

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: 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.

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Approved by: Quality Management Committee (QMC) – Approved May 18, 2010. Next revision May 2012.

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PRINCIPLES OF PAIN MANAGEMENT

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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 elder 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:** Hicks, C, L., von Baeyer, C.L., Spafford, P.A., van Korlaar, & Goodenough, B., (2001). The Faces Pain Scale–revised toward a common metric in pediatric pain measurement, *Pain* 93 (2001); 173–183.

Faces Pain Scale—Revised (FPS-R)

Instructions:


“The faces show how much pain or discomfort someone is feeling. The face on the left shows no pain. Each face shows more and more pain and the last face shows the worst pain possible. Point to the face that shows how bad your pain is right NOW.”

Scoring: The score the chosen face as 0, 2, 4, 6, 8 or 10, counting left to right so 0= “no pain” and 10= “worst pain possible”



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PRINCIPLES OF PAIN MANAGEMENT: ADULT GUIDE

Assessment and Diagnosis	Treatment	Management and Monitoring
<p>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.</p> <p>History: Assess</p> <ul style="list-style-type: none"> 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 <p>Psychosocial History: Assess</p> <ul style="list-style-type: none"> 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 <p>Assessment:</p> <ul style="list-style-type: none"> Order and evaluate appropriate diagnostic testing Evaluate pain on all patients using the 0-10 scale: <ul style="list-style-type: none"> A. mild pain: 1-3 B. moderate: 4-7 (interferes with work or sleep**) C. severe: 8-10 (interferes with all activities***) <div style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p style="text-align: center;">FACES PAIN SCALE-REVISED</p> <p style="text-align: center;">CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL</p>  <p style="text-align: center;"> 0 No Hurt 2 Hurts Little Bit 4 Hurts Little More 6 Hurts Even More 8 Hurts Whole Lot 10 Hurts Worst </p> <p style="font-size: small; text-align: center;">From Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. Faces Pain Scale-Revised: Toward a Common Metric in Pediatric Pain Measurement. PAIN 2001; 93:173-183. This figure has been reproduced with permission of the International Association for the Study of Pain® (IASP®). The figure may not be reproduced for any other purpose without permission.</p> </div> <p>Diagnostic Terms:</p> <p>*Somatic pain: localized; ache, throb, or gnaw</p> <p>*Visceral pain: often referred; cramp, pressure, deep ache, squeeze</p> <p>*Neuropathic pain: burns, electric shock, hot, stab, numb, itch, tingle</p> <p>Cancer pain: associated with cancer, HIV</p> <p>Non-cancer pain: e.g. arthritis or musculoskeletal disorders</p> <p>Acute Pain: ↑HR, HBP, diaphoresis, pallor, fear, anxiety</p> <p>Chronic pain: sleep difficulties, loss of appetite, psychomotor retardation, depression, career/relationship change</p> <p>** <i>interferes with work or sleep</i>, *** <i>interferes with all activities</i></p>	<p>Treatment</p> <p>Goals:</p> <ul style="list-style-type: none"> Rx acute pain aggressively to avoid chronic pain Rx 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 Negotiate target pain level with patient <p>Non-Pharmacological Therapy</p> <ul style="list-style-type: none"> Patient / Family Education Cognitive Behavioral Therapy; Supportive Counseling Chiropractic Care; Osteopathic Manipulation; Massage Physical Therapy/Exercise/Strength/Flexibility Cutaneous Stimulation: Ice, Heat Counterstimulation: TENS Acupuncture & Acupressure (trigger point Rx) Relaxation Techniques: Biofeedback, Music, Hydrobath Meditation, Prayer, Spiritual & Pastoral Support Visualization/Interactive Guided Imagery <p>Pharmacological Therapy:</p> <ul style="list-style-type: none"> Use WHO/AHCP step care as "ramp" [See pg.2] Use adjuvant therapies prn [See pg.2] Avoid Demerol® (meperidine) & Darvon® (propoxyphene) Use care with combinations (acetaminophen/ASA) Use short acting meds for acute pain exacerbation Switch to long acting meds when pain stabilized <p>For chronic moderate or severe pain:</p> <ul style="list-style-type: none"> 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 <p>Anticipate side effects:</p> <ul style="list-style-type: none"> 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 	<p>Management and Monitoring</p> <p>General</p> <ul style="list-style-type: none"> 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 <p>Acute Pain</p> <ul style="list-style-type: none"> Refer early to appropriate specialist or Pain Center, if diagnosis unclear or pain refractory to treatment <p>Chronic, "Non-cancer" Pain</p> <ul style="list-style-type: none"> Set realistic chronic care goals Transition from passive recipient to patient-directed management of therapies. <p>"Cancer" Pain</p> <ul style="list-style-type: none"> Refer "difficult to treat" cases to MD with Palliative Care expertise: H/O substance abuse, neuropathic pain, rapidly escalating opioid doses <p>Neuropathic Pain</p> <ul style="list-style-type: none"> Use anti-epilepsy drugs (AED's) first Use step 2 or 3 drug to help Rx <p>SPECIAL SITUATIONS:</p> <p>Anxiety and depression</p> <ul style="list-style-type: none"> Refer to Depression Principles <p>Verbally Noncommunicative Patients</p> <ul style="list-style-type: none"> Infants, children & cognitively impaired all feel pain Evaluate patient's non-specific signs: noisy breathing, grinding teeth, bracing, rubbing, crying, agitation <p>Elderly/ renal or hepatic disease</p> <ul style="list-style-type: none"> Start at ½ usual dose Watch carefully for toxicity from accumulation <p>Patients with substance abuse history</p> <ul style="list-style-type: none"> 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 history of substance abuse

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; avoid long term use
Cox-2 anti-inflammatory	Caution in pts with cardiovascular disease or at risk for CV disease; avoid Celebrex with known sulfa allergy; use 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 1 st line; risk of seizures (↑ risk with higher doses and combination with SSRI/TCA); withdrawal symptoms can occur; risk of serotonin syndrome when combined with SSRIs

