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Pain Management Pocketcard Set

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General Approach to Pain Management

ASK:
Always ask patient about the presence of pain and accept the patient's report of pain.

ASSESS:
Perform a comprehensive pain assessment:

- Onset, duration, and location
- Quality (sharp, dull, diffuse, throbbing, etc)
- Intensity (1-10 scale, for example)
- Aggravating and alleviating factors
- Effect on function and quality of life
- Patient's goal for pain control
- Response to prior tx if available is chronic
- History and physical examination

TREAT:

- With older adults, start dose low, go slow, but go!
- Avoid IM route, the PO route is preferred
- Treat persistent pain with regular scheduled meds
- Two drugs of the same class (eg, NSAIDs) should not generally be given concurrently, however long- and short-acting opioids may be prescribed together
- Avoid ropivacaine (see American Pain Society and ISMP) and propofol (see Lexicomp and Lex-Comp)

MONITOR:

- Assess and reassess pain frequently
- Most opioid agonists have no analgesic ceiling dose; strive to relief and assess for adverse effects
- Assess, anticipate, and manage opioid adverse effects appropriately
- Discuss goals and plans with patient and family
- Addiction rarely occurs unless there is a hx of abuse
- Watch for red flags of addiction:
 - 1) Compulsive use
 - 2) Loss of control
 - 3) Use despite harm

Breakthrough Pain Management

General:

- Use long-acting opioids around the clock for baseline management of persistent pain
- Use short-acting opioids PRN (rescue) for breakthrough pain
- Consider using the same drug for both baseline and rescue doses whenever possible (eg, long-acting morphine + short-acting morphine)

Rescue Dosing:

- The rescue dose is 10%-15% of the 24-h total daily dosage
- Oral rescue doses should be available every 1-2 h; parenteral doses every 15-30 minutes

Adjustment:

- If the patient is consistently taking 2-3 rescue doses daily, consider increasing the baseline round-the-clock dosage
- Reevaluate rescue dose whenever the baseline dosage is changed

Example:
 Calculate rescue dose for patient on baseline coverage of MS Contin 200 mg q 12 h:

1. Calculate total daily dosage: 200 mg x 2 = 400 mg morphine/d
2. Establish rescue dose: 10%-15% of 400 mg = 40-60 mg short-acting morphine
3. Oral rescue dose therefore is: morphine 40-60 mg PO q 1-2 h
4. Parenteral rescue dose (based on continuous infusion): Calculate based on 20%-50% of hourly dose

Pain Types

Type	Examples	Quality
Somatic pain	Trauma, lacer, bone fractures	Constant, well-circumscribed or aching, localized, and localized to the site of origin
Visceral pain	Renal stone passage, small bowel obstruction, appendicitis, cancer	Deeply localized, may be referred to distant structures (eg, diaphragmatic irritation referred to ipsilateral shoulder), often associated with nausea or diaphoresis
Neuropathic pain	Nerve compression, cancer invasion of neural structures, diabetic neuropathy, postherpetic neuropathy, trigeminal neuralgia	Prolonged, jolting, burning, lancinating, spreading, hypersensitivity to pain; possible tachycardia; diaphoretic; tends to be resistant to opioids and difficult to treat

Interventional Pain Management Techniques

Technique	Indications
Lumbar epidural steroid injection (ESI)	Inflammation associated with conditions such as spinal stenosis, disc herniation or degenerative disc disease
Pain block	Diagnostic tool used to isolate and confirm the specific source of back pain (facet joint)
Selective nerve root block (SNRB)	Primarily used to diagnose the specific source of nerve root pain and, secondarily, for therapeutic purposes such as treatment for a far lateral disc herniation
Neurolytic blocks (chemical splanchnic denervation)	Good for localized pain not requiring multiple segmental blocks; successful SNRBs should be done prior to neurolysis

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Synopsis

This pocketcard Set contains the crucial information on pain management: guidelines on the assessment and management of pain; breakthrough pain management and rescue dosing; opioid equianalgesic dosing table & management of opioid-related events. For physicians, physician assistants, nurses, students and all other healthcare professionals.

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Customer Reviews

This Pocket Card is okay but it seems to be a bit out dated and incorrect. I wish I would of researched the author of it first. Not a bad tool for a beginner.

Received several days ago. Information is good, but it is very difficult to read and to find information on the card.

Very important information, but the font and print are much too small to read. I have to use a magnifying glass to read the information.

it will be a useful tool for my practice! I will use it a lot! I like the style and convenience of the pocket cards

I use this often. It is a great reference and accurate. Thank you. I have looked for more pocket cards

Very handy; only one negative - opioid equanalgesic chart should be more accessible.

This pocketcard set is the perfect size with all of the ideal information contained in one small resource that can be taken anywhere and is easily wiped clean if exposed to spills!

Pain Guidelines

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