Pain Management in the Interventional Suite

AQ Urbanes MD
Lifeline Vascular Access
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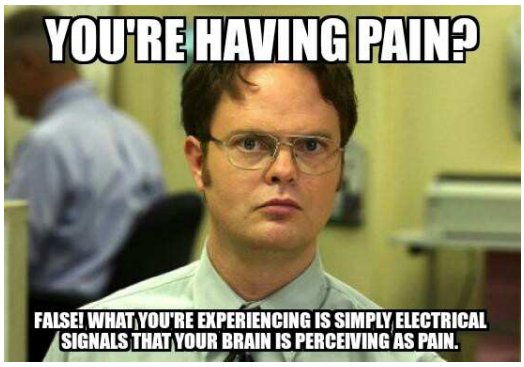


Pain in ESRD

- 55% of HD population with severe* chronic§ pain
  - 1% to 14% of general population
- same magnitude as patients with cancer or HIV
- causes of pain

Musculoskeletal	63.1%
Related to dialysis procedure	13.6%
Peripheral neuropathy	12.6%
Peripheral vascular disease	9.7%
Other (trauma, PKD, cancer, etc.)	18.4%

LBP in gen pop

arthritis in HD

*≥ 7/10 scale
§>3 mos duration

Davison 2003. *AJKD* 42: 1239.

Severity & Management of Pain

- 82.5% report moderate to severe pain in previous 24h of survey
- 35% of survey participants report no treatment received for pain
  - 9.7% received opiates
- 74.8% report negative Pain Management Index PMI) scores → inadequate treatment
- 72% chronic pain sufferers have significant depressive symptoms

Davison 2003. *AJKD* 42: 1239.

Pain Experience

- Patients report pain associated with procedure to be worse than the condition necessitating procedure.
- Based on perceptions of patient.
- Pain response may be influenced by patient's
  - age: younger experience worse pain before, during & after procedure
  - gender
  - culture: vary between and within cultures

Harmful Effects of Pain

- Immediate and long-term harmful effects
- physical, emotional, behavioral, cognitive and psychological manifestations
  - fear, anxiety, anger, aggressive behavior, inability to concentrate, embarrassment, refusal to consent to further procedures, distrust of the health care system
  - invariably may affect overall economic, social & spiritual well-being

Immediate and Long-term Effects of Pain

- Related to the stress response
  - cardiopulmonary, metabolic & immune responses
- If patient prepared for the pain, adaptive responses assist to attenuate degree of fear and anxiety.
- insomnia, depression, Δ in appetite, fatigue

Patient with Dementia

- higher risk for pain before, during and after procedure
- difficulty in interpreting the painful experience in the context of the procedure
- may not be able to verbally express their discomfort and advocate for themselves

Barriers to Procedural Pain Management

- Patient-specific factors influencing adequacy of pain management
  - diagnosis, age, gender, race, ethnicity, cognitive level, literacy level, mental illness, history of chemical dependence, socio-economic background, patient's ability to communicate
- More influential than patient-specific factors is the lack of acknowledgement by HCPs that pain may occur during or after a procedure.

Barriers to Implementing Pain Comfort Management

- unawareness of the existence of guidelines
- HCPs not realizing there is a "better way" to perform procedures
- poor communication between teams
- lack of input from patients and families
- underuse of topical anesthetics
- insufficient medication orders
- insufficient time to administer medications before procedure
- lack of consistency in patient care & lack of cooperation between HCPs

Ethical Considerations

- WHO, 2006
  - "The unreasonable failure to treat pain is viewed as an unethical breach of human rights."
- Principles

Beneficence	Moral obligation to act for the benefit of another
Non-maleficence	Duty to do no harm
Fidelity	Keep one's promise; treat patients with dignity by respecting the patient as a unique and important person
Autonomy	Provide same level of care to all patients experiencing pain regardless of age, gender, cognition, race, ethnicity, religion or socioeconomic status
Veracity	"This will hurt" vs. "This won't hurt" "You'll be out" vs. "You'll be awake and aware"

Philosophy

- Procedures are considered bio-psycho-social experiences for the patient.
- Maintaining patient comfort before, during and after the procedure includes
  - collaborating with the patient and family in creating an individualized cognitively and developmentally appropriate plan of care for comfort and coping
  - should occur before the procedure begins
  - should be agreed upon by entire team before the start of the procedure.

1. Before the Procedure

- Establish a plan
  - appropriate pharmacologic & non-pharmacologic interventions
  - mutually agreed upon comfort goal with patient & family
- Develop a plan to help patient cope
  - examples: distraction, breathing, relaxation
- Consider sedation if
  - procedure is believed to be significantly painful
  - immobility of patient is required for a longer period of time
  - patient expresses great concern or distress

2. Prepare patient & family

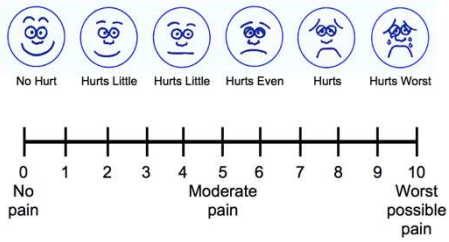
- Provide education tailored to meet their needs.
- Acknowledge patient's fears/concerns; modify comfort management plan accordingly.
- Provide coaching to family regarding their role.
- If family member is to be present, role is to support, not participate in or interfere with the procedure.
- Family member should be allowed to step away if needed.

3. Timing & location of procedure

- adequate space
- maximum privacy
- adjustable lighting
- minimal noise and interruptions
- accessibility to pharmacologic agents
- selection of music for relaxation, as per patient's preference
  - some kinds of music may heighten patient's anxiety; inter-patient variability (eg, classical vs. rock vs. rap)

4. Communication

Decide how patient will communicate unrelieved pain or anxiety to nurse during the procedure.



5. Prepare the team

- What will be done?
- How long is it anticipated to take?
- What kind of pain is anticipated?
- Identify someone to lead distraction and coping techniques so that the patient is not confused or over-stimulated.
- Know how the patient & family member think the patient will respond.
- Know how often the procedure will need to be repeated.

6. During the procedure

- Use agreed-upon distraction & coping techniques.
- Assess pain and anxiety.
- If not well controlled, ask HCP performing the procedure to stop so that further evaluation can be conducted and need for additional support.
- Provide coaching in a calm and re-assuring manner.

6.1. Signs that the procedure is not progressing as expected

- needing to restrain patient
- raised volume of voices, strained voices
- multiple people trying to lead; confusion
- patient is moaning, crying or striking out
- upset family member
- feeling the need to "get it over with" instead of calmly performing the procedure

7. After the procedure

- Discuss & evaluate the procedure with the patient & family.
- Document the procedure
  - evaluate patient experience from patient, family & HCP perspectives
- Develop & implement a comfort management plan for after the procedure
  - pain resulting from procedure may not subside when procedure is completed

Summary

- Prevalent baseline pain in ESRD patients is an under-recognized and under-treated problem.
- Procedural pain and anxiety compounds the baseline pain experienced by patients → altered perception.
- Patients deserve clinically informed, respectful and compassionate treatment of pain.
- Poorly controlled pain has real and significant biological and emotional effects.