

# WORKSHOP: COMPLEX PAIN MANAGEMENT

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PROF ROD MACLEOD

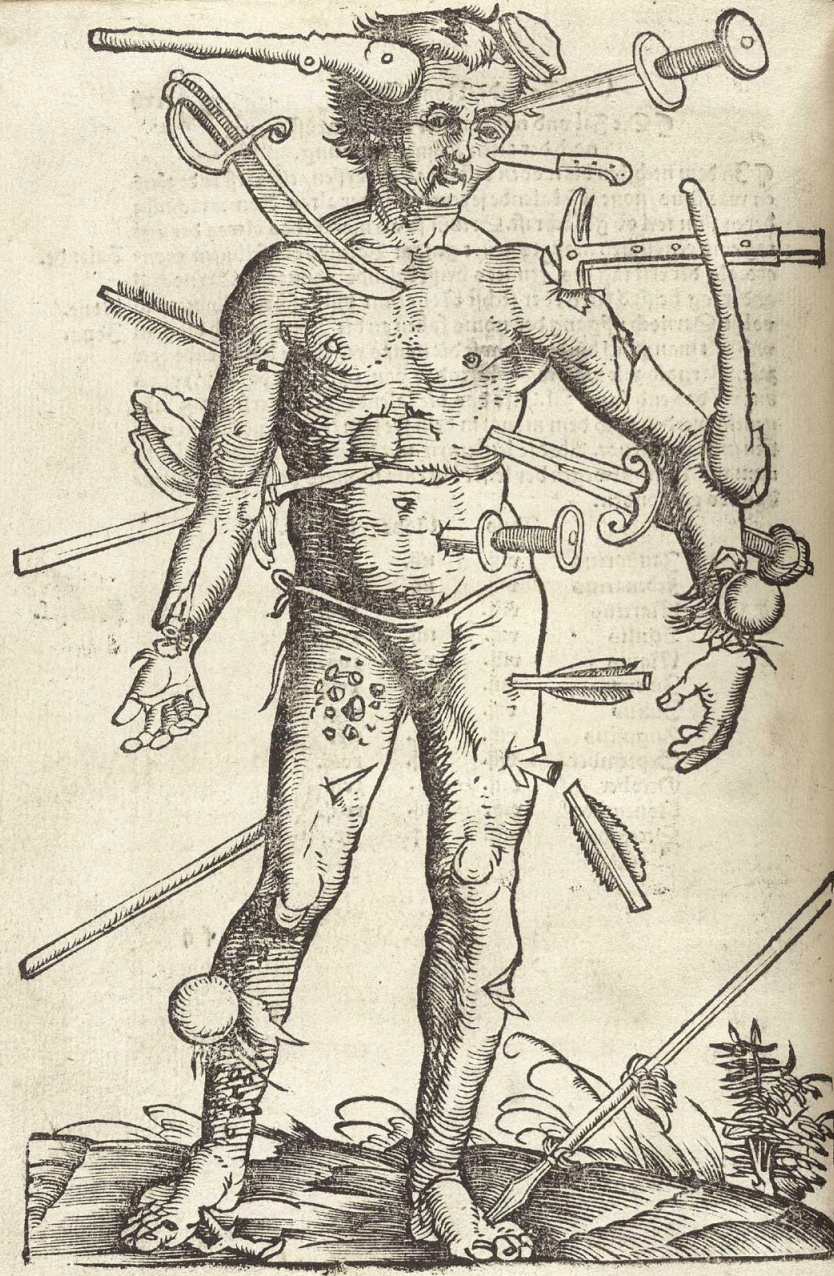
WAYNE NAYLOR



# WOUND PAIN

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# WHAT IS PAIN?

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- “An unpleasant sensory and emotional experience which we primarily associate with tissue damage or describe in terms of tissue damage, or both” (International Association for the Study of Pain 1999)
- Provides information about noxious stimuli causing actual or potential tissue injury



# WOUND PAIN – WHAT IS NOT WORKING

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- Inappropriate or non-existent pain assessment
- Inefficient prescribing of analgesia
- Lack of knowledge about pain
- Inappropriate beliefs and attitudes
- Inappropriate wound care practices