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


MEDICATION	GENERIC / BRAND (Cost)	EQUIANALGESIC DOSE		USUAL STARTING DOSES for ADULT>50kg ^a		COMMENTS
		IM/IV (onset 15-30 min)	PO (onset 30-60 min)	PARENTERAL ♦ ½ dose for elderly, or severe renal or liver disease	PO	
Morphine	Generic - \$ - \$\$ Brand - \$\$\$ - \$\$\$\$	10 mg	30 mg	2.5-5 mg SC/IV q3-4h (♦ 1.25-2.5 mg)	5-15 mg q3-4h IR or oral solution (♦ 2.5-7.5 mg)	IR tablets (15,30mg); Rectal suppository (5,10,20,30mg) Oral solution (2mg/ml, 4mg/ml); Concentrate (20mg/ml) can give buccally; Morphine ER tablets (15,30,60,100,200mg) q8-12h Kadian ER capsules (10,20,30,50,60,80,100,200mg) q12-24h Avinza ER capsules (30,45,60,75,90,120mg) Q24h Not recommended in renal failure
Oxycodone	ER Brand - \$\$\$\$ IR Generic - \$ - \$\$ APAP combo - \$ - \$\$	Not Available	20 mg	Not Available	5-10 mg q3-4h IR or oral solution (♦ 2.5 mg)	IR capsule (5mg); IR tablet (5,10,15,20,30mg) Solution (5mg/5ml); Concentrate (20mg/ml) Oxycontin (10,15,20,30,40,60,80mg) – Due to high cost and potential for abuse, use only if failure or contraindication to morphine sulfates ER APAP Combo - 2.5–10mg oxycodone combined with 325–650mg APAP; Ibuprofen combo and ASA combo also available Not enough literature regarding dosing in renal failure. Use caution.
Hydromorphone	Generic - \$ Brand - \$\$	1.5 mg	7.5 mg	0.2-0.6 mg SC/IV q2-3h (♦ 0.2 mg)	1-2 mg q3-4h (♦ 0.5-1 mg)	Tablet (2,4,8mg); Oral liquid (1mg/ml), Suppository (3mg) Use carefully in renal failure
Methadone (see separate sheet with detail dosing information)	Generic - \$ Brand - \$	1/2 oral dose 2mg PO methadone = 1mg parenteral methadone	24 hr oral morphine <30mg 2:1 31-99mg 4:1 100-299mg 8:1 300-499mg 12:1 500-999mg 15:1 1000-1200mg 20:1 > 1200mg Consider consult	1.25-2.5 mg q8h (♦1.25 mg)	2.5-5 mg q8h (♦1.25-2.5 mg)	Tablet (5,10mg) Solution (1mg/ml, 2mg/ml & concentrated 10mg/ml) Usually q12h or q8h; Long variable T½; Acceptable with renal disease Small dose change makes big difference in blood level; tends to accumulate with higher doses; always write "hold for sedation" Many drug interactions with commonly used medications When converting from oral to parenteral, cut dose in half for safety When converting from parenteral to oral, keep dose the same
Fentanyl	Patch Generic - \$\$ - \$\$\$ Brand - \$\$\$\$ Oral Generic - \$\$\$ - \$\$\$\$ Brand - \$\$\$ - \$\$\$\$	100 mcg (single dose) t ½ and duration of parenteral doses variable	24 hr oral MS dose 30-59mg 12mcg/hr 60-134mg 25mcg/hr 135-224mg 50mcg/hr 225-314mg 75mcg/hr 315-404mg 100mcg/hr	Initial patch dose 25-50 mcg IM/IV q1-3h (♦ 12.5-25 mcg)	Transdermal patch 12 mcg/hr Q72h (use with caution in opioid naïve and in unstable patients because of 12 hour delay in onset and offset)	Transdermal patch (12,25,50,75,100mcg) – Because of its high potency and potential for overdose or abuse, use only if failure or contraindication to morphine sulfate ER in the primary care setting N.B. Incomplete cross-tolerance already accounted for in conversion to fentanyl; when converting to other opioid from fentanyl, generally reduce the equianalgesic amount by 50% IV: very short acting; associated with chest wall rigidity. Oral lozenge (200mcg to start) and buccal tablet (100mcg start) indicated for breakthrough cancer pain only Acceptable in renal failure, monitor carefully if using long term.
Codeine	Generic - \$ APAP combo - \$\$	130mg	200 mg	15-30 mg IM/SC q4h (♦ 7.5-15 mg) IV contraindicated	30-60 mg q3-4h (♦ 15-30 mg)	Tablet (15,30,60mg); Elixir 12mg and 120mg APAP/5ml Tylenol #3 (30mg w/ 300mg APAP); Tylenol #4 (60mg w/ 300mg APAP) Monitor total acetaminophen dose
Hydrocodone	Generic - \$ Brand - \$\$ - \$\$\$	Not Available	30 mg	Not Available	5 mg q3-4h (♦ 2.5 mg)	Tablet – multiple brand and generic strengths ranging from 2.5-10mg combined with 300-750mg APAP; Elixir 2.5mg and 167mg APAP/5ml Tablet – with ibuprofen (7.5/200mg) Monitor total acetaminophen or ibuprofen dose

^a – “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.

^b – Pricing accurate as of 2/10 for equianalgesic dosing of an average 30 day supply (\$ = \$1-\$50 \$\$=\$50-\$100 \$\$\$=\$100-\$400 \$\$\$\$=>\$400 / month)

