

## Pain Relief as an Integral Part of the Palliative Care

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### Abstract

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**BACKGROUND:** Palliative therapy represents active care for patients whose illness has such nature that is not responding to the curative treatment. The palliative care aims to provide comfort and prevention from the suffering of the patients at the end of their life. Treatment of the pain presents an important integral part of palliative care.

**AIM:** This article aims to discuss and answer to some of the analgesic regimes and therapeutic dilemmas.

**RESULTS:** Pain control, in addition to the other treatments such as alleviation of psychological, sociological and spiritual problems, has a priority. The proper pain management can achieve a better quality of life for the patients and their families.

**CONCLUSION:** It can be concluded that because of the different origin of the pain, the use of analgesic therapy should be individualised and adapted to the real need of every person. Finally, only a good organisation and institutionalisation of the palliative care in one society could permit better prevention of suffering at the end of the life.

## Introduction

The complexity of the management of the patients suffering the pain is a challenge for professionals, particularly for the patients at the end of the life. Most of the terminal patients, especially those with malignancy have a poor quality of life. The persistence of the pain is a result of the terminal illness itself, or of the therapeutic approach, such as chemotherapy, neuropathic, or from concomitant diseases such as osteoarthritis, spondylolisthesis, migraine, etc.

Pain evokes unpleasant sensation to the patients. This is a result of stimulations which hurt or destroy tissues and commonly is associated with a pathological event in the body. Pain is a subjective phenomenon, and its objective evaluation is difficult. This is especially difficult in palliative care because of the pain complexity. The reason for the pain, especially in malignant diseases, is very often neural

compression and infiltration, bone metastasis, obstructions and infiltration of the soft tissues. In approximately 70–90% of the patients, during the palliative phase, the pain is present in one moment [1]. The patients on palliative care had fear of the pain with a physical, emotional and psychological component of the pain. In early 1900, Sherrington attempted to define the pain and he accentuated the two components of the pain: sensitivity and affection. Later, Henry Head found a double reaction in acute sensation. Today it is accepted to speak about pain as a complex perception experience with plasticity [2].

The reaction to the pain is complex and individual. The magnitude, the severity of the illness and the degree of patients' discomfort, all take part in the formation of individual experience to pain. Different physiological and psychological phenomena in the body produce modifications of the quality of the pain. The memories of pain episodes, the patients' reactivity to pain, families and friends support, religions, personal defence skills, and therapeutic

strategies are the most frequent reasons for these modifications. The level of education, culture and tradition take an important part in the formation of the pain experience. The threshold to the pain is individual. Severe pain produces mental and physical torture of the body. The person is exhausted, fatigue and without energy. Fatigue is one of the leading symptoms of the terminal states and often concomitant symptom of the malignancy, producing a poor quality of life [3]. The pain experience is unique, stretch individual and leads to changes in the personality. It has social implications; it disturbs the sleep, appetite, lowers the tolerance to the stress and is often the reason for depression [4].

In the strategy for pain management, and in palliative care, there are two known approaches: evaluation of the pain, and the treatment (management) of the pain.

Even though pain is an individual complex experience, it is supported by different physiological, psychological and spiritual factors. During the evaluation of the quality and quantity of pain, all additional factors and their interactions must be taken into account. The detailed anamnesis is essential. It orients the clinician for the patient's needs and determines whether an aggressive and sufficient therapy for pain relief is necessary or not [5].

## Evaluation of the pain

Since pain is an individual experience, symptoms should be converted to measurable magnitudes in purpose to make an appropriate assessment. Taking anamnesis is the first step which helps tremendously, and also pain must be described in details. This is not so easy in palliative care!

To assign the appropriate management, it is important to discover: the origin of the pain, the states in which the pain is more intensive, the quality of the pain, the route of propagation of the pain, and the degree and the intensity of the pain. There are several methods that help in the evaluation of the severity of the pain. The approach is as follows:

- 1<sup>st</sup>: Where? (Location and propagation of the pain)
- 2<sup>nd</sup>: When? (Constant: intermittent: night pain)
- 3<sup>rd</sup>: How? (Description of the pain)
- 4<sup>th</sup>: How much? (Intensity of the pain)

Methods for the evaluation of the pain are Type I and Type II (Figure 1). They are based on the physiological, neurological and neuro-pharmacological findings or the patient's subjective experience [6].

