

Pain

When people think about life-limiting illnesses and dying, they often believe that pain is inevitable. However, not everyone who has a life-limiting illness such as cancer will necessarily experience pain. As has been stated often throughout this book, everyone is different, and therefore everyone's experience of illness will be different.

The word 'pain' comes from the Latin '*poena*' meaning punishment, a fine or a penalty,¹ and is defined by the International Association for the Study of Pain (IASP) as 'an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage.'²

Pain is usually a sign that something is wrong – that there is illness or injury to the body. When there is damage to any part of the body, the nervous system sends a message along the nerves to the brain. When the brain receives these messages, pain is felt. Pain is generally divided into two categories.

- *Acute pain* has a relatively recent onset, and resolves as soon as the cause of the pain has been dealt with – for example, removal of the decayed tooth that is causing toothache, or removal of the inflamed appendix that is causing appendicitis.
- *Chronic pain* is pain or discomfort that continues for more than a month after an acute illness, or a reasonable time after healing is expected following an illness – for example, osteoarthritis (a degenerative joint disease that causes inflammation of the joints, and which is very common in the elderly), and recurrent backache following a back injury.

However, regardless of the definition of pain, the type of pain or how it occurs, the important thing to remember is that 'Pain is what the patient says hurts.'³

No two people will experience pain in quite the same way. What is described as excruciating by one may be described as bearable by someone

else. Furthermore, a person's mood, morale and perception of the meaning of the pain can alter the way in which they experience pain and the severity with which they feel it.³

Think about the times when you have experienced pain and some of the things that have influenced or reduced its intensity. For example, a headache may be more pronounced if you are feeling in low spirits. On the other hand, if you are doing something enjoyable, you may not notice your headache so much. If you get toothache while you are at work, you may not feel it so intensely because you are distracted by everything that is going on around you. However, the same pain that wakes you up in the early hours of the morning may be felt much more intensely because that is all you have to think about. Another example is a pain that develops for no obvious reason. This type of pain will most probably be felt more intensely because you are scared of the possible cause. However, if you get toothache, you will be less worried because you know that the pain is caused by something wrong with that tooth.

So, with an understanding that pain is what the patient says it is, and that its severity can be influenced by other factors, how can you as a carer help to relieve a patient's pain? The important thing is to listen and observe. The elderly in particular can be quite stoical about pain, sometimes believing that one can't get old without discomfort, or they may be afraid to complain of pain in case they are sent to hospital for tests, or prescribed further medication.

Some doctors are concerned about prescribing pain medication for older patients because of their tendency to process medication more slowly than do younger adults, and because of side-effects such as constipation or mental impairment. However, when medication for pain is prescribed correctly, at the right dose, physical and mental functioning should be improved.

In elderly patients there is very often more than one source of pain. In addition to the possible symptoms from their life-limiting illness, the chances are that they will also have other conditions, such as osteoarthritis, osteoporosis (thinning of the bones) or some nerve damage (such as occurs in patients with long-term diabetes).

Never underestimate the discomfort that can be felt from a pressure sore, even a superficial one, or the discomfort felt by someone as they are lifted in a hoist or turned in a bed. Remember that their limbs and joints are not as supple as they would be in a younger patient, and may be stiff and painful to move after a while.

LISTEN AND OBSERVE

It is up to you as carers to report and document whether you consider that a patient for whom you are caring is in pain. The earlier someone receives treatment for their pain, the easier it is to get it under control. With the right treatment, it is possible to relieve all pain to some extent. The medication that is most effective for controlling pain will depend on what is causing it, and this is where the GP and/or specialist palliative care nurse can help.

When you are talking to a patient who has pain, it helps to find out as much as possible about how they are feeling.

- Ask them to describe their pain. They may use words such as ‘throbbing’, ‘stabbing’, ‘burning’, ‘cramping’, etc.
- Ask them where the pain is located. Is it in one place or does it spread around to other places?
- Ask them whether anything helps to relieve the pain or makes it worse, such as changing position, sitting down or walking, or heat or cold.
- Ask them whether the pain is there all the time, or if it comes and goes.
- Ask them what they think the cause of the pain might be.

Even if you are not a trained nurse, asking these simple questions will help you to explain the situation to others, so that a more experienced person can decide what might be causing the pain and the best way of treating it.

