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Review Article

Pain and its management: a precise summary

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ABSTRACT

Pain may be portrayed as an unpleasant, subjective, sensation, that may be resulting from a sudden 'tissue damage'. 'Pain management'; implemented for patients should involve both 'pharmacologic' and 'nonpharmacologic' protocols. Medical therapies, such as mind-body practice, acupuncture, massage therapy, and music therapy, have been well appreciated for their roles in pain management. Since recent past, numerous studies have emphasized upon the effect of hypnosis, acupuncture, and music therapy in reduction of pain. Mindfulness meditation, yoga, qigong, and massage therapy, although may not bear the potential of completely reducing the pain, but can still offer adequate relief from persistent anxiety and phenomenal mood changes, which may be commonly associated with pain. Recent screening tools and brief intervention techniques can be effective in helping clinicians identify, stratify and manage both patients already living with chronic pain and those who are at risk of developing chronic pain from acute pain. Frequent assessment and re-assessment are key to ensuring treatment is appropriate and safe, as well as minimizing and addressing side effects. Therefore, in clinical practice, it is always suggested for the practitioners; to earnestly consider the various burdens and risks to patients, consequent patient preference, and the presence or absence of better alternatives while opting for an integrative medical therapy.

Keywords: Pain, Acute, Chronic, Fibres, Transduction, Transmission, Perception, Modulation, Medication

INTRODUCTION

Pain is defined as an unpleasant sensory and emotional experience arising from actual or potential tissue damage, or described in terms of such damage (Mersskey and Bogduk, 1994). It is a subjective and protective experience that is influenced by developmental, behavioural, personality, and cultural factors, and it may not always be directly proportional to the extent of tissue injury.[1,2] In some advanced diseases, the intensity of pain is about 70-90% (Figure 1).[3]

Figure 1: Pain- an important parameter.

CLASSIFICATION OF PAIN

Acute pain

Acute pain arises from injury, trauma, muscle spasm, or disease affecting the skin, muscles, somatic structures, or internal organs. It is perceived and transmitted through peripheral pathways and is often accompanied by autonomic responses such as tachycardia, hypertension, sweating (diaphoresis), pallor, and pupil dilation (mydriasis). This type of pain typically subsides quickly once the underlying cause or stimulus is removed and may also be associated with anxiety.[4]

Figure 2: Different types of pain.

Chronic pain: non-malignant

Chronic pain can persist beyond the initial precipitating injury, continuing even after the tissue has ostensibly healed. It is rarely accompanied by autonomic symptoms, making it less likely to trigger immediate physiological warning signs. Patients often struggle to interpret objective evidence of the underlying pathology, which can complicate diagnosis and management. This type of pain is typically characterized by its location and may arise from visceral, myofascial, or neurologic causes, reflecting the diverse mechanisms through which pain can manifest and persist.[5,6]

Chronic pain: malignant

This type of pain exhibits characteristics of both chronic pain and acute pain, often presenting as breakthrough pain that suddenly intensifies despite ongoing baseline pain control. Unlike some chronic pain, it typically has a definite underlying cause, such as the recurrence of a tumour, which directly contributes to the onset and severity of the pain episodes.

VARIETIES OF PAIN

Somatic pain

Aching pain often remains constant and can present as either a dull or sharp sensation. It frequently worsens with subsequent movement, reflecting the sensitivity of the affected tissues. This type of pain is usually well-localized, occurring in the skin, muscles, joints, or deeper structures. Common examples include pain originating from bone and soft tissue, such as that experienced in the chest wall.[9,10]

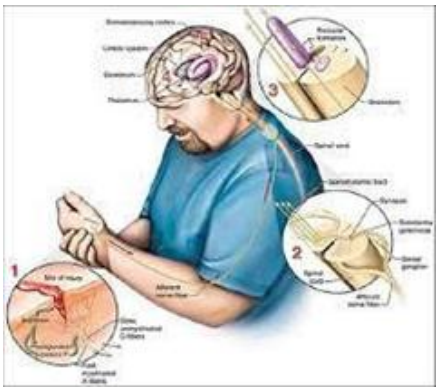

Figure 3: Wide varieties of pain.

