



Emergency Medical Services

Partners

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Pain Management– A Tale of Two Cases

A 95-year-old female is found lying on floor on left side moaning. The patient is examined by a paramedic who downgrades the call. The BLS run form notes “Pt stated ‘oh my back’ when ambulance hit bumps on roadway.” The ED triage notes state: “patient crying with midback pain.” “10 of 10 pain.” The patient is diagnosed with a hip fracture and receives 12 mg of morphine over 4 hours in the ED.



A 97-year-old female is found lying on floor on right side moaning. The patient is assessed by a paramedic, who after checking vitals signs and allergies, gives the patient 50 mcgs of Fentanyl IV, followed by an additional 50 mcgs of Fentanyl five minutes later. The patient’s hip is splinted with a pillow and she is gently secured to a scoop stretcher with bath blankets for padding. On arrival at the ED the patient is calm, her pain is down from a 10 to a 2. The patient and her family thank EMS for their kindness in caring for her.

“Relief of pain and suffering should be the goal of every emergency medical services (EMS) system.. Adequate analgesia is an important step in achieving this goal.”

-National Association of Emergency Medical Services
Physicians position statement

Pain Documentation

All PCRs should include an assessment of patient’s pain, description of nature of pain, treatment of pain, reassessment of pain, and patient’s satisfaction with pain management efforts. All patients get a pain scale score.

Pain

Pain frequently occurs when tissues of the body are being damaged. It’s primary purpose is to alert patients to injury to help eliminate the source of the injury and halt damage to the affected tissue.



Untreated pain is destructive. It stresses the body, damages the immune system, hinders wound healing, and sets off a physiological cascade that can rewire the body’s neurological circuits. Ultimately, untreated pain can make the body more sensitive to pain in the future and can often lead to chronic pain syndromes. Some of these changes can begin within 20 minutes of an event. The sooner pain can be treated, the fewer the damaging consequences.

The pre-hospital practitioner has the first and perhaps only opportunity to break the pain cascade.”

-R.McKenzie

Journal of Royal Army Medical Corps

6 Pain Myths

1. We are able to accurately judge another’s pain.
2. Pain and vitals signs correlate.
3. Patients with chronic pain are largely drug seekers.
4. Prehospital pain management prevents ED staff from properly assessing a patient.
5. Giving a patient pain medicine will often lead to the patient become dependent on pain medicine.
6. As a system we do a good job of treating pain.

All of the above are false. As prehospital providers, we have a unique opportunity to relieve suffering by treating pain. Whether applying an ice pack, carefully splinting an injury, or giving a patient analgesia we can make a lasting difference in our patients’ well-being.

STEMI Kudos

Paramedics are taught not to tunnel vision, to keep an open mind, to maintain a high index of suspicion. Last month **Bristol EMS** paramedics P.J. Roche and Shawn McKay responded to a 32-year-old patient with a complaint of not feeling well for two hours with a cough, chest pain on inspiration and movement, and nausea. The patient's skin was warm and dry. Her pulse was 64, BP 150/P, respirations of 24 with an oxygen saturation of 100% on ambient air. Roche and McKay did a cautionary 12-lead and found the patient had ST elevation in leads II, III, and AVF. They transported the patient to John Dempsey Hospital as a possible STEMI Alert. Our doctors agreed with the medics' suspicions and the patient was taken to the cardiac catheterization lab, where it was discovered she had an occlusion of the posterior lateral branch of the right coronary artery. The occlusion, likely embolic in origin, was successfully angioplastied and blood flow was restored. The patient did well and was soon home thanks to Roche and McKay's outstanding recognition of a critical patient.



November Morning EMS CME



Weapons of Mass Destruction Chemical, Biological, Radiological and Nuclear Threats

Major Christopher A Cavanna, PAC
Civil Support Team

Journal Review:

A re-conceptualisation of acute spinal care
Mark Hauswald
Emergency Care Journal, September 2012

Case Reviews:

Richard Kamin, M.D.

November 21, 2012
8:30 AM.
Keller Auditorium

Paramedic Skills Sessions

October 24, 2012

9:00 A.M. and 11:00 A.M. Sessions
UCONN Sim Lab and Keller Auditorium

Contact Peter Canning at

canning@uchc.edu

to reserve your spot.

Space is limited

John Dempsey Hospital

EMS Conference

Date To Be Announced

Coming Spring 2013

UCONN Health Center EMS Web Site

For news, educational information, CME schedule and past copies of our newsletter *Partners*, check out our web site at:

uconnems.uchc.edu



John Dempsey Hospital EMS CME 2012



Morning (8:30 A.M.)

November 21, 2012 (Wednesday)

December 19, 2012 (Wednesday)

Evening (7:00 P.M.)

December 5, 2012 (Wednesday)

Held in Keller Auditorium. Coffee, juice and bagels will be available provided free prior to all morning CMEs and pizza and soft drinks before the evening CMEs. All EMS Responders and general public are welcome!

Enter main door, take escalator down one floor. Daytime parking in main lot at top of hill is now limited to visitors and patients. If you are unable to find parking, please park in lower lots and take shuttle bus. For the evening CME, there is plenty of parking at the top of the hill. 3 Hours CME are offered. One additional hour will be given for reading journal article and completing short quiz.

Note: Due to construction, Fire and EMS vehicles should not park at non-ED entrances during the day when attending EMS sessions.

CONTACT US:

Any questions or suggestions about EMS? Looking for patient follow-up?



Contact EMS Coordinator Peter Canning at
canning@uchc.edu or call (860) 679-3485.