

# The painful truth: Five acute pain management myths in the ED

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Adequately treating acute pain is an ethical obligation by the entire health care team (Butcher, 2005). Many barriers exist that create challenges to effective pain management in the emergency department (ED). Inconsistencies in practice occur for a variety of reasons, including inadequate knowledge, especially in pharmacological techniques (Butcher, 2005). At times, shared practices of health care delivery are maintained based on repetition and belief rather than evidence and new information in the ED. This article serves to review some of the common practice myths related to the treatment of acute pain management in the ED. Current evidence will be discussed to deconstruct these myths and promote best practice.

## Myth #1: Giving analgesia to a patient with abdominal pain will interfere with getting accurate diagnosis

When pain is perceived as everlasting and unresolvable, it can further aggravate and exaggerate the pain with which a patient presents (Gallagher, 2004). If analgesia is delayed, the central nervous system has an opportunity to go into “wind up” mode due to nerve fibres being repeatedly stimulated (Butcher, 2005). A literature search found that for those patients presenting to the ED with acute abdominal pain, delaying the administration of opioids does not interfere with diagnosis and sometimes enhances its accuracy (Pace & Burke, 2008). In another study of patients who received intravenous morphine for acute abdominal pain, physical examination findings were not masked and there was no change of diagnostic accuracy found (Thomas et al., 2003).

The diagnosis of causes of abdominal pain occurs through a variety of tests and physical assessment. We are no further ahead if a patient’s pain level is so severe that these diagnostic tests cannot be performed. Providing timely analgesia should be a principle goal of emergency staff when caring for patients with abdominal pain.

## Myth #2: Neonates and infants do not require analgesic

It is now well understood that neonates and infants feel pain (Taddio & Katz, 2005; Wilson-Smith, 2011). However, in the ED, this population’s pain perception and need for analgesia are often underestimated or overlooked. While the study of pain in this age range is complex and many factors are at play, there is accumulating evidence that failing to treat pain in neonates can cause long-term alterations on their pain responses later in life (Taddio & Katz, 2005).

Neonates and infants commonly present to the ED with complaints relating to pain, or may undergo painful treatments, as part of their emergency care. There is no doubt assessing pain level of preverbal patients is challenging. Being armed with an appropriate resource such as FLACC (Faces, Legs, Activity, Cry, and Consolability) Pain Assessment Tool, pain intensity can be assessed effectively (Manworren & Hynan, 2003). This tool provides ED nurses a means to determine pain scores out of 10 and pain should be managed accordingly. It has been suggested when a FLACC pain scale is six or greater, analgesia is required (Manworren & Hynan, 2003).

Some common barriers to effective pharmacological pain management often stem from fear of administering analgesic to neonates and infants and the invasiveness of some necessary routes of administration. While there are some considerations for pharmacological pain management in the age group, they should not be the reason that treating pain is neglected. It is true: neonates have greater sensitivity to numerous analgesics, but this only demands careful choice of technique and close monitoring with administration (Wilson-Smith, 2011). If IV access is not necessary for a neonate or infant, intranasal drug administration can be considered (Regan et al., 2013). Also, a variety of topical anesthetic creams, vapo-coolant sprays, and lubricants are available and commonly used in pediatric patients when an invasive procedure is anticipated (Wilson-Smith, 2011).

A variety of simple, non-pharmacological methods effective in pain prevention or reduction in neonates and infants receiving a painful procedure are recommended in the literature. Stroking a baby’s skin and rocking them while having a painful procedure has shown to decrease the pain response (Wilson-Smith, 2011). Decreased pain response is also shown when the infant is non-nutritive sucking on a pacifier (Liaw, Yang, Blackburn, et al., 2010; Yilmaz & Arikan, 2010) or breastfeeding (Wilson-Smith, 2011; Yilmaz & Arikan, 2010). Giving a neonate or infant sweet glucose or sucrose oral solution a few minutes before a painful procedure has also shown to elicit a less-pronounced pain response (Wilson-Smith, 2011; Yilmaz & Arikan, 2010). Many of these strategies would be simple for nurses to do themselves or in collaboration with the parent or guardian when a painful procedure is anticipated. Neonates and infants feel pain, and with the use of an age appropriate pain assessment tool, an ED RN can assist in the recognition, prevention, and treatment of pain in these delicate patients.

### Myth #3: Geriatric patients do not require analgesic as often because they complain of pain less

There are many barriers to effective pain management in geriatric patients despite the availability of many suitable pain control options. It has been shown that the elderly population is the most frequently under-dosed (Terrell, Heard & Miller, 2006). Chronic or concurrent illness in the elderly complicates pain management in the ED. There are barriers the health care team can address in practice, which can aid in effectively treating pain in older persons: under-reporting pain, communication difficulties, and under-treatment (Tracey & Morrison, 2013).

