**SECTION:** Adult General Medical Emergencies

**PROTOCOL TITLE:** General – Pain Control

**REVISED:** 07/2017

Protocol
3-10

PAIN MANAGEMENT

**OVERVIEW:**
The practice of pre-hospital emergency medicine requires expertise in a wide variety of pharmacological and non-pharmacological techniques to treat acute pain resulting from a myriad of injuries and illness. One of the most essential missions for all healthcare providers should be the relief and / or prevention of pain and suffering. Approaches to pain relief must be designed to be safe and effective in the organized chaos of the pre-hospital environment. The degree of pain and the hemodynamic status of the patient will determine the rapidity of care.

| HPI | Signs and Symptoms | Considerations |
|---|---|---|
| • Age<br>• Location<br>• Duration<br>• Severity (1 - 10)<br>• Past medical history<br>• Medications<br>• Drug allergies | • Severity (pain scale)<br>• Quality (sharp, dull, etc)<br>• Radiation<br>• Relation to movement,<br>• respiration<br>• Increased with palpation of area | • Musculoskeletal<br>• Visceral (abdominal)<br>• Cardiac<br>• Pleural, respiratory<br>• Neurogenic<br>• Renal (colic) |

| | EMR | EMT | A | I | P |
|---|---|---|---|---|---|
| 1. Perform general patient management. | • | • | • | • | • |
| 2. Administer oxygen to maintain $SPO_2$ 94 - 99% | • | • | • | • | • |
| 3. Determine patient's pain score assessment using a standardized scoring system. Refer to Universal Pain Assessment tool on this protocol. | • | • | • | • | • |
| 4. Place patient on cardiac monitor per patient assessment. | | | | • | • |
| 5. Determine if pain is acute or chronic (3 weeks or more). If chronic, attempt to identify cause (cancer/palliative care) | | • | • | • | • |

# Protocol 3-10

Continued

## PAIN MANAGEMENT

| | EMR | EMT | A | I | P |
|---|---|---|---|---|---|
| 6. If pain is mild, moderate, or chronic (cancer/palliative care excluded), *consider* use of non-opioid treatment. If age > 10 yrs, may alternatively consider one of the following, *if available*:<br>a. Nitronox (via patient administered dosing system)<br>b. Acetaminophen 650 mg PO<br>c. Nonsteroidal such as ibuprofen 400 mg PO (avoid in pts with open fractures or suspected hip/femur fractures) | | OMD Option | OMD Option | OMD Option | OMD Option |
| 7. If NO nonsteroidal administered, for mild, moderate, or chronic pain (cancer/palliative care excluded), consider TORADOL 15 mg IV or 30 mg IM. Avoid use If age less than 10 years, older than 65 years of age, or patients with history of renal disease. | | | • | • | • |
| 8. If pain rated **7 or above** and/or chronic pain from cancer/palliative car, establish IV of normal saline if indicated for medication administration. | | | • | • | • |
| 9. If pain rated **7 or above**, administer fentanyl 2 mcg / kg INTRANASAL (max first dose of 100 mcg) half dose in each nostril. May consider additional dose of up to 100mcg after 5 minutes if pain persists –OR- *fentanyl* 1 mcg / kg IV, or IM (max single dose of 100 mcg).<br>*** *There are no documented cases of chest rigidity with the administration of fentanyl INTRANASALLY* *** | | | • | • | • |
| 10. If fentanyl unavailable, administer morphine sulfate 0.1 mg / kg IV or IM (max single dose of 5.0 mg). *Sickle cell* patients may be given higher doses up to 10 mg IV or IM. | | | • | • | • |

PAIN MANAGEMENT

| | EMR | EMT | A | I | P |
|---|---|---|---|---|---|
| 11. Repeat the patient's pain score assessment. | • | • | • | • | • |
| 12. Consider Odansetron (ZOFRAN) 0.1 mg/kg IV up to 4 mg over 2 to 5 minutes for nausea or to prevent nausea. | | | • | • | • |
| 13. If indicated based on pain assessment, repeat pain medication administration after 10 minutes of the previous dose. Maximum total dose of fentanyl is 200 mcg and morphine sulfate is 20 mg for non-sickle cell patients. Sickle cell patients may have up to a total of 400 mcg of fentanyl or 40 mg of morphine sulfate. | | | • | • | • |
| 14. Transport in position of comfort and reassess as indicated. | | • | • | • | • |

**Universal Pain Assessment Tool**

| | | | | | | |
|---|---|---|---|---|---|---|
| Verbal Descriptor Scale | 0 1 2 3 4 5 6 7 8 9 10 | | | | | |
| | No pain | Mild pain | Moderate pain | Severe pain | Very severe pain | Excruciating Pain |
| Wong - Baker Scale |  | | | | | |
| | Alert Smiling | No humor Serious, flat | Furrowed brow Pursed lips Breath holding | Wrinkled nose Raised upper lip Rapid breathing | Slow blink Open mouth | Eyes closed Moaning Crying |
| Activity Tolerance Scale | No pain | Can be ignored | Interferes with tasks | Interferes with concentration | Interferes with basic needs | Bed rest required |
| Spanish | Nada de dolor | Un poquito dedolor | Un dolor leve | Dolor fuerte | Dolor demasiado fuerte | Un dolor insoportable |

**PEARLS:**

1. Pain severity (0 - 10) is a vital sign that should be recorded before and after IV or IM medication administration and upon arrival at destination.
2. Contraindications to narcotic medication administration include hypotension, head injury, respiratory depression, and severe COPD.
3. All patients should have drug allergies ascertained prior to administration of pain medication.
4. Patients receiving narcotic analgesics should be administered oxygen.
5. Narcotic analgesia was historically contraindicated in the pre-hospital setting for abdominal pain of unknown etiology. It was thought that analgesia would hinder the ER physician or surgeon's evaluation. Recent studies have demonstrated opiate administration may alter the physical examination findings, but these changes result in no significant increase in management errors.[1]
6. Fentanyl is contraindicated for patients who have taken MAOIs within past 14 days, and used with caution in patients with head injuries, increased ICP, COPD, and liver or kidney dysfunction.

[1]Do opiates affect the clinical evaluation of patients with acute abdominal pain?
JAMA. 2006; 296(14):1764-74 (ISSN: 1538-3598)
Ranji SR; Goldman LE; Simel DL; Shojania KG