PAIN/DISTRESS TOOLS

Sometimes it is difficult for a person to describe their pain and distress. To monitor when pain or distress occurs, what it feels like, its severity, and what helps to relieve the pain, it can be very helpful to use a pain tool. There are many different tools on the market. Some of the simpler ones just use a number score. However, for a patient who has communication problems, such as dementia, a different approach to assessing pain or distress may be needed. Although I refer to each of the following as a ‘pain tool or chart’, any of them can also be used to measure distress.

Table 13.1 is a chart that helps the patient to select a word or words that best describe their pain. It is always preferable initially to ask the patient to describe their pain/distress using their own words. If they get stuck, you can use this chart to help them.

Table 13.2 is a simple number chart. The patient is asked to select a number between 0 and 4 that best describes the severity of their pain. This is a useful tool for obtaining a quick general idea of the severity of the pain/distress.

TABLE 13.1 Words that are used to describe pain

throbbing	pounding	shooting
pricking	stabbing	stinging
dull	sharp	pulling
gnawing	cramping	beating
smarting	sore	drilling
frightening	tiring	exhausting
constant	annoying	dreadful
comes and goes	agony	miserable
irritating	consuming	burning
discomfort	aching	excruciating
gripping	blinding	twinges
torture	miserable	bruised

TABLE 13.2 Number pain chart

0	None
1	Mild pain
2	Moderate pain
3	Severe pain
4	Excruciating pain

The Wong–Baker FACES Pain Rating Scale (*see* Figure 13.1) uses faces to show a range of expressions that depict ‘hurt.’ It is used mainly for children, but can also be used for adults who have communication difficulties.⁴

The Abbey Pain Scale (*see* Figure 13.2) is an excellent tool used for patients with dementia or people who cannot verbalise.⁵

Pain is not only felt in the physical sense of the word. In palliative care in particular, we often talk about the concept of ‘total pain’ (*see* Figure 13.3).

Think of a time when you may have visited your GP with a symptom – say, for example, earache. The chances are that the doctor will examine your ear and prescribe you some eardrops or antibiotics. The GP generally does not have the time or the need to know whether the pain is affecting your sleep (physical), whether you are worried that the pain may indicate something more serious (spiritual), whether you are unable to join in your usual social activities with your friends (social), and whether you are frustrated because of loss of independence, due to needing people to care for you until you get better (emotional). This is what is known as *total pain*. However, you and your



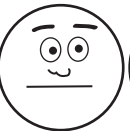
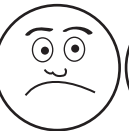
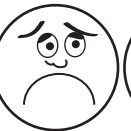

						
	0	1	2	3	4	5
	No hurt	Hurts a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts worst
Number coding	0	2	4	6	8	10
Brief verbal instructions: Point to each face using the words to describe the pain intensity. Ask the patient to choose the face that best describes their own pain, and record the corresponding number.						
Original instructions: Explain to the patient that each face is for a person who feels happy because he has no pain (or hurt), or who feels sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt at all. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the patient to choose the face that best describes how they are feeling.						
Complete the chart as in the example below:						
Date	Time	Which face number	What helped			
1/1/08	09.00	1	Making patient more comfortable by changing her position			
	09.30	0				
1/1/08	12.00	4	Paracetamol 1 g given as prescribed			
	12.30	1				
1/1/08	16.30	2	Helped back to bed and given 5 mg of oral morphine as prescribed			
1/1/08	17.00	0				

FIGURE 13.1 Wong-Baker FACES Pain Rating Scale. Reproduced with the permission of the publisher from Hockenberry MJ, Wilson D and Winkelstein ML. *Wong's Essentials of Paediatric Nursing*, 7th edn. St Louis, MO: CV Mosby; 2005. p. 1259.

Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6

Name of resident:

Name and designation of person completing the scale:

Date:**Time:**

Latest pain relief given was.....**at****hrs.**

Q1.	Vocalisation eg. whimpering, groaning, crying <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>	Q1	<input style="width: 40px; height: 30px;" type="text"/>
Q2.	Facial expression eg: looking tense, frowning grimacing, looking frightened <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>	Q2	<input style="width: 40px; height: 30px;" type="text"/>
Q3.	Change in body language eg: fidgeting, rocking, guarding part of body, withdrawn <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>	Q3	<input style="width: 40px; height: 30px;" type="text"/>
Q4.	Behavioural Change eg: increased confusion, refusing to eat, alteration in usual patterns <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>	Q4	<input style="width: 40px; height: 30px;" type="text"/>
Q5.	Physiological change eg: temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>	Q5	<input style="width: 40px; height: 30px;" type="text"/>
Q6.	Physical changes eg: skin tears, pressure areas, arthritis, contractures, previous injuries. <i>Absent 0 Mild 1 Moderate 2 Severe 3</i>	Q6	<input style="width: 40px; height: 30px;" type="text"/>

Add scores for 1 – 6 and record here ➔ **Total Pain Score**

Now tick the box that matches the Total Pain Score ➔

0 – 2 No pain	3 – 7 Mild	8 – 13 Moderate	14+ Severe
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Finally, tick the box which matches the type of pain ➔

Chronic	Acute	Acute on Chronic
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Abbey, J; De Bellis, A; Piller, N; Esterman, A; Giles, L; Parker, D and Lowcay, B.
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FIGURE 13.2: Abbey Pain Scale. Reproduced with permission. Available at www.dementiacareaustralia.com

<p>Physical pain</p> <p>Hurting Not sleeping Not eating Restless Mobility affected</p>		<p>Spiritual pain</p> <p>General fears Fear of dying Anxiety General unrest Nightmares</p>
	<p>TOTAL PAIN</p>	
<p>Emotional pain</p> <p>Anger Frustration Despair Irritable with others Mood swings</p>		<p>Social pain</p> <p>Change of role Loss of finances Loss of independence Helplessness Worry about family/others</p>

FIGURE 13.3 Total pain.

doctor are fairly certain that your pain and debility should only be transient, and that in a few days' time you should be back to normal. For someone with a life-limiting illness, total pain is likely to be more of an issue.

A DESCRIPTION OF TOTAL PAIN

Consider the following description of total pain for May, an elderly resident in a care home.

May has been diagnosed with heart failure, and has been managing reasonably well until just recently, when she started to become more breathless and her hands and feet started to swell. The doctor has visited and prescribed a diuretic (water tablet) to reduce the swelling and ease May's breathing. She will probably have to remain on these tablets to prevent her symptoms from recurring. May has always enjoyed taking part in activities in the main lounge with some of the other residents, but now she feels breathless if she does too much (physical pain). She is worried about her deterioration and wonders whether the doctor has been honest with her or if there may be something he is not telling her (spiritual pain). She is very frustrated and embarrassed because

whereas previously she could always walk the short distance to the toilet and get there in time, she can no longer walk quickly enough, and because of the water tablets she finds that she wets herself before she can get there (emotional pain). May used to enjoy going out for Sunday lunch with her family, but she has stopped doing this because of her worries about not being close enough to the toilet (social pain).

So what can you do to help?

- 1 **Physical pain** – breathlessness. The GP has prescribed medication to relieve this, but there are also non-drug measures that you can use to help. Encourage May to take her time. Sitting in a more upright chair may be helpful. Sitting in the lounge near an open window, or near an electric fan, will help to increase air movement around her face. Encourage her family to bring in loose comfortable clothing (*see* Chapter 8).
- 2 **Spiritual pain** – worrying whether the doctor has told her everything. Allow time for May to express her fears. If you are able to do so, reiterate what the doctor said and offer explanations and reassurance. Ask the doctor to visit again to talk to May. Make sure that someone is with her when this happens so that they can also listen to what the doctor is saying.
- 3 **Social pain** – not being able to go out for lunch with her family. You could suggest that May's family share Sunday lunch with her in the home, or that they choose a restaurant that is not too far away, to keep the journey short, and that their table is close to a toilet.
- 4 **Emotional pain** – frustration and embarrassment due to loss of independence. Use any resources that help to maintain May's independence and ease her embarrassment, such as a commode in her room, sitting her near an exit for the nearest toilet, and using a wheelchair to get her to the toilet. Discuss whether she might be willing to use a small incontinence pad for extra security.

Pain can seriously affect an elderly person's enjoyment of life, and it should always be taken seriously.

Remember: Pain is what the patient says it is, and the right treatment is the one that relieves the pain.

REFERENCES

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