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For the Relief of Pain

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Abstract

“We humans are the most exquisite devices ever made for the experiencing of pain: the richer our inner lives, the greater the varieties of pain there are for us to feel - and the more resources we will have for mitigating pain” so say the authors of your trusty Oxford Handbook of Clinical Medicine. Hmm. Few people like to experience pain (there is the odd masochist out there) but we endure it knowing it is for our own good. Looking back though my second year neuroscience notes I find Dr. Malcom Wright exhorting us to remember that: “Pain is an unpleasant sensory experience quite distinct from any other form of sensation. It occurs following noxious (nociceptive) stimuli in normal persons and is the presenting symptom in many disease states. It is a warning that damage has occurred in the body”².

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For the Relief of Pain

Lucy M^cDowall

*"We humans are the most exquisite devices ever made for the experiencing of pain: the richer our inner lives, the greater the varieties of pain there are for us to feel – and the more resources we will have for mitigating pain"*¹ so say the authors of your trusty Oxford Handbook of Clinical Medicine. Hmm. Few people like to experience pain (there is the odd masochist out there) but we endure it knowing it is for our own good. Looking back though my second year neuroscience notes I find Dr. Malcom Wright exhorting us to remember that:

"Pain is an unpleasant sensory experience quite distinct from any other form of sensation. It occurs following noxious (nociceptive) stimuli in normal persons and is the presenting symptom in many disease states. It is a warning that damage has occurred in the body"².

Pain is not only useful to the individual, but also to the medical student and doctor. Imagine how much harder our job of diagnosis and management would be if none of our patients could tell us "where it hurts" or when it "feels better". But what if the underlying condition has been treated as far as possible and the pain still remains? Such a pain signal which is no longer "useful" is labelled chronic pain³ or

neuropathic pain. It is estimated that 11% of the UK population currently suffer from this; approximately 6.42 million people⁴. The college of health suggests:

Chronic pain often has a powerful emotional accompaniment: the pain is anxious - they don't know when the pain will come or when it will end. This may lead to depression, requiring psychotropic drugs as well as analgesia. Autonomic accompaniments such as faintness, sickness and palpitations add to the problems and patients often complain that their chronic pain "rules their lives" and "makes life a misery".

"There has been a failure to understand the essential nature of chronic pain, of how it needs to be viewed as different from acute pain, and as an illness in its own right"⁵.

There are pain relief clinics being established in hospitals across the country, but demand far outstrips supply and the waiting times can be long – up to 40 weeks⁴. The Pain Association Scotland is a voluntary organisation that exists to help such unreached people through patient support groups, pain management courses for sufferers and the dissemination of information on alternative methods of coping with pain such as hypnosis, hydro therapy and acupuncture⁶. This is aimed to back up and in

some cases replace the care offered by anaesthetists, psychotherapists and physiotherapists in the hospital setting.

As current and future medical practitioners we are all expected to use our “medical knowledge ...to benefit peoples’ health....and provide the best care(we)....can”⁷. Why and how do we do this in the realm of pain control?

Returning to the wisdom of Malcom Wright, this is why he suggested to us that we might want to relieve pain²: (these points relate especially to post operative patients)

- For humanitarian reasons
- To allow the patient to breathe deeply (shallow breaths can lead to alveolar collapse at the bases of the lungs on expiration, a left to right shunt and a fall in arterial PaO₂).
- To allow the patient to cough and expectorate secretions. Retained secretions lead to blockage of bronchi, alveolar collapse, a right to left shunt and a fall in PaO₂. Following bronchial obstruction, pneumonia may occur.
- To allow mobility. Immobility predisposes to deep venous thrombosis and increases the risk of pulmonary embolism.
- To reduce sympathetic stimulation (which causes a rise in BP)
- To reduce the tendency to paralytic ileus.
- To reduce the metabolic response to trauma.

As a house officer on the ward, pain control most frequently takes the form of administering analgesic drugs. Below are guidelines to help in this¹:

- Pain is affected by mood, morale and meaning. Explain its origin to both patient and relatives, as explanation and reassurance can lessen the amount of analgesia required.
- Identify and treat the underlying pathology wherever possible.
- Review and chart each pain regularly eg. On a pain score chart so you can monitor how effective your treatment is.
- Assess each pain carefully- different types of pain respond to different approaches and analgesics eg. Amitriptyline in nerve conduction pain, and NSAIDs in bone pain.
- Choose the best route: oral if possible, or PR, IM, epidural, sub-cut, inhalation or infusion
- Give regular doses with the aim of preventing the pain, rather than analgesia on an “as required” basis.¹ (Remember pre-emptive analgesia before surgery)

Due to the wind up phenomenon and alterations in the pain pathway which have been produced following chronic pain, these patients are often taking maximum doses of analgesics without relief, and putting themselves at risk of severe side effects. Other methods of pain control have been used in these circumstances:

1. Nerve blocks – an analgesic procedure more appropriate for acute pain.
2. Manipulation methods and exercise eg. Physiotherapy, osteopathy, chiropractice, Alexander Technique, massage and ultrasound.
3. Electrical methods – Transcutaneous electrical nerve stimulation (TENS): a small battery operated pulse generator

used externally with two or more electrodes to relieve localised pain.

4. Behavioural management eg. Psychology, education, biofeedback and relaxation.
5. Complementary therapies eg. acupuncture, reflexology and homeopathy.

Dealing with people in pain is something most of us will be doing every day of our working lives. Remember some of the points outlined above will help us and our patients. Remember, next time you discharge someone suffering with chronic pain, think: hospital follow up and support from the Pain Association Scotland (telephone 0131 312 7955. Head office: Cramond House , Kirk Cramond , Cramond Glebe Road, Edinburgh EH4 6NS).

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*"Never forget how painful pain is"*¹

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