Community Principles of Pain Management

PRACTICE PRINCIPLES

Practice Guidelines and Principles: Guidelines and Principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines and Principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

Purpose and Scope: To identify and promote the essential elements to acute and chronic pain assessment and management for both children and adults, as well as recognize the risks of abuse and misuse. Pain and addiction to pain medications are both major public health problems that exist across the continuum of care. Pain is the most common symptom that prompts patients to seek medical care. The importance of effective pain assessment and management has been affirmed by the release of standards by the Joint Commission on Accreditation of Health Care Organization. Pain is now considered “The Fifth Vital Sign,” as important to assess and measure as pulse, respiration, temperature, and blood pressure. All patients should be screened for pain. Once identified, a complete assessment, including physical, emotional and spiritual components is necessary to determine the cause and appropriate therapy. Treatment begins with patient education, which serves to dispel myths, relieve fears, give patients a sense of control and empower them to partner with health care professionals. Effective pain management promotes healing and increases patient satisfaction.

Key Recommendations/Messages:
- Recognize that the patient self-report is the most reliable indicator of pain
- Recognize that pain has both emotional and cognitive components. Patients can significantly impact their own pain experience.
- Discuss with the patient the type and amount of pain. Use the Faces Pain Scale - Revised for patients ≥~6 years old to identify the intensity of pain and to monitor progress in pain management. (For children <6 years old or individuals unable to communicate use the FLACC scale.)
- Recognize that choices for treatment of pain are numerous and often involve multiple disciplines, and always involve the patient.
- Discuss the benefits and drawbacks to the use of pharmacological agents with the patient – use the guidelines for information about choice, dosage and contraindications of pharmacological agents
- Be familiar with the non-pharmacological approaches to pain management and discuss these fully with the patient
- Have the patient complete a pain management contract when s/he is prescribed a controlled substance for chronic pain
- Careful patient selection and close monitoring (urine drug screen) of all non-malignant pain patients on chronic opioids is necessary to assess the effectiveness and watch for signs of misuse (see Prescription Drug Misuse section and the Abuse & Misuse web page on CompassionAndSupport.org for more information)
- Be mindful of the possibility of unintentional overdose and diversion when writing prescriptions for pain medications

When to Refer:
- For acute pain, refer early to appropriate specialist or pain center if diagnosis unclear or pain refractory to treatment
- For chronic pain, refer “difficult to treat” cases to a physician with pain management expertise.

High Risk Populations/Disparities: Racial minorities, women, older adults, especially vulnerable elders and substance abusers are victims of deficiencies in pain management and suffer needlessly. In a number of studies, physicians inadequately managed pain in Hispanics and African Americans as compared to whites, no matter the type of pain or the healthcare setting in which it was being managed. Women identified pain more frequently than men did but physicians were more likely to manage effectively men’s pain than women’s pain even when the intensity was the same. Substance abusers were less likely to receive adequate treatment of their pain. There are differences between how opioid-dependent patients feel pain as they tend to have decreased tolerance to pain due to neurophysiologic changes associated with long-standing drug use.
Distributed to: All primary care physicians, specialists and allied health professionals including nurse practitioners, physician assistants, nurses, nursing assistants, rehabilitation specialists, physical therapists, occupational therapists, chiropractors, acupuncturists, other complementary medicine providers, dentists, clergy, psychologists, pharmacologists, social workers, skilled nursing facilities, assisted living centers, homecare agencies, and hospice organizations.

Revisions by: Patricia Bomba, MD, FACP, Excellus BlueCross BlueShield, Carol Beechy, MD, Jeanne Bishop, MD, Carl Cameron, MD, John Chamberlain, MD, Nicole Dawley, RPh, Oscar DeLeon-Casasola, MD, Michael DiSalle, MD, Eugene Gosy, MD, Keela Herr, PhD, RN, FAAN, AGSF, Patrick Hopkins, RN, Pamela Horst, MD, Brian Justice, DC, Christopher Kerr, MD, PhD, David Korones, MD, Karen Kremer, Michael Kuttner, PhD, Kevin Mathews, MD, Kathleen McGrail, MD, Daniel Mendelson, MD, Dallas Nelson, MD, Katie Orem, MPH, Alan Peppard, PT, Kathy Plyter, RN, Joel Potash, MD, Gilbert Proper, MD, Timothy Quill, MD, Steve Ryan, MD, OJ Sahler, MD, Jim Schuppert, MD, Judith Setla, MD, Bernard Shore, MD, Mary Slayton, RN, Julia Smith, MD, and Jaimala Thanik, MD.

Approved by: Quality Management Committee (QMC) – Approved: July 2014; next revision: 2016.

Use the “Order Resources” button on the home page of CompassionAndSupport.org to place a free order for:

- Pain Management Patient Guide (available in English and Spanish)
- Equianalgesic Table for Adults (Pocket Card)
- Equianalgesic Table for Pediatrics (Pocket Card)

The comprehensive Practice Principles and all individual components, along with additional resources, including a web page dedicated to abuse and misuse, can be found in the Pain Management Professionals section of CompassionAndSupport.org: http://www.compassionandsupport.org/index.php/resource_directory/pain_management

Information can also be found on the Monroe County Medical Society website: http://cwcg.mcms.org/CWCGClinicalGuidelines.aspx

Reference:

COMMUNITY PRINCIPLES OF PAIN MANAGEMENT (CPPM)

Table of Contents

Professional Resources

1. Faces Pain Scale - Revised
   Tool for assessment, diagnosis, treatment, and management of pain
   Tool for assessment, diagnosis, treatment, and management of pain
4. Principles of Pain Management: Bedside Nursing Assessment Tool
   Includes Pain Assessment in Advanced Dementia
6. Equianalgesic Table for Adults
   Pocket trifold guideline for effective opioid dosing
7. Equianalgesic Table for Pediatrics
   Pocket trifold guideline for effective opioid dosing
8. Methadone Dose Conversion Guidelines
9. Prescription Drug Misuse
    For use with patients
11. Physician Assessment Progress Note
    Front side: Patient self-assessment Backside: Physician progress note
12. “Pain as the 5th Vital Sign” Fax Referral Form
    Intra-professional referral form for pain management appropriate for fax, email, or electronic referral
13. References
    Detailed listing of references for information used in the creation of the CPPM
    Websites with tools for documenting pain

Patient Resources

16. Myths and Truths About Pain
    Patient guide to myths and truths about pain
17. Pain Management Patient Resources
    Community support groups
    Website links
Faces Pain Scale-Revised (FPS-R)

Purpose:
To assess pain intensity in persons who are able to self report, but unable to use a numeric rating scale (NRS). Some studies show African Americans and Asians prefer the FPS.

When to Use:
1) At admission
2) At each quarterly nursing review
3) Each shift in resident with pain
4) Each time a change in resident pain status is reported
5) Following a pain intervention to evaluate treatment effectiveness

How to Use:
Instruct the person that “The faces show how much pain or discomfort one is feeling. The face on the left shows no pain. Each face shows more and more pain up to the last face that shows the worst pain possible. Point to the face that shows how bad your pain is right now.”

Then score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so ‘0’ = ‘no pain’ and ‘10’ = ‘very much pain.’

NOTE: This tool is not to be used by the health care provider to look at the resident’s facial expression and pick a face.

Documentation:
Document/record all scores in a location that is readily accessible by other health care providers.

Note:
To use as a pocket guide, print the FPS-R and directions document front to back on card stock paper to create two tools. Cut to size and laminate for increased durability.

Additional information about the Faces Pain Scale-Revised (FPS-R) including instructions in 33 translations can be found at www.painsourcebook.ca.

