

# **ATYPICAL PAINS**

## **101**

# OBJECTIVES

- Learn principles of a pain management
- Identify atypical pains and management
- Describe pharmacological/non-pharmacological management of pain

# PAIN IS:

- whatever the experiencing person says it is, existing whenever he/she says it does.”

»

(McCaffery & Pasero, 1999)

# FACTS ON PAIN

- Persons with dementia can relate their pain intensity.
- Unrelieved pain is unacceptable.

# FACTS ON PAIN

- 45-80% of patients in extended care facilities experience pain.
- Taking opioids for pain relief leads to addiction in less than 1%.
- The dose and analgesic effect of mu agonist opioids have no ceiling.
- All pain responds to opioids, but some types of pain are more responsive than others.

# FACTS ON PAIN

- Analgesia for post-operative pain should initially be given around the clock.
- Analgesia for chronic non-malignant pain should be given around the clock.
- Analgesia for chronic cancer pain should be given around the clock

# FACTS ON PAIN

- Patients may sleep in spite of severe pain.
- In treating neuropathic pain with an anti-convulsant, a trial period of 1-2 weeks is necessary.
- To increase the dosage or convert a narcotic from one form to another, remember to add up ALL analgesia given in a 24 hour period.

# FACTS ON PAIN

- 45-80% patients in ECF experience pain
- 20% patients have one pain
- 80% patients have two or more pains
- 30% have 4 or more pains

# FACTS ON PAIN

- If the patient is drowsy on the opioid, THINK atypical pain.
- If the patient is treated for atypical pain and remains in pain, THINK anxiety.
- If the patient is treated for anxiety and is still in pain, THINK psychological pain.

# TITRATION OF MEDICATIONS

BE SURE TO CONSIDER ALL MEDICATIONS DEALING WITH PAIN

## TITRATING GUIDELINES

- If 3 or more breakthrough doses are used in a 24 hour period

Increase both ATC dose and Breakthrough dose

Total ATC dose + Breakthrough used in 24 hour ÷  
by 6

Increase both ATC dose and Breakthrough dose

OR

- Pain >7      Increase dose by 50-100%
- Pain 4-7      Increase dose by 25-50%
- Pain <4      Increase dose by 25%

# BONE PAIN

- BONE PAIN IS THE MOST COMMON TYPE OF ATYPICAL PAIN
- **ANY** CANCER CAN METASTASIZE TO THE BONE
- MORE THEN 50% OF PATIENTS WITH END STAGE CANCER EXPERIENCE IT
- OPOIDS DULL THE PAIN BUT DO NOT ELIMINATE IT

# DISEASE/CAUSE

- Metastatic CA from breast, lung, prostate, rectum, renal system, head and neck, thyroid
- Mesothelioma
- Primary bone cancer

# DISEASE/CAUSE

- Myeloma
- Renal Failure
- Chronic back/spine injury
- AIDS
- Leukemia
- DJD
- Dementia



# NON-VERBAL

- Increase in restlessness
- Constant movement with extremities
- Moaning, biting, scratching, hitting

# SUGGESTED MANAGEMENT BONE PAIN

## PHARMACOLOGICAL

### Early bone invasion:

#### NSAID's:

Ibuprofen 400-800 mg tid (Not to exceed  
2,400 mg/24hr)

Naprosyn 250-500 mg bid (Not to exceed  
1,000mg/24hr)

Trilisate 1,500 mg loading dose, then  
500 mg bid or tid (Not to exceed  
4,500mg/24hr) (little action in  
platelet count)

# SUGGESTED MANAGEMENT BONE PAIN

- More advanced: **ADD**

Prednisone 40-80 mg.

After 7-10 days, titrate to  
effective dosage

Radiation Therapy: A SINGLE DOSE  
OF 800cGy CAN RELIEVE PAIN

# NON-PHARMACOLOGICAL

- Relaxation
- Chiropractic
- Massage
- Physical Therapy
- Walking
- Water Therapy

# NEUROPATHIC PAIN

- NEUROPATHIC PAIN IS THE MOST DIFFICULT PAIN TO MANAGE

# DISEASE/CAUSES

- Metastatic CA of breast, lung
- CA prostate, bowel
- Lymphoma
- Involvement of the sacral nerve roots, rectum, genitalia

# DISEASE/CAUSES

- AIDS
- Diabetes
- Stroke/Coma
- Leukemia
- DJD
- Phantom Leg
- Hepatitis
- Dystrophic Diseases (ALS- MS- MD)
- Arthritis





# NON-VERBAL

- Rubbing area
- Hate anything touching around area (clothes/bedding/bath time)

# **SUGGESTED MANAGEMENT**

- **PHARMACOLOGICAL  
ANTIDEPRESSANTS**

Amytriptyline (Elavil) 25-150 mg PO/HS with titration

**DO NOT DIVIDE DOSES**

Day 1            10-25 mg

Day 3            25-50 mg

Day 7            50-100 mg

Day 10   100-150 mg

Desipramine (Norpramin) 25-100 mg PO/HS with titration

# **SUGGESTED MANAGEMENT**

**ANTICONVULSANTS** (trial period of 1-2 weeks is necessary)

Pregabalin (Lyrica) 50 mg t.i.d. may titrate to 100 mg t.i.d over a week

Gabapentin (Neuronitin) 300 mg day (100 mg on the medically frail elderly) Increase doses daily up to 2,400mg day in three divided doses.

