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OH, WHAT A RELIEF IT IS! REVISITING PAIN MEDICATION USE IN EMS

Treating Pain

- ◎ “Care more for the individual patient than for the special features of the disease”
 - William Osler, 1899



Why Treat Pain?

- ◎ Safe relief of suffering is our job
 - “The safety issue should neither be forgotten nor unreasonably applied”
 - Thomas et al, J Emerg Med 2008
- ◎ Pain is physiologically bad
 - Anxiety
 - Immune system
 - Wound healing



Benefits of Treating Pain

- Patient satisfaction
 - McEachin et al, Prehosp Emerg Care 2004
- “Up-triage” on arrival to the ED
 - Vassiliadis et al, Emerg Med 2002



Why Treat Pain?



Pain Control

- ◎ Most common
 - Complaint
 - Reason for seeking medical attention
 - Up to 70%
 - Reason for dispatching an ambulance



Pain Control

◎ The studies

- We are not as good as we could be
 - Berben et al, Injury 2011
 - McManus et al, Emerg Med Clin N Am 2005
 - Turturro, Prehosp Emerg Care 2002
 - Fullerton-Gleason et al, Prehosp Emerg Care 2002
- Oligo-evidence for oligo-analgesia
 - Still room for improvement
 - Steven Green, Ann Emerg Med 2012 (August)

Pain Control

- The studies
 - Still a number of modifiable barriers to appropriate pain management in the field
 - Walsh et al, Prehosp Emerg Care 2013



Pain Myths

⦿ “It can wait”

- No!

- Waiting until the patient gets to the ED can result in a 2 hour delay in treatment
 - And that is IF the ED has its act together
 - Abbuhl et al, Prehosp Emerg Care 2003
- Higher overall doses when started in the field
 - Vassiliadis et al, Emerg Med 2002

Pain Myths

- It isn't safe

- Side effects (hypotension, respiratory depression)

- It is!

- Barber et al, Pediatr Emerg Care 2004
- Kanowitz et al, Prehosp Emerg Care 2006
- Krauss et al, Acad Emerg Med 2007

Barriers

- Paramedics perception of pain
 - We underestimate pain
 - Turturro et al, Prehosp Emerg Care 2002
 - Walsh et al, Prehosp Emerg Care 2013
 - Perception of distress
 - Tachycardia?
 - Vital signs unreliable in estimating pain severity
 - Lord et al, Emerg Med J 2011



Pain Management

◉ Masking symptoms

- Can't evaluate
 - Not true!
 - Alonso-Serra et al, Prehosp Care 2003
 - Ranji et al, JAMA 2006
- Can't consent
 - They can!
 - Gabbay et al, Prehosp Emerg Care 2001
- ED will get mad



Pain Management

⦿ Abdominal pain?

- Yes!
 - Thomas et al, J Am Coll Surg 2003
 - Gallagher et al, Ann Emerg Med 2006

⦿ Trauma patients?

- Yes!
 - Soriya et al, J Trauma 2012

Pain Management

- ◎ Be careful

- Elderly

- But still give it

- Platts-Mills et al, Ann Emerg Med 2012
- Cinar et al, Ann Emerg Med 2012

- Altered

- Drugs/alcohol
- Trauma
- Other



Options

● IV

- Fentanyl
 - 1-3 ug/kg
 - Typical dose 100 ug
- Morphine
 - 0.1 mg/kg
 - Typical dose 5-10 mg
- Hydromorphone
 - 0.015 mg/kg
 - Typical dose 1-2 mg



Options

● Intranasal

● Fentanyl

- 2-4 mcg/kg
 - Max is 1 cc/nostril
 - Concentration is 50 mcg/cc

● Midazolam

- 0.2 – 0.4 mg/kg
 - Concentration is 5mg/cc

● Rule of thumb, double the dose for IN



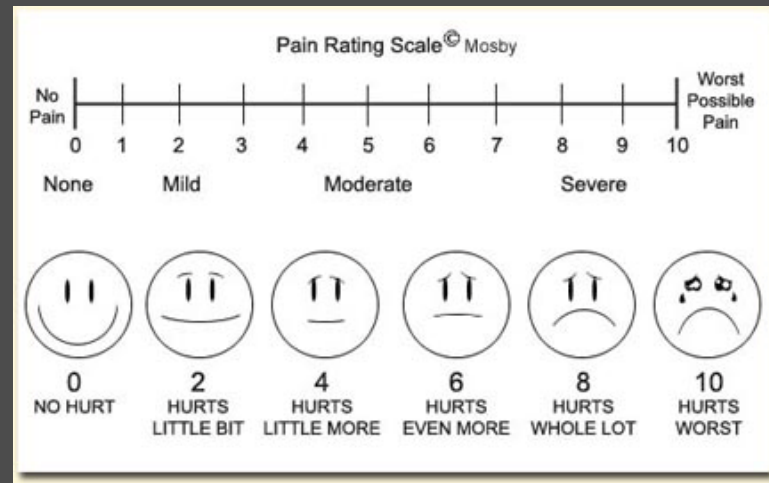
Options

- Non-pharmacologic
 - Splinting
 - Bandages
 - Ice
 - Position of comfort
 - Get rid of back boards!



Techniques

- Pain scales
 - Silka et al, Acad Emerg Med 2004
- Standard protocols
 - Standing orders
 - Fullerton-Gleason et al, Prehosp Emerg Care 2002
- Trauma training
 - Bowman et al, J Trauma 2012
- CMS mandates?



Diversion

- ⦿ Significant issue in all areas of medicine
- ⦿ Have a clear process of how you handle narcotics
 - Usage tracking
 - Wasting



Drug Seeking?

⦿ Narcotic seeking

- Differentiating acute from chronic pain
- Overly concerned with “drug-seeking”
 - Even in pediatric patients
 - Hennes et al, Prehosp Emerg Care 2005

⦿ Addiction

- Big issue nationally
 - Not in the back of an ambulance
 - Rupp et al, Ann Emerg Med 2004

Summary

- ◉ Pain management is important
- ◉ Still significant barriers
- ◉ Make it the culture
 - It will become the norm
- ◉ More attention in this area will result in better care
- ◉ At the end of the day....

