INDIANA PAIN ACADEMY Newsletter

STATE CHAPTER OF NORTH AMERICAN PAIN ACADEMY

President: Randall Lee Oliver, M.D.

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Welcome to the Indiana Academy of Pain Medicine. The goal of this newsletter is to discuss the practical treatment of pain. Who do we refer to and how do we recognize and treat pain? Our mission is that we believe in the Hippocratic Oath. The basic principle that medicine's greatest goal is the relief of human suffering. To that end we bind together all the various modalities involved in pain relief: Medicine, Chiropractic, Alternative, and Nutritional. We believe that it's the quality of life that matters, not the length of life. We believe in pain relief.

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J AHO Pain Standards

by April Taylor, RN, BSN

Since January 1, 2001 all on-site surveys by Joint Commission will be evaluating compliance with the JCAHO Pain Standards. The Joint Commission has upgraded from recommendations to standards regarding pain. This means that an organization is expected to follow the standards or intent 100% of the time.

Standard RI.1.2.7 — The Health Organization Addresses Care at the End of Life

This standard requires that staff are "sensitized to the needs of the patient at the end of life." This area of care is not as difficult for physicians and nurses to understand. The fear of addiction and manipulation of the caregiver by the patient is less due to the situation.

Joint Commission goes on to say that treatment of ain is not just for the dying patient and that all pa nts have a right to pain relief (RI.1.2.8 and PE.1.4).

St ard RI.1.2.8 — Patients Have the Right to A priate Assessment and Management of Pain

Joint commission requires that all patients have an initial assessment and regular reassessment of pain, education of all relevant providers of pain assessment and management, education of patients and families, and communication to patients and families that pain management is an important part of care.

It is not adequate pain management to just prescribe a pain medication. JCAHO expects pain to be assessed and reassessed, all of the staff to understand the pain management care, and for patients to understand the pain management goals and care.

Standard TX.3.3 — Policies and Procedures Support Safe Medication Prescription or Ordering

Medications are appropriately documented, stored, distributed, and monitored.

Standard CC.6.1 — The Discharge Process Provides for Continuing Care Based Upon the Patient's Assessed Needs at the Time of Discharge

It is important to continue to assess and reassess pain upon discharge. Hospital stays are shorter than ever and patients are sent home to recuperate. This means that many go home requiring pain medication. Caregivers need to teach patients and families that pain control at home is also important for restoration to normal functioning.

— www.JCAHO.org

Case Study: What Do You Expect The Nurse To Do?

by April Taylor, RN, BSN

Seventy-year-old female was admitted three days ago with hip fracture. She was on Darvocet QID at home for osteoarthritis of the spine. She is two days post-op and on a Morphine PCA pump. She is using up to her dose limit of 30mg every four hours with moderate pain relief. She is able to sit up in the chair and is participating in physical and occupational therapy. The nurses are concerned that she is using too much pain medication and that she needs to be converted to oral medication to plan for discharge. The patient and family are also expressing desire to go to rehabilitation.

1. What do you tell the nurses?

a. There is no limit on the amount of Morphine that a patient may receive. As long as she is monitored for excess sedation, it is necessary to treat her pain

b. I know what you mean, so I am going to try to get her off the Morphine

c. She was on Darvocet at home and I think she likes the pain medicine.

d. Her family thinks she is on too much also.

2. What do you give her for pain?

a. Continue the PCA.

b. Take her off the Morphine pump and put her on Darvocet QID PRN.

c. Stop the PCA and start Morphine 2-4mg Q4 hours PRN or Lortab 5mg one to two Q4 hours PRN.

d. Begin Oxycontin 10mg BID and consider stopping the PCA tomorrow.

3. What should your plans be for pain control during rehab and at home?

a. Resume her home medication of Darvocet because Darvocet is safer than Oxycontin.

b. Continue the Oxycontin during rehab and titrate it up to a dose that provides adequate pain relief. Send home on a maintenance dose of Oxycontin.

c. Discuss with the patient and family the financial situation of the patient and take into consideration the cost when determining the medication best for her.

d. Now she has had surgery and rehab, at her age she is safer without any pain medication.

4. What alternatives to narcotics do you have for after discharge?

a. NSAIDS

b. Continue rehabilitation outpatient

c. An anti-seizure medication (such as Neurontin) to alter the transmission of pain signals to the brain.

d. Refer to chiropractic care.

e. All of the above.

See Answers Page 4...