Reference:
### PRINCIPLES OF PAIN MANAGEMENT: ADULT GUIDE

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<th>Assessment and Diagnosis</th>
<th>Treatment</th>
<th>Management and Monitoring</th>
<th>General</th>
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<tr>
<td>All patients should be screened for pain. Once identified, a complete assessment, including physical, emotional, and spiritual components is necessary to determine cause of pain and appropriate therapy.</td>
<td>Goals</td>
<td>• Reassess regularly</td>
<td>• Measure “5th vital sign” using tools (i.e. The Faces Pain Scale – Revised or FLACC scale); respond urgently to pain ≥8</td>
</tr>
<tr>
<td><strong>History: Assess</strong></td>
<td>• Treat acute pain aggressively to avoid chronic pain</td>
<td>Follow amount and duration of response</td>
<td>• Follow amount and duration of response</td>
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<td>- Onset, location, quality, intensity, temporal pattern, aggravating and alleviating factors, associated symptoms</td>
<td>• Treat chronic pain thoughtfully and systematically</td>
<td>Assess performance status</td>
<td>• Assess performance status</td>
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<tr>
<td>- Characteristics of pain*</td>
<td>• Identify and address the cause of pain</td>
<td>Partner with patient/family in setting goals of care</td>
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<td>- Previous methods of treatment</td>
<td>• Maintain alertness, ability to function safely/productively</td>
<td>Balance function vs. complete absence of pain</td>
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<td>- Other medical and surgical conditions</td>
<td>• Allow emergence of emotions associated with pain</td>
<td></td>
<td></td>
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<tr>
<td>- Substance use</td>
<td>• Negotiate target pain level with patient</td>
<td></td>
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<td><strong>Psychosocial History: Assess</strong></td>
<td><strong>Non-Pharmacological Therapy</strong></td>
<td><strong>Referrals and Management</strong></td>
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<td></td>
<td>• Patient / Family Education</td>
<td><strong>Acute pain</strong></td>
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<tr>
<td></td>
<td>• Community &amp; Web-based Support Groups</td>
<td>• Set realistic chronic care goals</td>
<td></td>
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<tr>
<td></td>
<td>• Cognitive Behavioral Therapy; Supportive Psychotherapy</td>
<td>• Transition from passive recipient to patient-directed management of therapies.</td>
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<tr>
<td></td>
<td>• Physical Therapy; Chiropractic/ Osteopathic Care; Massage</td>
<td>• Refer “difficult to treat” cases (H/O substance abuse, neuropathic pain, rapidly escalating opioid doses) to MD with pain management expertise</td>
<td></td>
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<tr>
<td></td>
<td>• Exercise: Yoga, Tai Chi, Qi Gong, Walking, Water Therapy</td>
<td><strong>Neuropathic pain</strong></td>
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<tr>
<td></td>
<td>• Cutaneous Stimulation: Ice, Heat; Counterstimulation: TENS</td>
<td>• Use anti-epilepsy drugs (AEDs) first</td>
<td></td>
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<tr>
<td></td>
<td>• Acupuncture &amp; Acupressure (trigger point Rx)</td>
<td>• Use step 2 or 3 drug to help Rx</td>
<td></td>
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<tr>
<td></td>
<td>• Relaxation Techniques: Biofeedback, Music, Hydrobath, Reiki, Therapeutic Touch, Healing Touch</td>
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<tr>
<td></td>
<td>• Meditation, Mindful Practice; Visualization/Interactive Guided Imagery; Prayer, Spiritual &amp; Pastoral Support</td>
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<tr>
<td><strong>Assessment</strong></td>
<td>Pharmacological Therapy</td>
<td></td>
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</tr>
<tr>
<td>• Order and evaluate appropriate diagnostic testing</td>
<td>• Use WHO/AHCPR step care as “ramp” (see reverse side)</td>
<td></td>
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</tr>
<tr>
<td>• Evaluate pain on all patients using the 0-10 scale:</td>
<td>• Use adjuvant therapies prn (see reverse side)</td>
<td></td>
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</tr>
<tr>
<td>A. mild pain: 1-3</td>
<td>• Avoid Demerol® (meperidine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. moderate: 4-7 (interferes with work or sleep**)</td>
<td>• Use care with combinations (consider total consumption of APAP from multiple Rx and OTC sources)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. severe: 8-10 (interferes with all activities***)</td>
<td>• Use ONE long-acting med when pain stabilized</td>
<td></td>
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<tr>
<td><strong>Diagnostic Terms</strong></td>
<td>Chronic moderate or severe pain</td>
<td>Avoid multiple agents of similar duration</td>
<td></td>
</tr>
<tr>
<td>*Somatic pain: localized; ache, throb, or gnaw</td>
<td>• Give baseline long acting med around the clock</td>
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<tr>
<td>*Visceral pain: often referred; cramp, pressure, deep ache, squeeze</td>
<td>• For breakthrough, give 10% of total daily dose as prn</td>
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<tr>
<td>*Neuropathic pain: burns, electric shock, hot, stab, numb, itch, tingle</td>
<td>• PRN interval: 1-2 h oral, and 30-60 min parenteral</td>
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<tr>
<td>Cancer pain: associated with cancer, HIV</td>
<td>• Adjust baseline upward daily by total amount of prn</td>
<td></td>
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<tr>
<td>Non-cancer pain: e.g. arthritis or musculoskeletal disorders</td>
<td>• When converting from one opioid to another, reduce total dose by 1/3-1/2 to account for incomplete cross tolerance</td>
<td></td>
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</tr>
<tr>
<td>Acute Pain: ↑HR, HBP, diaphoresis, pallor, fear, anxiety</td>
<td>Adjunct therapy and anticipate side effects</td>
<td>Use step 2 or 3 drug to help Rx</td>
<td></td>
</tr>
<tr>
<td>Chronic pain: sleep difficulties, loss of appetite, psychomotor retardation, depression, career/relationship change **interferes with work or sleep, *<strong>interferes with all activities</strong></td>
<td>• Prevent constipation: start senna, sorbitol</td>
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<tr>
<td></td>
<td>• Nausea: treat with antiemetics or change meds</td>
<td><strong>Special Situations</strong></td>
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<tr>
<td></td>
<td>• Pruritus: treat with antihistamines or change meds</td>
<td>Anxiety and depression</td>
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<td></td>
<td>• Myoclonus: treat with benzodiazepine or change meds</td>
<td>• Refer to Depression Guidelines</td>
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<tr>
<td></td>
<td>• Mental impairment: avoid driving/hazardous situations until side effect profile stabilizes; reassess safety periodically</td>
<td>Verbally non-communicative patients</td>
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<tr>
<td></td>
<td>• Use prescribing contracts for outpatient use</td>
<td>• Infants, children &amp; cognitively impaired all feel pain</td>
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<tr>
<td></td>
<td>• Refer early to appropriate specialist or Pain Center, if diagnosis unclear or pain refractory to treatment</td>
<td>Evaluate patient’s non-specific signs: noisy breathing, grinding teeth, bracing, rubbing, crying, agitation</td>
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<tr>
<td></td>
<td>• Use anti-epilepsy drugs (AEDs) first</td>
<td>Elderly or people with renal or hepatic disease</td>
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<tr>
<td></td>
<td>• Use step 2 or 3 drug to help Rx</td>
<td>• Start at 1/2 usual dose</td>
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<tr>
<td></td>
<td>• Monitor carefully for toxicity from accumulation</td>
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<tr>
<td><strong>Patients with substance abuse history</strong></td>
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<tr>
<td>• May need higher starting dose (tolerance)</td>
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<tr>
<td>• Use prescribing contracts for outpatient use</td>
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<tr>
<td>• Consider abuse-deterrent formulations</td>
<td>Be aware of potential for addiction and misuse</td>
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<tr>
<td>• Encourage established functional goals</td>
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<tr>
<td>• Ensure follow-up</td>
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</tbody>
</table>
**Step 1: Treatment of Mild Pain (Score of 1-3)**

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Practical Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen (APAP)</td>
<td>NOT anti-inflammatory; maximum 3 grams/24 hours from ALL sources for ALL purposes and 2-3 grams/day for frail elders, alcohol use, renal impairment; limit to 325mg or less per dose; leading cause of acute liver failure (including accidental overdose); monitor for severe liver injury &amp; acute renal failure</td>
</tr>
<tr>
<td>Non-steroidal anti-inflammatory</td>
<td>Assess risk of nephrotoxicity, drug interactions, and GI toxicity prior to prescribing; administer with PPI if GI intolerance or high risk; topical agents may be appropriate for individuals unable to use oral therapy</td>
</tr>
<tr>
<td>Cox-2 anti-inflammatory</td>
<td>Caution in pts with cardiovascular disease or at risk for CV disease; use celecoxib if contraindication or severe intolerance to NSAIDs</td>
</tr>
</tbody>
</table>

**Step 2: Treatment of Moderate Pain (Score 4-7), pain not alleviated with medicine from Step 1, and/or if pain worsens**

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Practical Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codeine /APAP; Oxycodone/ASA or APAP; Hydrocodone/APAP</td>
<td>Total dose limited by APAP; all combination products now contain ≤325mg of APAP per unit dose, consistent with FDA guidance</td>
</tr>
<tr>
<td>Tramadol, Tramadol with APAP</td>
<td>Not 1st line; risk of seizures (↑ risk with higher doses and combination with SSRI/TCAs); withdrawal symptoms can occur; risk of serotonin syndrome when combined with SSRIss</td>
</tr>
<tr>
<td>Tapentadol</td>
<td>Dual mechanism – mu agonist/noradrenaline reuptake inhibitor; Risk of serotonin syndrome when combined with serotonergic drugs; Maximum dose: IR 600mg/day, ER 500mg/day</td>
</tr>
</tbody>
</table>

**Step 3: Opioid Treatment of Moderate – Severe Pain (Score 4-10), pain not alleviated with medicine from Step 2: Using Equianalgesic Dosing**

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>EQUIANALGESIC DOSE</th>
<th>USUAL STARTING DOSES for ADULT&gt;50kg*</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>10 mg</td>
<td>2.5-5 mg SC/IV q3-h (1.25-2.5 mg)</td>
<td>IR tablets (15,30mg); Rectal suppository (5,10,20,30mg)</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Not Available</td>
<td>5-10 mg q3-h or oral solution (2.5-7.5 mg)</td>
<td>Not recommended in renal failure.</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>1.5 mg</td>
<td>0.2-0.6 mg SC/IV q2-3h (0.2 mg)</td>
<td>Tablets (24hr), Oral solution (4mg/ml), Suppository (3mg)</td>
</tr>
<tr>
<td>Methadone</td>
<td>2mg PO morphine = 1mg parenteral methadone</td>
<td>1.25–2.5 mg q8h (1.25 mg)</td>
<td>Tablets (0.1mg), Solution (0.1mg/ml); Concentrate (1mg/ml)</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>100 mcg (single dose)</td>
<td>2.5–5 mg q8h (2.5 mg)</td>
<td>Usually q12 or q48h; Long variable T1/2 and high interpatient variability</td>
</tr>
<tr>
<td>Codeine</td>
<td>130 mg</td>
<td>IR tablets (15,30,60mg); Solution (30mg/5ml); APAP combo solution (12mg with 120mg APAP/5ml)</td>
<td>Tablets (5,10,15,20,30mg), Oral Solution (5mg/5ml), Concentrate (30mg/ml)</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Not Available</td>
<td>30-40 mg q6-8h</td>
<td>APAP combo tablets – 2.5–10mg oxycodone combined with 300–325mg APAP (combos generally not recommended for chronic use)</td>
</tr>
</tbody>
</table>

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* – “Usual starting doses” apply to opioid naïve patients, not for patients who have been on opioids and whose starting dose should take their usual consumption into account. 