Adjuvant Therapies

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

Assessment and Diagnosis	Treatment	Management and Monitoring
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Substance use <p>Psychosocial History: Assess</p> <ul style="list-style-type: none"> 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 <p>Assessment:</p> <ul style="list-style-type: none"> Order and evaluate appropriate diagnostic testing Evaluate pain on all patients using the 0-10 scale: <ul style="list-style-type: none"> A. mild pain: 1-3 B. moderate: 4-7 (interferes with work or sleep**) C. severe: 8-10 (interferes with all activities***) <div data-bbox="46 857 730 1192" style="border: 1px solid black; padding: 5px;"> <p style="text-align: center;">Wong-Baker FACES Pain Rating Scale</p> <p style="text-align: center;">CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL</p>  <p style="font-size: small;">From Wong D.L., Hockenberry-Baron M., Wilson D., Winkelschtein M.L., Schwartz P.: Wong's Essentials of Pediatric Nursing, ed. 6, St. Louis, 2001, p. 1301. Copyrighted by Mosby, Inc. Reprinted by permission.</p> </div> <p>Diagnostic Terms:</p> <ul style="list-style-type: none"> *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: ↑HR, HBP, diaphoresis, pallor, fear, anxiety Chronic pain: sleep difficulties, loss of appetite, psychomotor retardation, depression, career/relationship change 	<p>Treatment</p> <p>Goals:</p> <ul style="list-style-type: none"> Rx acute pain aggressively to avoid chronic pain Rx chronic pain thoughtfully and systematically Identify and address the cause of pain Maintain alertness, ability to function safely/productively Allow emergence of feelings other than pain Intervene as noninvasively as possible Negotiate target with patient <p>Non-Pharmacological Therapy</p> <ul style="list-style-type: none"> 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 Counterstimulation: TENS Acupuncture & Acupressure (trigger point Rx) Relaxation techniques: Biofeedback, Reiki Meditation, Prayer, Spiritual & Pastoral Support Visualization/Interactive Guided Imagery <p>Pharmacological Therapy:</p> <ul style="list-style-type: none"> Use WHO/AHCPDR 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) Use short acting meds for acute pain exacerbation Switch to long acting meds when pain stabilized <p>For chronic moderate or severe pain:</p> <ul style="list-style-type: none"> 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 <p>Anticipate side effects:</p> <ul style="list-style-type: none"> 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 	<p>Management and Monitoring</p> <p>General</p> <ul style="list-style-type: none"> 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 versus complete absence of pain <p>Acute Pain</p> <ul style="list-style-type: none"> Refer early to appropriate specialist or Pain Center, if diagnosis unclear or pain refractory to treatment <p>Chronic, "Non-malignant" Pain</p> <ul style="list-style-type: none"> Set realistic chronic care goals Transition from passive recipient to patient-directed management of therapies <p>"Malignant" Pain</p> <ul style="list-style-type: none"> Refer "difficult to treat" cases to MD with Palliative Care expertise: H/O substance abuse, neuropathic pain, rapidly escalating opioid doses <p>Neuropathic Pain</p> <ul style="list-style-type: none"> Use anti-epilepsy drugs (AED's) first Use step 2 or 3 drug to help Rx <p>SPECIAL SITUATIONS:</p> <p>Anxiety and depression</p> <ul style="list-style-type: none"> Refer to Depression Principles <p>Verbally Noncommunicative Patients</p> <ul style="list-style-type: none"> Infants, children & cognitively impaired all feel pain Evaluate patient's non-specific signs: noisy breathing, grinding teeth, bracing, rubbing, crying, agitation <p>Elderly/ renal or hepatic disease</p> <ul style="list-style-type: none"> Start at ½ usual dose Watch carefully for toxicity from accumulation <p>Patients with substance abuse history</p> <ul style="list-style-type: none"> May need higher starting dose (tolerance) Use prescribing contracts for outpatient use N.B. 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Assessment and Diagnosis	Treatment	Management and Monitoring ⁴																																																									
<p>QUEST Principles of pain assessment ¹</p> <ul style="list-style-type: none"> • 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 <p>Neonates ²</p> <table border="1" data-bbox="100 438 619 755"> <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 flailing 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></td> </tr> <tr> <td>Guarding</td> <td></td> </tr> <tr> <td>Changes in vital signs and pupillary dilatation</td> <td></td> </tr> </tbody> </table> <p>Older Children ²</p> <ul style="list-style-type: none"> • Children < 3 years old or unable to communicate, clinicians should use the FLACC scale • Children over 3 may use the Faces scale • Children over 5 may be able to use descriptor words (stinging, burning) • Children over 6, who understand the concepts of rank and order, can use numerical scale, color scale, and word scale <p>Categories of Pain ³</p> <p>Procedure-Related Pain</p> <ul style="list-style-type: none"> • Anticipation of intensity, duration, coping style and temperament child, type of procedure, history of pain and family support system <p>Operative Pain and Trauma-Associated Pain</p> <ul style="list-style-type: none"> • Postoperative pain management should be discussed prior to surgery • Control pain as rapidly as possible <p>Acute Illness</p> <ul style="list-style-type: none"> • Determine severity of pain by the particular illness and situation (e.g. Otitis media, meningitis, pharyngitis, etc.) 	Signs of Acute Pain	Signs of Chronic Pain	Crying and moaning	Apathy	Muscle rigidity	Irritability	Flexion or flailing of the extremities	Changes in sleeping and eating patterns	Diaphoresis	Lack of interest in their surroundings	Irritability		Guarding		Changes in vital signs and pupillary dilatation		<p>Pharmacologic ²</p> <ul style="list-style-type: none"> • 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. <table border="1" data-bbox="703 251 1333 560"> <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) NSAID</td> <td>Tylenol®, Ibuprofen, Naproxen</td> </tr> <tr> <td>Moderate (pain score 4-6)</td> <td>IV / PO Ketorolac**, PO APAP/opioid combinations IV / PO low dose MSO4</td> <td>Toradol®, Vicodin®, Tylox®, Tylenol® with codeine #3</td> </tr> <tr> <td>Severe (pain score 7-10)</td> <td>Opioid</td> <td>Morphine, Fentanyl®, Hydromorphone</td> </tr> </tbody> </table> <ul style="list-style-type: none"> • 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. <table border="1" data-bbox="693 682 1365 1088"> <thead> <tr> <th rowspan="2">Drug</th> <th colspan="2">Dose (PO)</th> </tr> <tr> <th>Child</th> <th>Adolescent</th> </tr> </thead> <tbody> <tr> <td>Mild Pain</td> <td></td> <td></td> </tr> <tr> <td>Ibuprofen</td> <td>5-10 mg/kg</td> <td>400-600 mg q6^o prn</td> </tr> <tr> <td>Acetaminophen (APAP) APAP, or ibuprofen to enhance analgesia</td> <td>10-15 mg/kg</td> <td>300-600 mg q4-6^o prn</td> </tr> <tr> <td>Ketorolac**</td> <td>0.5-1 mg/kg</td> <td>10 mg q6^o prn</td> </tr> <tr> <td>Severe or moderate pain</td> <td></td> <td></td> </tr> <tr> <td>Morphine</td> <td colspan="2">IR = 0.2-0.5 mg/kg/dose q 4-6 hrs CR = 0.3-0.6 mg/kg/dose q 8-12 hrs</td> </tr> <tr> <td>Hydromorphone</td> <td colspan="2">0.03-0.08mg/kg/dose q3-6 hrs</td> </tr> <tr> <td>Oxycodone</td> <td colspan="2">0.05-0.15/mg/kg/dose q4-6 hrs</td> </tr> </tbody> </table> <p>*Daily dosing of Acetaminophen not to exceed 1000 mg /24 hrs. in children < 40 kg and 4000 mg /24 hrs. in adolescents > 40 kg</p> <p>**Ketorolac – monitor in patients on anticoagulation therapy and/or history of bleeding disorder; limit use ≤ 5 days.</p> <p>Non-Pharmacologic ²</p> <p>Cognitive-behavioral</p> <ul style="list-style-type: none"> • Education, imagery, relaxation, psychotherapy, counseling, hypnosis, biofeedback, music, literature, art, play, prayer, and meditation. <p>Physical</p> <ul style="list-style-type: none"> • Massage, acupuncture, acupressure, application of heat or cold, TENS, immobilization, graded mobilization, and therapeutic exercise. 	Pain Severity	Analgesic Choice	Examples	Mild (pain score 1-3)	Acetaminophen* (APAP) NSAID	Tylenol®, Ibuprofen, Naproxen	Moderate (pain score 4-6)	IV / PO Ketorolac**, PO APAP/opioid combinations IV / PO low dose MSO4	Toradol®, Vicodin®, Tylox®, Tylenol® with codeine #3	Severe (pain score 7-10)	Opioid	Morphine, Fentanyl®, Hydromorphone	Drug	Dose (PO)		Child	Adolescent	Mild Pain			Ibuprofen	5-10 mg/kg	400-600 mg q6 ^o prn	Acetaminophen (APAP) APAP, or ibuprofen to enhance analgesia	10-15 mg/kg	300-600 mg q4-6 ^o prn	Ketorolac**	0.5-1 mg/kg	10 mg q6 ^o prn	Severe or moderate pain			Morphine	IR = 0.2-0.5 mg/kg/dose q 4-6 hrs CR = 0.3-0.6 mg/kg/dose q 8-12 hrs		Hydromorphone	0.03-0.08mg/kg/dose q3-6 hrs		Oxycodone	0.05-0.15/mg/kg/dose q4-6 hrs		
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1. Baker CM, Wong DL, Q.U.E.S.T.: a process of pain assessment in children (continuing education credit), *Orthopedic Nursing*, 6(1):11-21, 1987 Jan-Feb.
 2. American Academy of Pediatrics. The Assessment and Management of Acute Pain in Infants, Children, and Adolescents (Policy Statement, 0793). 108(3): 793-797, Sept. 2001.
 3. <http://www.aap.org/policy/015642.htm>
 4. Acute Pain Management in Infants, children and Adolescents: Operative Procedures Quick Reference guide for Clinicians No. 1b. AHCPR Publication No: 92-0020: February 1993.