# LIVING WITH A CHRONIC WOUND

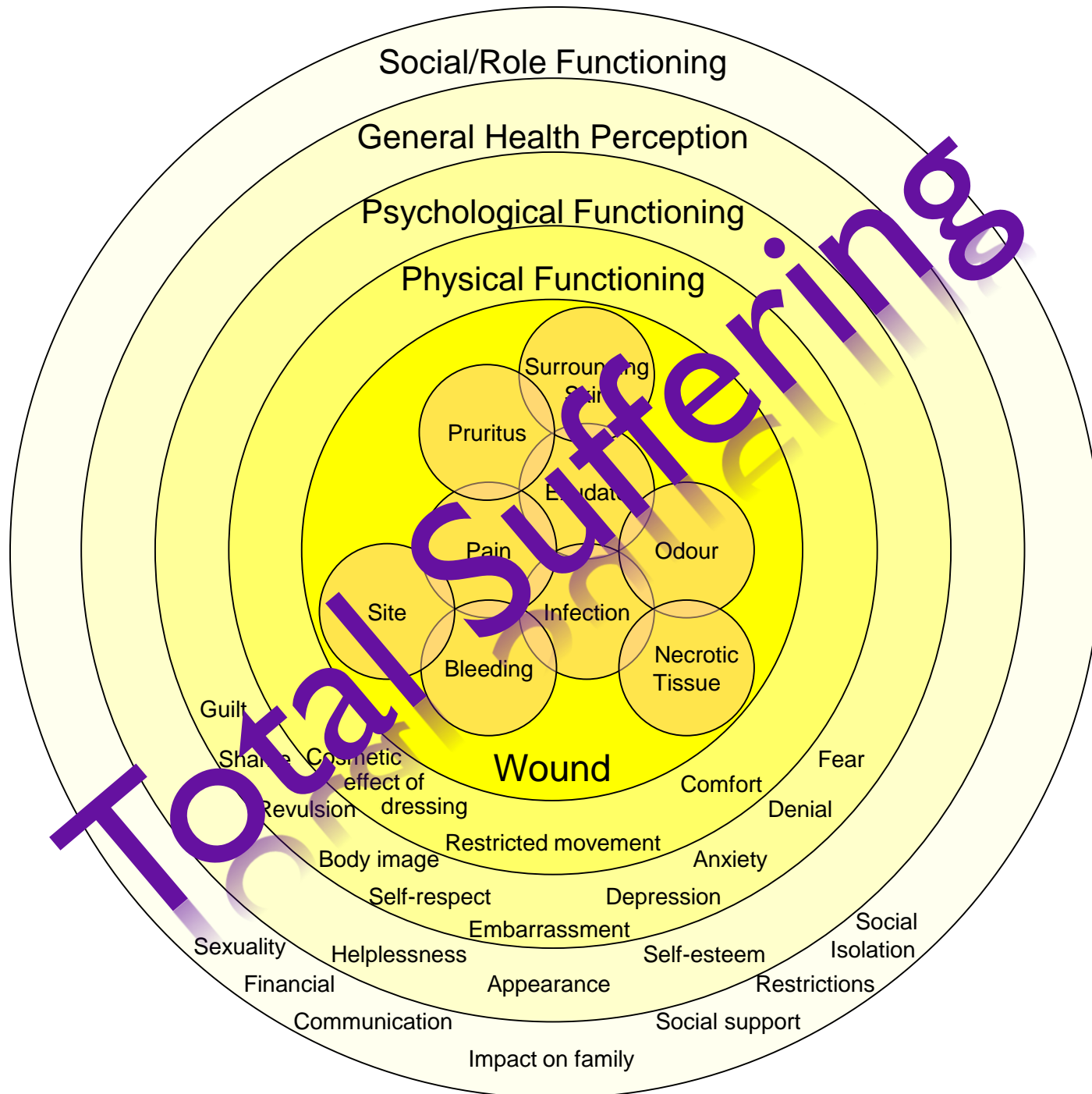
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- Pain
- Exudate and malodour
- Anxiety, depression, self-neglect
- Loss of self-esteem/ Loss of control
- Social isolation
- Poor sleep
- Role functioning (work, financial, mobility)
- Inconvenience (dressings, clinic etc)

