

## Importance of Pain Management in Intensive Care and Resuscitation

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Pain is a symptom known to all through our own experience, through one of our loved ones or even through our professional education. It touches us all at one time or another in our life. Pain is a vast subject, complex (with multiple components: physical, psychological, other...) and sometimes complicated (difficult to understand). Pain is equated with "an unpleasant sensory and emotional experience associated with, or described in terms of, actual or potential tissue damage", according to the International Association for the Study of Pain [1]. Different types of pain exist, which makes diagnosis and management difficult. These pains are grouped into three categories according to their physiological mechanisms. There is the pain of excess nociception, which are the most common, neurogenic pain or otherwise called neuropathic pain and lastly psychological or psychogenic pain [2]. To this can be added mixed pains that are both caused by over-excitement of the nociceptive receptors and nerve involvement [3]. In addition to this classification, a pain can be called acute (brutal tissue involvement), chronic (pain "evolving for more than 3 to 6 months and/or likely to negatively affect the behavior or well-being of the patient") or induced (pain following care) [4]. This notion is essential to guide the management of pain.

Pain in intensive care is a frequent phenomenon, since 40 to 65% of patients report having had a painful experience during their stay in intensive care unit. The care, although necessary for the patient, can be a source of pain by their repetition during the day and/or their intense character. Thus, tracheal aspiration, removal of chest drains and patient mobilization for dressings are regularly cited as the most painful gestures [5]. In addition to this, there is a certain difficulty in assessing the degree of pain in the non-communicating patient, and prescriptions for analgesic therapies that are often inappropriate, related to prescribers' personal preferences, the caregivers' workload, and the frequent confusion between sedation and analgesia, a lack of knowledge of the pharmacology of sedative and analgesic agents in intensive care. Pain caused by painful procedures rarely leads to the prescription of specific analgesia. Conversely, the patient may systematically receive continuous administration of sedatives and opioids, exposing him to a risk of overdose. Half of the patients hospitalized in intensive care develop a state of pain of moderate to severe intensity, whether the reason for admission is postoperative, traumatic, or a medical pathology [6]. The patient's pain of resuscitation is a model of acute/subacute pain evolving on a painful background with episodes related to the care or evolution of the pathology. Despite the difficulty of managing pain in intensive care, efforts are currently being made to identify and improve practices. The management of pain in intensive care begins with a regular evaluation of the analgesia, in order to recognize the most painful pathologies and care, to adapt accordingly the analgesic treatment and, in the long term, to improve the comfort of the patient. The French study DOLOREA [7], conducted in 44 resuscitation departments in 1381 ventilated patients, showed at day 2 a pain intensity of at least moderate intensity of 33% at rest and 56% during a procedure of care and increased during the stay to reach a maximum of more than 80% during care at day 6.

The importance and specificity of pain management in intensive care has been reaffirmed by recent consensus conferences [8,9]. The management of pain is of increasing importance because it has been shown that this management was associated with a better prognosis in intensive care [10-13]. A post-hoc analysis of the DOLOREA study [10] showed that among patients receiving an analgesic on day 2, and after adjusting for intercurrent factors using a propensity score, patients evaluated for pain had a duration of mechanical ventilation and

shorter ICU stay than unassessed patients. The latter were less evaluated for their level of sedation and received more hypnotics. Thus, the last consensus conference on sedation-analgesia in intensive care clearly distinguishes sedation from analgesia both with regard to the therapeutic management of pain and the evaluation on which it is based. The challenge of pain assessment, which is the basis of any rationalized management, is determined by the communication difficulties commonly observed in resuscitation patients.

Significant progress has been made in the last 10 years in the management of pain, whether acute or chronic, post-operative, traumatic or medical, in children as in adults. However, there is still little explored land, especially that of pain in intensive care. It is true that the main part of the care provided to a patient of resuscitation is to fight against the visceral failure (s) which are the object of the admission of the patient and/or its maintenance in resuscitation. However, this management generates a painful situation for the patient, accompanied by frequent and intense pain. This explains the recent interest of North American and French learned societies in proposing recommendations for the management of pain and sedation in intensive care [14].

Pain in intensive care is frequent and sometimes intense. The sources of difficulties in the management of pain in intensive care are multiple: care objectives focused on major vital distress, personal preferences of prescribers, workload of caregivers, confusion between sedation and analgesia, lack of knowledge of the pharmacology of sedative agents and analgesics in intensive care, difficulty in assessing pain in non-communicating patients. However, efforts are currently being made to identify or even improve practices. The management of pain in intensive care begins with a regular evaluation of analgesia, a real measure of the 5th vital sign, in order to recognize the most painful pathologies and care, to adapt the analgesic therapy accordingly, and eventually, to improve the comfort of the patient.

### Bibliography

1. Gaillard A. "Douleur morale, douleur physique: mécanismes neurobiologiques et traitements". *Annales Médico-Psychologiques, Revue Psychiatrique* 172.2 (2014): 104-107.
2. Vuillet-A-Ciles H and Billet F. "L'essentiel pour comprendre la douleur". *Actualités Pharmaceutiques* 52.527 (2013): 18-20.
3. Bouhassira D. Douleur. Inserm. [En ligne] Mai (2016).
4. Guy-Coichard C., et al. "Conduite à tenir vis-à-vis d'une douleur chronique". *EMC-Anesthésie-Réanimation* 2.1 (2005): 1-22.
5. Puntillo K., et al. "Pain behaviors observed during six common procedures: results from Thunder Project II". *Critical Care Medicine* 32.2 (2004): 421-427.
6. Chanques G., et al. "A prospective study of pain at rest: incidence and characteristics of an unrecognized symptom in surgical and trauma versus medical intensive care unit patients". *Anesthesiology* 107.5 (2007): 858-860.
7. Payen JF, et al. "Current practices in sedation and analgesia for mechanically ventilated critically ill patients: a prospective multi-center patient-based study". *Anesthesiology* 106.4 (2007): 687-695.
8. Sauder P., et al. "Sédation et analgésie en réanimation (nouveau-né exclu)". *Annales Françaises d'Anesthésie et de Réanimation* 27.7-8 (2008): 541-551.
9. 6ème Conférence de Consensus SFAR-SRLF. Mieux vivre la Réanimation (2009).
10. Payen JF, et al. "Pain assessment is associated with decreased duration of mechanical ventilation in the intensive care unit: a post Hoc analysis of the DOLOREA study". *Anesthesiology* 111.6 (2009): 1308-1316.
11. Chanques G., et al. "Impact of systematic evaluation of pain and agitation in an intensive care unit". *Critical Care Medicine* 34.6 (2006): 1691-1699.

12. Robinson BR, *et al.* "An analgesia-delirium-sedation protocol for critically ill trauma patients reduces ventilator days and hospital length of stay". *Journal of Trauma* 65 (2008): 517-526.
13. Skrobik Y, *et al.* "Protocolized intensive care unit management of analgesia, sedation, and delirium improves analgesia and subsyndromal delirium rates". *Anesthesia and Analgesia* 111 (2010): 451-463.
14. Jacobi J, *et al.* "Clinical practice guidelines for the sustained use of sedatives and analgesics in the critically ill adult". *Critical Care Medicine* 30.1 (2002): 119-141.

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