

The control of pain

We humans are the most exquisite devices ever made for the experience of pain: the richer our inner lives, the greater the varieties of pain there are for us to feel—and the more resources we will have for mitigating pain. You can connect with your patient's inner life you may make a real difference. *Never forget how painful pain is*—nor how fear magnifies pain. Try not to let these sensations, so often interposed between your patient and his recovery, be invisible to you as he or she bravely puts up with them.*

Guidelines for success Assess each pain carefully. This is important: different types of pain respond to different approaches and analgesics.

- Identify and treat the underlying pathology wherever possible.
- Review and chart each pain regularly, eg on a **pain score chart**.
- Give **regular doses** rather than on an *as required* basis.
- Choose the best route: oral, PR, IM, epidural, sc, inhalation, or iv infusion.
- Explanation and reassurance contribute greatly to analgesia.

Non-narcotic (simple) analgesia Paracetamol: 0.5–1.0g/4h po (up to 4g daily). Caution in liver impairment. Non-steroidal anti-inflammatory (NSAIDs), eg ibuprofen 400mg/8h po or diclofenac 75mg/12h po, or (100mg) or IM; these are good for musculoskeletal pain and renal colic. c: peptic ulcer, clotting disorder, anticoagulants. Cautions: asthma, renal or hepatic impairment, pregnancy, the elderly, and children.¹

Narcotic ('controlled') drugs for severe pain Morphine (eg 10–15mg/2–4h) or diamorphine (5–10mg/2–4h) po, sc, or slow iv, but you may need much more) are best. For terminal care, see p688).

Side-effects of narcotics: These include nausea (so give with an anti-emetic eg prochlorperazine 12.5mg/6h IM), respiratory depression, constipation, cough suppression, urinary retention, BP↓, and sedation (do not use in hepatic failure or head injury). Dependency is rarely a problem.

How effective are standard analgesics? Pain is subjective, but its measurement by patients is surprisingly consistent and reproducible. The table below gives 'numbers needed to treat' (NNT, p748), that is the number of patients who need to receive the drug for one to achieve a 50% reduction in pain (the range is 95% confidence intervals). Ibuprofen comes out best.¹

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|---|-------|---|-------|
| Codeine ^{60mg} | 11–20 | Paracetamol ⁶⁵⁰ /propoxyphene ¹⁰⁰ | 3–4 |
| Tramadol ^{50mg} | 6–13 | Paracetamol ^{1000mg} | 3–4 |
| Paracetamol ^{300mg} /codeine ^{60mg} | 4–8 | Paracetamol ^{600mg} /codeine ^{60mg} | 2.5–4 |
| Aspirin ^{650mg} /codeine ^{60mg} | 4–7 | Ibuprofen ^{400mg} | 2–3 |

Epidural analgesia Opioids and anaesthetic are given into the epidural space by infusion or as boluses. Ask the advice of the Pain Service (if available).¹ se: thought to be less as drug more localised: watch for respiratory depression; local anaesthetic-induced autonomic blockade (BP↓).

Adjuvant treatments Eg radiotherapy for bone cancer pain; anticonvulsants, antidepressants or steroids for nerve pain, antispasmodics eg buscopan 10–20mg/8h for intestinal, renal, or bladder colic. If brief pain relief is needed (eg for changing a dressing or exploring a wound), try inhaled nitrous oxide (with 50% O₂—as Entonox®) with an 'on demand' valve. Transcutaneous electrical nerve stimulation (TENS), local heat, local or regional anaesthesia, and neurosurgical procedures (eg excision of neuroma) may be tried but can prove disappointing. Treat conditions which exacerbate pain (eg constipation, depression, anxiety).

*Compare with Proust's 'egg of pain'... this structure... interposed between the face of a woman and the eyes of her lover which encases it and conceals it as a mantle of snow conceals a fountain... Marcel Proust 1925 *Remembrance of Things Past* II; *Albertine Disparue* 30, Chatto

<1> Co-codamol 30/500 (codeine phosphate and paracetamol) 2 tablets/6h is a less effective alternative: H McQuay 1997 *BMJ* i 153 & <http://www.jr2.ox.ac.uk/Bandolier/painres/MApain.html>

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