

# Management of Chronic Pain

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## Case Study

D.P., a 49-year-old woman, was diagnosed with metastatic renal cell carcinoma of the left kidney about a year and a half prior to this visit to the Symptom Management Clinic. She had just completed a course of radiation to the sternum for bony metastasis during which time she also was seen regularly by the palliative care interdisciplinary team. She complains of severe abdominal pain for the past two days without nausea, constipation, fever, or chills. On examination, her blood pressure is 107/60, her pulse is 97 beats per minute regular, and her respiratory rate is 20 breaths per minute. Her abdomen is mildly distended and diffusely tender. She is admitted to the hospital for further evaluation of an acute abdomen, probably secondary to metastatic disease.

## Etiology

At initial diagnosis, D.P.'s cancer was metastatic. Her chronic pain had been well controlled prior to this admission. In the past, the lack of pain control heralded new disease sites. Palliative care and effective symptom management are critical for her quality of life, pain often being her number one complaint. As pain expert Margo McCaffery expressed, "Pain is whatever the experiencing person says it is and existing whenever he says it does," (Mann & Carr, 2006, pp. 1-2).

Chronic pain is defined primarily by duration, persisting for weeks, months, or years. Although the neurophysiology associated with it continues to be studied, the term *neuromatrix* is used to describe the complexity of chronic pain and characterizes chronic pain as

- Subjective and unique to each individual.

- Generated from within the brain and involving many central regions of the brain. Thus, the brain may produce the pain experience rather than it arising from the periphery as in acute pain.

- Influenced by past pain experiences (Mann & Carr, 2006).

In 2001, the Pain Management Standards became part of the survey and accreditation process of the Joint Commission on Accreditation of Healthcare Organizations (Joint Commission, 2004). Even so, significant barriers to effective pain management remain. Although not an exhaustive list, the barriers include lack of pain assessment, particularly when chronic pain is rarely accompanied by signs of sympathetic nervous system stimulation such as tachycardia, diaphoresis, or pallor; fear of opioids and addiction; fear of delayed recovery because of overuse of analgesics; and religious and cultural prejudices against pain relief and bias toward the rewards of suffering (American Pain Society, 2003, 2007; Paice & Fine, 2005; Hospice and Palliative Nurses Association, 2003; American Nurses Association, 2007; Oncology Nursing Society, 2006).

## Assessment

D.P. was hospitalized for three days. Imaging procedures during admission revealed the following findings: Bone scan showed evidence of further metastatic disease in the pelvis, new right rib lesions, unchanged sterna, and xiphoid process metastases; flat plate of the abdo-

men showed no obstruction; computed tomography scan of the abdomen and pelvis revealed disease progression intra-abdominally with bony lytic destruction evident in the left ileum, sacrum, and pelvis. Her prescribed analgesia regimen included morphine sulfate sustained release (MSSR) 100 mg by mouth every eight hours (her same dose as at home), morphine sulfate 5 mg IV every 1-2 hours as needed for breakthrough pain, and ibuprofen 1,000 mg by mouth twice a day.

## Pain Management

It is important to examine D.P.'s pharmacologic and nonpharmacologic interventions for pain control. D.P.'s need for breakthrough medication averaged 40 mg over 24 hours of morphine sulfate IV. Breakthrough pain may be *incident pain* that can be anticipated, *spontaneous pain* that is unpredictable, or *end-of-dose failure pain* that occurs when around-the-clock (ATC) medication blood levels have declined to a nontherapeutic level before the next scheduled dose (Paice & Fine, 2005). D.P.'s pain could be anticipated with increased activity. Her past experience with pain is the best gauge to adjust and titrate the breakthrough medication to maintain pain control.

On assessment, when she previously complained that the MSSR "helped her pain but does not last until the next dose," it indicated that the right drug was prescribed but that the interval was too long. If a patient complains that the analgesic drug "helps a little but not enough," it may indicate that a higher dose is needed.

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