Visceral pain

This type of pain is often constant or crampy and is poorly localized, typically described as aching or burning in nature. It is frequently referred, meaning the sensation is perceived at a site distant from the actual source of the problem. Such pain can result from stretching, infiltration, or compression of tissues. Both somatic and visceral pain travel along the same neural pathways, so stimuli originating from the viscera are often perceived by the brain as coming from somatic structures. This neural confusion leads to what is commonly known as “referred pain.”[10-12]

Bone pain

This pain is typically poorly localized and can be aching, deep, or burning in nature. In severe cases, it may contribute to pathological fractures. It is commonly associated with malignancies of the breast, lung, prostate, bladder, cervix, kidney, colon, stomach, and oesophagus, reflecting its frequent occurrence in patients with advanced cancer.[12,13]

Neuropathic pain

Neuropathic pain is caused by disturbances in nerve function or pathological changes affecting a nerve. It may arise from trauma, lesions, infections, or tumour invasion. Patients often describe this pain as burning, shooting, or tingling in nature. Unlike other types of pain, neuropathic pain does not usually respond well to standard analgesics.[14,15]

CATEGORIES OF PAIN

Pain can also be categorized based on inferred pathophysiology into nociceptive and neuropathic pain. Nociceptive pain arises from stimulation of pain receptors

in somatic or visceral structures, such as skin, muscles, joints, or internal organs, typically due to injury, inflammation, or tissue damage. In contrast, neuropathic pain results from abnormal processing of stimuli within the nervous system and is caused by damage or dysfunction of the nerves themselves, leading to altered pain perception.[15]

Neuropathic pain

This type of pain arises from abnormal stimuli processed by the nervous system and is often caused by pressure on or destruction of peripheral autonomic or central nervous system structures. The pain frequently radiates along dermatomal or peripheral nerve distributions. It is commonly described as a deep, aching, or burning sensation and is often associated with dysesthesia or lancinating pain.[17,18]

Nociceptive pain

This pain arises from stimuli originating in both somatic and visceral structures. It is caused by invasion, destruction, or pressure on superficial structures like the skin, deeper skeletal tissues such as bone and muscle, as well as visceral structures and internal organs. Pain can be classified into three main types: superficial somatic, deep somatic, and visceral. Each type originates from different tissues and structures, influencing the quality, intensity, and localization of the pain.[16]

PHYSIOLOGY OF PAIN

The process of pain involves four key stages: transduction, transmission, perception, and modulation. Transduction (Figure 4) refers to the conversion of noxious stimuli into electrical signals by nociceptors.

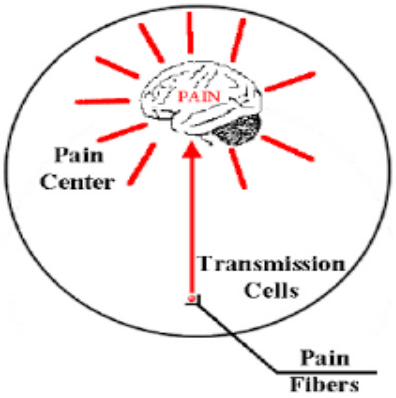

Figure 4: Way of transmission of pain from the centre.

Transmission (Figure 5) is the relay of these signals through peripheral nerves to the spinal cord and brain. Perception is the conscious awareness of pain, while modulation (Figure 5) involves the enhancement or inhibition of pain signals within the nervous system, influencing how pain is ultimately experienced.[18]

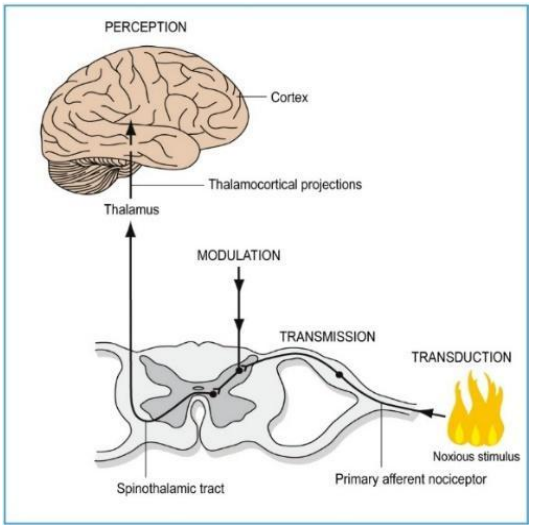

Figure 5: Pain pathway.