**Adjunct Therapies**

<table>
<thead>
<tr>
<th>Therapeutic Class / Drug Name</th>
<th>Indication</th>
<th>Practical Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tricyclic antidepressants: amitriptyline, imipramine, nortriptyline, desipramine</td>
<td>Neuropathic pain and chronic pain</td>
<td>Anticholinergic effects, elderly more sensitive to adverse effects, use cautiously with comorbid CV disease</td>
</tr>
<tr>
<td>Other antidepressants: citalopram, sertraline, fluoxetine, venlafaxine, duloxetine, mirtazapine</td>
<td>Neuropathic pain, fibromyalgia, depression</td>
<td>May increase bleeding risk especially if combined with ASA or NSAIDs; taper dose prior to discontinuing</td>
</tr>
<tr>
<td>Anti-epilepsy: gabapentin, phenytoin, carbamazepine, pregabalin, topiramate</td>
<td>Neuropathic pain</td>
<td>Numerous drug interactions (except minimal for gabapentin and pregabalin)</td>
</tr>
<tr>
<td>Benzodiazepines: diazepam, lorazepam</td>
<td>Skeletal muscle spasm, akathisia</td>
<td>Monitor for CNS/respiratory depression; do not stop abruptly; avoid in liver impairment; avoid long-acting in elderly</td>
</tr>
<tr>
<td>Anti-spasticity: baclofen, cyclobenzaprine, methocarbamol, tizanidine, carisprodol, metaxalone</td>
<td>Muscle spasm</td>
<td>Recommended short term use for relief of acute pain; avoid in the elderly due to limited efficacy and adverse effects</td>
</tr>
<tr>
<td>Topical agents: lidocaine patch, gel</td>
<td>Localized Neuropathic pain</td>
<td>Monitor for rash or skin irritation; potential for systemic absorption; dosing limit of 3 patches applied 12hrs/day</td>
</tr>
<tr>
<td>Topical agents: capsaicin cream or lotion (OTC)</td>
<td>Only use: dermal neuropathic pain</td>
<td>Regular and frequent administration is essential, can cause burning sensation which is intolerable to some</td>
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</table>
### PRINCIPLES OF PAIN MANAGEMENT: PEDIATRIC GUIDE

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<td>• Other medical and surgical conditions.</td>
<td>• Allow emergence of feelings other than pain</td>
<td>• Partner with patient/family in setting goals of care</td>
</tr>
<tr>
<td>• Substance use</td>
<td>• Intervene as noninvasively as possible</td>
<td>• Balance function vs. complete absence of pain</td>
</tr>
<tr>
<td><strong>Psychosocial History: Assess</strong></td>
<td>• Negotiate target with patient/family</td>
<td><strong>Referrals and Management</strong></td>
</tr>
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<td>• Depression, anxiety, PTSD, sleep pattern**, suicide risk</td>
<td><strong>Acute pain</strong></td>
<td><strong>Acute pain</strong></td>
</tr>
<tr>
<td>• Impact on quality of life, ADLs &amp; performance status***</td>
<td>• Set realistic chronic care goals</td>
<td>• Refer early to appropriate specialist or Pain Center, if diagnosis unclear or pain refractory to treatment</td>
</tr>
<tr>
<td>• Patient, family, and caregiver’s cultural and spiritual beliefs</td>
<td>• Transition from passive recipient to patient-directed management of therapies</td>
<td><strong>Chronic pain</strong></td>
</tr>
<tr>
<td>• Secondary gain: psychosocial/financial</td>
<td>• Refer “difficult to treat” cases (H/O substance abuse, neuropathic pain, rapidly escalating opioid doses) to MD with palliative care or pain expertise</td>
<td><strong>Neuropathic pain</strong></td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td><strong>Pharmacological Therapy</strong></td>
<td><strong>Use anti-epilepsy drugs (AEDs) first</strong></td>
</tr>
<tr>
<td><strong>Order and evaluate appropriate diagnostic testing</strong></td>
<td>• Use WHO/AHCPR step care as “ramp” (see reverse side)</td>
<td><strong>Use step 2 drug to help Rx</strong></td>
</tr>
<tr>
<td>• Evaluate pain on all patients using the age/developmentally appropriate scale:</td>
<td>• Use adjuvant therapies prn</td>
<td><strong>Special Situations</strong></td>
</tr>
<tr>
<td>1. Numeric scale &amp; FPS-R: Adolescents and older children</td>
<td>• Avoid Demerol (meperidine)</td>
<td><strong>Anxiety and depression</strong></td>
</tr>
<tr>
<td>A. mild pain: 1-3</td>
<td>• Use care with combinations (consider total consumption of APAP from multiple Rx and OTC sources)</td>
<td>• Refer to Depression Guidelines</td>
</tr>
<tr>
<td>B. moderate: 4-7 (interferes with work or sleep**)</td>
<td>• Use ONE short-acting med for acute pain exacerbation</td>
<td><strong>Verbally non-communicative patients</strong></td>
</tr>
<tr>
<td>C. severe: 8-10 (interferes with all activities***</td>
<td>• Switch to ONE long-acting meds when pain stabilized</td>
<td>• Infants, children &amp; cognitively impaired all feel pain</td>
</tr>
<tr>
<td>2. Faces Pain Scale-Revised (FPS-R): Younger children (~6-10 years old)</td>
<td>• Avoid multiple agents of similar duration</td>
<td>• Evaluate patient’s non-specific signs: noisy breathing, grinding teeth, bracing, rubbing, crying, agitation</td>
</tr>
<tr>
<td>3. FLACC-revised scale: &lt;8 years old/developmentally delayed</td>
<td><strong>Chronic moderate or severe pain</strong></td>
<td><strong>Infants (use appropriate pain scale)</strong></td>
</tr>
<tr>
<td>4. NIPS: Neonatal Infant Pain Score</td>
<td>• Give baseline long acting opioid around the clock</td>
<td>• Start at ½ usual dose</td>
</tr>
<tr>
<td><strong>Faces Pain Scale - Revised</strong></td>
<td>• For breakthrough, give 10% of total daily dose as prn</td>
<td>• Watch carefully for toxicity from accumulation</td>
</tr>
<tr>
<td>Choose the face that shows how bad your pain is right now.</td>
<td>• PRN interval: 1-2 h oral, and 30-60 min parenteral</td>
<td><strong>Patients with substance abuse history</strong></td>
</tr>
<tr>
<td>No pain</td>
<td>• Adjust baseline upward daily by total amount of prns</td>
<td>• May need higher starting dose (tolerance)</td>
</tr>
<tr>
<td>Very much pain</td>
<td>• When converting from one opioid to another, reduce total dose by 1/3-1/2 to account for incomplete cross tolerance</td>
<td>• Use prescribing contracts for outpatient use</td>
</tr>
<tr>
<td><strong>Adjunct therapy and anticipate side effects</strong></td>
<td><strong>Be aware of potential for addiction and misuse</strong></td>
<td>• Consider abuse-deterrent formulations</td>
</tr>
<tr>
<td><strong>Somatic pain:</strong> localized; ache, throb, or gnaw</td>
<td>• Prevent constipation: start senna or polyethylene glycol</td>
<td>• Encourage established functional goals</td>
</tr>
<tr>
<td><strong>Visceral pain:</strong> often referred; cramp, pressure, deep ache, squeeze</td>
<td>• Nausea: treat with antiemetics or change meds</td>
<td>• Ensure follow-up</td>
</tr>
<tr>
<td><strong>Neuropathic pain:</strong> burns, electric shock, hot, stab, numb, itch, tingle</td>
<td>• Pruritus: treat with antihistamines or change meds</td>
<td></td>
</tr>
<tr>
<td><strong>Cancer Pain:</strong> associated with cancer, HIV</td>
<td>• Myoclonus: treat with benzodiazepine or change meds</td>
<td></td>
</tr>
<tr>
<td><strong>Non-cancer pain:</strong> e.g. arthritis or musculoskeletal disorders</td>
<td>• Mental impairment: avoid driving/hazardous situations until side effect profile stabilizes; reassess safety periodically</td>
<td></td>
</tr>
<tr>
<td><strong>Acute Pain:</strong> ↑HR, HBP, diaphoresis, pallor, fear, anxiety</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chronic pain:</strong> sleep difficulties, loss of appetite, psychomotor retardation, depression, relationship change</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guidelines and principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines and principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care can and should be tailored to fit individual needs.

Approved in July 2014; Next Scheduled Update in 2016
**QUEST Principles of Pain Assessment**
- Question the child
- Use pain rating scales
- Evaluate behavior and physiological changes
- Secure parent's involvement
- Take cause of pain into account
- Take action and evaluate results

**Neonates**

<table>
<thead>
<tr>
<th>Signs of Acute Pain</th>
<th>Signs of Chronic Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crying and moaning</td>
<td>Apathy</td>
</tr>
<tr>
<td>Muscle rigidity</td>
<td>Irritability</td>
</tr>
<tr>
<td>Flexion or flaring of the extremities</td>
<td>Changes in sleeping and eating patterns</td>
</tr>
<tr>
<td>Diaphoresis</td>
<td>Lack of interest in their surroundings</td>
</tr>
<tr>
<td>Irritability</td>
<td>Guarding</td>
</tr>
<tr>
<td>Changes in vital signs and pupillary dilatation</td>
<td></td>
</tr>
</tbody>
</table>

**Older Children**
- Children < 6 years old or unable to communicate, clinicians should use the FLACC-revised scale
- Children > 6-10 may use the Faces (FPS-R) scale
- Children over 5 may be able to use descriptor words (stinging, burning)\(^2\)
- Children over 6, who understand the concepts of rank and order, can use scales\(^2\)

**Categories of Pain**

**Procedure-Related Pain**
- Anticipation of intensity, duration, coping style and temperament child, type of procedure, history of pain and family support system

**Operative Pain and Trauma-Associated Pain**
- Postoperative pain management should be discussed prior to surgery
- Control pain as rapidly as possible

**Acute Illness**
- Determine severity of pain by the particular illness and situation (e.g. otitis media, meningitis, pharyngitis, etc.)

**Pharmacological Therapy**
- Oral or IV administration of pain medication is the preferred method.
- Avoid painful IM injections.
- The initial choice of analgesic should be based on the severity and type of pain (see table below).
- IV Opioids can be safely titrated to effect in the pediatric setting
- PCA is an acceptable form of administering pain medication with proper patient and family education.

**Operative Pain Management**

<table>
<thead>
<tr>
<th>Pain Severity</th>
<th>Analgesic Choice</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild (pain score 1-3)</td>
<td>Acetaminophen*(APAP) or NSAID**</td>
<td>Tylenol®, Ibuprofen, Naproxen</td>
</tr>
<tr>
<td>Moderate (pain score 4-7)</td>
<td>PO APAP/opioid combinations IV/PO low dose MSO4</td>
<td>Toradol®, Vicodin®, Tylx®</td>
</tr>
<tr>
<td>Severe (pain score 8-10)</td>
<td>Opioid</td>
<td>Morphine, Fentanyl®, Hydromorphone</td>
</tr>
</tbody>
</table>

**Drug**

<table>
<thead>
<tr>
<th>Oral Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild Pain</td>
</tr>
<tr>
<td>Ibuprofen**</td>
</tr>
<tr>
<td>Acetaminophen (APAP)*</td>
</tr>
</tbody>
</table>

*Use APAP* or ibuprofen** to enhance analgesia

<table>
<thead>
<tr>
<th>Moderate or Severe Pain</th>
<th>Children &amp; Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>0.2-0.5 mg/kg/dose q3-4 hrs</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>0.03-0.08 mg/kg/dose q3-4 hrs</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>0.1-0.2 mg/kg/dose q3-4 hrs</td>
</tr>
</tbody>
</table>

*Daily dosing of Acetaminophen not to exceed 15 mg/kg/dose or 5 doses per day (75 mg/kg/24 hrs) in children <40 kg and 3000 mg/24 hrs in adolescents ≥40 kg.

