



Hospice of the Twin Cities

# Hospice Insights

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*“An open home, an open heart, here grows a bountiful harvest.”*  
-Judy Hand

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## Pain Management at the End of Life

Pain management is an important part of quality care. At the end of life it becomes even more important. We know from years of experience in delivering end of life care most patients experience some kind of pain as part of their dying experience.

It is up to all of us caring for individuals at the end of their lives to be proficient in managing pain and other symptoms so our patients can have the highest quality of life in the time they have remaining, maintenance of their dignity, and the ability to continue making their own decisions for as long as possible. We also know pain can erase all possibility of this happening. Luckily, we have many tools to help us manage pain, but in order to do so we must know the location, type, intensity, worst pain, best pain, tolerable level, duration, onset, patterns, effects, how the patient expresses their pain, current treatments, and the patient's goals for managing their pain.

Our first step is the initial pain assessment. It must include all of the informa-

tion listed in the previous paragraph. Pain intensity should always be listed according to a pain rating scale. There are many different scales which can help us do this, however, Hospice of the Twin Cities chooses to use a 0-10 scale. There are occasions when the 0-10 scale may not be the best scale to use with your patient. Keep in mind there are many scales available (0-5 scale, narrative scale, smiley face scale, etc.). Not only is it important to get a patient's current pain rating, but it is just as important to get as many facts as possible about the patient's pain in the past 24 hours, including worst pain, best pain, average pain, what precedes the pain, etc.

One of the most important parts of excellent pain management is **professional caregivers must believe the patient's report of pain.** Individuals who are dying are encouraged not only to report their pain, but to rate their pain and describe their pain using their own words.

There are different types of pain, which is important

to know if pain management is going to be successful. They are as follows:

**Nociceptive Pain:** This pain is the result of tissue damage and includes somatic and visceral pain.

**Somatic Pain:** Aching, throbbing, stabbing and/or pressure sensation in the skin, bone, or muscle. *Usually responds to nonsteroidal anti-inflammatory drugs (NSAIDS).* For those who cannot take NSAIDS, Trilisate might be tolerated.

**Visceral Pain:** Gnawing, cramping, aching, sharp or stabbing sensation coming from the internal organs. Most commonly related to partial or total bowel obstruction. *Limit intake to clear liquids. Administer antiemetics. If previous treatment is not successful, administer anticholinergic drug to control pain. Scopamine subQ or transdermally may alleviate symptoms.*

**Neuropathic Pain:** Two types ~ Continuous

dyesthesias (continuous burning, electrical sensations or other abnormal sensations). *Tricyclic antidepressants recommended as first-line treatment.* Chronic lancinating or paroxysmal pain (sharp, stabbing, shooting, knife-like pain with sudden onset, usually). *Anticonvulsants are first-line treatment (Tegretol, Klonopin, Neurontin, etc.).*

**Bone Pain:** *Cannot be completely controlled with opioids. Adjuvant drugs need to be added to the opioid regimen, usually NSAIDS and corticosteroids.*

**Breakthrough Pain:** When sustained-release pain medications are being used for pain control there are times the medication may not be sufficient to control the pain. It is during these times that an immediate release medication must be used to control the individual's pain. Each administered dose of the immediate release medication is 10-30 % of the total daily dose of the sustained-release medication.

*If a patient is receiving 60mg MS Contin bid, their breakthrough dose of immediate release morphine should be 15-40 mg q1-2h prn, until the pain is controlled.*

***The use of the breakthrough medication does not change the dose or time of administration of the sustained release medication.***

*If an individual is using many doses of the immediate release opioid then the sum of all of the sustained release medication and the sum of the immediate release*

*medication should be added together and that becomes the new dosage for sustained release medication in a 24 hour period of time. (Individual takes 60mg MS Contin bid + 5 doses of the immediate release morphine, equals 75 mg in 24 hours, the new dose of MS Contin will be 100 mg bid and the new dose of breakthrough med will be 20-60 mg immediate release morphine q1-2h prn, until pain is controlled.)* **When the physician gives a range of doses, ALWAYS start with the lowest dose. If the lowest dose is not effective, you can titrate slowly until the pain is controlled.**

**Acute pain: When a patient is in good pain control but develops an acute onset of pain this should be considered a pain emergency.** Immediate attention must be given to the patient and the management of their pain.

**Incident Pain:** This pain happens in relationship to certain activities (getting up, turning over, bathing, etc.) It is important to give a dose of their immediate release medication 30 minutes before an activity that may cause them pain.

**Cognitively Impaired Patients:** There is confusion around assessing pain in those who are cognitively impaired. It has been found that many cognitively impaired patients are able to use a word-anchored pain scale. They were most responsive when in a familiar environment, if given an adequate amount of time to process the question, and it is facilitated by an

individual who is familiar to the patient and uses vocabulary the patient understands.

**Psychosocial/Spiritual Pain:** In Hospice, a wholistic approach is used in pain management. It is known that individuals who are dying not only suffer from physical pain, but also may suffer from psychosocial, emotional, and spiritual pain. It is important to realize that unresolved psychosocial and/or spiritual pain may impact overall pain control, and that is why Hospice uses an interdisciplinary team approach.

**Uncontrolled Pain:** There are cases where intractable pain occurs. In those cases it is best to consult with a physician who specializes in pain control. This may be a neurologist, hospice and palliative care physician, or a pain control specialist.

It is evident pain management is a huge responsibility for all professional caregivers who provide end-of-life care. If we all work together with a goal of keeping our patients comfortable physically, psychologically, emotionally, and spiritually we can attain a better life for all of them. This is not an easy task, but it is a goal that will maintain their dignity, alleviate their suffering, respect their decisions, affirm their life has had meaning, and advocate for their choices.

*Reference: Challenges in Pain Management at the End of Life. Miller, K.E. MD, Miller, M.M. RN, and Jolley, M.R. PHARM.D.; American Family Physician, October 1, 2001.*



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**We're on the Web!**  
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#### *Mission Statement*

*Hospice of the Twin Cities' mission is to enhance the quality of the lives of our patients and their families by providing respectful care based on maintaining dignity, alleviating physical, psychosocial, and spiritual suffering, advocating for fundamental rights, and affirming the sacred value of life.*