Pain Medications

Written by Janet Taylor, RN CEN.

Here is the pharmacology part of pain control. You ***will*** be called out to respond to someone who is in pain. Some times you will pick someone up who has had chronic pain and is already on a bunch of pain medications. I want to review some of the stuff you are sure to come across in your EMS career.

Muscle relaxers: flexeril (cyclobenzaprine), norflex, soma,

Anti-inflammatories: motrin, tylenol, aleve, aspirin, anaprox, torodol,

Narcotic: lortab, Lorcet, vicodin, tylenol #3 (codeine), darvocet , percocet (oxycodone), MSIR, MS Contin, oxycontin, hydromorphone (dilaudid),

Sedatives/anti-anxiety: valium, versed, ativan, xanax,

Hypnotics: haldol

Muscle relaxers and anti-inflammatories are just what the name says... they make your tense muscles all loosey-goosey and will decrease the inflammation created by an injury. This usually does a pretty good job of taking down the pain since it is acting directly on the source of the pain. Muscle relaxers often work so well in making the muscles loosey-goosey that pts will take them in order to sleep.

Narcotics are what you are going to see chronic pain pts on as regular home medications. The best way to get pain under control is to mix an anti-inflammatory with a narcotic. vicodin is quite popular among the Hollywood crowd. vicodin is actually hydrocodone mixed with tylenol.

When you see any pain pill with the letters, "cet" on the end of it, it means there is tylenol in the mix. (percocet, darvocet, lorcet) If you see the letters, "prophen" or "profen" on the end of it then it usually means there is Motrin in the mix (vicoprofen is the most common)

MSIR and MS Contin is Morphine. MSIR stands for Morphine Sulfate Immediate Release. A pt takes this and they will have pain relief within minutes. MS Contin is Morphine Sulfate Continuous. This is a time release formula that keeps working for 12 to 24 hours. To put this in perspective, we give morphine 2 mg at a time IV. MS Contin comes in 30 and 60 mg tablets. If someone crushes an MS Contin and takes the whole thing they have just given themselves 30-60 mg of morphine at once. Expect agonal respirations upon arrival. Have your ambu-bag ready.

Fentanly: We give fentanyl all the time in EMS because it is quick onset, doesn't affect the patient's blood pressure and doesn't make them prone to puke. The usual dose for an adult is 100-300 mcg depending on the severity of injury.
Duragesic is a pain patch the is worn just like a nitro patch. It is actually fentanyl gel inside this semipermeable membrane that allows the fentanyl to be absorbed slowly over the course of 72 hours. Duragesic isn't for acute pain control. This is a slow onset pain medication so if you have a patient who has a pain patch on you need to find out when they applied the pain patch. If it is less than 2 hours then the peak dose hasn't had time to be absorbed. If it over 72 hours then the patch is no longer effective.

For someone who has a duragesic patch on, if is less than 72 hours old and they are still hurting they are having what is called "break-through pain". Cancer patients get this a lot. Their pain is under control for a while but then all of the sudden they get spasms, stabbing pain, strong aching, etc.... The duragesic patch isn't going to help this because it is meant for long lasting, slow and steady pain relief. You may have to give an IV dose of pain medication in addition to them having their duragesic patch on just to get the pain under control.

Now, knowing how a duragesic patch works, lets look at the doses. Duragesic is prescibed in mcg/hr. This means that there is enough fentanyl is each patch to give the patient 12.5 mcg/hr for 72 hours. 900 mcg in one patch!!!! And that is the smallest dose patch available. They go up to 100 mcg/hr. That is 7200 mcg !!!!!!!! Now imagine a drug abuser getting ahold of one of these beauties and cutting it open to suck out the contents. (This is so common). This is going to look like a crumpled up piece of clear plastic. It will have the word, "Duragesic" right on the plastic along with the dose. Remove the plastic and save it for the ER doctors, Police, CSI, etc.... and get that ambu-bag out.

Sedatives and Anti-anxiety medications do nothing for pain. They simply make the patient not care if they are in pain or not. Chronic alcoholics brains process pain medication effects differently than non-drinkers. You can give fentanyl or morphine but if they are still restless, agitated and complaining of pain, just touch them with a little ativan or valium. Just a dab will do ya! It does something in a pickled brain that makes it receive the pain medication better.

Hypnotics: We have talked about haldol before. It also does nothing for pain. It puts your patient brain in a holding pattern. This medication is to be used for combative or behavioral patients. If you pt is getting hateful, look for a good reason. Some people can't deal with a huge stressful event and they will get nasty with you. Sometimes, it is just pain that will cause patients to react. Try your calm soothing voice to get them talked down but if you know they have behavioral problems or you can't charm your way into them being nice, then Haldol is warranted. Haldol does not affect the pts neurological exam like versed does.

PEARLS.....

Motrin, Ibuprofen and Advil are all the same thing. Can be very toxic to the **kidneys** if you take too much for too long or if you don't drink enough water when you take a dose.

Tylenol and Acetaminophen are the same thing. Can be very toxic to the **liver** if you take too much for too long or if you don't drink enough water when you take a dose.

Morphine is a great drug but can dump your blood pressure fairly easily and can make patients vomit. Pre-medicate with benedryl prior to Morphine administration to stop the histamine release.

Toradol is the pain medication of choice for kidney stones. It isn't because it takes care of the PAIN so much as a side effect of the medication is that it dilates the ureters. Obviously when you dilate the ureters, the stone is able to descend more easily and you don't feel every little barb of the rock raking against the inner lumen.

Aspirin is the pain killer of choice for sunburns. Morphine is the pain killer of choice for bad burns. But if a patient has a large surface area burn there isn't enough morphine in the world to get the pain under control. If you give them a little versed with the morphine it works sooo great. If the patient is hemodynamically unstable go ahead and give them fentanyl until you can get their BP up. Very often, I give them morphine, a fluid bolus, fentanyl AND versed.

Pt's who have neuropathies (irritable nerve endings) will often be on Baclofen. These medications alleviates spasticity and muscle rigidity. People who have spinal cord injuries will often be on a baclofen pump. This looks like a Skoal Can underneath the skin on their abdomen. This delivers a steady dose of baclofen so they don't have to worry about missing a dose and getting that break-though pain.
Make sure and clarify that the pump is a Baclofen pump and not an insulin pump or something else.