

Pediatric Pain Management



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KEYWORDS

- Pain • Pediatrics • Emergency • Self-report • Behavioral-observational • Pain scale
- Intranasal • Nonpharmacologic

KEY POINTS

- There are challenges and barriers to pain management in the pediatric emergency department.
- Age-appropriate pain scales and other techniques suitably evaluate pediatric pain.
- Pediatric pain can be treated effectively via pharmacologic and nonpharmacologic methods.

INTRODUCTION

The complaint of pain is a common reason for families to seek care for their children in the emergency department (ED). Alleviating pain is an important component of emergency care, improving the experience for the patient and contributing to improved accuracy of evaluation. Adequate pain control during assessment and procedures can prevent long-term negative consequences, including heightened pain experiences, noncompliance with vaccines, and avoidance of future medical procedures.¹⁻⁵ From an operations perspective, rapid time to analgesia has been associated with shorter ED stays for adults.⁶

Pain assessment and management have been identified as a priority by several organizations and accreditation bodies. Standards for pain assessment and treatment were established by The Joint Commission (TJC) in 2001. Current standards require hospitals to have policies for pain assessment and treatment and to ensure staff are educated and compliant with the policies.⁷ A 2012 American Academy of Pediatrics (AAP) clinical report provides evidence-based guidance for pain management and analgesia in emergency services. It describes pain assessment instruments and includes education tips and treatment protocols.⁸ A 2003 National Association of

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Emergency Medicine Service Physicians (NAEMSP) position statement states that the relief of pain should be a priority for every emergency medical services (EMS) system and recommends elements that should be present in prehospital pain management protocols.⁹

PAIN IN THE EMERGENCY DEPARTMENT

Of the 23 million ED visits by patients younger than 15 years in 2013, injury accounted for 30%, and painful conditions such as headache, ear pain, and abdominal pain accounted for an additional 9%.¹⁰ Additionally, children may be subject to several painful procedures during an emergency visit, and considerations for preventing pain during procedures are as important as treating existing pain.

Oligoanalgesia (the undertreatment of pain), is prevalent in both adult and pediatric EDs.¹¹ Children are prone to oligoanalgesia and frequently experience unnecessary pain with minor illnesses and injuries.^{12–14} Pain management begins with appropriate assessment and documentation. Prior to TJC establishment of standards for pain assessment and documentation, ED documentation of pediatric pain scores was reported at 23% to 44% of visits.^{15,16} One study in the postmandate era reported pain score documentation in 87% of visits during a 14-month period and a significant association between pain score documentation and the prescription of analgesics.¹⁷ Increased efforts to assess and document pain scores can decrease oligoanesthesia.

The busy environment in the ED can amplify parental and patient anxiety, leading to an increased awareness of pain.⁸ Factors inhibiting optimal assessment of pediatric pain include the failure to understand the caregiver's role and decision to seek evaluation, adults' limited understanding of children's pain experience, and sociocultural influence on pain expression.¹⁸ A comparison of pediatric pain assessment by patients, caretakers, and professionals in the ED found that professionals scored pain lower in comparison with guardians and patients, and that guardians were more likely to rate pain similar to the rating given by their child.¹⁹

Relative unfamiliarity with children of different ages and developmental stages may be a barrier to pain management, as over 80% of children seeking emergency care do so in general EDs treating adults and children.²⁰ Another factor may be an erroneous belief that infants and neonates do not feel pain, or that children will not remember painful experiences to a significant extent.²¹ Additional barriers include difficulty assessing and measuring pain in young patients, unfamiliarity with pain score instruments or scales, distinguishing pain from anxiety, fears of medication adverse events, and concerns of masking serious conditions.⁸

EVALUATION AND ASSESSMENT OF PAIN

Pain assessment tools are commonly defined as one of two types. Observational-behavioral measures aim to reflect a patient's reaction to pain. Self-report measures rely on the patient's ability to quantify and describe his or her pain. Using the appropriate type of tool to assess pain accurately is essential to establishing baseline discomfort and measuring response to treatment.

Self-report scales are currently the standard in the assessment of pain. There are 6 self-report pain scales that have been shown to have well-founded reliability, validity, and feasibility for use in the assessment of acute and chronic pain in children.²² These include the Faces Pain Scale (FPS), Faces Pain Scale – Revised (FPS-R), Oucher-Photographic, Oucher-Numeric Rating Scale (NRS), Wong-Baker FACES Pain Scale, and Visual Analog Scale (VAS). Multiple studies have found that younger and older

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