**NSAIDs – monitor in patients on anticoagulation therapy and/or history of bleeding disorder; limit use ≤5 days.

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### PRINCIPLES OF PAIN MANAGEMENT: BEDSIDE NURSING ASSESSMENT TOOL

#### Assessment and Diagnosis

"Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does." (McCaffery, 1999)

**History: Assess**
- Onset, location, quality, intensity, temporal pattern, aggravating and alleviating factors, associated symptoms
- Characteristics of pain*
- Previous methods of treatment
- Other medical and surgical conditions
- Substance use

**Psychosocial History: Assess**
- Depression, anxiety, sleep pattern**
- Impact on quality of life, ADLs & performance status***
- Patient, family, and caregiver’s cultural and spiritual beliefs

**Assessment**
- Evaluate pain on all patients using the 0-10 scale:
  - A. mild pain: 1-3
  - B. moderate: 4-7 (interferes with sleep**)  
  - C. severe: 8-10 (interferes with all activities***)

![Faces Pain Scale - Revised](image)

Choose the face that shows how bad your pain is right now.

---

#### Treatment

**Goals**
- Treat acute pain aggressively to avoid chronic pain
- Treat chronic pain thoughtfully and systematically
- Identify and address the cause of pain
- Maintain alertness, ability to function safely/productively
- Allow emergence of emotions associated with pain
- Intervene as noninvasively as possible
- Support target pain level set by patient

**Non-Pharmacological Therapy**
- Patient/Family Education
- Community & Web-based Support Groups
- Cognitive Behavioral Therapy; Supportive Psychotherapy
- Physical Therapy; Chiropractic/Osteopathic Care; Massage
- Exercise: Yoga, Tai Chi, Qi Gong, Walking, Water Therapy
- Cutaneous Stimulation: Ice, Heat; Counterstimulation: TENS
- Acupuncture & Acupressure (trigger point Rx)
- Relaxation techniques: Biofeedback, Music, Hydrobath, Reiki, Therapeutic Touch, Healing Touch
- Meditation, Mindful Practice, Visualization/Interactive Guided Imagery; Prayer; Spiritual & Pastoral Support

**Pharmacological Therapy**
- Dispense medication as ordered using the 5 Rights:
  - dose
  - patient
  - time
  - medication
  - route
- Assess effectiveness of pain medication

**Anticipate side effects**
- Prevent constipation: start senna, sorbitol
- Nausea: treat with antiemetics or change meds
- Pruritus: treat with antihistamines or change meds
- Myoclonus: treat with benzodiazepine or change meds
- Mental impairment: avoid driving/hazardous situations until side effect profile stabilizes; reassess safety periodically

---

#### Management and Monitoring

**General**
- Reassess regularly for pain and pain relief
- Measure "5th vital sign" using tools (i.e. numeric scale, face scale); respond urgently to pain ≥8
- Clearly document time medication is given and response to pain medication
- Assess ADLs status
- Partner with patient/family in setting goals of care
- Balance function versus complete absence of pain

**Special Situations**
- **Anxiety and depression**
  - Provide emotional support
  - Advocate for psychosocial consultation prn
- **Verbally non-communicative patients**
  - Infants, children & cognitively impaired patients all feel pain
  - Infants, children & cognitively impaired patients may not be able to express level of pain
  - Evaluate patient’s non-specific signs of discomfort such as noisy breathing, grinding teeth, bracing, rubbing, guarding, crying, frightened facial expressions, tense, fidgeting, reoccurring agitation
- **Elderly or people with renal or hepatic disease**
  - Start at 1/2 usual dose
  - Watch carefully for toxicity from accumulation
- **Infants (use appropriate pain scale)**
  - Start at 1/2 usual dose
  - Watch carefully for toxicity from accumulation
- **Patients with substance abuse history**
  - May need higher starting dose (tolerance)
  - Use prescribing contracts for outpatient use
  - Consider abuse-deterrent formulations

**Be aware of potential for addiction and misuse**
- Encourage established functional goals
- Ensure follow-up

Guidelines & principles are intended to be flexible. They serve as reference points or recommendations, not rigid criteria. Guidelines & principles should be followed in most cases, but there is an understanding that, depending on the patient, the setting, the circumstances, or other factors, care should be tailored to fit individual needs.

Approved in July 2014; Next Scheduled Update in 2016.
# Pain Assessment In Advanced Dementia - PAINAD (Warden, Hurley, and Volicer, 2003)

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent of vocalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan. Low-level of speech with a negative or disapproving quality</td>
<td>Repeated troubled calling out. Loud moaning or groaning. Crying</td>
<td></td>
</tr>
<tr>
<td>Facial expression</td>
<td>Smiling or inexpressive</td>
<td>Sad, frightened, frown</td>
<td>Facial grimacing</td>
<td></td>
</tr>
<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>Distracted or reassured by voice or touch</td>
<td>Unable to console, distract or reassure</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL**

* Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0="no pain" to 10="severe pain").

**Instructions**: Observe the older person both at rest and during activity/with movement. For each of the items included in the PAINAD, select the score (0, 1, or 2) that reflects the current state of the person's behavior. Add the score for each item to achieve a total score. Monitor changes in the total score over time and in response to treatment to determine changes in pain. Higher scores suggest greater pain severity.

**Note**: Behavior observation scores should be considered in conjunction with knowledge of existing painful conditions and surrogate report from an individual knowledgeable of the person and their pain behaviors.

Remember that some patients may not demonstrate obvious pain behaviors or cues.


Developed at the Geriatric Research, Education Clinical Center at Edith Nourse Rodgers Memorial Veterans Medical Center, Bedford, MA.

Reviewed and Approved: July 2014
<table>
<thead>
<tr>
<th>Self-Help Treatment Options*</th>
<th>What it is / When to use it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/ Family Education</td>
<td>Serves to dispel myths, relieve fears, give patients a sense of control and empower them to partner with health care professionals. Assists the patient in understanding what pain is, its cause, what treatments are available, and when to seek help in between visits. Allows patient to learn to ultimately self-direct management of therapy.</td>
</tr>
<tr>
<td>Community Support Groups/ Educational Programs</td>
<td>Assists patients in learning more about their diagnosis, gain support in managing their disease and controlling their pain.</td>
</tr>
<tr>
<td>Supportive counseling</td>
<td>Assists patients with the anxiety, fear and depression that often accompanies pain and can interfere with work, sleep or daily activities. Helps patients to recognize that pain is “not in their head.”</td>
</tr>
<tr>
<td>Exercise, Yoga, Tai Chi, Qi Gong</td>
<td>Moderate, active exercises to decrease muscle spasm improve patient functioning and self-image.</td>
</tr>
<tr>
<td>Ice, Heat (Cutaneous stimulation)</td>
<td>Applying heat or cold to a painful area can help reduce pain. Both decrease sensitivity to pain.</td>
</tr>
<tr>
<td>Relaxation Techniques</td>
<td>Structured training to relax specific muscle groups or for general decrease of anxiety.</td>
</tr>
<tr>
<td>Distraction Techniques</td>
<td>Focusing attention elsewhere, e.g., doing puzzles, video games, listening to music, reading.</td>
</tr>
<tr>
<td>Meditation</td>
<td>Intentional self-regulation of attention to focus on particular aspects of inner/outer experience.</td>
</tr>
<tr>
<td>Spiritual / Pastoral</td>
<td>Provide relief from pain by strengthening belief systems and providing comfort/support during periods of illness, trauma and or stress.</td>
</tr>
<tr>
<td>Guided Imagery and Visualization</td>
<td>Using the power of the patient’s imagination to reduce pain and increase relaxation.</td>
</tr>
<tr>
<td>Humor/Laughter</td>
<td>Laughter is a whole-body stress reducer.</td>
</tr>
<tr>
<td>Music Therapy</td>
<td>Use of music experiences and the relationships that develop through them as dynamic forces to promote health.</td>
</tr>
</tbody>
</table>

* Please check with your health insurance plan for payment benefits.
# Self-Help / Alternative / Complementary Therapies for Pain Management

## Health Care Professional Guide

“Pain as the 5th vital sign”

<table>
<thead>
<tr>
<th>Treatment Options*</th>
<th>What it is / When to use it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic Care</td>
<td>Spinal manipulation to treat pain and/or disease.</td>
</tr>
<tr>
<td>Osteopathic Manipulation</td>
<td>Reestablish a normal relationship between anatomic and physiologic components thus removing barriers to self-healing.</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Active exercises to restore muscle mass and preserve the normal range of joint motion.</td>
</tr>
<tr>
<td>Therapeutic Massage</td>
<td>Use of ice, heat, manipulation of soft tissues of body to normalize those tissues to aid relaxation and increase circulation.</td>
</tr>
<tr>
<td>TENS (Counterstimulation)</td>
<td>Transcutaneous electrical nerve stimulation (TENS) small non-invasive device that delivers low voltage electrical stimulation via wires to ECG electrodes, placed proximal or directly over painful site.</td>
</tr>
<tr>
<td>Acupuncture and Acupressure</td>
<td>Insertion of small needles or application of pressure at specific points along 12 meridian zones of the body.</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Structured training to relax specific muscle groups or for general decrease of anxiety.</td>
</tr>
<tr>
<td>Reiki</td>
<td>Reestablished the energy balance in areas of the body experiencing disease and discomfort.</td>
</tr>
</tbody>
</table>

* Referral needed by physician; please check with your health insurance plan for payment benefits.
<table>
<thead>
<tr>
<th>HALF LIFE (hours)</th>
<th>DURATION (hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5-2</td>
<td>3-7</td>
</tr>
<tr>
<td>3-4</td>
<td>4-6</td>
</tr>
<tr>
<td>2-3</td>
<td>4-5</td>
</tr>
<tr>
<td>15-190 (N.B. Huge Variation)</td>
<td>6-12</td>
</tr>
<tr>
<td>13-22 (Patch)</td>
<td>48-72 (Patch)</td>
</tr>
<tr>
<td>7 (Lozenge)</td>
<td>60+ min (Lozenge)</td>
</tr>
<tr>
<td>12-22 (Buccal)</td>
<td>120+ min (Buccal)</td>
</tr>
<tr>
<td>15-25 (Intranasal)</td>
<td>120+ min (Intranasal)</td>
</tr>
<tr>
<td>3</td>
<td>4-6</td>
</tr>
<tr>
<td>3.3-4.5</td>
<td>4-6</td>
</tr>
<tr>
<td>7-10</td>
<td>4-6</td>
</tr>
</tbody>
</table>

**GUIDELINES**

1. Evaluate pain on all patients using a 0 -10 scale
   A. Mild pain: 1 – 3  
   B. Moderate pain: 4 – 7  
   C. Severe pain: 8 – 10

2. For chronic moderate or severe pain:  
   A. Give baseline medication around the clock  
   B. Order 10% total daily dose as a PRN given  
      q 1-2h for oral and q 30-60 min for SC/IV  
   C. For continuous infusion, PRN can be either the  
      hourly rate q 15 minutes or 10% of total daily  
      dose q 30-60 minutes.  
   D. Adjust baseline upward daily in amount roughly  
      equivalent to total amount of PRN  
   E. Negotiate with patient target level of relief,  
      but usually at least achieving level <4.