# LIVING WITH A CHRONIC WOUND

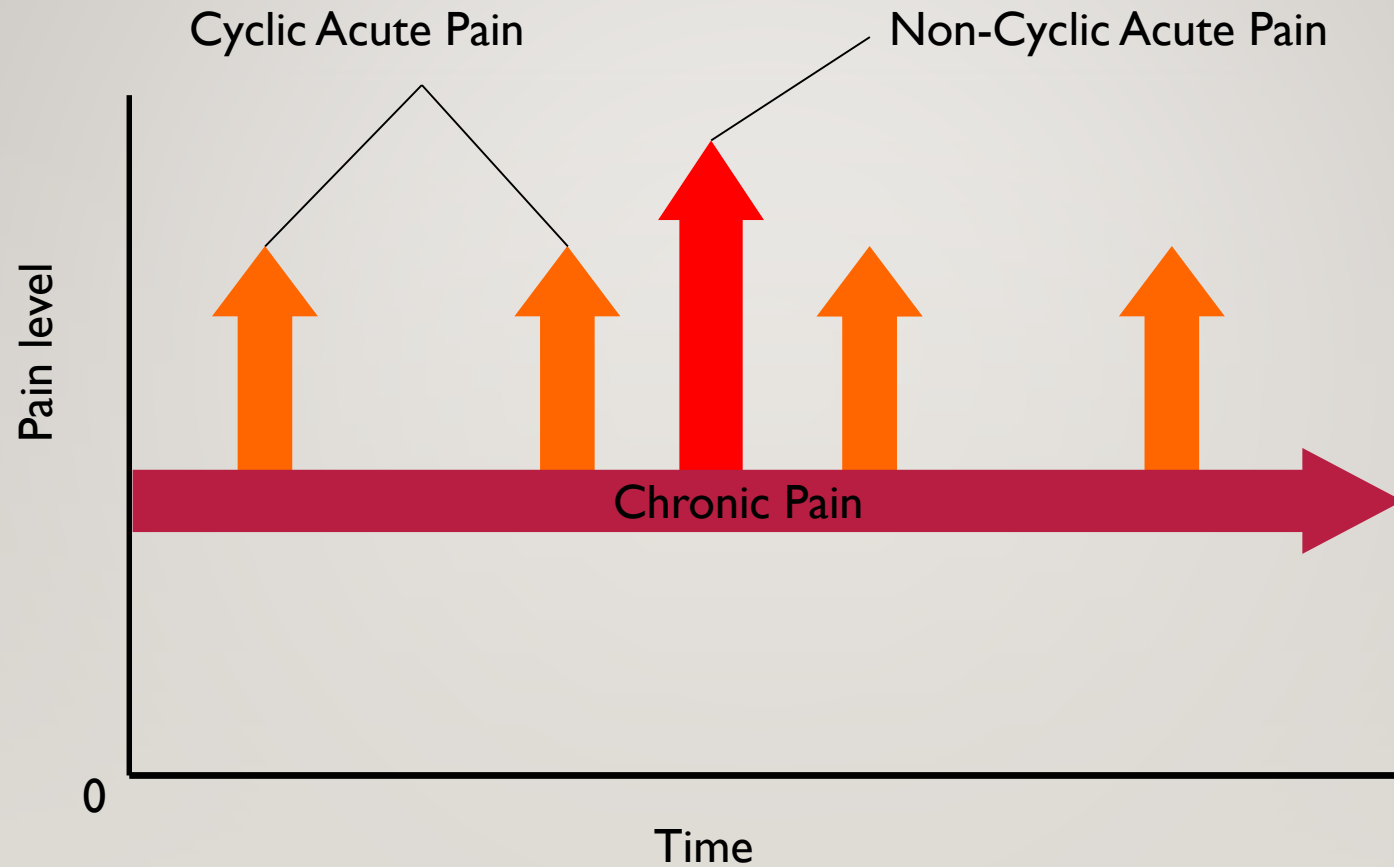
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- Body image - presence of an unsightly (possibly unnecessary) leaky, malodorous, painful wound
- Withdrawal and social isolation
- Relationship problems
- Emotional distress:
  - Anger
  - Disgust
  - Embarrassment
  - Shame
  - Depression
  - Denial
  - Anxiety
  - Fear
  - Guilt



# TYPES OF WOUND PAIN

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# CAUSES OF WOUND PAIN

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- Superficial somatic pain
  - Tissue injury
  - Stimulation of nociceptors
  - Injury to skin - 'cutting' or 'burning' pain
  - Injury to blood vessels - 'throbbing' pain



# CAUSES OF WOUND PAIN

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- Superficial somatic pain
  - Tissue injury
  - Stimulation of nociceptors
  - Injury to skin - 'cutting' or 'burning' pain
  - Injury to blood vessels - 'throbbing' pain
- Peripheral neuropathic pain
  - Nerve damage due to disease process – e.g. diabetes
  - Secondary to nerve damage such as trauma, surgery, or locally invasive malignancy
  - Spontaneous 'burning' pain with intermittent 'sharp stabbing' pains
  - 'itching', 'tingling', 'smarting' or 'stinging' pain