Assessment and Diagnosis	Treatment	Management and Monitoring
<p>"Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does" (McCaffery, 1999) History: Assess</p> <ul style="list-style-type: none"> 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 <p>Psychosocial History: Assess</p> <ul style="list-style-type: none"> Depression, anxiety, sleep pattern** Impact on quality of life, ADL's & performance status*** Patient, family, and caregiver's cultural and spiritual beliefs <p>Assessment:</p> <ul style="list-style-type: none"> Evaluate pain on all patients using the 0-10 scale: <ul style="list-style-type: none"> A. mild pain: 1-3 B. moderate: 4-7 (interferes with sleep**) C. severe: 8-10 (interferes with all activities***) <div data-bbox="100 836 783 1149" style="border: 1px solid black; padding: 5px; margin: 10px 0;"> <p style="text-align: center;">FACES PAIN SCALE-REVISED</p> <p style="text-align: center;">CHOOSE THE FACE THAT BEST DESCRIBES HOW YOU FEEL</p> <p style="font-size: small;">From Hicks CL, von Baeyer CL, Spafford P, van Korlaar I, Goodenough B. Faces Pain Scale-Revised: Toward a Common Metric in Pediatric Pain Measurement. PAIN 2001; 93:173-183. This figure has been reproduced with permission of the International Association for the Study of Pain* (IASP*). The figure may not be reproduced for any other purpose without permission.</p> </div>	<p>Goals:</p> <ul style="list-style-type: none"> 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 emotions associated with pain Intervene as noninvasively as possible Support target pain level set by patient <p>Non-Pharmacological Therapy:</p> <ul style="list-style-type: none"> Patient/Family Education Cognitive Behavioral Therapy/Distraction Passive Range of Motion Massage Relaxation Techniques: Deep Breathing, Music, Hydrobath Meditation, Prayer, Spiritual & Pastoral Support Cutaneous Stimulation: Ice, Heat Splinting Humor Visualization <p>Pharmacological Therapy:</p> <ul style="list-style-type: none"> Dispense medication as ordered using the 5 Rights: <ul style="list-style-type: none"> → dose → patient → time → medication → route Assess effectiveness of pain medication Addiction is rare in patients without abuse history when opioids are prescribed for pain <p>Pain Types:</p> <p>Acute pain: often associated with tachycardia, hypertension, diaphoresis, pallor, fear & anxiety</p> <p>Chronic pain: often associated with sleep difficulties, loss of appetite, irritability, psychomotor retardation, depression, career/relationship change</p> <p>Cancer pain: associated with cancer, HIV</p> <p>Non-cancer pain: e.g. arthritis or musculoskeletal disorders; may be acute or chronic</p>	<p>General</p> <ul style="list-style-type: none"> 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 <p>SPECIAL SITUATIONS:</p> <p>Anxiety and depression</p> <ul style="list-style-type: none"> Provide emotional support Advocate for psychosocial consultation prn <p>Verbally Noncommunicative Patients</p> <ul style="list-style-type: none"> 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) <p>Elderly/ renal or hepatic disease</p> <ul style="list-style-type: none"> Meds start at ½ usual dose Watch carefully for toxicity from accumulation <p>Anticipate side effects:</p> <ul style="list-style-type: none"> 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
<p>Diagnostic Terms:</p> <p>*Somatic pain: localized; aching, throbbing, or gnawing</p> <p>*Visceral pain: often referred; cramping, pressure, deep aching, or squeezing</p> <p>*Neuropathic pain: burning, electric shock, hot, stabbing, shooting, numbing, itching, or tingling</p> <p><i>**interferes with work or sleep, *** interferes with all activities</i></p>		

Pain Assessment IN Advanced Dementia- PAINAD (Warden, Hurley, Volicer, 2003)

ITEMS	0	1	2	SCORE
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low- level of speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling or inexpressive	Sad, frightened, frown	Facial grimacing	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
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.