3. In general, oral route is preferable, then  
   trans-cutaneous > subcutaneous > intravenous.

4. When converting from one opioid to another, some  
   experts recommend reducing the equianalgesic  
   dose by 1/3 to 1/2, then titrate as in #2 above.

5. Elderly patients, or those with severe renal or liver  
   disease, should start on half the usual starting dose.

6. If parenteral medication is needed for mild to  
   moderate pain, use half the usual starting dose  
   of morphine or equivalent.

7. Refer to PDR for additional fentanyl guidelines.

8. Naloxone (Narcan) should only be used in  
   emergencies:  
      Dilute naloxone 0.4 mg with 9 ml NS  
      Give 0.1mg (2.5 ml) slow IVP until effect  
      Monitor patient q15 minutes  
      May need to repeat naloxone again in  
      30-60 minutes

9. Short-acting preparations should be used acutely  
   & post-op. Switch to long-acting preparations  
   when pain is chronic and the total daily dose  
   is determined.

Information adapted from Facts and Comparisons 2008 and  
APS Principles of Analgesic Use in the Treatment of Acute Pain  
B-1537 / 8642-14G
<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>EQUIANALGESIC DOSE (for chronic dosing)</th>
<th>USUAL STARTING DOSES</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IM/IV (onset 15-30 min)</td>
<td>PO (onset 30-60 min)</td>
<td>PARENTERAL</td>
</tr>
<tr>
<td>MORPHINE</td>
<td>10 mg</td>
<td>30 mg</td>
<td>2.5-5 mg SC/IV q3-4h (\bullet1.25-2.5, mg)</td>
</tr>
<tr>
<td>OXYCODONE</td>
<td>Not Available</td>
<td>20 mg</td>
<td>Not Available</td>
</tr>
<tr>
<td>HYDROMORPHONE</td>
<td>1.5 mg</td>
<td>7.5 mg</td>
<td>0.2-0.6 mg SC/IV q2-3h (\bullet0.2, mg)</td>
</tr>
<tr>
<td>METHADONE</td>
<td>1/2 oral dose (2, mg) PO methadone = 1mg parenteral methadone</td>
<td>24 hour (\text{oral morphine: methadone ratio})</td>
<td>1.25-2.5 mg q8h (\bullet1.25, mg)</td>
</tr>
<tr>
<td>FENTANYL</td>
<td>100 mcg (\text{single dose}) (t) 1/2 and duration of parenteral doses variable</td>
<td>24 hour (\text{Initial patch dose})</td>
<td>25-50 mcg IM/IV q1-3h (\bullet12.5-25, mcg)</td>
</tr>
<tr>
<td>CODEINE</td>
<td>130 mg</td>
<td>200 mg</td>
<td>15-30 mg IM/SC q4h (\bullet7.5-15, mg) (\text{IV Contraindicated})</td>
</tr>
<tr>
<td>HYDROCODONE</td>
<td>Not available</td>
<td>30 mg</td>
<td>Not Available</td>
</tr>
<tr>
<td>OXYMORPHONE</td>
<td>1 mg</td>
<td>10 mg</td>
<td>1-1.5 mg IM/SQ q4-6h (\bullet0.5, mg)</td>
</tr>
<tr>
<td>HALF LIFE (hours)</td>
<td>DURATION (hours)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
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<td>3.3 - 4.5</td>
<td>4-6</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**GUIDELINES**

1. Evaluate pain on all patients using a 0 - 10 Numeric Scale or developmentally appropriate scale (eg. FACES-R, Revised FLACC)
   A. Mild pain: 1 – 3
   B. Moderate pain: 4 – 7
   C. Severe pain: 8 – 10
2. For chronic moderate or severe pain:
   A. Give baseline medication around the clock
   B. Order 10% total daily dose as a PRN given q 1-2h for oral and q 30-60 min for SC/IV
   C. For continuous infusion, PRN can be either the hourly rate q 15 minutes or 10% of total daily dose q 30-60 minutes.
   D. Adjust baseline upward daily in amount roughly equivalent to total amount of previous day's PRNs
   E. Negotiate with patient/family to target level of relief, but usually at least achieving level pain score <4.
3. In general, oral route is simplest/preferable, then transcutaneous > subcutaneous > intravenous. Determine route as appropriate for situation/acuity and type of pain
4. When converting from one opioid to another, some experts recommend reducing the equianalgesic dose by 1/3 to 1/2, then titrate as in #2 above.
5. Infants < 6 months or those with severe renal or liver disease, should start on 1/4 to 1/2 the usual starting dose.
6. If parenteral medication is needed for mild to moderate pain, use half the usual starting dose of morphine or equivalent.
7. Naloxone (Narcan) should only be used in emergencies:
   - Dilute naloxone (0.4 mg/ml) 0.1 mg (0.25 ml) with 9.75 ml NS (final strength 10 mcg/ml)
   - Give 2 mcg/kg IV, repeat q2 minutes for total of 10mcg/kg
   - Monitor patient q15 minutes for at least 90 minutes
   - May need to repeat naloxone again in 30-60 minutes
8. Short-acting preparations should be used acutely & post-op. Switch to long-acting preparations when pain is chronic and the total daily dose is determined.
9. Administering opioids to children <24 months:
   A. Infants < 6 months: place on apnea/bradycardia monitor and pulse oximeter
   B. Infants/children 6 months - 24 months: place pulse oximeter (also consider for children with developmental disabilities, h/o prematurity and known respiratory difficulties)
10. These guidelines do not apply to infants in the NICU.
    Please refer to NICU pain management guidelines.

B-4196 / 8642-14G
<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>EQUIANALGESIC DOSE (for chronic dosing)</th>
<th>USUAL STARTING DOSES</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MORPHINE</td>
<td>10 mg (IM/IV) 30 mg (PO)</td>
<td>0.05 - 0.1 mg/kg/dose q 2-4 hrs</td>
<td>Oral Solution (2 mg/ml); Concent. oral solution (20 mg/ml) can be given buccally. In some post-op patients, up to 0.2 mg/kg IV may be required as an initial IV dose. IR tablets (15, 30 mg). ER tablets (15, 30, 60, 100, 200 mg). q8-12h (MS Contin). ER capsules (10, 20, 30, 50, 60, 70, 80, 100, 130, 150, 200) q12-24h (Kadian). ER capsules (30, 45, 60, 75, 90, 120) q4-6h (Avinza). Not recommended in renal failure.</td>
</tr>
<tr>
<td>OXYCODONE</td>
<td>Not Available 20 mg (PO)</td>
<td>0.1-0.2 mg/kg/dose q 3-4h</td>
<td>Oral solution (5 mg/5 ml). Concentrate (20 mg/ml) can be given buccally. IR capsule (5 mg). IR tablets (5, 10, 15, 20, 30). ER tablets (10, 15, 20, 30, 40, 60, 80) q8-12h (Oxycotin). Designated with abuse-deterrent properties. Combos available with acetaminophen or ibuprofen (generally not recommended). Not enough literature regarding dosing in renal failure. Use with caution.</td>
</tr>
<tr>
<td>HYDROMORPHONE</td>
<td>1.5 mg (IM/IV) 7.5 mg (PO)</td>
<td>0.015 mg/kg/dose q 3-4h</td>
<td>Oral Solution (1 mg/ml); Suppository (3 mg). Tablets (2, 4, 8 mg). Erectile dysfunction (5, 10, 15, 20, 30). Not recommended in renal failure.</td>
</tr>
<tr>
<td>METHADONE</td>
<td>1/2 oral dose 2 mg PO 1 mg parental</td>
<td>Consult Pediatric Supportive (Palliative) Care or Anesthesia Pain Service</td>
<td>Oral Solution (1 mg/ml); Suppository (3 mg). Tablets (2, 4, 8 mg). Erectile dysfunction (5, 10, 15, 20, 30). Not recommended in renal failure.</td>
</tr>
<tr>
<td>FENTANYL</td>
<td>100 mcg (single dose) 1/2 and duration of parenteral doses variable</td>
<td>0.5 - 2 mcg/kg/dose q 30-60 minutes</td>
<td>Transdermal patch (12.25, 50, 75, 100 mcg); If transitioning from IV Fentanyl to patch, the hourly rate is the patch dose; eg, if patient is on 50 mcg/hr IV, start with a 50 mcg patch. Buccal film (200-1200 mcg). Buccal tablet (100-800 mcg). Nasal solution (100 &amp; 400 mcg/vial). SL tablet (100-800 mcg). Lozenges (200-1600 mcg). SL spray (100-1600 mcg). Indicated for breakthrough cancer pain only. NB: Incomplete cross-tolerance already accounted for in conversion; when converting to other opioid from fentanyl, generally reduce equianalgesic amount by 50%. IV: very short acting; associated with chest wall rigidity if given quickly or in high dose. Acceptable in renal failure, monitor carefully if using long term.</td>
</tr>
<tr>
<td>HYDROCODONE</td>
<td>Not available 30 mg (PO)</td>
<td>0.2 mg/kg/dose q 4-6h</td>
<td>APAP combo tablets - 2.5-10 mg hydrocodone with 300-325 mg APAP. APAP combo solution - 2.5 mg hydrocodone with 108 mg APAP per 5 ml. IBU combo tablets - 2.5-10 mg hydrocodone with 200 mg ibuprofen. ER tablets (10, 15, 20, 30, 40, 50 mg). Not an abuse-deterrent formulation. Monitor total acetaminophen or ibuprofen dose.</td>
</tr>
</tbody>
</table>
Methadone Dose Conversion Guidelines
Adapted from AAHPM Palliative Care Primer, 2010 edition with permission from Timothy Quill M.D.