THEORIES RELATED TO PAIN

Gate control theory of pain

This theory was first introduced by Melzack and Wall in 1965.[19] The "gate control" theory explains about a pain-modulating system, in which a neural gate present in the spinal cord can open and thereby close subsequently modulating the perception of pain.[20] It suggests that the psychological factors do play a significant role in pain perception.[20] It therefore suggests that the physical pain is not a direct result of activation of pain receptor neurons, but rather its perception is modulated by the continuous interaction between different neurons.[21]

Centres in the CNS

Within the spinal cord, three key systems work together to influence the perception of pain. The dorsal column fibres transmit sensory information, including touch and proprioception. The substantia gelatinosa plays a critical role in modulating incoming pain signals, acting as a gatekeeper. Central transmission cells relay processed signals from the spinal cord to higher centers in the brain, contributing to the conscious perception of pain.

The dorsal horn is responsible for passing on the information, which can be interpreted as pain; the above area is referred to as the 'gate'; as it prevents the brain from receiving too much information quickly.[22]

Neurons involved in pain conduction

Primary: from the "nociceptors" to the dorsal horn of the spinal cord.

Secondary: from the dorsal horn to the thalamus.

Tertiary: From the thalamus to the cortex.[22]

Nerve fibres involved

The smaller, unmyelinated A delta fibres and C nerve fibres sense pain such as sharp burning and the aching feeling. Larger, myelinated A (beta) skin nerves which carry senses of touch, heat, cold and pressure.[23] The A Delta nerves are faster, also possess priority which effectively blocks out then pain messages to the brain, thereby closing the gate.[23] Stimulation of the large diameter fibres (A delta) inhibits the transmission of pain. ("closing the gate").[24] Stimulation of the C fibres stimulate the transmission of pain- ("opening of the gate").[24] When the gate is closed, signals from small diameter pain fibres do not excite the dorsal horn transmission neurons.[25] When the gate is opened, pain signals excite the dorsal horn transmission cells, being influenced by nerve impulses, descending from the brain (Figure 6).[25]

Factors influencing the opening and closing of gates:

The amount of activity in the pain fibres.

The amount of activity in other peripheral fibres.

Messages that descend from the brain.[26]

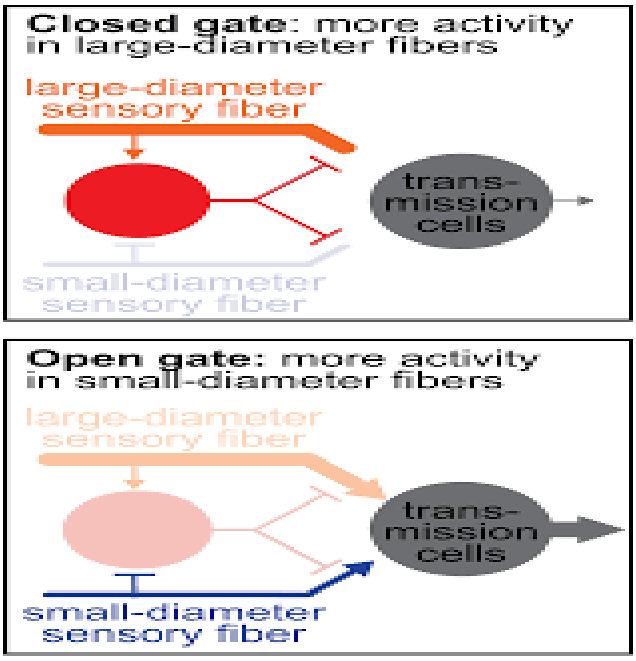

Figure 6: Gate control theory of pain.

