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: Pain is a major health issue that exists 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.

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, Excellus, Inc., Wendy Knight, RN, MSN, Ajai Nemani, MD, Russ Acevedo, MD, Nancy Adams, Jeanne Bishop, MD, Gail Brocious, RN, Carl Cameron, MD, Carol Beechy, MD, John Chamberlain, MD, Mona Chitre, Pharm D, Oscar DeLeon-Casasola, MD, Nicole Dawley, RPh, Carl Devore, MD, MPH, Michael DiSalle, MD, Marsha Fitzgerald, RN, Chris Kerr, MD, Donavan Holder, MD, Pam Horst, MD, Eugene Gosy, MD, Brian Justice, DC, David Korones, MD, Michael Kuttner, Ph D, Kevin Matthews, MD, Kathy McGrail, MD, Dan Mendelson, MD, Al Peppard, PT, Joel Potash, MD, Gilbert Proper, MD, Tim Quill, MD, Kathy Rideout, PNP, Steve Ryan, MD, OJ Sahler, MD, Jim Schuppert, MD, Judy Setla, MD, Bernard Shore, MD, Julia Smith, MD, Jaimala Thanik, MD, Elise van der Jagt, MD, Paul Updike, MD, and Kathryn Vullo, PhD.

Table of Contents

1. **Pain Principles – Adult Guide**  
   Tool for assessment, diagnosis, treatment, and management of pain
2. **Pain Principles – Pediatric Guide**  
   Tool for assessment, diagnosis, treatment, and management of pain
   Complementary guide to the Physician Guide
   Listing of Self-Help / Alternative / Complementary therapies for pain management
5. **Equianalgesic Table for Adults**  
   Pocket trifold guideline for effective opioid dosing
6. **Physician Assessment Progress Note**  
   Front side: Patient self-assessment          Backside: Physician progress note
7. **“Pain as a 5th Vital Sign” Fax Referral Form**  
   Intra-professional fax referral form for pain management
8. **Pain Principles Reference Guide**  
   Detailed listing of references for expert based information used for creation of pain principles  
   Web site physician tools for documenting pain
9. **Pain Principles – Patient Information**  
   Guide to understanding and managing pain for patient use
    Patient listing of Self-Help Options / Alternative / Complementary therapies for pain management
11. **Myths and Truths About Pain – Patient Information**  
    Patient guide to myths and truths about pain
12. **Pain Management Patient Resources**  
    Community support groups  
    Website links
13. **Pain Principle Toolkit and Patient Education Resource Fax Form**  
    Resource Form to be used to gather patient education resources (books, video & audiotapes that patients find useful) as part of a quality improvement process of the toolkit as well as an assessment of this toolkit
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.

**Goals**

- **General**
  - 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.
  - Reassess regularly
  - Measure “5th vital sign” using tools (i.e. numeric scale, face scale); respond urgently to pain ≥ 8 or more
  - Follow amount and duration of response
  - Assess performance status
  - Partner with patient/family in setting goals of care
  - Balance function vs. complete absence of pain

- **Non-Pharmacological Therapy**
  - Patient / Family Education
  - Cognitive Behavioral Therapy; Supportive Counseling
  - Chiropractic Care; Osteopathic Manipulation; Massage
  - Physical Therapy/Exercise: Tai Chi, Qi Gong, Yoga
  - Cutaneous Stimulation: Ice, Heat, Capsaicin
  - Counterstimulation: TENS
  - Acupuncture & Acupressure (trigger point Rx)
  - Relaxation Techniques: Biofeedback, Reiki
  - Meditation, Prayer, Spiritual & Pastoral Support
  - Visualization/Interactive Guided Imagery

- **Pharmacological Therapy**
  - Use WHO/AHCPR step care as “ramp” [See pg.4]
  - Use adjuvant therapies prn [See pg.4]
  - Avoid Demerol® (meperidine) & Darvon® (propoxyphene)
  - Give baseline long acting med around the clock
  - For breakthrough, give 10% of total daily dose as prn
  - PRN interval: 1-2 h oral, and 30-60 min parenteral
  - Adjust baseline upward daily by total amount of prns
  - When converting from one opioid to another, reduce total dose by 1/3-1/2 to account for incomplete cross tolerance

**Diagnostic Terms**

- Somatic pain: localized; ache, throb, or gnaw
- Visceral pain: often referred; cramp, pressure, deep ache, squeeze
- Neuropathic pain: burns, electric shock, hot, stab, numb, itch, tingle
- Malignant pain: associated with cancer, HIV
- Non-malignant pain: e.g. arthritis or musculoskeletal disorders