Background
Methadone is a potent opioid with several favorable characteristics, including oral bioavailability of 80%, no active metabolites requiring dose adjustments in renal impairment, low cost, steady analgesic effect, and (possibly) more efficacy when used for neuropathic pain than other opioids. However, methadone has a long, variable half-life (ranging from 6 to 190 hours depending on the dosage). The rapid titration guidelines used for other opioids do not apply to methadone; in general, do not increase dosage more frequently than every 4 days in lower doses and 1 to 2 weeks in higher doses. Small changes in total daily dosage may slowly and progressively have a larger effect on blood level when patients are on dosages greater than 30 mg per day. Dose-conversion ratios are complex and vary based on current opioid dosage and individual factors (see table below).

Conversion table from morphine to methadone (most commonly used in the USA)

<table>
<thead>
<tr>
<th>24 hour total dose of oral morphine</th>
<th>Conversion ratio (oral morphine: oral methadone)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30mg</td>
<td>2:1 (2mg morphine to 1mg methadone)</td>
</tr>
<tr>
<td>31-99mg</td>
<td>4:1</td>
</tr>
<tr>
<td>100-299mg</td>
<td>8:1</td>
</tr>
<tr>
<td>300-499mg</td>
<td>12:1</td>
</tr>
<tr>
<td>500-999mg</td>
<td>15:1</td>
</tr>
<tr>
<td>1000-1200mg</td>
<td>20:1</td>
</tr>
<tr>
<td>&gt;1200mg</td>
<td>Consider consult with palliative care or pain specialist</td>
</tr>
</tbody>
</table>

Because of the potential for drug accumulation from the long half-life, always write “hold for sedation” when initially prescribing or changing dosages of methadone.

Converting from methadone back to morphine or other opioids is especially complex, because methadone affects more opioid receptors than other opioid analgesics; assistance from palliative care or pain management experts is generally advisable for this transition if patients have been on more than 30 mg for more than a few weeks.

Because of its long half-life, methadone is better used as a baseline, scheduled analgesic, with shorter-acting opioids such as morphine or hydromorphone used prn. In relatively stable situations, however, small doses of methadone can be given prn in addition to the scheduled regimen. In general, no matter how high the regular standing methadone dosage, the prn should be no more than 2.5 to 5 mg two or three times daily. Because of the progressively long half-life, small incremental doses for patients receiving a large baseline dose may have a major effect on blood level if taken regularly.

Although the ratio of oral methadone to intravenous methadone may vary from 1:1 to 2:1, when converting to oral to intravenous methadone it is prudent to reduce the total daily dose of methadone by 50%. On the other hand, when converting from intravenous methadone to oral methadone, it is recommended to use the most conservative 1:1 conversion to avoid over-medicating the patient. In these transitions, the patient should be carefully observed for under- and over-dosing.

Under most circumstances, unless the prescriber is very familiar with methadone pharmacokinetics, it is safer to use a different opioid with a much shorter half-life as a prn when using methadone as the baseline opioid. The usual calculation ratios and intervals used for determining breakthrough doses of other opioids do not apply to methadone (and fentanyl).

Cautions about Methadone
• The long half-life can lead to drug accumulation, sedation, confusion, and respiratory depression, especially in the elderly or with rapid dose adjustments.
• Methadone in moderate to high dosages can prolong the QTc interval and increase the risk of the potentially lethal *torsades de pointes* arrhythmia. Depending on the goals of treatment, the presence of associated heart disease, the patient’s prognosis, and the presence of other medications that might cause similar problems (e.g. haloperidol), consider checking the QTc at baseline, and begin monitoring after each dosage change for patients taking over 60 mg of methadone per day. For high-risk patients, consider monitoring at a lower dose of 40 or 50 mg of methadone per day. Once a new steady state has been achieved, repeat ECG. There is no need for repeated checking unless dose is changed or another drug is added that would raise the blood level. If QTc becomes significantly prolonged (QTc 450-499 milliseconds moderate risk; QTc > 500 milliseconds = high risk), consideration should be given to lowering the methadone dosage or rotating to an alternate opioid. Formal consultation with palliative care, acute pain service, cardiology, and pharmacy should be considered.
Medications that can decrease methadone levels include rifampin, phenytoin, corticosteroids, carbamazepine, bosentan, Phenobarbital, St. John's Wort, and a number of antiretroviral agents.

Medications that can increase methadone levels include tricyclic antidepressants, azole antifungals (especially voriconazole), macrolides and fluoroquinolones, amiodarone, selective serotonin reuptake inhibitors (SSRIs), and diazepam. Grapefruit juice also can increase methadone levels.

Sample Calculation - Conversion to Methadone

A 50-year-old woman with metastatic breast cancer has good pain control with sustained-release oral morphine 200 mg, two tablets twice a day. However, she develops persistent myoclonus. A decision is made to rotate opioids to methadone. (Our conversion table [Table 2.1] always requires that the equianalgesic amount of oral morphine be determined to calculate a daily dosage of methadone.)

Step 1. Calculate the total daily oral morphine dosage.

- Two tablets of 200 mg each, taken twice daily = 800 mg total oral morphine per day

Step 2. Convert to methadone.

- For a dosage of 800 mg per day, the conversion ratio of morphine to methadone is 15:1 (see "Conversion table from morphine to methadone" on previous page).
- 800 mg per day oral morphine × 1 mg methadone/15 mg oral morphine = 53 mg methadone per day

Step 3. Reduce the dosage because of incomplete cross-tolerance.

- Reduce the equianalgesic dose by 1/3 to 1/2 when switching opioids because of incomplete cross-tolerance. (N.B. With methadone, generally use the more conservative conversion of reducing by ½ at the end of the calculation.)
- 53 mg × 1/2 equals about 26 mg methadone
- Total daily dosage should be about 26 mg methadone per day.
- The baseline methadone dosage would be increased no more frequently than every 4 days because of the danger of gradual accumulation.


- Methadone is initially dosed in divided doses three times per day (the analgesic effect is shorter than the half-life, so methadone should be generally given three times per day for pain, even though for methadone maintenance it can be given daily or even less frequently).
- A dosage of about 26 mg per day of methadone can be given as 7.5 mg to 10 mg of methadone three times per day (total daily dose of methadone being either 22.5mg or 30mg respectively).
- When ordering methadone, because of its long and variable half-life, always write “hold for sedation.”

Step 5. Choose a prn medication.

- Because of its potentially long half-life, prn doses of methadone are difficult to manage correctly and are subject to completely different rules than other prn opioids. Therefore, unless you are an experienced methadone prescriber, an opioid with a short half-life is generally preferable for prn dosing.

Step 6. Determine the prn dose (morphine).

- The prn dose should be 10% of the total daily opioid dosage.
- Because the patient was already on 800 mg per day of oral morphine, the prn dose based on the prior total daily dosage of morphine would be: 800 mg oral morphine × 10% = 80 mg oral morphine every 1 to 2 hours as needed.
- This could be given as 4 cc of 20 mg/cc morphine concentrate or equivalent every 1 to 2 hours as needed.

Practical facts

- Tablets 5, 10mg; Liquid 1mg/mL, 2mg/mL; Concentrate 10mg/ml
- Cost of methadone: 1/10 morphine sulfate ER, 1/75 oxycodone ER, 1/15 of transdermal fentanyl.
- Any physician with a Schedule II DEA license can prescribe methadone for pain. A special license is only required when using for the treatment of addiction. (N.B. Must write “for pain” on the prescription when used for pain.)
- Get help if converting from large doses of other opioids, converting to IV, or if inexperienced.

References


Prescription Drug Misuse
Community Principles of Pain Management

Prescription drug abuse is an emerging problem in our country, and one that is showing an increasing trend. This problem is particularly alarming in the adolescent population.\(^1\)\(^2\)

- According to the 2009 Partnership Attitude Tracking Study, over half of teens agree prescription drugs are easier to get than illegal drugs.
- Most teens surveyed believe that the prescription drugs are being taken from the family medicine cabinet.
- 1 in 7 teens in grades 9-12 have reported taking a prescription pain reliever for non-medicinal purposes in the past year.

"Prescription drug abuse has reached an all time high and we, as physicians, can play an important role in providing treatment" stated the late Dr. Richard F. Daines, former commissioner, New York State Department of Health. Every month the NYS Department of Health identifies thousands of patients who obtain controlled substance prescriptions from multiple prescribers within the same month. Emergency room visits due to abuse of prescription drugs are higher than the number of visits due to abuse of marijuana and heroin combined. For every person addicted to heroin, there are two persons addicted to prescription narcotics.\(^3\)

When treating a patient with chronic pain, there must be a balance of controlling the individual’s pain with minimizing the risks of treatment. Risk assessment should be conducted prior to initiating opioid therapy. Patients should be assessed for known risk factors for opioid abuse, including smoking, psychiatric disorders, and personal or family history of substance abuse. These risk factors do not exclude an individual from receiving proper pain treatment, but would suggest that this patient may require strict or frequent monitoring. Some aberrant drug taking behaviors are more obvious (such as doctor shopping, prescription forgery, inappropriate route of administration), while others are less suggestive (such as requesting specific drugs, multiple occasions of non-adherence with therapy, resistance to a change in therapy).\(^4\)

Numerous screening tests are available to assist with risk assessment.\(^5\)\(^6\) The Opioid Risk Tool (OPP) is a simple 5 question survey that can predict an individual’s risk. Other helpful tools include prescription monitoring programs (available in most states, including New York State), random urine drug screening, pill counts and patient education.