Reference: Warden, V, Hurley AC, Volicer, V. (2003). Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) Scale. *J Am Med Dir Assoc*, 4:9-15. Developed at the New England Geriatric Research Education & Clinical Center, Bedford VAMC, MA.

B-1937

Revised and Approved May 10, 2010

Self-Help / Alternative / Complementary Therapies for Pain Management
Health Care Professional Guide
“Pain as the 5th vital sign”

Self-Help Treatment Options*	What it is / When to use it
Patient/ Family Education	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.
Community Support Groups/ Educational Programs	Assists patients in learning more about their diagnosis, gain support in managing their disease and controlling their pain.
Supportive counseling	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.”
Exercise, Yoga, Tai Chi, Qi Gong	Moderate, active exercises to decrease muscle spasm improve patient functioning and self-image.
Ice, Heat (Cutaneous stimulation)	Applying heat or cold to a painful area can help reduce pain. Both decrease sensitivity to pain.
Relaxation Techniques	Structured training to relax specific muscle groups or for general decrease of anxiety.
Distraction Techniques	Focusing attention elsewhere, e.g., doing puzzles, video games, listening to music, reading.
Meditation	Intentional self-regulation of attention to focus on particular aspects of inner/outer experience.
Spiritual / Pastoral	Provide relief from pain by strengthening belief systems and providing comfort/support during periods of illness, trauma and or stress.
Guided Imagery and Visualization	Using the power of the patient’s imagination to reduce pain and increase relaxation.
Humor/Laughter	Laughter is a whole-body stress reducer.
Music Therapy	Use of music experiences and the relationships that develop through them as dynamic forces to promote health.

*** 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”

Treatment Options*	What it is / When to use it
Chiropractic Care	Spinal manipulation to treat pain and/or disease.
Osteopathic Manipulation	Reestablish a normal relationship between anatomic and physiologic components thus removing barriers to self-healing.
Physical Therapy	Active exercises to restore muscle mass and preserve the normal range of joint motion.
Therapeutic Massage	Use of ice, heat, manipulation of soft tissues of body to normalize those tissues to aid relaxation and increase circulation.
TENS (Counterstimulation)	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.
Acupuncture and Acupressure	Insertion of small needles or application of pressure at specific points along 12 meridian zones of the body.
Biofeedback	Structured training to relax specific muscle groups or for general decrease of anxiety.
Reiki	Reestablished the energy balance in areas of the body experiencing disease and discomfort.

*** Referral needed by physician; please check with your health insurance plan for payment benefits.**

MEDICATION	EQUIANALGESIC DOSE (for chronic dosing)		USUAL STARTING DOSES Adult > 50KG; for opioid naïve patients (♦1/2 dose for elderly, or severe renal or liver disease)		COMMENTS	
	IM/IV onset 15-30 min	PO onset 30-60 min	PARENTERAL	PO		
MORPHINE	10 mg	30 mg	2.5-5 mg SC/IV q3-4h (♦1.25–2.5 mg)	5-15 mg q3-4h IR or Oral Solution (♦2.5-7.5 mg)	IR tablet (15,30 mg); Rectal suppository (5,10,20,30 mg) Conc (20 mg/ml) can give buccally; Solution (2 mg/ml, 4 mg/ml) Morphine ER tablet (15, 30, 60, 100, 200 mg) q8-12h Kadian ER capsule (10,20,30,50,60,80,100,200mg) q12-24h Avinza ER capsule (30,45,60,75,90,120mg) q24h Not recommended in renal failure	
OXYCODONE	Not Available	20 mg	Not Available	5-10 mg q3-4h IR or Oral Solution (♦2.5 mg)	IR capsule (5mg); IR tablet (5,10,15,20,30mg) Oral solution (5mg/5ml) Concentrate (20mg/ml) Oxycontin (10,15,20,30,40,60,80mg) – Due to high cost and potential for abuse, use only if failure or contraindication to morphine ER Combos available with APAP or Ibuprofen (generally not recommended) Not enough literature regarding dosing in renal failure. Use caution.	
HYDROMORPHONE	1.5 mg	7.5 mg	0.2-0.6 mg SC/IV q2-3h (♦.2 mg)	1-2 mg q3-4h (♦0.5-1 mg)	Tablet (2,4,8mg); Oral liquid (1mg/ml); Suppository (3mg) Use carefully in renal failure.	
METHADONE (see detailed sheet for dosing conversions)	1/2 oral dose 2mg PO methadone = 1mg parenteral methadone	24 hour oral morphine < 30 mg 31-99 mg 100-299 mg 300-499 mg 500-999 mg 1000-1200 mg > 1200 mg	Oral morphine: methadone ratio 2:1 4:1 8:1 12:1 15:1 20:1 consider consult	1.25-2.5 mg q8h (♦1.25 mg)	2.5-5 mg q8h (♦1.25-2.5 mg)	Tablet (5,10mg); Solution (1mg/ml, 2mg/ml); Concentrate 10 mg/ml Usually q12h or q8h; Long variable t½; Acceptable with renal disease Small dose change makes big difference in blood level Tends to accumulate with higher doses, always advise “hold for sedation” Because of long half-life, do not use methadone prn unless experienced Many drug interactions with commonly used medications When converting from oral to parenteral, cut dose in half for safety When converting from parenteral or oral, keep dose the same
FENTANYL	100 mcg (single dose) t 1/2 and duration of parenteral doses variable	24 hour MS dose 30-59 mg 60-134 mg 135-224 mg 225-314 mg 315-404 mg	Initial patch dose 12 mcg/hr 25 mcg/hr 50 mcg/hr 75 mcg/hr 100 mcg/hr	25-50 mcg IM/IV q1-3h (♦12.5-25 mcg)	Transdermal patch 12 mcg/hr q72h <i>Use with caution in opioid naïve and in unstable patients because of the 12 hour delay in onset and offset</i>	Transdermal patch (12,25,50,75,100mcg); Due to its high potency and potential for overdose and abuse, use only if failure or contraindication to morphine sulfate ER in the primary care setting N.B. 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. Oral lozenge (200mcg start) and buccal tablet (100mcg start) indicated for breakthrough cancer pain only Acceptable with renal disease, monitor carefully if using long term
CODEINE	130 mg	200 mg	15-30 mg IM/SC q4h (♦7.5-15 mg) <i>IV Contraindicated</i>	30-60 mg q3-4h (♦15-30 mg)	Tablet (15,30,60mg); Elixir 12mg and 120mg APAP/5ml Tylenol #3 (30mg w/ 300mg APAP); Tylenol #4 (60mg w/ 300mg APAP) Monitor total APAP dose	
HYDROCODONE	Not available	30 mg	Not Available	5 mg q3-4h (♦2.5 mg)	Tablet – multiple brand and generic strengths ranging from 2.5-10mg combined with 300-750mg APAP Tablet (hydrocodone/ibuprofen: 7.5 /200 mg) Elixir 2.5mg and 167mg APAP/5ml Monitor total acetaminophen or ibuprofen dose	

