ADULT ANALGESIA in the acute setting

You are called to the ward to see a patient in pain.

1. Look at the patient
2. What are they admitted for?
    a. PMHx, medications.
    b. Timing is important!
3. Brief medical assessment/examination – can you find the cause of the pain?
4. WHAT COULD I BE MISSING?
5. Is the patient safe? Unsafe? Likely to deteriorate?
    a. Consider blood tests/imaging as needed
    b. Plans in place to ensure follow up
6. How to treat pain:
    a. Non-pharmacological
    b. Surgical
    c. Pharmacological

Non-pharmacological

- RICE
- Reassurance/education
- Pillows/tents/slings/bandages/bandaids
- Psychology

Surgical

- Drainage of collection/effusion/abscess
- Re-dressing of wound
- Decompression of whatever is inflated

Pharmacological

Basic principles:

- Don't forget basic drugs! They work for lots of things....
- Start with gentle, then move to the big guns
- Always give an oral AND an injectable option
- If in doubt, use short-acting analgesics first
- ALWAYS ASK FOR ALLERGIES
- Only an idiot prescribes a drug without at least a basic understanding of the major side effects. Just ask the coroner!
- Reassess and follow up
- If in doubt, ASK SOMEONE! We are not alone...

If you want the drugs:

Panadol

- Safe for most patients, even hepatic encephalopaths
- Cheap
- Can be given IV, but costs more
- Few side effects
- Good for baseline analgesia (1g QID PO)

Aspirin

- Often forgotten, but good for back pain, inflammation

- Always ask about GI bleeds, asthma, previous serious bleeds

NSAIDS

- Useful for inflammatory pains.
- Ibuprofen 200-400mg tds/prn po. PR options available.
- Always ask about GI bleeds, asthma
- Can be given with a bit of pantoprazole if you're keen

Oxycodone

- Dose for adults 18-60 years of age: 5-20 mg Q4H/PRN. Older adults: 2.5 or 5 – 10mg Q4H/PRN.
- Please warn patient about constipation, and consider coloxyl and senna (2 tabs bd). Interns are usually the disempactors, so do yourself a favour!
- Use for breakthrough pain relief

Morphine

- IV (only in ICU/ED), SC, IM. Dose according to age.
- Patients on morphine type drugs will have tolerance, so may need higher doses.
- Side effects to know: respiratory depression, hypotension, bradycardia, nausea and vomiting, constipation
- Always prescribe maxolon/antiemetic with morphine
- Consider naloxone if the patient stops breathing.

Fentanyl

- IV (ED/ICU), SC, IM
- 100 mcg fentanyl = 10mg morphine
- Usual doses: elderly 25-50 mcg Q2H/PRN. Younger people: 50-200mcg Q2H/PRN.
- Side effects: as for morphine. Reversal: same as morphine
- Useful for patients allergic to morphine
- Short acting, so if you're unsure of the effect of opiates on pt, consider fentanyl.

Note: both morphine and fentanyl can cause histamine release, so watch for this. It's pretty quick to occur.

Left-field options:

Buscopan

Good for tummy cramps. Safe for pretty much everyone. 20mg PO/IV, qid.

Panadeine forte

Constipating as anything, but some patients like it.

Benzodiazepines

I like to use diazepam for muscle spasms, particularly back pain. Lets the muscle relax, and makes the patient calmer (decreases SNS). 10mg diazepam PR/PO.

Remember: pain is a multifactorial thing, so needs a multifactorial approach!

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The pain is immense –
Mountains roll over my brain
My agony - severe