**Acute Pain**

- 1HR, HBP, diaphoresis, pallor, fear, anxiety
- Chronic pain: sleep difficulties, loss of appetite, psychomotor retardation, depression, career/relationship change

**Anticipate side effects**

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

**Psychosocial History: Assess**

- Depression, anxiety, PTSD, sleep pattern *, suicide risk
- Impact on quality of life, ADL’s & performance status**
- Patient, family, and caregiver’s cultural and spiritual beliefs
- Secondary gain: psychosocial/financial

**Assessment**

- Order and evaluate appropriate diagnostic testing
- Evaluate pain on all patients using the 0-10 scale:
  - A. mild pain: 1-3
  - B. moderate: 4-7 (interferes with work or sleep**)
  - C. severe: 8-10 (interferes with all activities***)

**Acute Pain**

- Refer early to appropriate specialist or Pain Center, if diagnosis unclear or pain refractory to treatment

**Chronic, “Non-malignant” Pain**

- Set realistic chronic care goals
- Transition from passive recipient to patient-directed management of therapies.

**“Malignant” Pain**

- Refer “difficult to treat” cases to MD with Palliative Care expertise: H/O substance abuse, neuropathic pain, rapidly escalating opioid doses

**Neuropathic Pain**

- Use anti-epilepsy drugs (AED’s) first
- Use step 2 or 3 drug to help Rx

**SPECIAL SITUATIONS:**

- **Anxiety and depression**
  - Refer to Depression Principles

- **Verbally Noncommunicative Patients**
  - Infants, children & cognitively impaired all feel pain
  - Evaluate patient verbally
  - For breakthrough, give 10% of total daily dose as prn
  - PRN interval: 1-2 h oral, and 30-60 min parenteral
  - Adjust baseline upward daily by total amount of prns
  - When converting from one opioid to another, reduce total dose by 1/3-1/2 to account for incomplete cross tolerance

- **Elderly/ renal or hepatic disease**
  - May need higher starting dose (tolerance)
  - Use prescribing contracts for outpatient use
  - N.B. Addiction is very rare when opioids are used for pain in patients with no prior substance abuse hx

Guidelines and 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 can and should be tailored to fit individual needs. Approved 9/12/08. Next Scheduled Update by Sept. 2010.
Principles of Pain Management: Adult Guide

Step 1: Treatment of Mild Pain (Score of 1-3)

**Drug Class** | **Practical Considerations**
--- | ---
Acetaminophen (APAP) | NOT anti-inflammatory; excess alcohol intake risks hepatotoxicity; possible interaction with warfarin; maximum 4 grams/24 hours from all sources
Salicylates (ASA) | Inhibits platelet aggregation; possible post-op bleeding; hepatic/renal impairment; GI ulcers; increased risk of bleeding with warfarin; monitor level (150-300 mcg/ml)
Non-steroidal anti-inflammatory | Can increase likelihood of renal impairment in pts with HTN or CHF; take with food; most are inexpensive; administer with PPI (omeprazole) if mild stomach upset occurs
Cox-2 anti-inflammatory | Caution in pts with cardiovascular disease or at risk for CV disease; avoid Celebrex with known sulfa allergy; use only if contraindication or severe intolerance to NSAID

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

**Drug Class** | **Practical Considerations**
--- | ---
Codeine /APAP; Oxycodone/ASA or APAP; Hydrocodone/APAP | Total dose limited by APAP(maximum 4 grams/24 hours); lower threshold for elderly, counsel about additive APAP in over-the-counter medications
Tramadol; Tramadol with APAP | Not 1st line; risk of seizures (↑ risk with higher doses and combination with SSRIs/TCA); withdrawal symptoms can occur; risk of serotonin syndrome when combined with SSRIs

**EQUIANALGESIC DOSE USUAL STARTING DOSES for ADULT>50kg**

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>GENERIC / BRAND (Cost)</th>
<th>IM/IV (onset 15-30 min)</th>
<th>EQUIANALGESIC DOSE</th>
<th>PARENTERAL</th>
<th>PO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>Generic - $</td>
<td>Brand - $$$</td>
<td>10 mg</td>
<td>30 mg</td>
<td>2.5-5 mg IV q3-4h (1.25-2.5 mg)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5-15 mg q3-4h IR or oral solution (2.5-7.5 mg)</td>
</tr>
<tr>
<td>Oxycodeone</td>
<td>ER Brand - $$$$</td>
<td>IR Generic - $</td>
<td>20 mg</td>
<td>Not Available</td>
<td>Not Available</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>5-10 mg q3-4h (2.5 mg)</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>Generic - $ Brand - $$$</td>
<td>1.5 mg</td>
<td>7.5 mg</td>
<td></td>
<td>0.2-0.6 mg IV q2-3h (0.2 mg)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1-2 mg q3-4h (0.5-1 mg)</td>
</tr>
</tbody>
</table>

