

Pain Management

Infants and Children

I. Misconceptions/Problems in Pain Management of Pediatric Patients

- A). Under treatment of Pain
- B). Pain Perception issues
- C). Communication issues- young children may not be able to communicate pain
- D). Parental Concerns- fear of child becoming addicted or having adverse reactions to pain meds.

II. Unrelieved Pain

- A). Physiological effects
- B). Psychological effects

III. Age Considerations for Pain Responses

- A). Infants- crying, body gets rigid, facial expression gets tense (think bulged eyebrows, eyes squeezed shut)
- B). Toddlers/Preschoolers- may be quiet/less active and even deny pain. Parents may say “she/he just isn’t acting normal”. Yells ouch or no!!
- C). School Age- can draw pictures of where they hurt. May want to delay a painful procedure, muscular rigidity.
- D). Adolescents- can describe their pain, how they are feeling better. Use correct vocab words. Less motor activity in response to pain.

IV. Assessing Pain- No easily administered or widely accepted uniform technique. Self - reported pain, physiological monitoring and behavioral observations are used to assess.

V. Pain Scales

- A) Selection based on age/developmental stage
- B) Types of Scales
 - PIPP- Premature Infant Pain Profile- measures 7 indicators on a scale.

- CRIES- Post op pain scale for neonates. Crying, Requires oxygen for sat >95%, Increased vital signs, expression, and sleepless
- FLACC- Face, Legs, Activity, Cry and Consolability. Can be used for children 2 mths old to 7 years old
- FACES- ages 3+: child can choose face that best rates their pain or discomfort

VI. Pain Management

A). Multimodal

- Medications
- Imagination/Play therapy
- Environmental
- Non-Pharm techniques- Distraction, Guided Imagery, Positive Self Talk

B). Medications

- Opioid
- Non-Opioid
- Other Adjunct therapy

C) Pain Medication Routes

- IV
- IM
- PO
- Sublingual
- PR
- Topical