No pain – all gain: Advocating for improved paediatric pain management

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Children experience a wide variety of acute, recurrent and chronic pains. A recent epidemiological study in southwestern Ontario found that the majority of school-aged children (96%) experienced acute pain (eg, injury-related pains, headache, sore muscles, toothaches) over the past month, 57% reported having at least one recurrent pain (eg, headaches, stomach pains and growing pains), and 6% were found to have chronic pain (eg, illness-related pain, back pain) (1). Pain complaints are one of the top reasons for patient-doctor encounters in primary care settings. Pain in children is now recognized as a major health problem because of its prevalence (1,2), negative impact on all aspects of quality of life (3) and economic burden (4).

The treatment and alleviation of pain is a basic human right (5). Researchers have demonstrated that well-managed acute pain is associated with faster recoveries, fewer complications and decreased use of health care resources (6). However, research continues to uncover and document the prevalence of unrelieved pain in infants and children, despite evidence of physiological and psychological negative consequences (7,8). For example, two surveys (9,10) in Canadian paediatric hospitals indicated that there has been no significant change in the levels of pain experienced by infants and children or the frequency of the administration of pain-relieving interventions over the past decade. In both studies, researchers found that approximately 50% of patients reported clinically significant levels of pain and consistently received less analgesia than was prescribed (9,10). As a result, children are still suffering needlessly, despite the availability of adequate pain control for most pain problems. Therefore, it is our hope that this special issue on pain in infants, children and youth.

Most pain is preventable, or at least treatable. There are many things that primary care physicians, paediatricians and other allied health care professionals can do to reduce or eliminate pain. Pain can be effectively managed using a wide range of pharmacological, physical and psychological approaches. Effectively managing pain enhances children’s lives and the lives of their parents and health care professionals. The present issue focuses on practical strategies that we can all implement in our everyday practices to help children who have pain. For example, in the articles by MacLaren and Cohen on procedural pain (pages 111 to 116) and by Jacobson on common medical pains (pages 105 to 109), evidence-based pharmacological and nonpharmacological interventions are discussed. Furthermore, given that pain is a complex, multidimensional phenomenon, the articles by von Baeyer (pages 121 to 125) and Eccleston and Clinch (pages 117 to 120) speak to the need for interdisciplinary and multimodal approaches to treat recurrent and chronic pain in children and adolescents.

The need for evidence-based pain management has been acknowledged by professional organizations (eg, American Academy of Pediatrics in 2000; Canadian Paediatric Society in 2000; Canadian Pain Society in 1997) (5,11) and quality care initiatives, and has been a focus of patient safety initiatives such as the Canadian Council on Health Services Accreditation pain standards (12). There is now a plethora of evidence-based guidelines based on systematic reviews and meta-analyses that may be used to direct our assessment and treatment of pain in children. Thus, the undertreatment of pain in children can no longer be attributed to a lack of research evidence, but rather to our inability to use what we know in our everyday practices. As clinicians, we have an individual and collective responsibility to decrease pain and suffering in children by narrowing the gap between clinical practice and the research evidence supporting optimal patient care. The joint statement with the American Academy of Pediatrics (pages 137 to 138) and an article by McMurtry on the management of needle pain in children (pages 101 to 102) set the stage for this to happen by outlining ways to implement evidence-based guidelines in clinical practice settings.

Other barriers to optimal assessment and treatment of pain in children include a lack of community-based resources (especially for the treatment of recurrent and chronic pain), misconceptions about pain in infants and children, and the lack of education and training in pain for family practitioners, paediatricians and other health care professionals. There are certain assumptions or beliefs that influence health care professionals’ clinical decision making about the presence or absence of pain, actions taken, and evaluation of patient outcomes. For example, health care

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professionals continue to believe that infants and young children are less sensitive to pain than adults, that they are incapable of expressing or adequately describing their pain, and that opioids are more dangerous for infants and children than adults, despite evidence to the contrary. The commentary by Kavanagh and Watt-Watson (pages 97 to 99) provides one example of an innovative interactive interdisciplinary approach to the training of health care professionals that strives to correct these misconceptions and close the research-to-practice gap.

Finally, parental attitudes have also been found to handicap adequate pain treatment. Unlike adult patients, pain management in children is often dependent on the ability of the parent to recognize and assess pain and on their decision to treat or not treat it (3). In addition, educating patients and their families about pain and its management has been shown to decrease anxiety, pain intensity and misconceptions regarding pain management (13). The Canadian Pain Society position statement notes that the “best pain management involves patients, families and health professionals” (5). Therefore, primary care physicians, paediatricians and nurses play a key role in educating parents regarding the assessment and management of pain in children. There are also several resources that have been developed across Canada to provide children and families with information about pain, including the Caring for Kids Web site <www.caringforkids.cps.ca> and the AboutKidsHealth Web site <www.aboutkidshealth.ca>. The latter Web site was developed in collaboration with the pain team at The Hospital for Sick Children in Toronto, Ontario.

It is our hope that this special issue on pain in children will inspire readers to make pain a priority in their everyday practices and advocate for improving the assessment and management of pain in children, so that there is all gain from having no pain.

REFERENCES