Under-reporting pain by the elderly patient is due to loss of autonomy or depression. Geriatric patients can become depressed due to their quality of life and inability to function and may suffer longer than necessary. Depression can alter the perception of pain and result in an inability to cope. They may have a lack of understanding of their diagnosis and feel that pain is a normal part of aging. Some may further feel embarrassment about using devices or medications to relieve pain or emotional stress (Tracey & Morrison, 2013). Recognition of the potential for depression should influence an ED nurse's pain assessment in this population.

Difficulty communicating pain may be a result of cognitive impairment. It can be challenging to assess pain levels with a cognitively impaired elderly patient. However, even mild to moderate dementia patients are capable of reporting pain using a number of validated tools (Hwang & Platts-Mills, 2013). Family members and caregivers can also be utilized, asking for their impression of the patient's comfort level. At times it is necessary to rely on more objective findings during the physical assessment.

Due to concerns about the use of analgesic medications with older patients, pain may be under-treated (Tracey & Morrison 2013). It becomes important to take into account elderly patients' liver and renal function and what current medications they might be taking. The adverse effects of daily medications coupled with current renal and liver functions may alter the amount or type of analgesic given. It is recommended that patients be reassessed frequently when initiating or adjusting any of their medications. When considering analgesia for older adults a reasonable starting dose may be 30%–50% of that recommend for a younger adult (Tracey & Morrison, 2013).

Understanding the psychological needs of geriatric patients can aid in obtaining a more accurate assessment of their pain. An evaluation of physiological and pharmacological considerations will lead to more safe and effective pain management for elderly patients in the ED.

### Myth #4: An antiemetic medication should be administered prior to an opioid analgesic


The most commonly used analgesic in the ED setting is an opioid, as an initial attempt for general pain management (Todd et al., 2007). Due to potential side effects of the opioid analgesic, an antiemetic such as dimenhydrinate is usually given in the event of nausea and/or vomiting (Talbot-Stern & Paoloni,

2000). Common practice has been to administer an antiemetic prior to an opioid agent for this reason, but the result is further delay of analgesic for actual pain due to the potential for nausea and vomiting. Literature has shown that nausea and vomiting occurs in less than 6% of patients post-opioid administration (Talbot-Stern & Paoloni, 2000). Therefore, this is no evidence for the co-administration of a prophylactic antiemetic with opioid analgesic (Thomas, 2013). Often, doctors will order the two drugs concurrently in order to anticipate the potential indication for an antiemetic post opioid administration, not as a prophylactic dose, but common practice has become the opposite.

### Myth #5: Opioid dependent patients do not require more pain medications than those who are not dependent

Emergency nurses often care for those addicted to or dependent on opioids. Patients who frequently use opioids can experience a condition known as hyperalgesia, in which an abnormally heightened pain sensation is noted and characterized by a decreased pain threshold (Morgan & White, 2009). Mehta and Langford (2006) provide clinical evidence showing opioid-addicted patients are less able to tolerate pain and require larger doses of analgesia due to higher cross-tolerance. Analgesic response is diminished at the pain receptors when opioids are taken repeatedly, creating a medication tolerance (Laroche, Rostaing, Auburn & Perrot, 2012). Hyperalgesia combined with medication tolerance will have the opioid-addicted population in constant and often uncontrolled pain. Despite tolerance and hyperalgesia, the etiology of the pain warrants true investigation while pain is managed in the emergency department. Therefore, opioid-dependent patients do require larger or more frequent doses of pain medication in this context while investigations are completed.

### Implications for practice

This article examined the common myths associated with pain management in the emergency department context. Regardless of the myth addressed, the overall theme was to examine some commonly held misconceptions or questionable practice routines around pain management in the ED. Given pain management is the number one factor with which patients evaluate their satisfaction in emergency department care (Todd et al., 2007), continued reflection around common practices and review of current evidence will result in increased patient satisfaction and best practice for pain management in the ED. 

### About the authors



Adrienne Olszewski completed a BA in Psychology in 2003 then graduated from the University of Toronto Nursing program in 2006. While now working towards her Master's of Nursing at Athabasca University, Adrienne is a member of the emergency nursing faculty at the British Columbia Institute of Technology. She practises clinically at the Emergency Department Surrey Memorial Hospital and is a member of the Surrey Forensic Nursing Services program.



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