**Pricing accurate as of 4/08 for equianalgesic dosing of an average 30 day supply ($ = $1-$50 $$ = $50-$100 $$$ = $100-$400 $$$$ = $400 / month)

**Adjuvant Therapies**

<table>
<thead>
<tr>
<th>Therapeutic Class / Drug Name</th>
<th>Indication</th>
<th>Contraindications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tricyclic antidepressants: amitriptyline, imipramine, nortriptyline, desipramine</td>
<td>Neuropathic pain and chronic pain</td>
<td>Use of MAO Inhibitor in the past 14 days; prolonged QRS, narrow-angle glaucoma</td>
</tr>
<tr>
<td>Other antidepressants: citalopram, sertraline, paroxetine, fluoxetine, duloxetine, venlafaxine</td>
<td>Neuropathic pain and depression</td>
<td>Use of MAO Inhibitor in the past 14 days</td>
</tr>
<tr>
<td>Anti-epilepsy: gabapentin, phenytoin, carbamazepine, pregabalin, oxcarbazepine</td>
<td>Neuropathic pain</td>
<td>Numerous drug interactions (except minimal for gabapentin and Lynica)</td>
</tr>
<tr>
<td>Benzodiazepines: diazepam, lorazepam</td>
<td>Skeletal muscle spasm, akathisia</td>
<td>Patients with CNS/respiratory depression, narrow-angle glaucoma</td>
</tr>
<tr>
<td>Anti-muscle spasticity: baclofen, cyclobenzaprine, methocarbamol</td>
<td>Muscle spasm</td>
<td>Use of MAO Inhibitor in the past 14 days (for cyclobenzaprine only)</td>
</tr>
<tr>
<td>Anesthetics: Lidoderm patch</td>
<td>Dermal neuropathic pain</td>
<td>Known history of sensitivity to local anesthetics of the amide type</td>
</tr>
</tbody>
</table>

Updated September 2008
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.

### 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, PTSD, sleep pattern, suicide risk
- Impact on quality of life, ADL’s & performance status
- Patient, family, and caregiver’s cultural and spiritual beliefs
- Secondary gain: psychosocial/financial

### Assessment:
- Order and evaluate appropriate diagnostic testing
- Evaluate pain on all patients using the 0-10 scale:
  - A. mild pain: 1-3
  - B. moderate: 4-7 (interferes with work or sleep)
  - C. severe: 8-10 (interferes with all activities)

---

### Wong-Baker FACES Pain Rating Scale

![Wong-Baker FACES Pain Rating Scale](image)

**Choose the face that best describes how you feel**

- No Hurt
- Hurts Little Bit
- Hurts Little More
- Hurts Even More
- Hurts Whole Lot
- Hurts Worst

### Diagnostic Terms:
- **Somatic pain:** localized; ache, throb, or gnaw
- **Visceral pain:** often referred; cramp, pressure, deep ache, squeeze
- **Neuropathic pain:** burns, electric shock, hot, stab, numb, itch, tingle
- **Malignant (cancer) pain:** associated with cancer, HIV
- **Non-malignant pain:** e.g. arthritis or musculoskeletal disorders

### Acute Pain
- 1st HR, HBP, diaphoresis, pallor, fear, anxiety

### Chronic Pain
- Sleep difficulties, loss of appetite, psychomotor retardation, depression, career/relationship change

---

### Treatment

#### Goals:
- Rx acute pain aggressively to avoid chronic pain
- Rx chronic pain thoughtfully and systematically
- Identify and address the cause of pain
- Maintain alerter, ability to function safely/productively
- Allow emergence of feelings other than pain
- Intervene as minimally as possible
- Negotiate target with patient

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- Patient/Family Education
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- Cutaneous Stimulation: Ice, Heat
- Counterstimulation: TENS
- Acupuncture & Acupressure (trigger point Rx)
- Meditation, Prayer, Spiritual & Pastoral Support
- Visualization/Interactive Guided Imagery

#### Pharmacological Therapy:
- Use WHO/AHCPR step care as "ramp" (See pg. 6.)
- Use adjuvant therapies prn (See pg. 6)
- Avoid Demerol (meperidine) & Darvon (propoxyphene)
- Use care with combinations (acetaminophen/ASA)
- Give baseline long acting med around the clock
- Switch to long acting meds when pain stabilized