Terms associated with drug therapy are often used interchangeably; however, they have drastic differences in definition. Below is some of the terminology associated with opioid therapy.\(^7\)\(^8\)

- **Abuse** — although the frequency of consumption of the drug may vary, some adverse consequences of that use are experienced by the user.
- **Physical dependence** — A state of adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation or rapid dose reduction of a drug, or by administration of an antagonist.
- **Psychological dependence** — A subjective sense of a need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence.
- **Tolerance** — increasing amounts of drug are required to produce an equivalent level of efficacy.
- **Addiction** — A primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. Addiction is characterized by behaviors that include impaired control over drug use, compulsive use, continued use despite harm, and craving.
- **Pseudoaddiction** — A situation in which a legitimate chronic pain condition is undertreated with pain medication (either intentionally or unintentionally). The individual will display aberrant behaviors; however, the behaviors will disappear when the pain is adequately controlled.

The New York State Department of Health maintains a secure website which provides information as to whether a patient has received controlled substance prescriptions from two or more physicians and filled them at two or more pharmacies during the previous calendar month. To access this information, a current Health Commerce Account (formerly HPN) is needed. If you do not have an account, visit this website to establish one: [https://hcsteamwork1.health.state.ny.us/pub/top.html](https://hcsteamwork1.health.state.ny.us/pub/top.html). If you currently have a HCS account but are having difficulty logging in, please contact the Commerce Accounts Management Unit (CAMU) at 1-866-529-1890.

If you have identified an individual who has a problem with opioid drug abuse and you are not qualified to treat the patient, assistance is available. Qualified physicians are able to dispense or prescribe medications for the treatment of opioid addiction in treatment settings other than the traditional Opioid Treatment Program (i.e. methadone clinic). Visit [http://www.buprenorphine.samhsa.gov](http://www.buprenorphine.samhsa.gov) for more information.
References:
PAIN MANAGEMENT GUIDELINES AND CONTRACT

Name ___________________________ DOB _____________

Goals for Taking Opioid Medications: ______________________________________________________

I, _____________________________, understand that compliance with the following guidelines is important to the continuation of pain treatment by __________________________

1. I will take medications at the dose and frequency prescribed. No other pain medications are to be taken unless discussed first with __________________________

2. I will comply with my scheduled appointments. Next appointment: __________________________

3. No pain medication will be refilled by phone. I understand that pain medication prescriptions will only be refilled at the scheduled clinic appointments.

4. I will not request controlled-substances or any other pain medicine from prescribers other than __________________________

5. I will consent to random drug testing.

6. I will protect my prescribed medications. No lost or stolen medications will be replaced.

7. I will tell all my physicians that I am receiving pain treatments through and/or from __________________________

8. I agree to participate in psychiatric, neuropsychology and substance abuse assessments.

9. This agreement will be placed in my medical record.

10. I understand that if I have any questions or concerns regarding my pain treatment that I will call my primary care provider at __________________________

I have read and understand the above guidelines.

_________________________________ Date ______________________
Patient

_________________________________ Date ______________________
Physician

Developed as part of the Community-wide Principles of Pain Management Project. Adapted and used with permission from St. Joseph’s Hospital Health Center, Family Practice Center in Syracuse, New York.
PAIN ASSESSMENT PROGRESS NOTE

SUBJECTIVE: Please describe your pain:
How did your pain start?
________________________________

What do you think is causing your pain?
________________________________

How long have you had the pain? _______
Is it occasional? □ Y □ N
Is it continuous? □ Y □ N

What makes the pain better? __________

What makes the pain worse? __________

Is it due to an:
☑ accident (MVA)
☑ worker’s injury

How does your pain feel?
☑ aching
☑ throbbing
☑ gnawing
☑ _________
☑ cramping
☑ pressure
☑ deep aching
☑ _________
☑ burning
☑ electric shock
☑ hot
☑ _________
☑ shooting
☑ numbness
☑ _________
☑ throbbing
☑ pain
☑ _________
☑ pressure
☑ electric shock
☑ _________
☑ numbing
☑ _________
☑ burning
☑ electric shock
☑ _________
☑ _________

Do you have any other symptoms in addition to pain? □ Y □ N
☑ __________
☑ sleep problems
☑ irritability
☑ fear
☑ _________
☑ _________
☑ _________
☑ _________
☑ nausea
☑ _________
☑ _________
☑ _________
☑ _________
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☑ _________

Does the pain disturb your
☑ sleep
☑ eating
☑ self-care
☑ walking
☑ work
☑ concentration
☑ _________
☑ _________
☑ _________
☑ _________
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☑ _________
☑ _________
☑ _________
☑ _________
☑ _________
☑ _________
☑ _________
☑ _________
☑ _________
☑ _________
☑ _________

Are you depressed? □ Y □ N

Do you have any allergies? □ Y □ N

What have you tried to treat the pain? Do you have any allergies? □ Y □ N

Medications: Did it help? How much? Side effects?
☑ __________ □ Y _________ □ N □ Y _________ □ N
☑ __________ □ Y _________ □ N □ Y _________ □ N
☑ __________ □ Y _________ □ N □ Y _________ □ N

Other treatment: Did it help? How much? Side effects?
☑ __________ □ Y _________ □ N □ Y _________ □ N
☑ __________ □ Y _________ □ N □ Y _________ □ N

Do you have any important medical problems?
☑ peptic ulcer disease
☑ high blood pressure
☑ edema/swelling of legs
☑ kidney disease
☑ cancer
☑ other
PAIN ASSESSMENT PROGRESS NOTE

DATE:  /  /  

OBJECTIVE:

Faces Pain Scale - Revised
Choose the face that shows how bad your pain is right now.

0 2 4 6 8 10

No pain

Very much pain

VS: BP: _____ HR: _____ T: _____ RR: _____ Weight: ___

Pertinent physical findings:

Ambulation: □ limping □ cane □ walker □ wheelchair

ASSESSMENT:

PLAN:

Diagnostic plan:

- X-ray
- Lab
- Consultation
- other

Goals for Therapy:

- relieve pain
- get back to work
- improve sleep
- other

Educate Patient □ Brochure Given □

Non-pharmacological Therapy:

- ice
- heat
- exercise
- support group
- acupuncture

- physical therapy
- chiropractor Rx
- massage
- acupuncture

Medications:

Mild (1-3)-moderate(4-7):

- APAP:
- NSAID/Cox-2:
- Combination:

- Adjuvant medications:

Moderate-severe(4-10):

- Long acting opioid:
- Breakthrough dose (10% of 24 hr total q1 hr):
- Bowel Regimen – Senna
- Bowel Regimen – Sorbitol

Referral to pain specialist:

□ Y □ N

- See intra-professional fax referral form

Counseling if needed:

□ Y □ N

Follow-up: ____________________________ 

Signature
All patients should be screened for pain. Once identified, a complete assessment, including physical, emotional, and spiritual components, is necessary to determine cause of pain and appropriate therapy.

### DATE:

<table>
<thead>
<tr>
<th>TO:</th>
<th>FROM:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
<th>DOB:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>INSURANCE:</th>
<th>RECEIVING FAX</th>
</tr>
</thead>
</table>

PAGES FOR TRANSMISSION: ____________

### REASON FOR REFERRAL

- Rx acute pain aggressively to avoid chronic pain.
- Rx chronic pain thoughtfully and systematically.
- Reassess regularly.

<table>
<thead>
<tr>
<th>AREA OF PAIN (CIRCLE)</th>
<th>ATTACHMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>R / L FOOT, ANKLE, LEG, KNEE, THIGH, HIP, LOW BACK, MID-BACK, NECK, SHOULDER, ARM, ELBOW, FOREARM, WRIST, HAND, HEAD</td>
<td></td>
</tr>
</tbody>
</table>

OTHER (please explain)

<table>
<thead>
<tr>
<th>ATTACHMENTS</th>
<th>Priority:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem list</td>
<td></td>
</tr>
<tr>
<td>Medication list</td>
<td>ASAP (please call)</td>
</tr>
<tr>
<td>Progress notes</td>
<td>Urgent</td>
</tr>
<tr>
<td>Labs</td>
<td>Semi-urgent</td>
</tr>
<tr>
<td>X-rays</td>
<td>Routine</td>
</tr>
</tbody>
</table>

### Referral for:

(circle the number(s) for the treatment requested)

1. Consultation with Orthopedist, Neurologist, Radiologist, Other________
2. Pain Specialist / Palliative Care Expert
3. Mental Health /Depression Screening Therapy
4. Cognitive Behavioral Therapy; Supportive Counseling
5. Physical Therapy, Chiropractic/ Osteopathic Manipulation, Massage
6. Relaxation Techniques: Progressive Muscle Relaxation, Biofeedback
7. Exercise: ROM, Strength, Function, Tai Chi, Qi Gong, Yoga
8. Cutaneous Stimulation: Heat, Cold
9. Counterstimulation: Transcutaneous Electrical Nerve Stimulation (TENS)
10. Acupuncture and Acupressure (Trigger Point Therapy)
Community Principles of Pain Management References

Practice Guidelines and Pharmacological Therapies


Visit [CompassionAndSupport.org](http://CompassionAndSupport.org) for additional resources.


