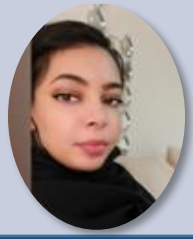

Case of the Month

Dr. Israa Abdelnasir Salih

Kill My Pain

Background

Pain relief is one of the best services the Emergency physician provides, a contemporary necessity to the emergency situation and patient satisfaction's primary element.

Oxford biology dictionary defines pain as severe physical or mental discomfort or distress.

Pain arises when sensory neurons detect a noxious stimulus which signals thalamus in the brain. The cortex determines perception, a process affected by many factors like emotions.

Pain is subjective; there is no absolute way to measure the actual patient perception of it. The use of objective observations like sweating, tachycardia and elevated blood pressure don't necessarily correlate.

We depend primarily on communication and what the patient states.

There are numerous pain scales which include the numeric rating scales, visual analogue, FACES pain scales and so many others.

The WHO analgesic ladder starts with non-opiate analgesics (Acetaminophen, NSAIDS) and ascends to involve mild and strong opioids. Adjuvants like antidepressants and anticonvulsants can be used along the way.

Management of acute vs chronic pain differs with more cautious use of opiates in the chronic pain settings.

No pain, No gain:

An almost 80-year-old male patient known to my facility has chronic neuropathic pain, frequently comes to the ED complaining of Lower legs pain. The patient answered my "How can I help you today?" saying "I have severe leg pain, I couldn't sleep). The patient was in a wheel chair, unable to ambulate unsupported which was his baseline status, and he looked euthymic and calm. Lower extremities exam was notable for bilateral muscle wasting, motor weakness and decreased sensation up to the knees not following a dermatomal fashion. The records showed past medical history significant for an old stroke and chronic neuropathic pain due to trauma which he follows in the pain. Patient records also showed multiple ED visits, sometimes biweekly with different complains. Among the medications he used, the patient was on regular acetaminophen and gabapentin.The patient told me that in his last visit the physician gave him an effective medication, but he didn't give a specific name.

For pain relief I went through the analgesic ladder starting with paracetamol but not NSAID because of his decreased kidney function. 20 mins later he asked for me and said "My pain is the same help me please".

By looking into the files, I noticed that in almost every visit the patient came with legs pain, he received an IV tramadol; and for any care taker who refuses to give tramadol, the patient starts complaining of new things (new weakness on a single leg or a unilateral calf swelling). The new complains always fit a certain emergency diagnosis that mandates specific testing and will make disposition delayed. The hospital length of stay depended on the time Tramadol was administered.

The patient exhibited a pattern highly suspicious of drug seeking, but saying NO to tramadol was not an easy call; the patient had impressive convincing and manipulation methods.

Is the pain real?

Drug-Seeking Behavior is an emerging phenomenon; the impact is strong and leads to significant morbidity and mortality.

Pain assessment and scoring became a standard of care in the early 2000s, a consequence of patient's right initiatives which lead to the more liberal use of opioids.

A portion of patients pretend or aggravate symptoms to receive controlled medications for abuse by recreation or selling.

Certain behaviors might suggest drug seeking or doctor shopping like injecting oral medications, concurrent abuse of alcohol and illicit drugs, repeated visits to other EDs, repeated dose escalation, aggressive and multiple complains, requesting specific drug or brand. Identification and management of drug seeking behavior is challenging. However, spending sometime checking hospital, Prescription control Programs, patients' contracts made life easier to some extent.

The doubt that a patient is exhibiting drug seeking behavior is linked to under treatment of pain. Unless drug seeking is confirmed by the patient being labelled in hospital records, previous prescriptions or by contacting other providers, pain should be addressed and managed properly.

Drug seeking requires multidisciplinary approach and collaboration between the ED physician, primary provider, a psychiatrist and a pain specialist.

On the other end of spectrum

Oligo-analgesia or inadequate pain control is a common practice. Reasons are underassessment of pain, medication safety considerations and delayed administration.

Extremes of age tend to suffer most of this, as well as miscommunication due to language barriers or cognitive or mental disabilities.

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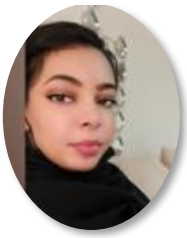

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