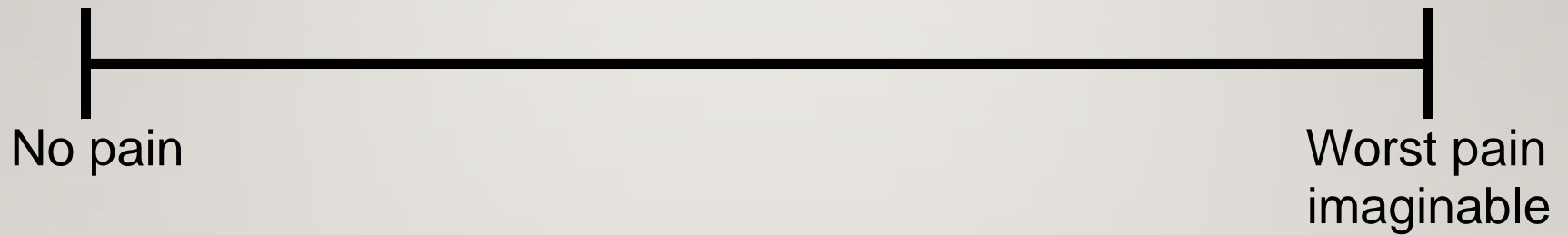
# PAIN ASSESSMENT

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- Location
- Nature
- Severity
- Onset / frequency
- Duration
- Aggravating factors
- Alleviating factors
- Current analgesia
- Effectiveness of treatments
- Impact on activities of daily living

# PAIN ASSESSMENT

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Please mark the line at a point that best reflects your pain

# PAIN ASSESSMENT

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**Wong-Baker FACES® Pain Rating Scale**



**0**

No  
Hurt



**2**

Hurts  
Little Bit



**4**

Hurts  
Little More



**6**

Hurts  
Even More



**8**

Hurts  
Whole Lot



**10**

Hurts  
Worst

Originally created with children for children to help them communicate about their pain. Now the scale is used around the world with people ages 3 and older, facilitating communication and improving assessment so pain management can be addressed

# REDUCING ACUTE WOUND PAIN

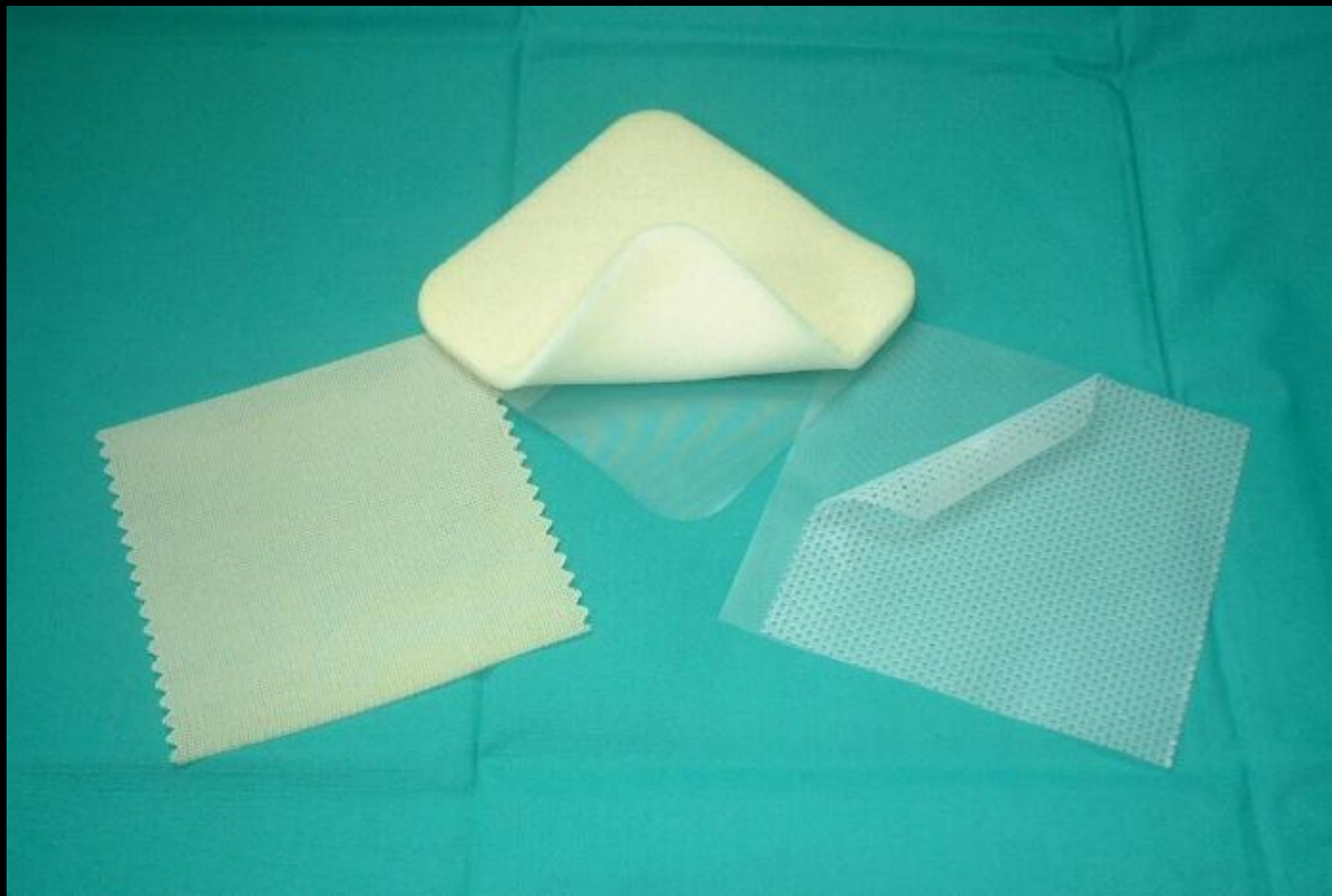
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- Irrigate gently with warm 0.9% sodium chloride or water
- Use a sterile gloved hand
- Use modern dressing products











