Rev Med Hosp Gen Méx. 2016;xxx(xx):xxx–xxx

REVISTA MÉDICA DEL
HOSPITAL GENERAL
DE MÉXICO
www.elsevier.es/hgmx

REVIEW ARTICLE

Pain in patients in critical condition and its environment

O. Carrillo-Torres[a,*], **M.A. Mendiola-Roa**[b], **M.A. Ramirez-Torres**[c]

[a] *Anaesthesiologist, Critical Care Pain Physician, Department of Anaesthesiology, ''Eduardo Liceaga'' General Hospital of Mexico, Mexico City, Mexico*
[b] *Anaesthesiologist, Department of Anaesthesiology, ''José G. Parres'' General Hospital, Cuernavaca, Morelos, Mexico*
[c] *Palliative Psychologist, Lira & Serafín Psychiatric Clinic, Mexico City, Mexico*

Received 19 February 2016; accepted 12 May 2016

KEYWORDS
Pain;
Critically ill patients;
Intensive care

Abstract It is known that pain is the most disturbing symptom-syndrome in patients in any context of medical therapy, so the comprehensive critical care (biological–psychological–social–spiritual) approach should be adequately addressed in the patient–family–healthcare team triad when structuring major therapeutic care. Health status, as well as admission to the High Dependency Unit and/or Intensive Care Unit represents an event often accompanied by dependency, uncertainty, fear, multiple losses, vulnerability, suffering and near-death experiences. Patients in intensive care often experience multiple and recurrent acute stressors, where their response and ability to cope depend on a variety of neuropsychological, cognitive, emotional, and social functions and the support that is given to them in these areas.

PALABRAS CLAVE
Dolor;
Paciente crítico;
Cuidados intensivos

El dolor en el paciente en estado crítico y su entorno

Resumen Se sabe que el dolor es el síntoma-síndrome más preocupante en los pacientes en cualquier contexto de terapéutica médica, por lo que en medicina crítica el abordaje integral (biológico–psicológico–social–espiritual) debe ser adecuadamente abordado en la tríada paciente-familia-equipo de salud (*ES*) al ser los principales estructurantes de la atención terapéutica. El estado de salud, así como el ingreso a la Unidad de Terapia Intermedia (UTI) y/o a la Unidad Cuidados Intensivos (UCI) representa un evento acompañado frecuentemente de

* Corresponding author at: Jardín 12 Belizario Domínguez sección XVI Tlalpan, Mexico City, Mexico.
E-mail address: orlo_78@hotmail.com (O. Carrillo-Torres).

http://dx.doi.org/10.1016/j.hgmx.2016.05.018

Please cite this article in press as: Carrillo-Torres O, et al. Pain in patients in critical condition and its environment. Rev Med Hosp Gen Méx. 2016. http://dx.doi.org/10.1016/j.hgmx.2016.05.018

dependencia, incertidumbre, temor, múltiples pérdidas, vulnerabilidad, sufrimiento y experiencias cercanas a la muerte. Los pacientes en cuidados intensivos experimentan a menudo múltiples y recurrentes factores de estrés agudo, donde la respuesta y afrontamiento depende de una variedad de funciones neurofisiológicas, cognitivas, emocionales, sociales y el apoyo que se les brinde en estos aspectos.

Introduction

The concept of a critically ill patient is not clear since it is often used a synonym for urgent or emergency patients. Urgent patients are defined as patients who have problems of diverse aetiology and varying severity that create awareness of an immediate need for care in the subject or their close friends or relatives. Its course is usually slow and not necessarily life-threatening, but care should not be delayed by more than 6 h. Emergency patients are all subjects in whom their life or the function of an organ is in danger. In this case a lack of healthcare will likely lead to death within minutes and it is essential to apply first aid. In these patients, the concept of the golden hour is promoted as the first hour after an event in which mortality is elevated due to the high onset frequency of complications.

Therefore, to prevent confusion, we will define patients as critically ill when, regardless of their baseline status as urgent or emergency patients, multiple organ failure or the failure of sequential vital signs begins with an imminent danger of death creating a persistent state of severity that requires continuous monitoring and treatment.[1]

This definition includes, but is not limited to, patients found in intensive care and/or high dependency units since there are critically ill patients with practically no possibility of recovery and who because of triage priorities are located outside these units.

The International Association for the Study of Pain (IASP) defines ''pain'' as an ''unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage''.[2] This ''symptom'' is important to always keep in mind since pain can become an illness if it is not adequately treated on time.[3] As it is a frequent and unpleasant symptom in critically ill patients it is considered a risk factor for several psychological and physiological complications, some of which are potentially fatal.

Nearly five million patients are admitted to the ICU each year. More than 70% of the patients in ICUs have pain, of which 63% have moderate to severe pain. It is also known that only half of the patients with sedation receive analgesics and 21% of those who have muscle relaxants do not receive analgesics. Forty percent of cases with acute respiratory failure, multiple organ failure, and sepsis who end up dying reported pain in the last 3 days of their life.[4]

Pain is one of the most common symptoms in patients in critical condition and it is experienced by every patient in a unique way. Procedures that cause pain, such as movement and tracheal aspiration, are common and trigger acute pain.[5] Furthermore, many of these patients have a history of chronic pain, which complicates their course and treatment.[6]

According to the international guidelines from the IASP, medical, surgical, and trauma patients in the ICU routinely present pain at rest, during care routines, and during procedures. In addition, pain in adult patients after heart surgery is common and poorly treated.[7]

Given the importance of an adequate approach to and treatment for pain, the interdependent actors in the comprehensive care plan for critically ill patients, both the family and the healthcare team, must be considered with the goal of achieving a good outcome in the psychosocial domain that, according to Garland,[8] is measured based on long-term function and the perception of quality of life among survivors, patient- and family-satisfaction, agreement between desired and actual end-of-life decisions, and the pertinence of the provided medical interventions.

In the healthcare team, all the staff involved to participate in psychosocial and spiritual care. Therefore it is important to understand the processes that take place in the context of critically ill patients, how to assess emotional, cognitive, and behavioural symptoms, as well as how to apply diagnostic and intervention methods based on the scientific literature.

The complete situation for critically ill patients is enormously complex. The health condition, as well as admission to the High Dependency Unit (HDU) and/or the Intensive Care Unit (ICU) represent a high-impact event where patients frequently confront a technologically driven environment, high noise levels, painful procedures, fear, loss of autonomy, vulnerability, suffering, and near-death experiences.[9] Therefore, patients in intensive care often experience multiple and recurrent acute stressors where their response and ability to cope depend on a variety of cognitive and neurophysiological functions,[10] as well as the degree of emotional and social support they receive.[11]

In this context, patients can be reduced to their illness, identified by room number, promoting a feeling of isolation, loneliness, loss of control, and uselessness. For these reasons, it is important that patients feel as if they have a name and are treated like a person with inherent dignity and worth.

Please cite this article in press as: Carrillo-Torres O, et al. Pain in patients in critical condition and its environment. Rev Med Hosp Gen Méx. 2016. http://dx.doi.org/10.1016/j.hgmx.2016.05.018