HALF LIFE (hours)	DURATION (hours)	RELATIVE COST (30 day supply of equianalgesic dose) \$ <\$50 \$\$ \$50-\$100 \$\$\$ \$100-\$400 \$\$\$\$ >-\$400
1.5-2	3-7	\$\$ (IR tablet) \$\$ (Solution) \$\$ (ER Generic) \$\$\$\$ (ER Brand)
3-4	4-6	\$\$ (IR tablet) \$\$ (Combo) \$\$\$ (Solution) \$\$\$\$ (ER Brand)
2-3	4-5	\$\$ (Tablet) \$\$\$ (Solution) \$\$\$\$ (Suppository)
15-190 (N.B. Huge Variaton)	6-12	\$ (Tablet) \$ (Solution)
13-22 (Patch) 7 (Lozenge) 12-22 (Buccal)	48-72 (Patch) 60+ min (Lozenge) 120+ min (Buccal)	\$\$ (Transdermal) \$\$\$\$ (Lozenge) \$\$\$\$ (Buccal)
3	4-6	\$\$ (Comb. w/APAP) \$\$\$ (Tablet)
3.3-4.5	4-6	\$ (Comb. w/APAP) \$\$ (Comb. w/IBU)

GUIDELINES

- Evaluate pain on all patients using a 0 -10 scale
 - Mild pain: 1 – 3
 - Moderate pain: 4 – 7
 - Severe pain: 8 – 10
- For chronic moderate or severe pain:
 - Give baseline medication around the clock
 - Order 10% total daily dose as a PRN given q 1-2h for oral and q 30-60 min for SC/IV
 - For continuous infusion, PRN can be either the hourly rate q 15 minutes or 10% of total daily dose q 30-60 minutes.
 - Adjust baseline upward daily in amount roughly equivalent to total amount of PRN
 - Negotiate with patient target level of relief, but usually at least achieving level <4.
- In general, oral route is preferable, then trans-cutaneous > subcutaneous > intravenous.
- 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.
- Elderly patients, or those with severe renal or liver disease, should start on half the usual starting dose.
- If parenteral medication is needed for mild to moderate pain, use half the usual starting dose of morphine or equivalent.
- Refer to PDR for additional fentanyl guidelines.
- 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
- 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 and Cancer Pain (4th Ed.) 1999.

B-1537 / 4606-10MA

Equianalgesic Table for Adults

Half-life, Duration,
Costs and Guidelines

The 5th
Vital Sign
Pain[®]

Community Principles of Pain Management

Developed by ViaHealth Pain Initiative
Revised by Strong Health Palliative Care 11/01
Revised by Specialty Advisory Committee, 2/02
Adopted by Excellus BlueCrossBlueShield 5/02
Reviewed and adopted by AAHPM 12/09

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 May 18, 2010.
Next scheduled Update by May 2012.

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)

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

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 (eg, haloperidol), consider checking the QTc at baseline, and begin monitoring after each dosage change for patients taking over 100 mg of methadone per day. 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 Table 2.1).

(*) $800 \text{ mg per day oral morphine} \times 1 \text{ mg methadone}/15 \text{ mg oral morphine} = 53 \text{ mg methadone per day}$

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.

(*) $53 \text{ mg} \times 2/3$ equals about 35 mg methadone; alternatively, $53 \text{ mg} \times 1/2$ equals about 26 mg methadone

(*) Total daily dosage should be between 26 mg and 35 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.

Step 4. Determine dosing schedule.

(*) Methadone is initially dosed in divided doses three times per day (higher doses can be given twice daily, given its long half-life).

(*) A dosage of 30 mg per day of methadone (between 26 mg and 35 mg) can be given as 10 mg three times per day.

(*) 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 can be difficult to manage correctly.

Therefore, 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: $800 \text{ mg oral morphine} \times 10\% = 80 \text{ mg oral morphine every 1 to 2 hours as needed}$.

(*) This could be given as 4 cc of 20 mg/cc morphine concentrate or equivalent every 1 to 2 hours as needed.

Practical facts

Pills 5, 10mg; Liquid 1mg/mL, 2mg/mL, 10mg/mL; Parenteral 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

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Krantz MJ, Martin J, Stimmel B, Mehta D, Haigney MC. QTc interval screening in methadone treatment. Ann Intern Med. 2009 Mar 17;150(6):387-95.

PAIN ASSESSMENT PROGRESS NOTE

DATE: / /

Name:
DOB
Medical Record Number:

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**?