# REDUCING ACUTE WOUND PAIN

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- Irrigate gently with warm 0.9% sodium chloride or water
- Use a sterile gloved hand
- Use modern dressing products
- Maintain moist wound environment
- “Adhesive dressings” - use with caution
- Protect surrounding skin







# Complex pain management

Rod MacLeod MNZM

New Zealand Wound Care Society 8th National Conference 2017

"Clearing the Air – Dispelling Myths and Misconceptions in Wound Care"

# Pain management

Ensure people have the time and space to express their concerns and receive validation from your team – they are going to need to trust you

Give a consistent message about pain etiology and pain management – why do they have the pain they have

People should be treated in a holistic way by a multidisciplinary approach

Patients should be involved in the development and review of a plan for their pain management

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# Pain management

Patient education: information about the pain, aggravating and alleviating factors, management strategies, lifestyle factors that may influence the pain (e.g. use of nicotine, alcohol)

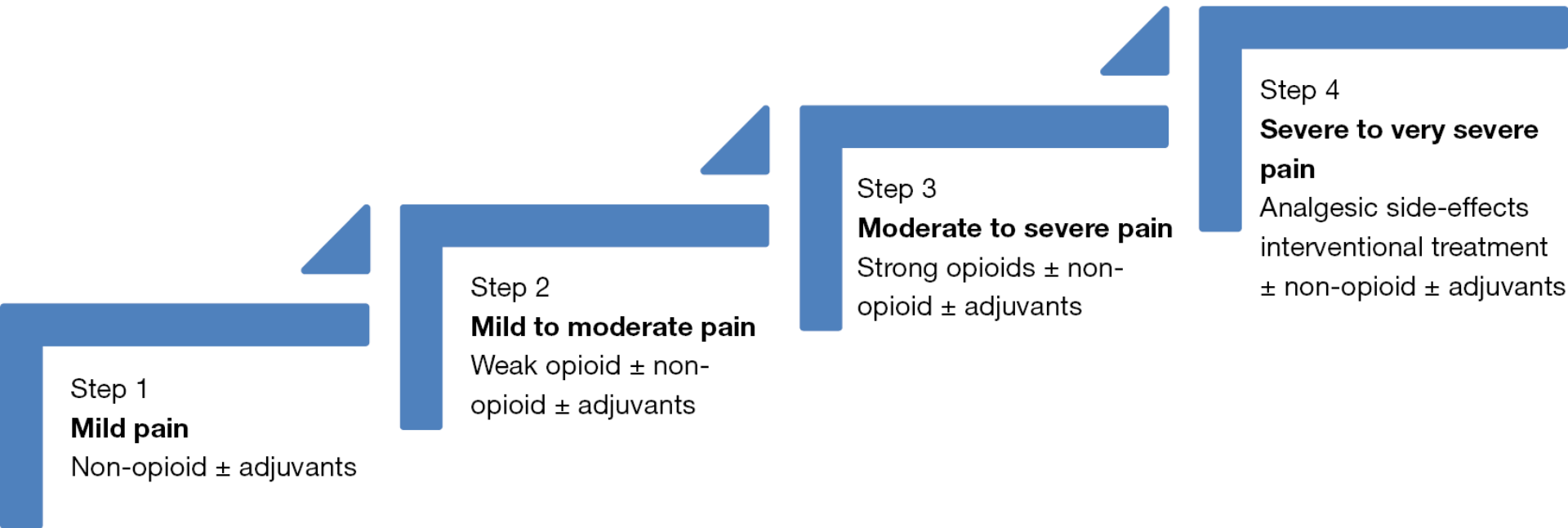
Physical rehabilitative approaches: physiotherapy for reconditioning (e.g., walking, stretching, etc)