Specificity theory

It is one of the earliest pain theories. Proposed by Descartes in the seventeenth century (1664) and Muller (1840). Distinct pain receptors free nerve endings in the tissue with the transmission by nerves directly to the brain.[27] Pain is purely regarded as an afferent sensory experience (Figure 7).[28]

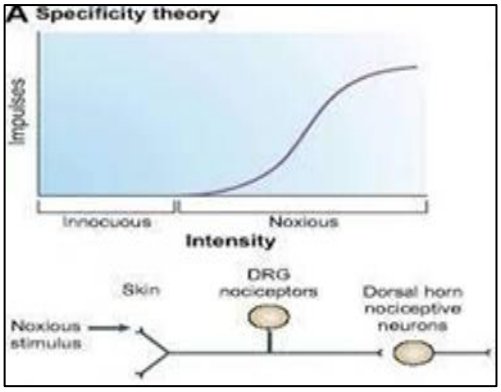

Figure 7: Specificity theory of pain.

Pattern theory of pain

It was introduced by Gold Schneider in 1896, further demonstrated by Weddell and Sinclair in 1947.[28] Pattern of stimulation of nerve endings determines whether the brain would interpret stimuli as pain attributes the sensation of pain to pattern or frequency and intensity of stimulation; applied that excite touch, pressure, or the temperature resources in the skin.[29]

Biochemical theories of pain

The pain producing, pain mediating and the pain chemoreceptors are located in the brain.[28] Endogenous opiates- inhibits pain by blocking the substance P. Chemical pain mediators and the inhibitors like Bradykinin, acetylcholine, Substance P, F. capsaicin, Histamine, prostaglandins, potassium.[29]

ASSESSMENT OF PAIN

Characteristics of pain

When assessing pain, several factors are considered to understand its full impact. These include intensity, timing, location, and quality of the pain. It is also important to identify aggravating and alleviating factors that influence pain severity. Additionally, pain behaviour, including how frequently pain occurs and its impact on daily life, provides insight into the functional and emotional effects of the condition.[30]

Pain assessment tools

Pain can be measured using various scales, including verbal analogue scales, visual analogue scales, and the Faces scale, which help clinicians assess the intensity of a patient's discomfort in a standardized way.

Factors to consider in selecting the pain scale

Assessment of pain also takes into account patient-specific factors such as age, physical condition, level of consciousness, mental status, and the ability to

communicate. These factors can significantly influence both the expression of pain and the strategies used for its evaluation and management.[31]

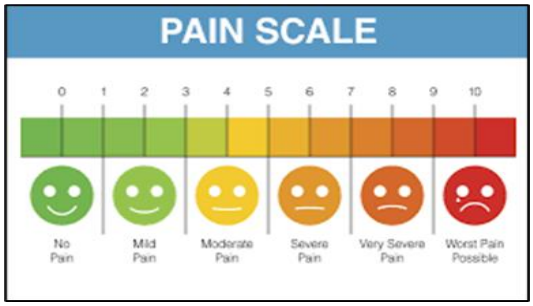

Figure 8: Different tools manifested for pain management.

Numeric pain rating scale

The patient is asked to rate their pain intensity on a scale of 0 ("no pain") to 10 ("the worst pain imaginable").[31] Some patients are simply unable to execute this with only verbal instructions; but may be able to look at a number scale and point to the number, that describes the intensity of pain.[32]

Wong- baker faces pain rating scale

Can be used with young children, sometimes as young as 3-year-old child. Is also very effective for older children and adults; as well as for those who speak a different language.[32] It is also explained that each face represents a person who have no pain; some pain or as much pain is imaginable.[33] The appropriate face is pointed at to describe appropriately.[33]

Colour pain rating scale

The patient is asked to point to the area on the scale; that shows their level of pain from white (no pain) to dark red (worst possible pain).[34] A number is obtained; corresponding to the area where the patient actually points out.[34]

Figure 9: Severity of pain grades.

Severity assessment

Mc Gill pain questionnaire

The McGill Pain Questionnaire uses a numeric scale ranging from 0 to 5, where 0 represents no pain and 5 represents severe pain. It is suitable for children or adults who understand numeric relationships, allowing them to quantify their pain intensity accurately.[3]

GOALS OF PAIN MANAGEMENT THERAPY

The objectives of pain management include identifying clear goals for controlling pain, establishing a strong doctor-patient relationship to promote quality healthcare, providing appropriate physical care, and managing anxiety associated with pain. Together, these objectives aim to improve both the physical and emotional well-being of the patient.[35,36]

PAIN MANAGEMENT THERAPY

They include both pharmacologic and nonpharmacologic approaches.

