Pain consult guide

Jun 13, 2018 | 0
|
| onthephones

Editor: Nat O'Halloran

Contributor: David D'Silva

Reviewed: Alan Nazha

In a hurry? Make sure you know

- Why is the patient in pain, what is the reason for admission? (recent surgery vs chronic pain condition)
- Where is the pain?
- Is it activity limiting? E.g. breathing, coughing, mobilising
- What medications are they usually on?
- What medications are they on now?
- How frequently are they using breakthrough analgesia?
- Does it help?
- Allergies, contraindications/co-morbidities (renal/hepatic impairment) and evidence of side effects? (e.g. sedation)

What history should JMOs know/collect?

- Basic pain history – Ask the patient for a self assessment of their pain. If non-communicative, demented or paediatric use objective signs/scoring systems to make an assessment.
- Is this pain new or chronic? Is this pain related to the admission, a new pathology or progression of the primary pathology? Is there any definitive management plan?
- Chronic pain – Patient known to pain specialists? Previous therapies? Do they have a plan for acute exacerbations of pain, stick to the plan!
- Post-op pain – any reason to believe there is a complication?
- History of pain medications (opioid naïve vs tolerant, allergies)
- Always assess for complications of analgesia, particularly opioids. Sedated? Itch? Constipated?

- Comorbid mood disorders (anxiety, depression, stress); previous substance abuse especially with opioids or other analgesics?

What examination and investigations should JMOs perform/order?

- Consider referred pain e.g. shoulder pain caused by diaphragmatic irritation
- Patients with *unexpected* severe pain post-op should be assessed by the surgical reg first
- No investigations required (but please let us know if liver or kidney failure)

What additional information would impress you?

- Calculate oral morphine equivalent daily dosing (OMEDD) – use the free FPM calculator app
- Instituting treatment/addressing the pathology causing the pain and then seeking analgesic options
- Consideration of neuropathic pain
- Consideration of regional analgesic techniques in the acute pain setting e.g. rib fractures *(NB: this would be very institution dependent)*

What common mistakes are made?

- Red flag: Do not use the word ‘addiction’ or ‘addict’ unless they are known or have been formally diagnosed by an addiction specialist/ psychiatrist /pain specialist. This may get you into trouble as there are legal implications and affects prescribing opioids for that patient.
- Not giving simple options before ringing pain registrar. (Everyone should have had paracetamol, NSAID, an opioid unless any contra-indications)
- Understand the difference between tolerance, dependence and addiction
- Do not give parenteral analgesia (i.e. Intravenous, subcutaneous) if patient can take oral analgesia
- PCAs are not necessarily better than oral analgesia
- Setting up unrealistic expectations to completely remove all pain, particularly after painful procedures e.g. knee arthroplasty
- Has patient exhibited ‘aberrant behaviour’ past or present e.g. self-escalation of opioid drug doses, diversion of drugs, doctor shopping?

Important notes:

You are rarely calling the pain team to help make a ‘diagnosis’ in a hospital setting; this should be something already known, or your team is currently in the process of working up; if diagnosis is unknown state so to the pain team. Giving information over the phone about finer details of the pain itself usually is of little benefit unless it is an atypical presentation. Having said that, you should already have a good idea about the pain if asked.
Usually the pain team will want to know more about:

- The patient
- Current medications
- Medications trialled
- Past history of chronic pain
- Likelihood of opioid tolerance/ dependence (understand the difference between the two terms)
- And if present significant aberrant behaviours.

Red flag: Never prescribe a fentanyl patch (Durogesic) or add extra opioids to a PCA without senior input. Be aware of a new Position Statement by ANZCA cautioning all doctors on the use of sustained release opioids for acute pain. Do not prescribe these without senior input.
Never say this patient has “inorganic pain”, “psychological pain” or “real pain”. If a patient says they have pain we must take their word for it, but you can state words to the effect of “pain is disproportionate to injury”.

Helpful resources would you recommend to JMOs?

For more detailed information: Acute pain management: scientific evidence – Fourth Edition 2015 (Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine). Available from:

– chapters on assessment of pain are particularly useful for JMOs.
How to access and use the FPM Opioid calculator app by Australian and New Zealand College of Anaesthetists. Available from:

Position statement on slow release opioids (Australian and New Zealand College of Anaesthetists). Available from:

Position statement on the use of slow-release opioid preparations in the treatment of acute pain. (Australian and New Zealand College of Anaesthetists). Available from:

Related Podcasts

- Part 1: Acute pain management
- Part 2: Acute pain management
- Postoperative Airway Concerns
- Prescribing opioids
- Chronic post-surgical pain
- Diagnosis and management of neuropathic pain

Tags: #acute pain,#acute pain management,#Anaesthetics,#analgesia,#Australian and New Zealand College of Anaesthetists,#chronic pain,#Faculty of Pain Medicine,#neuropathic pain,#NSAID,#OMEDD,#opioids,#oral morphine equivalent daily dosing,#pain,#pain consult guide,#pain management,#pain medication