#### For chronic moderate or severe pain:
- Give baseline long acting med around the clock
- For breakthrough, give 10% of total daily dose as prn
- PRN interval: 1-2 h oral, and 30-60 min parenteral
- Adjust baseline upward daily by total amount of prns
- When converting from one opioid to another, reduce total dose by 1/3-1/2 to account for incomplete cross tolerance

#### Anticipate side effects:
- Prevent constipation: start senna, sorbitol
- Mental impairment: avoid driving/hazardous situations until side effect profile stabilizes; reassess safety for self/others periodically
- Nausea: Rx with antiemetics or change meds
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- Myoclonus: Rx with benzodiazepine or change meds

---

### Management and Monitoring

#### General
- Reassess regularly
- Measure "5th vital sign" using tools (i.e. numeric scale, face scale); respond urgently to pain 8 or more
- Follow amount and duration of response
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- Partner with patient/family in setting goals of care
- Balance function versus complete absence of pain

#### Acute Pain
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#### Neuropathic Pain
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- Use step 2 or 3 drug to help Rx

#### SPECIAL SITUATIONS:
- Anxiety and depression
  - Refer to Depression Principles

#### Verbally Noncommunicative Patients
- Infants, children & cognitively impaired all feel pain
- Evaluate patient’s non-specific signs: noisy breathing, grinding teeth, bracing, rubbing, crying, agitation

#### Elderly renal or hepatic disease
- 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
- N.B. Addiction is very rare when opioids are used for pain in patients with no prior substance abuse hx

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## Assessment and Diagnosis

### 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

- **Signs of Acute Pain**
  - Crying and moaning
  - Muscle rigidity
  - Flexion or flailing of the extremities
  - Diaphoresis
- **Signs of Chronic Pain**
  - Apathy
  - Irritability
  - Changes in sleeping and eating patterns
  - Lack of interest in their surroundings

### Older Children

- **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.)

## Treatment

### Pharmacologic
- 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.

#### Pain Severity
- **Mild (pain score 1-3)**
  - Acetaminophen* (APAP) NSAI
  - Tylenol®, Ibuprofen, Naproxen
- **Moderate (pain score 4-6)**
  - IV / PO Ketorolac**, PO APAP/opioid combinations
  - Toradol®, Vicodin®, Tylox®, Tylenol® with codeine #3
- **Severe (pain score 7-10)**
  - Opioid
  - Morphine, Fentanyl®, Hydromorphone

### Non-Pharmacologic
- IV Opioids can be safely titrated to effect in the pediatric setting
- PCA or NCA is an acceptable form of administering pain medication with proper patient and family education.

## Management and Monitoring

- Preoperative patient assessment, preparation, and interventions
- Intraoperative anesthesia and analgesia, with preemptive measures for postoperative pain control

### Signs of Acute Pain
- Crying and moaning
- Muscle rigidity
- Flexion or flailing of the extremities
- Diaphoresis

### Signs of Chronic Pain
- Apathy
- Irritability
- Changes in sleeping and eating patterns
- Lack of interest in their surroundings

### Drug Dose (PO)

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose (PO)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mild Pain</strong></td>
<td></td>
</tr>
<tr>
<td>Ibuprofen</td>
<td>5-10 mg/kg 400-600 mg q6  prn</td>
</tr>
<tr>
<td>Acetaminophen</td>
<td>10-15 mg/kg 300-600 mg q4-6 prn</td>
</tr>
<tr>
<td>APAP, or Ibuprofen to enhance analgesia</td>
<td></td>
</tr>
<tr>
<td>Ketorolac**</td>
<td>0.5-1 mg/kg 10 mg q6-8 prn</td>
</tr>
<tr>
<td><strong>Severe or moderate pain</strong></td>
<td></td>
</tr>
<tr>
<td>Morphine</td>
<td>IR = 0.2-0.5 mg/kg/dose q 4-6 hrs</td>
</tr>
<tr>
<td></td>
<td>CR = 0.3-0.6 mg/kg/dose q 8-12 hrs</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>0.03-0.08 mg/kg/dose q3-6 hrs</td>
</tr>
<tr>
<td>Oxycodeine</td>
<td>0.05-0.15 mg/kg/dose q4-6 hrs</td>
</tr>
</tbody>
</table>

*Daily dosing of Acetaminophen not to exceed 1000 mg/24 hrs. in children < 40 kg and 4000 mg/24 hrs. in adolescents > 40 kg
**Ketorolac – monitor in patients on anticoagulation therapy and/or history of bleeding disorder; limit use < 5 days.