Normeperidine Toxicity

by Randall L. Oliver, MD

Demerol, when metabolized in the body, makes a by-product of NORMEPERIDINE. The significance of NORMEPERIDINE, is that is it is resistant to Narcan. The half-life of NORMEPERIDINE is 15 to 30 hours. If Demerol is repeatedly dosed, NORMEPERIDINE begins to accumulate in the body. High plasma levels of NORMEPERIDINE causes respiratory arrest, hyperreflexia, myoclonus, grand mal seizures, agitation, urinary retention, atrial flutter, and supraventricular tachycardia. These effects have be found in less than 24 hours use of Demerol and can not be reversed with narcan. These effects have been found in patient of any age and renal function.

Demerol also blocks the neuronal reuptake of serotonin leading to serotonin syndrome that has been reported with concomitant use of meperidine and fluoxetine. Demerol use may also aggravate preexisting seizure disorders.

What's New

Indiana Academy of Pain Medicine

Late in 2001,the North American Pain Academy was founded. Dr. Randall Oliver has developed the North American Pain Academy for the sharing of ideas and as an arena to pull the best practices in pain medicine together. It is also for the presentation and consideration of other pain experts and any other practitioners with the hopes of fostering improved awareness and treatment of pain.

The Tri-State Pain Partners will now be the first state chapter of the North American Pain Academy, named the Indiana Academy of Pain Medicine. The newsletter will continue to be a tool for communication. We encourage you to express your ideas, concerns and opinions by writing, phone or e-mail. Your thoughts will be published in the next newsletter, if you so wish.

New Cox-2 Inhibitor

Bextra, (valdecoxib) co-marketed by Pfizer and Pharmacia is the latest Cox-2 inhibitor. It is dosed Bextra 10mg po once daily. Bextra can be taken with no regard to food intake. Soon it will be available in an IM or IV form. Unlike Celebrex, Bextra does not have sulfa allergy interactions. Bextra can also be prescribed for dysmenorrhea at a dose of 20mg BID.

The average practice has 2000 charts. Ten to twenty percent have migraine incidents. Therefore, you should have 200 migraine patients in your practice. Do you have 200 patients on a triptan? Remember, Axert by Pharmacia has the least side effects.

Quick Notes on Narcotics

1. To convert from IV pain medication to oral, the oral dose is three times as high as the IV dose.

2. Remember the half-life of medication in the body. It takes 4 half lifes to reach a steady state of medication in the blood. If the medication is given every 4 hours, it takes 16 half lifes to reach an therapeutic dose. A more effective control of pain is to give a loading dose.

3. Pain should be relieved 50% with each intervention. If it is not, the next step is to reevaluate the current plan.

Pain Terms

Addiction — physiological or psychological dependence on some agent

Dependence — a state in which there is a compulsion to take a drug, either continuously or periodically, in order to experience its psychic effects or to avoid the discomfort of its absence.

Tolerance — A decreasing response to repeated constant doses of a drug or the need for increasing doses to maintain a constant response.

Coming Events

Indiana Academy of Pain Medicine Meeting

May 11, 2002
Evansville Marriott
For more information, please call
812 425-9824

Resources

JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS
www.jcaho.org

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That which hurts, also instructs. — *Ben Franklin*

Case Study Answers

Question #1 a.

Question #2 a & d

There is no dose limit on Morphine. Just because a patient is two days post-op and wants to go home, does not mean that she should not receive adequate relief and have to come off the PCA. It is important for you to encourage the nurses to treat the pain. By receiving the regular PCA she is able to be mobile and develop her strength. Since she was on Darvocet at home, she may require more medication for pain.

This is tolerance, not addiction. By beginning Oxycontin now, you are planning for discharge. She can go home on the Oxycontin and get better, more consistent relief for her osteoarthritis, as well as treating her post-op pain. You have to start the Oxycontin before stopping the PCA. Oxycontin is a slow-release medication. It will take a couple of doses to reach a steady plasma level. If you decide to stop the Morphine PCA and go to IV PRN, 2-4mg is not an equal conversion. She would need Morphine 10mg Q3-4hours.

Question #3 b & c.

Despite the publicity, Oxycontin when taken as directed is a safe medication. Darvocet is still a narcotic and a poor pain reliever. She takes it QID, and receives and average of 12 hours of relief, while with the Oxycontin she will receive 24 hours of relief. Despite her age, she still deserves to have relief from pain. The elderly who experience pain are at a great risk for depression and a poor quality of life.

Question #4 e.

All of the above are correct. A multi-disciplinary approach offers the most comprehensive care and the most options for the patient. Care must be coordinated with the patient to accommodate for financial or mobility problems.

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