Pharmacologic interventions

Pain management medications can be classified into three main categories. Non-opioids, such as aspirin and paracetamol, are often used for mild to moderate pain. Opioids, including codeine and morphine, are reserved for moderate to severe pain. Adjuvant medications, such as muscle relaxants, antidepressants, and anti-epileptics, are used to enhance pain relief or address specific types of pain like neuropathic pain.[38]

Figure 10: Different types of non-pharmacologic therapy.

Non-pharmacologic interventions

Non-pharmacological approaches to pain management include exercise and weight reduction to reduce strain on the body, as well as counselling to address emotional and psychological factors. Lifestyle modifications, such as

cessation of smoking and narcotic use, also contribute to overall pain control. Additional therapies include massage, relaxation techniques, and acupuncture (Figure 10), which can help alleviate pain and improve quality of life.[37]

WHO PAIN MANAGEMENT LADDER

The stepwise approach to pain management typically begins with the use of NSAIDs combined with adjuvants in Step 1, aiming to relieve mild pain while minimizing opioid exposure. In Step 2, for moderate pain, treatment progresses to a combination of NSAIDs, mild opioids, and adjuvants to achieve more effective pain control. Step 3 is reserved for severe pain, where strong opioids are used alongside NSAIDs and adjuvants to provide maximum analgesic effect, ensuring comprehensive pain relief while still utilizing adjuvant therapies to enhance efficacy and reduce side effects.

Analgesics (non-opiods)

Salicylates

Non- Steroidal Anti- Inflammatory Drugs

Acetaminophen.[40]

Characteristics

Non-opioid analgesics are typically administered in full therapeutic doses for most cases to achieve effective pain relief. A key characteristic of this group is the presence of a "ceiling effect," meaning that beyond a certain dose, no additional analgesic benefit is obtained even if the dose is increased. Additionally, selective COX-2 inhibitors within this category may be associated with fewer side effects, particularly gastrointestinal complications, compared to non-selective agents.[40]

Analgesics (Opioid)

Cytoprotective therapy should be used along with NSAIDs only in patients who have symptoms suggestive of gastrointestinal distress or who are at a higher risk of ulcer formation. In such cases, agents like H2 blockers, sucralfate, or misoprostol may be prescribed to help protect the gastric mucosa. For pain management, effective opioid medications such as morphine, hydromorphone, fentanyl, oxycodone, or methadone may be considered when appropriate. However, drugs like meperidine, anileridine, dextropropoxyphene, or pentazocine are generally not recommended for use in treatment.[40,41]

Side effects

Opioid analgesia is most effective when carefully titrated to the individual's needs, as standard doses may be insufficient for adequate pain control. When used appropriately, the risk of addiction is low, occurring in about 1% of patients. Common side effects include constipation, nausea or vomiting, urinary retention, itchy rash, and xerostomia (dry mouth). More serious complications can include respiratory depression and neurotoxicity, which may lead to myoclonus or seizures.

Adjuvant analgesics (coanalgesics)

Adjuvant analgesics are medications that, when added to primary analgesics, help to further improve pain control. In some cases, they can also serve as primary analgesics themselves; for example, tricyclic antidepressants are commonly used in the management of post-herpetic neuralgia. When the pain is neuropathic in nature, there is strong evidence supporting the early use of adjuvant medications, and a short clinical trial of 2-4 days is often recommended to assess their effectiveness.[43-45]

CONCLUSION

Pain is an unpleasant sensory and emotional experience; associated with tissue damage. Only the patient can demonstrate the characteristics, rate and the severity of pain. Therefore, the management of pain is a comprehensive, patient- centred process that includes pharmacological agent, psychosocial counselling and non-pharmacological treatments, whenever appropriate. At first, the non- pharmacological means of pain eradication should be considered. We should always begin with the administration of the lowest dose, so as to reassess the patient's response frequently.

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