## Acknowledgements
### 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, aggravating and alleviating factors, associated symptoms
- Characteristics of pain*
- Previous methods of treatment
- Substance use
- General medical condition
- Impact of concurrent medical & surgical diagnoses

**Psychosocial History:** Assess
- Depression, anxiety, sleep pattern**
- Impact on quality of life, ADL’s & 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***)

### Treatment

**Goals:**
- Rx acute pain aggressively to avoid chronic pain
- Rx chronic pain thoughtfully and systematically
- Identify and address the cause of pain
- Maintain alertness and function
- Allow emergence of feelings other than pain
- Intervene as noninvasively as possible
- Support target set by patient

**Non-Pharmacological Therapy**
- Patient/Family Education
- Cognitive Behavioral Therapy/Distraction
- Passive Range of Motion
- Massage
- Relaxation Techniques: Deep Breathing
- Meditation, Prayer, Spiritual & Pastoral Support
- Cutaneous Stimulation: Ice, Heat, Capsaicin
- Splinting
- Humor
- Visualization

**Pharmacological Therapy:**
- Dispense medication as ordered using the 5 Rights:
  - dose
  - patient
  - time
  - medication
  - route
- Assess effectiveness of pain medication
- Addiction is rare in patients without abuse history when opioids are prescribed for pain

### 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 or more
- Clearly document time medication is given and response to pain medication
- Assess ADL’s 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 Noncommunicative Patients
  - 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 expression, tense, fidgeting, reoccurring agitation (see pg. 8)
- Elderly/ renal or hepatic disease
  - Meds start at ½ usual dose
  - Watch carefully for toxicity from accumulation

**Anticipate side effects:**
- Prevent constipation: senna, sorbitol
- Mental impairment: may occur; monitor for safety during home & work activities. Consider risk to self & others as treatment & condition progresses
- Nausea: antiemetics may be used; may need new med
- Pruritus: antihistamines may be used; may need new med

**Pain Types:**
- "Malignant" pain: associated with cancer, HIV
- "Non-malignant" pain: e.g. arthritis or musculoskeletal disorders; may be acute or chronic

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## Discomfort Scale for Dementia of the Alzheimer’s Type

### Noisy Breathing

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Negative sounding noise on inspiration or expiration: breathing looks strenuous, labored, or wearing: respirations sound loud, harsh, or gasping: difficulty breathing or trying hard at attempting to achieve a good gas exchange: episodic bursts of rapid breaths or hyperventilation.

### Negative Vocalization

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

Noise or speech with a negative or disapproving quality: hushed low sounds such as constant muttering with a guttural tone: monotone, subdued, or varying pitched noise with a definite unpleasant sound: faster rate than a conversation or drawn out as in a moan or groan: repeating the same words with a mournful tone: expressing hurt or pain.

### Content Facial Expression

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Pleasant, calm looking face, tranquil, at ease, or serene: relaxed facial expression with a slack unclenched jaw: overall look is one of peace.

### Sad Facial Expression

<table>
<thead>
<tr>
<th></th>
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</table>

Troubled-looking face, looking hurt, worried, lost, or lonesome: distressed appearance: sunken “hang dog” look with lackluster eyes: tears: crying.

### Frightened Facial Expression

<table>
<thead>
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</table>

Scared, concerned-looking face: looking bothered, fearful, or troubled: alarmed appearance with open eyes and pleading face.

### Frown

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<tbody>
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</tbody>
</table>

Face looks strained: or scowling looks: displeased expression with a wrinkled brow and creases in the forehead: corners of mouth turned down.

### Relaxed Body Language

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<tr>
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<th>3</th>
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</thead>
<tbody>
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</tbody>
</table>

Easy openhanded position: look of being in a restful position: may be cuddled up or stretched out: muscles look of normal firmness and joints are without stress: look of being idle/lazy or “laid back”: appearance of “ just killing the day” casual.

### Tense Body Language

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<thead>
<tr>
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</table>

Extremities show tension: wringing of hands: clenched fists, or knees pulled up tightly: look of being in a strained and inflexible position.

### Fidgeting

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<thead>
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</table>

Restless inpatient motion, acting squirmy or jittery appearance of trying to get away from hurt area, forceful touching, tugging or rubbing of body parts.