**Assessment Tools**


**Non-Pharmacological / Alternative / Complementary Therapies**


**Prescription Drug Misuse**


**Web Sites**

- [www.aahpm.org](http://www.aahpm.org)
- [www.ampainsoc.org/](http://www.ampainsoc.org/)
- [www.epec.net](http://www.epec.net)
- [www.geriatricpain.org/pages/home.aspx](http://www.geriatricpain.org/pages/home.aspx)
- [www.healthinaging.org](http://www.healthinaging.org)
- [www.iasp-pain.org](http://www.iasp-pain.org)
- [www.mdanderson.org](http://www.mdanderson.org)
- [www.pain.com](http://www.pain.com)
- [www.partnersagainstpain.com](http://www.partnersagainstpain.com)
- [www.stoppain.org/services_staff/pcad1.html](http://www.stoppain.org/services_staff/pcad1.html)
# A Guide to Understanding and Managing Your Pain

<table>
<thead>
<tr>
<th>Helping Your Medical Provider Understand Your Pain</th>
<th>Treatment</th>
<th>Rights and Responsibilities</th>
</tr>
</thead>
</table>
| “Every person feels pain differently. Whatever the person feeling it says it is, it is.” | **Help Control Your Pain:**  
There are safe and effective ways to treat pain without using pills.  
- Patient/Family Education  
- Community Support Groups  
- Exercise, Yoga, Tai Chi  
- Massage  
- Relaxation by Deep Breathing  
- Meditation, Prayer, Spiritual & Pastoral Support  
- Imagery  
- Distraction  
- Humor  
- Music  
- Ice or Heat | **Your Rights to Pain Relief Are:**  
- Information and answers to your questions about pain and pain relief.  
- A feeling that your medical provider cares about you.  
- A quick response from your medical provider when you report pain.  
- A sense that your complaint of pain is believed. |
| **What is Pain?**  
- Pain is an uncomfortable feeling that comes from injury, disease or damage to your body.  
- Pain is sometimes a nuisance or it may be a signal that something is wrong. |                                         | **Your Responsibilities in Pain Relief Are:**  
- To discuss different kinds of pain relief choices with your medical provider.  
- To work with your medical provider to make a pain relief plan.  
- To help medical providers measure your pain.  
- To tell your medical provider about any pain that will not go away. |
| **SPEAK UP!**  
If you are currently suffering in pain, you need to talk to your medical provider so you can be prescribed treatment or medicine to help relieve your pain. | **Did You Know That…?**  
- If you act quickly when pain starts, you can often prevent it from getting worse.  
- Anxiety, fear and depression can worsen how you feel and can decrease your ability to cope with everyday life.  
- Pain is not all in your head  
- Pain is not something you “just have to live with.” | |
| **Help Yourself to Manage Pain:**  
- Ask about what is causing your pain and learn more about it.  
- Use information wisely.  
- Know when to seek help in between follow-up visits.  
- Do your best to stay active and healthy. | | |

*From American Pain Society*
<table>
<thead>
<tr>
<th>Self-Help Treatment Options*</th>
<th>What it is / When to use it</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/Family Education</td>
<td>Educates the patient along with the family in learning ways to control pain using various healing techniques.</td>
</tr>
<tr>
<td>Community Support Groups/ Educational Programs</td>
<td>Helps the patient to learn more about their diagnosis, how to handle their disease and control pain through support of others dealing with the same problem.</td>
</tr>
<tr>
<td>Exercise: Yoga, Tai Chi, Walking</td>
<td>Helps reduce tension, anxiety, depression and fatigue. Can also help with nausea.</td>
</tr>
<tr>
<td>Heat</td>
<td>Heat can reduce the pain caused by sore muscles and muscle spasms.</td>
</tr>
<tr>
<td>Ice</td>
<td>Ice will reduce pain that comes from joint problems or irritated nerves.</td>
</tr>
<tr>
<td>Massage</td>
<td>Helps the body heal itself by breaking down muscle tension and pressure on nerves.</td>
</tr>
<tr>
<td>Relaxation Through Deep Breathing</td>
<td>Deep breathing will help with ability to cope; to control stress, slow thinking down.</td>
</tr>
<tr>
<td>Distraction</td>
<td>Changing your attention to something else such as reading, music, walking or talking to a friend.</td>
</tr>
<tr>
<td>Meditation</td>
<td>Opening your mind to bring awareness to breathing, body sensations, and feelings to deal with chronic pain, panic disorders and anxiety.</td>
</tr>
<tr>
<td>Prayer</td>
<td>Provide relief from pain by providing comfort/support during periods of illness, trauma and or stress.</td>
</tr>
<tr>
<td>Guided Visual Imagery</td>
<td>Allows your mind to take you to a place that is safe and comfortable.</td>
</tr>
<tr>
<td>Humor/Laughter</td>
<td>Helps relieve anger, anxiety, tension and improves breathing and helps your heart.</td>
</tr>
<tr>
<td>Music</td>
<td>Helps with relaxation, decreases anxiety, nausea and vomiting.</td>
</tr>
</tbody>
</table>

*Please check with your insurance plan for payment benefits.
### Treatment Options*

<table>
<thead>
<tr>
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</thead>
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<tr>
<td>Chiropractic Care</td>
<td>Moving the spine to aid in the body’s self-healing process.</td>
</tr>
<tr>
<td>Osteopathic Manipulation</td>
<td>Supports the body’s natural ability to heal.</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Active exercises to restore muscle mass and preserve the normal range of joint motion.</td>
</tr>
<tr>
<td>Therapeutic Massage</td>
<td>Helps the body heal itself by breaking down muscle tension and pressure on nerves.</td>
</tr>
<tr>
<td>TENS Unit</td>
<td>Relief of pain by applying electrical stimulation to the skin.</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Insertion of small needles to areas of the body will relieve pain and treat assorted illnesses.</td>
</tr>
<tr>
<td>Acupressure</td>
<td>By applying pressure to areas of the body will relieve pain and treat assorted illness.</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Using special machines to learn how to relax specific muscles in the body to reduce tension</td>
</tr>
<tr>
<td>Reiki</td>
<td>Energy focus through healing touch.</td>
</tr>
</tbody>
</table>

*Referral needed from the physician; please check with your insurance plan for payment benefits.*
## MYTHS AND TRUTHS ABOUT PAIN

<table>
<thead>
<tr>
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<th>TRUTHS</th>
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<tbody>
<tr>
<td>Infants and children do not feel pain. This means they do not need as much medicine to stop their pain.</td>
<td>All children, no matter what their age, feel pain. All children in pain should be properly treated. A child’s age and weight are important information for medical providers to know. It helps them to decide the correct amount of medicine that should be given to help the child.</td>
</tr>
<tr>
<td>Children do not remember being in pain.</td>
<td>Many studies have shown that even infants have a memory of being in pain.</td>
</tr>
<tr>
<td>Children and adults will tell you when they are in pain.</td>
<td>Many children and adults will not tell medical providers or others that they are in pain because: they are afraid of what will happen to them; they do not understand why they have pain; they do not know what the medicine might do to them; they feel they need to be “brave” and not complain about their pain; or they feel it has redemptive/spiritual value.</td>
</tr>
<tr>
<td>You must see signs of pain in the person to know the person is in pain and how much pain.</td>
<td>What people say about their pain is the best way to know how much and what kind of pain they have. Some people with severe acute pain and many people with chronic (constant) pain may not show any signs of pain.</td>
</tr>
<tr>
<td>Individuals who take opioids (sometimes called narcotics) are not at risk of developing addiction.</td>
<td>Individuals who have a personal or family history of alcoholism or substance abuse are at high risk of developing addiction when taking prescribed opioids. Discuss your risk factors with your medical provider, follow their advice and let them know if you develop a problem. <strong>Do not:</strong> 1) combine opioid medicines with alcohol or illegal substances; 2) increase your dose on your own; 3) borrow or share medications with others; or 4) get refills from more than one medical provider.</td>
</tr>
<tr>
<td>Strong pain medicines are not good and/or cannot be handled by elderly persons.</td>
<td>Medications for pain should not be based on age but on the person’s medical condition and the person’s ability to handle uncomfortable side effects. The first doses of strong medications or prescription pain pills should be adjusted downward for elderly persons.</td>
</tr>
<tr>
<td>If the person has had lots of pain in life, he/she is able to stand pain longer than someone who has not had much pain in life.</td>
<td>Finding out what kind of pain the person has had in the past is very important. This information will help medical providers and others who care for the patient to know what the person needs to take care of the pain he/she has now. It will also let them know how the person thinks about pain.</td>
</tr>
<tr>
<td>You can learn how bad the pain is by how active the person is.</td>
<td>Some people may be able to be active when they are in pain; other people may not be able to move about.</td>
</tr>
<tr>
<td>-------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>A patient’s mood (happy, sad, blue, worried) has no effect on pain.</strong></td>
<td>The ideas a person has about pain can play an important part in how that person handles pain. Worry, concern, fear and sadness do not cause pain but they can increase the feeling of pain and make it harder to handle the pain.</td>
</tr>
<tr>
<td><strong>Opioids, sometimes called narcotics, should be given in small amounts to dying patients because the medicines could bring death sooner.</strong></td>
<td>At the end of life, the goal is to make the person comfortable and to keep him/her comfortable. Good pain care is more likely to lengthen life than shorten life. Talking with specialists in Palliative Care, Anesthesia Pain Service, the Chaplain’s Office, Child Life Program, Ethics Consultation Service, etc. may be helpful in difficult cases.</td>
</tr>
<tr>
<td><strong>The ways, customs and religious beliefs of families are not important in management of pain.</strong></td>
<td>Customs and beliefs of person and their family can have a great impact on how pain is judged and how that pain will be controlled. Medical providers and others need to include these customs and beliefs when deciding how a person’s pain is treated.</td>
</tr>
</tbody>
</table>
Pain Management Patient Resources

Community Support Groups
Arthritis Foundation, 3300 Monroe Avenue, Suite 319, Rochester, NY 14618, 585-264-1480  
www.arthritis.org/

Gilda's Club of Rochester, (a cancer support community), 255 Alexander St., Rochester, NY, 14607, 585-423-9700  
www.gildasclubrochester.org

Website Links
American Cancer Society (ACS)  
www.cancer.org

American Chronic Pain Association  
http://www.theacpa.org/

American Fibromyalgia Syndrome Association, Inc  
http://www.afsafund.org/

American Medical Association (AMA)  
http://www.ama-assn.org/

American Pain Foundation  
http://www.painfoundation.org/

American Pain Society  
http://www.ampainsoc.org

Cancer Care  
www.cancercare.org

CompassionAndSupport.org  
http://www.compassionandsupport.org/index.php/for_patients_families/pain_management

Dannemiller Memorial Educational Foundation  
http://www.pain.com

Fibromyalgia Network  
http://www.fmnetnews.com

International Association for the Study of Pain (IASP)  
http://www.iasp-pain.org

Medical College of Wisconsin Palliative Medicine Program  
www.mecw.edu/palliativecare.htm

National Fibromyalgia Partnership, Inc.  
www.fmpartnership.org/

Oregon Fibromyalgia Foundation  
http://www.myalgia.com/

Spondylitis Association of America  
http://www.spondylitis.org/

Department of Pain Medicine & Palliative Care at Beth Israel Medical Center  
www.stoppain.org