Other physical approaches: application of heat or cold, TENS, massage, acupuncture

Occupational therapy: attention to proper body mechanics, resumption of normal levels of activities of daily living



# Pain management



Review, review, review...

# Pain management

Pharmaceuticals: simple analgesics, opioids, antidepressants, anticonvulsant drugs – by mouth, by the clock, for the individual

Regional anesthesia: nerve blocks and/or intraspinal analgesia (e.g. opioids, clonidine, baclofen, local anesthetics)

Psychological approaches: relaxation training, biofeedback, counselling, behavior modification, psychotherapy, visualisation, guided imagery, hypnosis, music therapy/engagement

Surgery: neuroablation, neurolysis etc

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# Pain management

Once the pain is no longer managed by step 2 analgesics, (in combination with NSAIDs), it may be time to initiate morphine, oxycodone or fentanyl

Avoid morphine in renally impaired patients. Morphine is metabolised by glucuronidation to morphine-3 and morphine-6 glucuronide. Both are active metabolites and morphine-6 is renally excreted

Some pain may not respond completely to opioids - remember the non-physical elements of pain. Co-analgesics may be useful when response to opioids is poor

Review, review, review...

# Neuropathic pain management

Medication needs to be tailored to the patient

- Opioid analgesics (now first line for neuropathic pain) should be trialed, but doses may increase rapidly - some opioids may be more useful than others, eg, methadone, which has intrinsic NMDA blocking activity. (NMDA receptor antagonists are a class of anaesthetics that work to antagonise, or inhibit the action of, the N-methyl d-aspartate receptor) – don't forget laxatives
- Tricyclic antidepressants, eg, nortriptyline and SSRIs, eg, escitalopram, paroxetine - are recommended as second-line therapy, but may be of limited efficacy in palliative care



# Neuropathic pain management

- Anticonvulsants, e.g, valproate, (carbamazepine), gabapentin and pregabalin (not currently funded)
- Benzodiazepines, e.g, clonazepam
- Combining an antidepressant with an anticonvulsant may be more effective than either alone, e.g, nortriptyline + gabapentin

Other medications may be useful, e.g, ketamine and methadone - discussion with local specialists is recommended

Review, review, review...

# Pain management

When we are not getting it right

- Repeated complaints of pain
- Runs out of medication ahead of schedule
- Frequent calls for help
- Non-compliance?
- Diminished hygiene, nutrition, social contacts

# Always think about healing

- **D**iabetes – diminished sensation
- **I**nfection
- **D**rugs – steroids, antimetabolites
- **N**utritional problems – malnutrition and/or vitamin deficiency
- **T**issue necrosis – local or systemic ischemia or radiation therapy

# Always think about healing

- **H**ypoxia
- **E**xcessive tension on wound edges
- **A**nother wound (competing for substrates required for healing)
- **L**ow temperature



# Don't forget about you

You won't always get  
it right

That doesn't mean a failure



# Don't forget about you

You won't always get  
it right

That doesn't mean a failure

Look after yourself



# CASE REVIEWS

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# CASE 1: JEAN

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- 79, widowed 6 months
- Lives in ARC
- Diabetes, neuropathy, PVD, IHD
- Lost 15kg in last 4 mths
- Complaining of worsening pain in leg
- Does not want anything touching it, makes pain +++ worse





# CASE 2: ALAN

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- 56, married with adult children
- Cutaneous lymphoma
- Hospitalised 5 months
- Misdiagnosed
- Multiple surgical interventions
- Severe pain, especially at dressing change
- Exudate leaking onto clothing
- Undergoing chemotherapy