Type I – PAIN EVALUATION	Type II – PAIN EVALUATION
1. PHYSIOLOGICAL CHANGES <ul style="list-style-type: none"> <li>- Increased Plasma Cortisol</li> <li>- Increased Plasma Catecholamine's</li> <li>- Cardio-Circulatory Changes (PULSE, BP, SMV)</li> <li>- Respiratory Changes (RR, VC, FEV, TV<sub>max</sub>)</li> <li>- Tears, Facial grimacing</li> </ul>	1. ONE DIMENSIONAL METHODS <ul style="list-style-type: none"> <li>- Categorical Scale</li> <li>- Numerical Scale</li> <li>- Visual Analog Scale</li> </ul>
2. NEUROPHARMACOLOGICAL <ul style="list-style-type: none"> <li>- Inverse Correlation With Plasma Beta Endorphins</li> <li>- Changes In Dermal Temperature</li> </ul>	2. MULTI DIMENSIONAL METHODS <ul style="list-style-type: none"> <li>- Mc GILL Questionnaire</li> <li>- Dartmouth Questionnaire</li> <li>- List of West Haven-Yale</li> <li>- Pain perception profile</li> <li>- Behavior observation</li> <li>- Pain Diary</li> <li>- Pain Scoring</li> <li>- Prevocational Test</li> <li>- Rehabilitation Test</li> </ul>
3. NEUROLOGICAL <ul style="list-style-type: none"> <li>- Changes In Nervous Conductance Velocity</li> <li>- Evoked potential (neurologic dysfunctions)</li> <li>- Micro-neurographics</li> </ul>	

Figure 1: Methods for the evaluation of the pain

## Pain control

In general in palliative care, the pain therapy primary contains a general analgesic approach and secondary, use of additional alternative therapy.

The primary analgesic management starts with management of the nociception pain (by WHO as "step by step" approach), combined with the management of the neurogenic pain (anticonvulsive and antidepressants - gabapentin, carbamazepine, phenytoin, and Amitriptyline, Nortriptyline) and management with adjuvants (corticosteroids, sedatives, antiemetic, Alfa - 2 agonists, local anaesthetics, NMDA receptor antagonists etc.) [4] [5] [6].

Today a flexible approach to pain relief therapy for palliative care provides the best results. It consists of the use of more therapeutic abilities at the same time frame at different time intervals. The main characteristic of this therapy is a continuum of analgesic management. As an addition to the standard analgesic therapy is specific therapeutic operations (ex: anti-tumour therapy, neuroaxial therapy, parenteral PCA, neurolytic the etc.) [7].

The secondary, alternative approach in pain control is very popular in palliative care. It compromises of the use of several methods which are cheap, effective and popular for patients at the end of their life. Those are interventional, rehabilitation, stimulation, psychological and complementary approaches [8] [9].

## The organisation of the pain management in palliative care

Most of the patients undergoing palliative care are hospitalised in different institutions. Some of them are in geriatric centres or specialised clinics as surgery, oncology, intern medicines or others. This

approach is very expensive to the society. In developed countries, this category of patients (at the end of their life) is lodged in “hospices”. In this type of institutions, the quality of care is at a very high level, where the pain relief is performed by specialised professional team [9] [10] [11].

The second organisational model is “home care”. This type of palliative care is more practical and cheaper. A mobile team of one GP and one nurse (educated for assessing and treating the pain) visits the patients at their homes. This type of care needs big efforts from the families and their maximal support [12].

## Ethical dilemmas in palliative care

In terminal patients, the occurrence of ethical issues and questions is very frequent. Common response to these questions is to take measures that will help the sufferers. But when the conventional medical methods of management in palliative care are spent, the last choice is the use of alternative methods of treatment. Most of them must offer comfort to the patient and prevention from suffering [13].

In conclusion, pain management is an integral part of the palliative care. Pain relief is a very important part of improving the quality of life in terminal patients. Because of unpleasant sensations, experiences and fear of pain, the treatment must be complex and multidisciplinary. Good organisation and institutionalisation of the palliative care in one society could only permit better prevention of suffering at the end of the life.

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