

Pain Diagnosis:

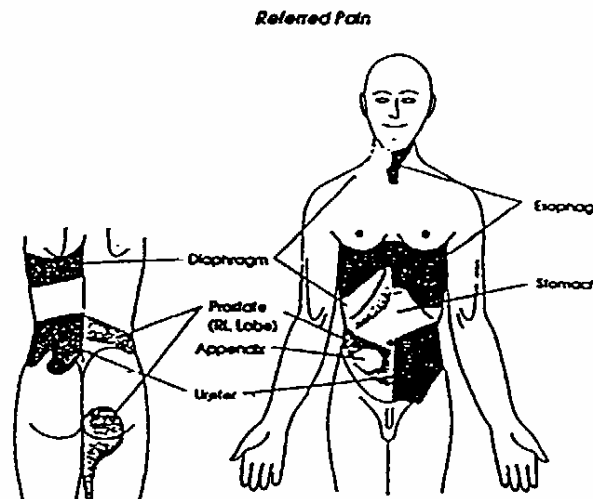
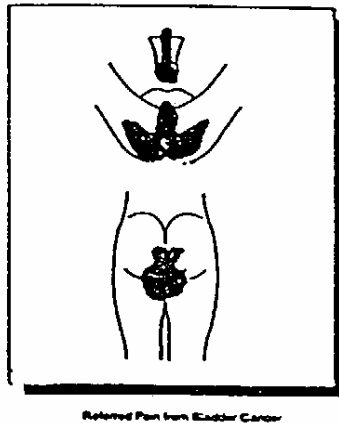
There are four classifications of pain; nociceptive pain, neuropathic pain, mixed pain and pain of unknown origin.

1. Nociceptive:

Nociceptive pain is caused by tissue damage created by pressure, infiltration or destruction by an identifiable somatic or visceral lesion.

Visceral:

Constant, dull, aching, poorly localized pain that has a gradual onset often felt at a distance from the origin.



- a) Solid Viscera (ex: liver, pancreas)
 - if intense, can be sharp and penetrating
- b) Hollow Viscera (ex: bowel, bladder)
 - diffuse, or colicky pain
 - feeling of pressure or fullness caused by blockage of previously open “tunnel”
 - may have shortness of breath or cough with thoracic viscera; abdominal distention, nausea, vomiting with abdominal viscera.

Somatic:

Constant gnawing or aching, usually well localized, worse on movement or weight-bearing if in pelvis, hips, femur, joints or spine.

- bony metastases
- skin invasion or ulceration
- muscle invasion, soft tissue masses
- pathologic fractures
- osteo-arthritis and other bone destructive diseases
- may be present in back and shoulder if it involves T1

Raised intracranial pressure:

- brain tumours
- meningeal carcinomatosis

Key for pain assessment tool

Adapted with permission from Grey Bruce Palliative Care/Hospice Association Manual Guidelines for developing a pain management program, 2001; 3rd edition

2. Neuropathic:

Neuropathic pain is caused by pressure, invasion or destruction of peripheral or central nervous tissues, which leads to complex and abnormal spinal cord or thalamic neural processes that produce sustained pain.

- invasion, destruction of lumbosacral or brachial plexus
- spinal cord compression
- pain often precedes sensory and motor loss
- constant ache to intermittent, sharp stabbing pain
- specific nerve root compression may cause dermatomal pain
- progressive damage may result in superficial burning pain
- can experience hyperaesthesia, dysaesthesia, progressive motor and sensory loss
- can have vasomotor changes

3. Mixed:

Mixed pain in many instances is a combination of nociceptive and neuropathic pain.

- tumour invasion of pancreas with spread to and destruction of vertebra including spinal cord compression.

4. Unknown:

Persistent pain, the cause of which cannot be determined by history and investigations.

- may be described with all the current word descriptors
- patient is often not believed if investigations are inconclusive
- is usually under treated
- can be debilitating
- lifelong suffering may lead to depression

Problem List:

Using the "Pain Assessment Tool" circle the pain diagnosis(es) and list them on the care plan. If you identify a problem that the resident did not, it is important to ensure the resident agrees and understands why this is a problem. This is an ongoing list. Please date each problem when identified and resolved.

Goals and Plans:

From the problem list, the resident creates goals and you work together to identify the interventions.

It is important to include who specifically will do what and to whom the resident has been referred. Also, include what outcome measure you will be using to re-evaluate the goal i.e. analog scale of

0 - 10 and what tool you will use if it is other than pain. i.e. 0 = no nausea, 10 = worst nausea imaginable; or scores from the behaviour checklist.

Include when you anticipate the plans to be carried out and when you will be re-evaluating the goal.

Make sure to sign and date each entry.

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