Pain after surgery

Surgical intervention saves lives and is one of the most effective weapons in the arsenal against cancer. However, many times surgical candidates are unprepared for what lies ahead. Surgery causes trauma that may likely be the most painful part of any cancer treatment. For this reason it is often advisable to speak with someone who has been through the procedure. With bladder cancer there are many different surgical approaches; TUR(transuretheral resection) or laser surgery for superficial tumors; deep resection or, partial cystectomy for more invasive tumors, urinary diversions such as ileal conduits, neobladders, pouches and continent reservoirs. Contact with others who are dealing with similar conditions is often very helpful, and can be arranged by the UOA, your doctor, the cancer center, or the internet.

Cystectomy is a complicated operation necessitating hours on an operating table. Aside from the acute pain which is a direct result of the procedure, a small percentage of people (10%) end up with chronic pain from nerve damage (also referred to as ‘neuropathy’). It may be helpful to realize that surgical pain can often last for up to 6 weeks, and is almost always temporary. However, in rare cases nerve damage can last up to a year or more, and is occasionally permanent. This risk exists in many major surgical procedures, and perhaps because patients do not usually receive any information about this ahead of time, post-op pain has long been underestimated and often undertreated.

Pain is a subjective experience that only the patient his/herself can verify. Anxiety and depression need to be taken into account when planning for pain control, and many people find relief after being treated for these psychological factors along with the physical complications.

In order to best prepare for surgery, it is imperative to have good dialogue and an understanding with your medical professionals. Inadequate management of inital post operative pain can contribute to it’s becoming chronic, and thus more difficult to control. In the event of chronic pain as a post-operative complication, early diagnosis and an effective multidisciplinary approach is advisable from the start. The success of pain control depends on knowing whether the pain is from nerve damage as a direct result of the knife, the position your body was in on the O.R. table during the surgical procedure itself, or from other body changes caused by the surgery.

The situation may be further complicated by pre-existing pain which is magnified through surgery, such as arthritis, or back problems. Often a problem of pain management is that patients fail to give a complete history, informing their medical professional of all existing medical problems as well as all medications used, whether doctor -prescribed or ‘over-the-counter’. Sometimes something so apparently harmless as heartburn tablets can interfere with a treatment. Aspirin or any use of analgesics is important to report.

The three types of surgical pain:

Nociceptive: This is caused by tissue damage and inflammation in response to trauma. The resulting pain is usually not well localized. It is opioid responsive.

Neuropathic: This is caused by direct peripheral nerve or CNS (central nervous system) injury and may be a complication in up to 10% of surgical cases. Neuropathic pain is usually localized and presents as a background of numbness with burning and the electrical shocks of shooting pain. It may be caused by tumor or infection invading the nerve, nerve injury from surgery, or toxins (chemotherapy). A special form of neuropathy, called allodynia, occurs in about 30% of the cases. Allodynia is defined as an abnormal sensation to a normal stimulus (e.g., clothes touching the skin), or pain due to a stimulus which does not normally provoke pain. Visceral neuropathic pain as caused by peritoneal malignancies (in the abdomen/pelvic region) may present as a dull ache.

Neuropathic pain, unlike nociceptive pain, responds poorly to opioids and may linger long after surgical wounds and trauma have healed. Traditional treatment of neuropathic pain usually includes tricyclic antidepressants, anticonvulsants, and anti-arrhythmics.

http://www.ocpi.org/

Psychological: This component of pain is caused by cognitive and affective factors. Includes depression, anxiety and/or drug-seeking.

Pain management

A helpful approach would be to discuss the use of a ‘pain scale’ with your medical professional (i.e. graded from 1-10), and use this scale to relay the actual state of post op symptoms as well as optimal medication doses. Intense discomfort is best treated round-the-clock in order to avoid ‘breakthrough pain’, and such schedules are more likely to keep pain at the lowest possible level.

If you have no pain, use a 0. A 10 means the pain is as bad as it can be. As the numbers get larger, they stand for pain that is gradually getting worse. Be sure to let others know what pain scale you are using: for example, "My pain is a 7 on a scale of 0 to 10." You can use a rating scale to answer:

How bad is your pain at its worst?

How bad is your pain most of the time?

How bad is your pain at its least?

How does your pain change with treatment?

Pain Diary

You may find it helpful to keep a record or a diary about your pain and what you try for pain relief. The record helps you and those who are caring for you understand more about your pain, how it effects you, and what works best to ease your pain. Items that should be included are:

- The number from your rating scale that describes your pain before and after using a pain- relief measure.
- The time you take pain medicine.
- Any activity that seems to be affected by the pain or that increases

or decreases the pain.

- Any activity that you cannot do because of the pain.

- The name of the pain medicine you take and the dose.

- How long the pain medicine works.

- Any pain relief methods other than medicine you use such as rest, relaxation techniques, distraction, skin stimulation, imagery.