---

<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.
## Treatment Options*

<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>
<th>Relative Cost</th>
<th>GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ - &lt;$50</td>
<td>$ - $50-$100</td>
<td>$ - $100-$400</td>
<td>1. Evaluate pain on all patients using a 0 -10 scale</td>
</tr>
<tr>
<td>$$$ - $100-$400</td>
<td>$$$ - $100-$400</td>
<td>$$$ - $100-$400</td>
<td>A. Mild pain: 1 – 3</td>
</tr>
<tr>
<td>$ - $400</td>
<td>$ - $400</td>
<td>$ - $400</td>
<td>B. Moderate pain: 4 – 7</td>
</tr>
<tr>
<td>$$$ - $100-$400</td>
<td>$$$ - $100-$400</td>
<td>$$$ - $100-$400</td>
<td>C. Severe pain: 8 – 10</td>
</tr>
<tr>
<td>A.  Mild pain: 1 – 3</td>
<td>A.  Give baseline medication around the clock</td>
<td></td>
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</tr>
<tr>
<td>B.  Moderate pain: 4 – 7</td>
<td>B.  Order 10% total daily dose as a PRN given q 1-2h for oral and q 30-60 min for SC/IV</td>
<td></td>
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<tr>
<td>C.  Severe pain: 8 – 10</td>
<td>C.  For continuous infusion, PRN can be either the hourly rate q 15 minutes or 10% of total daily dose q 30-60 minutes</td>
<td></td>
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<tr>
<td>D.  Adjust baseline upward daily in amount roughly equivalent to total amount of PRN</td>
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<tr>
<td>E.  Negotiate with patient target level of relief, but usually at least achieving level &lt;4.</td>
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<tr>
<td>2. For chronic moderate or severe pain:</td>
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<tr>
<td>A.  Give baseline medication around the clock</td>
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<td></td>
<td></td>
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<tr>
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<tr>
<td>3. In general, oral route is preferable, then transcutaneous &gt; subcutaneous &gt; intravenous.</td>
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<tr>
<td>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.</td>
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<tr>
<td>5. Elderly patients, or those with severe renal or liver disease, should start on half the usual starting dose.</td>
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<tr>
<td>6. If parenteral medication is needed for mild to moderate pain, use half the usual starting dose of morphine or equivalent.</td>
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<td></td>
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<tr>
<td>7. Refer to PDR for additional fentanyl guidelines.</td>
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<tr>
<td>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</td>
<td>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</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Short-acting preparations should be used acutely &amp; post-op. Switch to long-acting preparations when pain is chronic and the total daily dose is determined.</td>
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</table>


*Developed by ViaHealth Pain Initiative*

*Revised by Strong Health Palliative Care 11/01*

*Revised by Specialty Advisory Committee, 2/02*

*Adopted by Excellus BCBS 5/02*

*Guidelines and 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 can and should be tailored to fit individual needs. Approved on Sept. 12, 2008. Next scheduled Update by Sept. 2010.*

Revised 9/08
<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>EQUIANALGESIC DOSE (for chronic dosing)</th>
<th>USUAL STARTING DOSES Adult &gt; 50KG; for opioid naïve patients (•1/2 dose for elderly, or severe renal or liver disease)</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IM/IV onsets 15–30 min.</td>
<td>PO onsets 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 IV q3–4h (•1.25–2.5 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 IV q2–3h (•0.2 mg)</td>
</tr>
<tr>
<td>METHADONE</td>
<td>(see detailed sheet for dosing conversions)</td>
<td>10mg</td>
<td>Not recommended 1st line (See separate methadone dosing guidelines) Practitioners advised to consult with pain or palliative care specialist if unfamiliar with methadone</td>
</tr>
<tr>
<td>FENTANYL</td>
<td>100 mcg (single dose) 200 mcg (cont infusion)</td>
<td>24 hr oral MS dose</td>
<td>Initial patch dose 12.5mcg/hr 25mcg/hr 50mcg/hr 100mcg/hr</td>
</tr>
<tr>
<td>MEPERIDINE</td>
<td>75 -100 mg</td>
<td>300 mg</td>
<td>75 mg SC/IM q2–3h (•25-50 mg) Generally Not Recommended</td>
</tr>
<tr>
<td>CODEINE</td>
<td>130 mg</td>
<td>200 mg</td>
<td>15–30 mg IM/SC q4h (•7.5–15 mg) IV Contraindicated</td>
</tr>
<tr>
<td>HYDROCODONE</td>
<td>Not Available</td>
<td>30 mg</td>
<td>Not Available</td>
</tr>
<tr>
<td>PROPOXYPHENE</td>
<td>Not Available</td>
<td>130 mg (HCl)</td>
<td>200 mg (Napsylate)</td>
</tr>
</tbody>
</table>
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? __________

How does your pain feel?

- aching
- throbbing
- gnawing
- squeezing
- cramping
- pressure
- deep aching
- burning
- electric shock
- hot
- stabbing
- shooting
- numbing
- itching
- tingling

Do you have any other symptoms in addition to pain? □ Y □ N

- sleep problems
- irritability
- fear
- anxiety
- nausea
- vomiting
- constipation
- difficulty urinating
- weakness
- confusion
- sleepiness

Does the pain disturb your

- sleep
- eating
- self-care
- walking
- housework
- concentration
- energy
- mood
- relationships
- enjoyment of life
- recreation?

