



Pain management and total pain concept in palliative care

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1 INTRODUCTION

According to the International Association for the Study of Pain, pain is "an unpleasant emotional sensation or experience, associated with actual or potential tissue damage, or described in terms of such damage." (IASP, 2017) It is a unique and individual experience, modified by prior knowledge of damage that may exist or be presumed. (IASP, 2017) It is a unique and individual experience, modified by prior knowledge of a damage that may be existing or presumed, that is, in any situation pain is what the patient refers to and describes. (ANCP,2009)

The severity of pain is not directly proportional to the amount of tissue affected and many other factors can influence the perception of this symptom, such as: fatigue, depression, anger, fear, anxiety, and feelings of hopelessness. (GRANER, 2010) Thus, the sensory, emotional and cultural aspects are inseparable and should be equally investigated in each individual. (MICELI,2002)

Considering that feeling pain is not natural and that the absence of pain is a patient's right, efforts should be made to relieve and control pain, knowing that it is multiple and dynamic and, consequently, to periodically adapt the treatment offered (MICELI, 2002).

2 OBJECTIVE

The present work aims to search for scientific documents that exemplify the concept of "total pain" and describe the main forms of conduct and pain management in patients from the perspective of palliative care.

3 METHODOLOGY

This is an integrative review whose work was carried out through a bibliographic survey encompassing studies about the concept of total pain, pain management and treatment in palliative care.

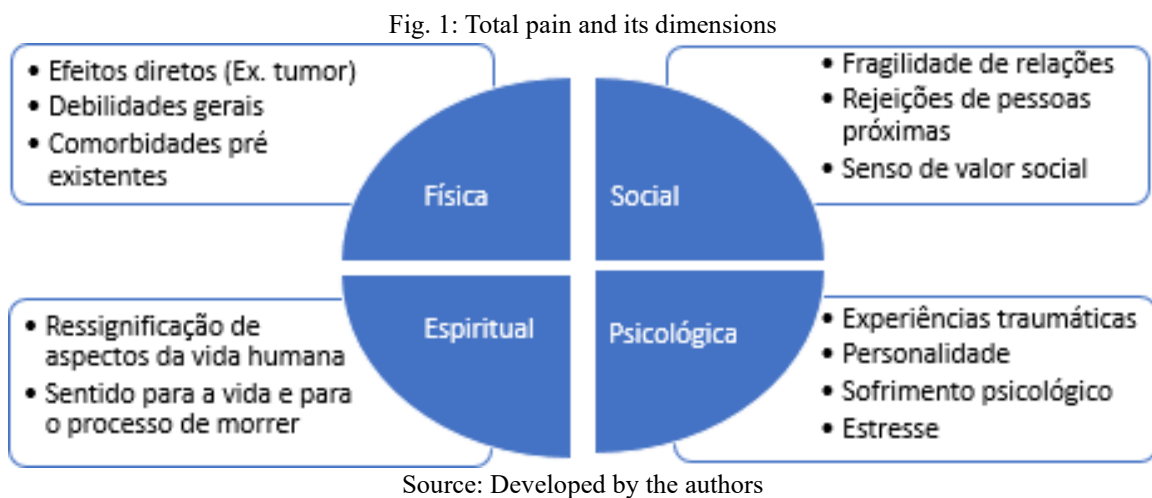


4 RESULTS

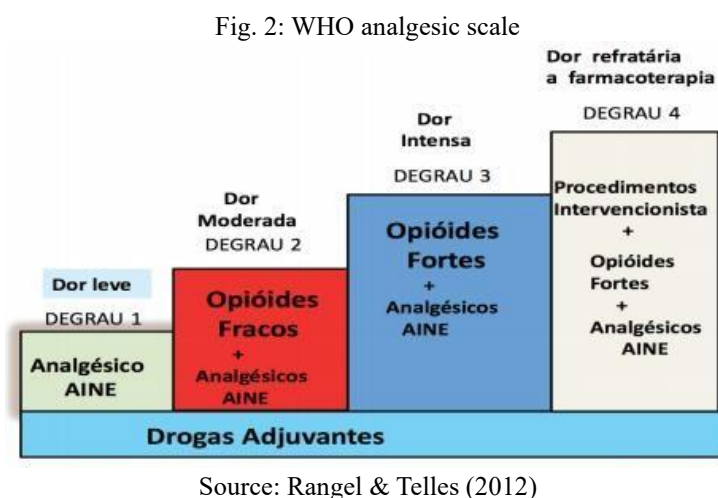
The study by Saunders (1967) found that drug treatment for chronic pain relief was often insufficient, in view of this it was possible to realize that pain must be based on a set of dimensions of the individual (Figure 1) that can contribute to the pain picture.

Non-pharmacological measures should consider the biopsychosocial complexity of the individual, proposing individualized strategies developed by a multiprofessional team.

These non-pharmacological strategies include guidance to the patient and family regarding antalgic positions, emotional support, massage therapy, music therapy, reiki, application of heat or cold, use of cushions, mechanical immobilization, among other measures that may be applied.



Pain assessment should include intensity classification using a Visual Analog Scale. Once the pain has been quantified, pharmacological treatment should proceed based on the WHO Analgesic Scale, as shown in Figure 2.





It is therefore recommended to use analgesics according to the intensity of pain, and treatment may start with analgesics and anti-inflammatory drugs for mild pain, evolve to the use of opioids in cases of moderate and severe pain and in cases of pain refractory to pharmacology, the use of interventional therapies should be evaluated, including: spinal analgesia, vertebroplasties, nerve and plexus blocks and neurosurgical procedures as part of pain management.

5 CONCLUSION

The interface between pain and suffering is undeniable, and since the relief and prevention of suffering is the main objective of palliative care, the role of this type of care in the treatment of patients with severe and/or incurable, advanced and progressive disease becomes indisputable.

In view of all the above, it is possible to realize that only pharmacological treatment is not sufficient in the management of pain in palliative care, it is necessary to monitor a multidisciplinary team, so that this team contemplates the biopsychosocial complexity of each individual, so that individualized care strategies are proposed, and it is still the responsibility of the team to maintain good communication with the patient and his family, in order to provide comprehensive care throughout the end of the patient's life, offering quality of life and dignity.



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