	Opioids Corticosteroids Adjuvant analgesics?

Pharmacologic Management: Non Opioids 3

- Acetaminophen**
 - Antipyretic and analgesics but not anti-inflammatory
 - Hepatic toxicity at doses \geq 2000-3000 mg per day

Educate regarding acetaminophen content in many OTC medications, e.g., sleep, cough, allergy, others.

- NSAIDs**
 - NSAIDs are antipyretic, analgesic, and anti-inflammatory
 - Toxicities include GI bleed, acute kidney injury and stroke/MI, particularly in those with risk factors

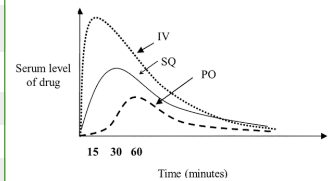
Pharmacologic Management: Opioids 4

For moderate to severe pain (and anyone with a serious illness with mild to moderate pain where NSAIDs and acetaminophen use limited)

When converting between opioids or from one route to another:

DRUG	IV/SQ	ORAL
Fentanyl IV	0.1mg = 100mcg	NA
Hydrocodone/Acetaminophen	NA	30
Hydromorphone	1.5	7.5
Morphine	10	30
Oxycodone	NA	20
Tramadol	NA	120

Peak effect: helps guide re-dosing and time activity to maximum effect



Guides for dosing opioids:

- When increasing an opioid dose: increase by 25-50% for mild to moderate pain and 50-100% for severe pain
- When rotating opioids, find the equianalgesic dose and decrease by 25-50% to account for incomplete tolerance
- The oral breakthrough dose should be 10-20% of the 24 hour total dose

Pharmacologic Management: Adjuvant Agents 5

- Gabapentinoids** - toxicity reported with chronic kidney disease or worsening acute renal failure
 - Renal dosing - If patient already on gabapentin or pregabalin for existing pain, dose reduce if CrClc < 60
 - Hepatic dosing – no adjustments warranted
- Duloxetine**
 - Renal dosing - If patient already on duloxetine, decrease dose if CrClc < 90, avoid use or stop if \leq 30
 - Hepatic dosing – avoid if pt with liver disease (Child-Pugh Class A, B, C)
- Corticosteroids**
- Local anesthetics**

Nonpharmacologic Management 6

Physical measures	Physical therapy, occupational therapy, recreational therapy, orthotics, heat/cold, ultrasound
Integrative therapies	Acupuncture, music, tai chi, yoga
Interventional therapies	Nerve blocks, kyphoplasty/vertebroplasty, neuraxial infusions
Psychological approaches	Cognitive-behavioral therapies, mindfulness, guided imagery, relaxation
Neuro-stimulatory techniques	TENS, spinal cord stimulation, peripheral nerve stimulation

References:

- American Association of Colleges of Nursing (AACN) and City of Hope (COH). (2023). End-of-Life Nursing Education Consortium (ELNEC). Accessed January 24, 2024 from: www.aacnnursing.org/ELNEC
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- Swarm RA, Paice JA, Anghelescu DL, et al. Adult cancer pain, Version 3.2019. J Natl Compr Canc Netw 17 (8):977-1007, 2019. doi: 10.6004/jcn.2019.0038

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