

Pain Management

Infants and Children

I. Misconceptions/Problems in Pain Management of Pediatric Patients

- A). Communication issues- young children may not be able to communicate pain
- B). Parental Concerns- fear of child becoming addicted or having adverse reactions

II. Unrelieved Pain

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

III. Age Considerations for Pain Responses

- A). Infants- cry, body rigid, facial tense (bulged eyebrows, eyes squeezed shut)
- B). Toddlers/Preschoolers- may be quiet/less active and 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, clenched fists, closed eyes.
- D). Adolescents- can describe their pain, how they are feeling better. Use correct vocab words. Less resistance.

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

V. Pain Scales

- A) Selection based on age/developmental stage
- B) Types of Scales (most commonly seen)
 - Numeric Scale- usually used for children who understand numbers. Ages ~5-8 and older. Ask child to choose number from 0-10 for pain.
 - FACES- ages 3+: child can choose face that best rates their pain or discomfort

VI. Pain Management

- A). Multimodal
 - Medications- opioids, non-opioids, anti-inflammatories, analgesics
 - Imagination/Play therapy- pain control strategies
 - Environmental- minimize noise, cluster care, comfort items
 - Non-Pharm techniques- Distraction, Guided Imagery, Positive Self Talk

C) Pain Medication Routes

- IV
- IM
- PO
- Sublingual
- PCA Pump
- PR
- Topical