Are you depressed? □ Y □ N Does the pain make you feel depressed? □ 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
- edema/swelling of legs
- cancer
- high blood pressure
- kidney disease
- other
### OBJECTIVE:

**Wong-Baker FACES Pain Rating Scale**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No Hurt</td>
</tr>
<tr>
<td>1</td>
<td>Hurts Little Bit</td>
</tr>
<tr>
<td>2</td>
<td>Hurts Little More</td>
</tr>
<tr>
<td>3</td>
<td>Hurts Even More</td>
</tr>
<tr>
<td>4</td>
<td>Hurts Whole Lot</td>
</tr>
</tbody>
</table>

**Pain scale**
- 1-3 mild
- 4-7 moderate
- 8-10 severe

- now: ___
- on average: ___
- best: ___
- worst: ___

**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  
- ◯ physical therapy  
- ◯ chiropractor Rx  
- ◯ massage  
- ◯ acupuncture  
- ◯ cognitive behavioral therapy  
- ◯ relaxation techniques  
- ◯ other: ______

**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: |  |
| TO: |  |
| FROM: |  |
| PATIENT NAME: |  |
| DOB: |  |
| INSURANCE: |  |
| RECEIVING FAX |  |
| PAGES FOR TRANSMISSION: |  |

### REASON FOR REFERRAL

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

### AREA OF PAIN (CIRCLE)

- R/L FOOT, ANKLE, LEG, KNEE, THIGH, HIP, LOW BACK, MID-BACK, NECK, SHOULDER, ARM, ELBOW, FOREARM, WRIST, HAND, HEAD
- OTHER (please explain)

### ATTACHMENTS

- Problem list □
- Medication list □
- Progress notes □
- Labs □
- X-rays □

Priority:
- ASAP (please call) □
- Urgent □
- Semi-urgent □
- Routine □

### 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) □

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Pain Management

PRACTICE PRINCIPLES

References

Pain Principles:


Clinical Practice Guideline and Management of Cancer Pain, AHCPR Publication No. 94-0592.


“Pain Assessment and Treatment in the Managed Care Environment”. A position statement from the American Pain Society. The Impacts of Pain, 1997; Louis Harris and Associates, 1996; Osterweis, Kleinman, & Mechanic.


Non-Pharmacologic Management of Pain:


Pharmacologic Management of Pain:


Porter J, Jick H. “Addiction Rare In Patients Treated with Narcotics”, NEJM. 1980; 302:123.

Assessment Tools:


Wallace, Ph.D., RN, CS-ANP, Meredith. “Pain in Older Adults”. Annals of Long-Term Care. Vol. 9, Number 7, July 2001, Reprinted by permission.


Alternative / Complementary Therapies:

Web Sites

www.aacpi.org/caho.htm
www.epec.net/content/contact.html
http://libraries.uta.edu/helen/Test&meas/Table%20of%20c…/McDowell&Newell_contents.ht
www.partnersagainstpain.com
www.stoppain.org/services_staff/pcad1.html
www.healthinaging.org
www.compassionatecare.net

Tool Sites

www.geocities.com/HotSprings/Villa/3221/painmeasurementscale/paindue.html
www.mdanderson.org/%7Eprg/bpisf.html
www.pain.com/resources/attachedbc.html
Helping Your Doctor Understand Your Pain

“Every person feels pain differently. Whatever the person feeling it says it is, it is.”

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.

SPEAK UP!
If you are currently suffering in pain, you need to talk to your doctor or nurse, so you can be prescribed treatment or medicine to help relieve your pain.

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.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Rights and Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help Control Your Pain: There are safe and effective ways to treat pain without using pills.</td>
<td></td>
</tr>
<tr>
<td>- Patient/Family Education</td>
<td>Your Rights to Pain Relief Are:</td>
</tr>
<tr>
<td>- Community Support Groups</td>
<td>• Information and answers to your questions about pain and pain relief.</td>
</tr>
<tr>
<td>- Exercise, Yoga, Tai Chi</td>
<td>• A feeling that your doctor or nurse cares about you.</td>
</tr>
<tr>
<td>- Massage</td>
<td>• A quick response from your doctor or nurse when you report pain.</td>
</tr>
<tr>
<td>- Relaxation by Deep Breathing</td>
<td>• A sense that your complaint of pain is believed.</td>
</tr>
</tbody>
</table>
| - Meditation, Prayer, Spiritual & Pastoral Support | Did You Know That…?
| - Imagery | • If you act quickly when pain starts, you can often prevent it from getting worse. |
| - Distraction | • Anxiety, fear and depression can worsen how you feel and can decrease your ability to cope with everyday life. |
| - Humor | • Pain is not all in your head. |
| - Music | • Pain is not something you “just have to live with”. |
| - Ice or Heat | Your Responsibilities in Pain Relief Are:
| | • To discuss different kinds of pain relief choices with your doctor or nurse. |
| | • To work with your doctor to make a pain relief plan. |
| | • To help doctors and nurse measure your pain. |
| | • To tell your doctor or nurse about any pain that will not go away. |