- | | | | |
|------------------------------------|--------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> aching | <input type="checkbox"/> cramping | <input type="checkbox"/> burning | <input type="checkbox"/> shooting |
| <input type="checkbox"/> throbbing | <input type="checkbox"/> pressure | <input type="checkbox"/> electric shock | <input type="checkbox"/> numbing |
| <input type="checkbox"/> gnawing | <input type="checkbox"/> deep aching | <input type="checkbox"/> hot | <input type="checkbox"/> itching |
| <input type="checkbox"/> _____ | <input type="checkbox"/> squeezing | <input type="checkbox"/> stabbing | <input type="checkbox"/> tingling |

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

- | | | | |
|----------------------------------|---|---|-------------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> sleep problems | <input type="checkbox"/> nausea | <input type="checkbox"/> itching |
| <input type="checkbox"/> _____ | <input type="checkbox"/> irritability | <input type="checkbox"/> vomiting | <input type="checkbox"/> weakness |
| <input type="checkbox"/> fear | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> constipation | <input type="checkbox"/> confusion |
| <input type="checkbox"/> anxiety | | <input type="checkbox"/> difficulty urinating | <input type="checkbox"/> sleepiness |

Does the pain **disturb** your

- | | | | |
|------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> sleep | <input type="checkbox"/> walking | <input type="checkbox"/> concentration | <input type="checkbox"/> relationships |
| <input type="checkbox"/> eating | <input type="checkbox"/> housework | <input type="checkbox"/> energy | <input type="checkbox"/> enjoyment of life |
| <input type="checkbox"/> self-care | <input type="checkbox"/> work | <input type="checkbox"/> mood | <input type="checkbox"/> recreation? |

Are you **depressed**? Y N Does the pain make you feel depressed? Y N

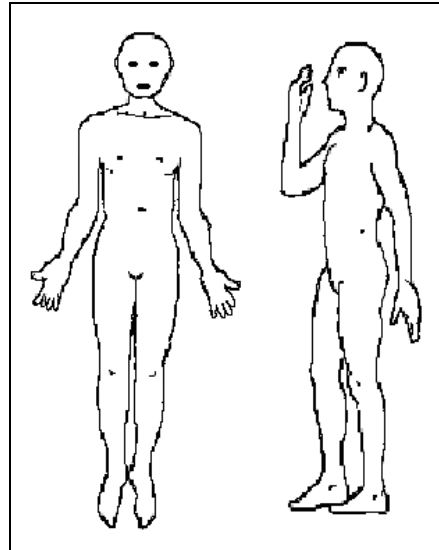
What have you tried to **treat** the pain? Do you have any **allergies**? Y _____ N

Medications:	Did it help? How much?	Side effects?
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____
Other treatment:	Did it help? How much?	Side effects?
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____

Do you have any important **medical problems**?

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> peptic ulcer disease | <input type="checkbox"/> edema/swelling of legs | <input type="checkbox"/> cancer _____ |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney disease | <input type="checkbox"/> other _____ |

Where is your pain? (See drawing.)
Is it **going anywhere** else? (Draw arrows.)



PAIN ASSESSMENT PROGRESS NOTE

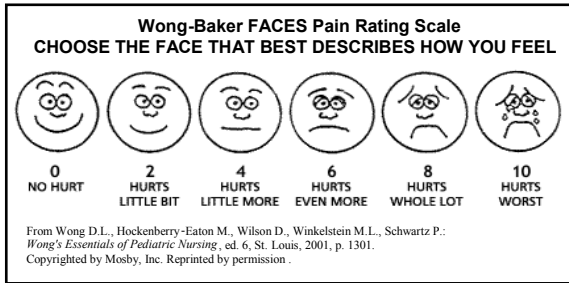
DATE: / /

Name: _____

DOB: _____

Medical Record Number: _____

OBJECTIVE:



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

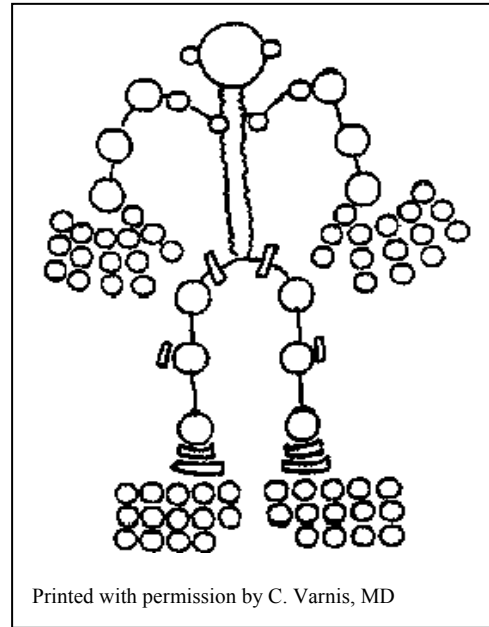
- now: _____
- on average: _____
- best: _____
- worst: _____

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



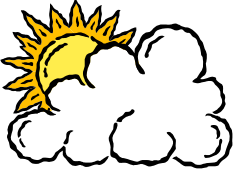
See intra-professional fax referral form

Counseling if needed: Y _____ N

Follow-up: _____ Signature: _____

“ Pain as the 5th vital sign “ FAX REFERRAL FORM

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 <ul style="list-style-type: none"> • <i>Rx acute pain aggressively to avoid chronic pain.</i> • <i>Rx chronic pain thoughtfully and systematically.</i> • <i>Reassess regularly.</i> 											
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  please	<table border="0"> <tr> <td>Problem list _____</td> <td>Priority:</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> </table>	Problem list _____	Priority:	Medication list _____	ASAP (please call) _____	Progress notes _____	Urgent _____	Labs _____	Semi-urgent _____	X-rays _____	Routine _____
Problem list _____	Priority:										
Medication list _____	ASAP (please call) _____										
Progress notes _____	Urgent _____										
Labs _____	Semi-urgent _____										
X-rays _____	Routine _____										
Referral for: (circle the number(s) for the treatment requested) 	<ol style="list-style-type: none"> 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) 										

Confidentiality Notice: The document accompanying this fax transmission contains confidential information belonging to the sender that is legal and privileged. This information is intended for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this faxed information for any purposes whatsoever is strictly prohibited. If you have received this faxed material in error, please notify us at the above telephone number immediately to arrange for the return of the faxed documentation to us.

