Challenging Acute Pain Scenarios

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Scenario 1:All is not what it seems?

- Man 32 years
- Charcot-Marie-Tooth disease
  - Hereditary sensorimotor neuropathy
- Wheelchair user
- Attended A/E having fallen out of his wheelchair and “dislocated” right shoulder
- Replaced the shoulder himself
- Increase in pain

Scenario 1 cont.

- Normally lives alone in an adapted flat in Worcester
- Currently staying at Jury's Hotel near Victoria station
- Poor relationship with parents
- Runs his own business as an Apple computer shipper

Scenario 1 cont

- RTA in 2003 with a right shoulder injury and rupture of the subclavian artery
- Surgery in Bristol
- MRSA/septicaemia
- ITU and in-patient care for several months
- Rehabilitation unit
- Eventually returned home
- Since then recurrent dislocations of right shoulder, treated at RNOH Stanmore

Current symptoms

- Neuropathic pain in feet
- No pain in shoulder, no swelling or bruising
- XRays normal
- Movement of shoulder reduced in all directions. Abduction to 40 degrees
- Can transfer from bed to wheelchair
- Numbness dorsal aspect of right thumb
- LFTs abnormal: ALP 158, GGT 166

Medication

- Oxycontin 40mg BD
- Amitriptyline 50 mg daily
- Paracetamol 1G QDS
- Gabapentin 300mg TDS
- Zopiclone 15mg Nocte
- Pethidine IM 100mg 2 hrly PRN, average daily dose 900mg, self administered.
- All drugs written up by admitting doctor

  “Allergic to morphine”

Unusual features

- Police went to Jury's Hotel to bring his supplies of Pethidine to King's
- Allegedly prescribed by Stafford Hospital
- He denied any previous admission to King's but notes located of a patient with nearly identical surname, date of birth one day later
- He denied previous admissions to hospital, but was well known to Whipps Cross and National Hospital and other hospitals, after falling out of wheelchair and "dislocating" right shoulder

Further information

- A doctor's letter states:

  "….on high doses of pethidine for Charcot-Marie-Tooth disease; this helps his painful terminal condition and should keep going"

Progress on ward

- Pain scores 10/10
- Very agitated and aggressive
- Self injecting pethidine 2 hrly, when challenged by nursing staff he became more aggressive and they backed off.
- Poor nutritional status
- Twitching
- After 5 days the Pain team was called….!

Discussion

Drug Dependency Review

- Patient denied dependency on Pethidine
- Affect inappropriate
- Tangential answers to questions
- Hypereflexia, ankle clonus
- Told he was not permitted to self inject in hospital and drugs confiscated
- Scared of withdrawal

Outcome

- Pethidine dosage halved for 2 days
- Amitriptyline increased to 100mg, gapapentin to 900mg TDS
- Continued oxyxontin 40 mg BD with oxynorm 20 mg PRN, average dose 5x daily
- Became much more amenable
- Twitching resolved
- Planned discharge to rehabilitation unit in Worcester

Scenario 2: Acute sickle cell crisis

- Man 30 years
- Sickle cell disease HbSS
- Frequent crises requiring hospital admission
- No infection present
- Avascular necrosis of both hips
- Left total hip replacement 2008

Psychosocial history

- Has completed College course and wants to work in IT, finds it difficult to sustain a regular work pattern but does some work from home
- Appears very motivated
- Happily married, one child age 4years

Scenario 2 cont

- Seen in Pain Clinic in 2006
- On tramadol and gabapentin regularly since then, oxycodone when the pain is severe, regularly 20mgs at night since 2010
- Walking with a limp
- Left lumbar plexus block with LA and steroid performed 2x in 2006/7 with good effect
- Left hip replacement in August 2008
- Currently AVN of right hip, not yet scheduled for surgery

Acute crisis September 2011

- Admitted with severe thoracic back and jaw pain
- Individualised regime in A/E
  - Ketolorac 30 mg IM
  - Oxycodone 15mg s/c
  - Dihydrocodeine 50mg orally
- Admitted to ward as pain unresolved
- Exchange transfusion scheduled

Further management

- Prescribed oxycodone 20mg 2 hourly s/c
- Using 200mg/24 hours
- After exchange transfusion pain did not subside as expected
- Day 6 Pain Team called as haematology wanted him off injected opioids and discharged home
- ?management

Scenario 3: previous IVDU

- Man 42 years
- Fell from a window in 1999
- Fractured left proximal femur and pelvis
- Left total hip replacement
- Residual significant leg length discrepancy
- August 2010 osteotomy and shortening of right leg

Scenario 3 cont

- Attended drug dependency unit and was maintained on methadone 10mg BD
- Treated at St Thomas's pain clinic, no record of this available
- September 2011 admitted under orthopaedic surgeons for further osteotomy to right femur
- Post op given standard PCA: oxycodone 2mg bolus, lock out 10 mins, s/c
- No regional analgesia given

Other regular medication

- Temazepam 20mg
- Diazepam 10mg
- Zopiclone 30mg
- Nitrazepam 15mg
- Citalopram 40mg
- Loperamide
- Buscopan
- Mebeverine

Further history

- Weight loss
- Chronic abdominal pain
- “Adhesions”
- CRP 140, ALP 265, GGT 147, WCC 4

Postoperative management

- Pain score 10/10
- How would you manage his pain?

What happened was….

- Day 1 PCA bolus increased to 3 mgs
- Pregabalin commenced
- Drowsy with slurred speech but still complaining of severe pain
- Day 2, eating and drinking but pain score still 10/10, bolus increased to 4mg. 304mg/24 hours
- Day 3 very drowsy, small pupils, slurred speech, bolus reduced to 2mgs

Further events….

- Day 3. He was found sniffing a “brownish powder” rolled in a £10 note, which he claimed was valerian when challenged
- Became unrousable. PCA removed
- Adverse incident recorded
- Drugs key worker informed
- Locker search revealed cannabis, heroin powder and benzodiazepines

Next day….

- Coherent, normal speech
- No further opioids prescribed
- Orthopaedic surgeon was advised that it would be wise not to recommend cannabis for abdominal pain!

Learning point: Interpret low dose methadone maintenance therapy carefully when assessing opioid requirement and take other drugs into consideration.

Scenario 4: abdominal pain

- Called by gastroenterologist to see a 26 year old lady with acute on chronic abdominal pain
- Previous resection for Crohn's disease
- Previous severe pain for 1 year which resolved after resection
- "Pseudo-obstruction"
- Not on opioids
- Using Entonox continuously

It’s Friday afternoon…….

- What would you do?

Scenario 5: Difficult neuropathic pain

- Graft versus host disease
- Peripheral neuropathic pain in hands and feet
- Appears unresponsive to gabapentin, pregabalin, amitriptyline and opioids
- Any ideas?

Scenario 6: difficult central neuropathic pain

- Lady 29, quadriplegia from cervical spinal cord injury
- Severe pain in neck and shoulders
- Using IV morphine PCA activating the machine via a straw
- Morphine is leading to shallow respiration and hypoxia
- Suggestions?

What are challenging cases?

- Previous opioid dependency, whether prescribed or recreational, often overlooked or misjudged
- Acute neuropathic pain
- Patient's expectations have not been explored
- Admitting team has different priorities
- Diagnosis of cause of pain is incorrect or uncertain