From American Pain Society
In order for your doctor to understand your pain, you will be asked to answer questions about your pain such as:

- Where is your pain?
- How does your pain feel?
- How often do you have pain?
- What time of day is your pain the worst?
- What gets your pain started?
- Does your pain stay, or come and go?
- What makes your pain better?
- What makes your pain worse?
- What have you tried that makes your pain better?
- Does your pain make you sad?
- What do you think causes your pain?
- Does pain cause you problems with your personal needs such as getting dressed, combing your hair, shaving, bathing, or eating?
- What medications have you used in the past for your pain?

**Your doctor may ask you to rate your pain:**

Choose a face that best describes how you feel: 

A. Mild pain: 1-3 
B. Moderate: 4-7 (interferes with work or sleep) 
C. Severe: 8-10 (interferes with all activities)

<table>
<thead>
<tr>
<th></th>
<th>__ now</th>
<th>__ on average</th>
<th>__ best</th>
<th>__ worst</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Mild</td>
<td></td>
<td></td>
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</tr>
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<td>C. Severe</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**Wong-Baker FACES Pain Rating Scale**

**Choose the face that best describes how you feel.**

- No Hurt
- Hurts Little Bit
- Hurts Little More
- Hurts Even More
- Hurts Whole Lot
- Hurts Worst

## Self-Help/Alternative/Complementary Therapies for Pain Management

### Patient Guide “Pain as a 5th Vital Sign”

<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.
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<tr>
<th>Treatment Options*</th>
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</thead>
<tbody>
<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>
<th>MYTHS</th>
<th>TRUTHS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infants and children do not feel pain. This means they do not need as much medicine to stop their pain.</strong></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 doctors to know. It helps them to decide the correct amount of medicine that should be given to help the child.</td>
</tr>
<tr>
<td><strong>Children do not remember being in pain.</strong></td>
<td>Many studies have shown that even infants have a memory of being in pain.</td>
</tr>
<tr>
<td><strong>Children and adults will tell you when they are in pain.</strong></td>
<td>Many children and adults will not tell doctors 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><strong>You must see signs of pain in the person to know the person is in pain and how much pain.</strong></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><strong>The use of strong medications or prescription pain pills for pain relief can lead to addiction.</strong></td>
<td>It is extremely rare for a person to become addicted to strong medications or prescription pain pills when they are used for pain relief.</td>
</tr>
<tr>
<td><strong>Strong pain medicines are not good and/or cannot be handled by elderly persons.</strong></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><strong>You can learn how bad the pain is by how active the person is.</strong></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>
</tbody>
</table>
## Myths and Truths About Pain

<table>
<thead>
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<tr>
<td>If the person has had lots of pain in life, he/she is able to stand</td>
<td>Finding out what kind of pain the person has had in the past is very important. This information will help doctors, nurses and others who care for the person 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>pain longer than someone who has not had much pain in life.</td>
<td></td>
</tr>
<tr>
<td>A person’s mood (happy, sad, blue, worried) has no effect on pain.</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>Narcotics should be given in small amounts to dying people because</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>the medicines could bring death sooner.</td>
<td></td>
</tr>
<tr>
<td>The ways, customs and religious beliefs of families are not important</td>
<td>Customs and beliefs of individuals and their families can have a great impact on how pain is judged and how that pain will be controlled. Doctors, nurses and others need to include these customs and beliefs when deciding how a person’s pain is treated.</td>
</tr>
<tr>
<td>in management of pain.</td>
<td></td>
</tr>
</tbody>
</table>
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/

AMA Website on Alternative Therapies  

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

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

Cancer Care  
www.cancercare.org

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

Fibromyalgia Network  
http://www.fmnetnews.com/

International Association for the Study of Pain (IASP)  
www.halcyon.com/iasp

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

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

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

Quackwatch: Guide to Health Fraud, Quackery and Intelligent Decisions  
http://www.quackwatch.com/

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

University of Iowa School of Nursing sites:  
http://www.nursing.uiowa.edu/sites/adultpain/
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.

_________________________________    ____________  ____________
Patient Date Physician Date

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.