Carbamazine (Tegretol) 100 mg PO QID to 200 mg PO QID (20% response rate).

# **SUGGESTED MANAGEMENT**

- **STEROIDS**

Dexamethasone (Decadron) 4-32 mg PO daily (single dose)

Prednisone 10-80 mg PO/Topically daily

- **TOPICALLY**

Lidocaine Patch 5%. 1-3 patches. Apply to affected area, 12 hrs on/12 hours off

## **NERVE COMPRESSION**

Dexamethasone (Decadron) 8-32 mg daily

# NON-PHARMACOLOGICAL

Massage

Heat/cold

Acupuncture

Anesthesia (Nerve Blocks)

Tens Unit

Chiropractic

Vibration

# **SMOOTH MUSCLE PAIN**

## **DISEASES/CAUSES**

- CA pancreas, rectum, bladder, head and neck with salivary duct invasion, rectum, ovarian, common bile duct, (stomach, colon—usually rare)
- AIDS
- Dementia
- Pancreatitis
- Hepatitis
- Renal Failure

# MANIFESTATION

- Muscle fatigue sets in
- Colicky
- Episodic
- Cramping
- Spasms

# MANIFESTATION

- **Common bile duct:**
  - comparable to passing a stone
  - waxes and wanes over 15-45 min period
  - located in the right upper quadrant of the abdomen, radiating to the tip of the scapula in the right side.
- **CA bladder and rectum:**
  - perceived need to evacuate
  - severe pressure sensation
- **Pancreas, salivary duct:**
  - pain remains constant

# NON-VERBAL

- Sudden, sporadic movement, jerky
- Clutching at abdomen
- Rubbing abdomen
- Doubling over

# **SUGGESTED MANAGEMENT**

## **PHARMACOLOGICAL**

- Hyoscyamine Sulfate (Levsin) 0.125 mg -.25 mg  
PO/SL/IV qid
- Atropine 0.3 mg every 4 hrs. with increases up to 4 mg  
(one test dose gives a simple, reliable and risk free  
reading)
- Scopolamine (Transderm Scop Patch) 1-3 every 3 days
- Oxybutynin (Ditropan) 5-10 mg PO tid  
B&O suppositories (long time sedation for episodic pain)

# NON-PHARMACOLOGICAL

- Heat/cold compresses
- Bath
- Massage
- Heat/cold compresses

# VOLUNTARY MUSCLE SPASM

## DISEASE/CAUSES

Spinal cord damage

Secondary to bone pain or fracture

Primary brain tumor in the posterior fossa

Invasion of the lumbar plexes or sciatic nerve

Hyperventilation due to anxiety

Walking pattern changed

AIDS

# VOLUNTARY MUSCLE SPASM

## DISEASE/CAUSES

COPD

DJD

Dystrophic Diseases

Heart Failure

Stroke/Coma

CHF

Bronchitis

Hemorrhoids

# MANIFESTATION

- Stiffness and/or rigidity in limb or back
- Tightness
- Manifested with movement
- Spasms
- Cramping (like a Charley Horse)
- Sharp

# NON-VERBAL

- Contracture of extremities
- Cry out with position changes
- Unable to stand/walk
- Bent over
- Painful to straighten up

# **SUGGESTED MANAGEMENT**

## **PHARMACOLOGICAL**

- Diazepam (Valium) 3-20 mg a day in divided doses
- Cyclobenzapine (Flexeril) 10 mg every 6 hours
- Baclofen (Lioresal) 5-30 mg up to tid

# **NON-PHARMACOLOGICAL**

- Warm, moist heat
- Cold
- Vibration

# RAISED INTRACRANIAL PRESSURE

- **DISEASE/CAUSE**

60% with primary CNS tumor

35% with cerebral metastases from CA:

Melanoma

Lung

Breast

Renal

Stroke

Aneurysm

# MANIFESTATION

- Tight band or pressure around the head, especially in the morning
- Seizure activity
- Sleepiness
- Lethargy

# NON-VERBAL

- Seizure activity
- Sleepiness
- Lethargy

# PAIN CONTROLLED

- Patients accepted pain level achieved
- Patient returns to “normal” ADL
- Two or less breakthrough doses in 24 hrs.
- Continue interventions as needed
- Reassess at regular intervals
- Titrate as needed

# PAIN NOT CONTROLLED

- Are analgesics being given as ordered?
- Need for a change to different opioid?
- Need to change route of administration?
- Need for upward titration?
- Need for adjuvant meds?
- Need to give before activities?
- Is time interval appropriate?