A Guide to Understanding and Managing Your Pain

Helping Your Doctor Understand Your Pain	Treatment	Rights and Responsibilities
<p><i>“Every person feels pain differently. Whatever the person feeling it says it is, it is.”</i></p> <p><u>What is Pain?</u></p> <ul style="list-style-type: none"> • 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. <p><u>SPEAK UP!</u> 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.</p> <p><u>HELP YOURSELF TO MANAGE PAIN.</u></p> <ul style="list-style-type: none"> • 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. 	<p><u>Help Control Your Pain:</u></p> <p><i>There are safe and effective ways to treat pain without using pills.</i></p> <ul style="list-style-type: none"> • 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 <p><u>Did You Know That...?</u></p> <ul style="list-style-type: none"> • 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”. 	<p><u>Your Rights to Pain Relief Are:</u></p> <ul style="list-style-type: none"> • Information and answers to your questions about pain and pain relief. • A feeling that your doctor or nurse cares about you. • A quick response from your doctor or nurse when you report pain. • A sense that your complaint of pain is believed. <p><u>Your Responsibilities in Pain Relief Are:</u></p> <ul style="list-style-type: none"> • 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. <p>From American Pain Society</p>

Prepare for Your Visit

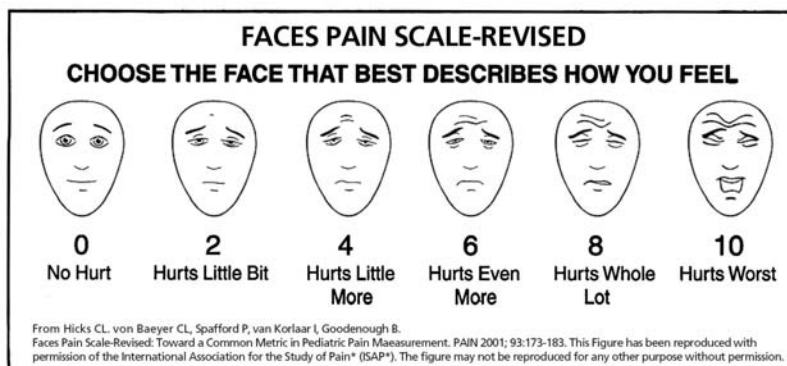
In order for your doctor to understand your pain, you will be asked to answer questions about your pain such as:

1. Where is your pain?
2. How does your pain feel?
3. How often do you have pain?
4. What time of day is your pain the worst?
5. What gets your pain started?
6. Does your pain stay, or come and go?
7. What makes your pain better?
8. What makes your pain worse?
9. What have you tried that makes your pain better?
10. Does your pain make you sad?
11. What do you think causes your pain?
12. Does pain cause you problems with your personal needs such as getting dressed, combing your hair, shaving, bathing or eating?
13. 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 (now):

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



For more information view, CompassionAndSupport.org.

Self-Help/Alternative/Complementary Therapies for Pain Management
Patient Guide “Pain as a 5th Vital Sign”

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

***Please check with your insurance plan for payment benefits.**

Self-Help/Alternative/Complementary Therapies for Pain Management
Patient Guide “Pain as a 5th Vital Sign”

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

*** Referral needed from the physician; please check with your insurance plan for payment benefits.**

Myths and Truths About Pain

MYTHS	TRUTHS
<i>Infants and children do not feel pain. This means they do not need as much medicine to stop their pain.</i>	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.
<i>Children do not remember being in pain.</i>	Many studies have shown that even infants have a memory of being in pain.
<i>Children and adults will tell you when they are in pain.</i>	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.
<i>You must see signs of pain in the person to know the person is in pain and how much pain.</i>	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.
<i>The use of strong medications or prescription pain pills for pain relief can lead to addiction.</i>	It is extremely rare for a person to become addicted to strong medications or prescription pain pills when they are used for pain relief.
<i>Strong pain medicines are not good and/or cannot be handled by elderly persons.</i>	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.
<i>You can learn how bad the pain is by how active the person is.</i>	Some people may be able to be active when they are in pain; other people may not be able to move about.

Myths and Truths About Pain

<i>MYTHS</i>	TRUTHS
<i>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.</i>	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.
<i>A person's mood (happy, sad, blue, worried) has no effect on pain.</i>	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.
<i>Narcotics should be given in small amounts to dying people because the medicines could bring death sooner.</i>	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.
<i>The ways, customs and religious beliefs of families are not important in management of pain.</i>	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.

Pain Management Patient Resources

Pain as a 5th Vital Sign

Community Support Groups

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

Cancer Action, Inc., 255 Alexander St., Rochester, NY 14607 585-423-9700 www.canceraction.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
http://www.medem.com/MedLB/sub_detaillb.cfm?parent_id=250&act=disp-wbsite

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

Pain Management

PRACTICE PRINCIPLES

References – Originally compiled in 2002. Refer to www.CompassionAndSupport.org for additional resources.

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

Columbia (MD): American Medical Directors Association; 1999. 39[57 references]. "Chronic pain management in the long-term care setting". National Guideline Clearinghouse.

Iowa City (IA): University of Iowa Gerontological Nursing Interventions Center; 1999 April 6. 37 "Acute pain management." National Guideline Clearinghouse.

Jacox A. et al Rookville, MD: Agency for Health Care Policy and Research (AHCPR), US Dept of Health and Human Services, Publication No.94-0592, 1994.

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"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.

"The Assessment and Management of Acute Pain in Infants, Children, and Adolescents" (0793) A policy statement from American Academy of Pediatrics.

Non-Pharmacologic Management of Pain:

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Mind, Body, Health by James S. Gordon, MD., Dennis T. Jaffe, Ph.D., and David E. Bresler, Ph.D. Published by Human Sciences Press, 1984.

Pharmacologic Management of Pain:

Adopted step pain treatment ladder from World Health Organization, 1990.

American Academy of Pain Medicine and American Pain Society, "The Use of Opioids for the treatment of chronic pain". A consensus statement. Glenview, Ill, 1997.

American Pain Society Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain (4th ed.) 1999.

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