If you and your doctor are having difficulty finding an effective method of pain relief, most major hospitals have a team that specializes in pain management. This is separate from the normal duties of the surgeons or other specialists that may be involved with your case. Pain specialists may be oncologists, anesthesiologists, neurosurgeons, other doctors, nurses, or pharmacists. A pain control team may also include psychologists and social workers. If you have difficulty locating a pain program or specialist, contact a cancer center, a hospice, or the oncology department at your local hospital or a medical center

Practical suggestions for those with chronic pain/neuropathy after surgery:

Regular excersize (non strenuous, stretching)

Keeping a pain diary

Hot baths

Deep breathing excersizes

Meditation

Biofeedback

Avoidance of unecessary stressful situations

Acupuncture

Hypnosis

See this article, “How to Relieve Pain Without Medicine” for more information.

http://www.hospicenet.org/html/without_meds.html

Non Invasive medical interventions for chronic pain

Capsaicin cream (a topical anesthetic, derivative of chili peppers)

Eutectic mixture of local anesthetics (EMLA)

Transcutaneous electrical nerve stimulation (TENS)

Spinal nerve stimulation

Antidepressants. This class of drug seems to help chronic pain because it increases the supply of a naturally produced neurotransmitter, serotonin. (low levels of which are associated with depression). Recent evidence is showing that cells using serotonin are also an integral part of a pain-controlling pathway.

Surgical intervention

There are a variety of operations to relieve pain, which cannot be felt if the nerve pathways that relay pain impulses to the brain are interrupted. To block these pathways, a neurosurgeon may cut a nerve close to the spinal cord (rhizotomy) or cut bundles of nerves in the spinal cord itself (cordotomy). When the nerves that transmit pain are destroyed, the sensations of pressure and temperature can no longer be felt. Therefore, after these operations, patients are more likely to injure the affected area because they no longer have the protective reflexes of pain, pressure, or temperature. Although surgery can bring about fast release from pain, it is not always permanent, may destroy other sensations, and become the source of new pain. Therefore serious thought must be given to this option to weigh its risks versus benefits.

Joint Commission Focuses on Pain Management

At a meeting in Illinois, Aug. 3, 1999, the Joint Commission on Accreditation of Healthcare Organizations http://www.jcaho.org/edu_pub/natlevnt/natlevnts_frm.html has developed standards that create new expectations for the assessment and management of pain in accredited hospitals and other health care settings. These standards have been endorsed by the American Pain Society http://www.ampainsoc.org/home.htm

Health related institutions will be called upon to:

*recognize the right of patients to appropriate assessment and management of pain;

*assess the existence and, if so, the nature and intensity of pain in all patients;

*record the results of the assessment in a way that facilitates regular reassessment and follow-up;

*determine and assure staff competency in pain assessment and management, and address pain assessment and management in *the orientation of all new staff;

*establish policies and procedures which support the appropriate prescription or ordering of effective pain medications;

*educate patients and their families about effective pain management; and address patient needs for symptom management in the discharge planning process.

"Unrelieved pain has enormous physiological and psychological effects on patients. The Joint Commission believes the effective management of

pain is a crucial component of good care. Research clearly shows that unrelieved pain can slow recovery, create burdens for patients and their families, and increase costs to the health care system, " said Dennis S. O'Leary, M.D., president, Joint Commission. http://www.jcaho.org/standard/pm_frm.html

"These [new] standards are putting the importance of pain management at center stage, ensuring that health care providers and professionals will take pain management in a serious way," says Russ Portenoy, M.D., president, American Pain Society.

For some interesting further reading:

The Biology of Pain Relief Differs Between Sexes

SAN FRANCISCO -- Oct. 29, 1996 -- For women, treatment of moderate to severe pain can be provided with fewer side effects by a neglected class of opioid drugs, according to researchers at the University of California San Francisco. According to the article, the 'kappa opiods' like Pentazocine, Nalbuphine and Butorphanol work better for women, while making pain in men worse.

http://www.pslgroup.com/dg/D4CA.htm

New Advanced Pain Therapy Initiative Focuses On Chronic Pain

MINNEAPOLIS, June 24, 1997 -- Millions of Americans suffering from chronic pain now have a new option for relief -- Advanced Pain Therapy (APT). APT Is a major chronic pain management initiative designed to offer relief and restore the quality of life to millions of Americans who suffer from severe intractable pain.

http://www.pslgroup.com/dg/2D1F2.htm

Pre-emptive Anesthesia Puts Stop To Post-Surgical Pain Before It Starts

PHILADELPHIA, PA. -- April 7, 1998 -- Post-operative pain can be vastly decreased by beginning pain treatment before surgery. Researchers at the University of Pennsylvania Medical Center have found that pre-emptive analgesia -- delivering pain medication to patients before surgery -- results in significant pain reduction long afterward. This confirms preliminary findings presented at the 1996 American Society of Anesthesiologists' annual meeting.

The complete study appears in the April 8 issue of the Journal of the American Medical Association. The rationale behind the use of pre-emptive analgesia is to stop pain from starting by blocking the nervous system's usual response to pain. The trauma from a surgical incision may cause the nerves in the spinal cord to "wind up" which leads to heightened sensitivity and enduring pain after surgery. http://www.pslgroup.com/dg/6B1EE.htm

See also: The American Pain Foundation (www.painfoundation.org), a nonprofit

information resource and patient advocacy organization serving people with pain. Their mission is to improve the quality of life of people with pain by providing practical information for patients, raising public awareness and understanding of pain, and advocating against barriers to effective treatment.

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