A. Introduction

Pain is a symptom commonly encountered in the out-of-hospital setting. It represents not only a psychological stressor to the patient, but is also a source of physiologic stress that might impact negatively on both the assessment and management of many chronic or acute illnesses or injuries. Pain management, therefore, may provide both physiologic and psychological support to our patients. It must be instituted with sound judgment, with consideration of the risks as well as the benefits of the treatment options.

B. Initial Approach

General Care

BLS

1. Most moderate pain can be managed with the following:

   a) Whenever it is safe and practical, allow the patient to maintain their own position of comfort.

   b) Cover wounds to limit air circulation.

   c) Treat burns **Protocol 21**

   d) Splint extremity injuries to limit movement.

   e) Apply cold pack(s) to areas of musculoskeletal injuries.

   f) Administer Oxygen **Procedure 1** to patients presenting with Sickle Cell crises.

C. Indications for Severe Pain Management

General Care

1. Isolated musculoskeletal injuries.
2. Painful crises in known Sickle Cell disease patients.
3. Burns.
4. Renal colic (kidney stones) in patients with history of the same if authorized by MCP.
5. Insect / marine animal bites and stings.
6. Any other illness/injury if authorized by MCP.

D. Severe Pain Management

NOTE: ALS pain management should NOT be given to patients meeting Trauma Alert Criteria involving blunt/penetrating injuries to head or torso.

The primary indicators of pain in nonverbal children include, but are not limited to: crying, facial grimacing, grunting (without signs of respiratory distress), poor movement of an injured part, general increase in muscle tone, and tachycardia. Determining whether the pain is severe should be based on the child's apparent distress. The child's caregivers may be helpful in this determination. (**Refer to Pain Assessment Scale below**).

ALS

1. In children > 1 year of age, administer **Fentanyl 1-2 mcg/kg SLOW IVP** (max single dose 25 mcg).

    a) This can be repeated ***once*** in 3-5 minutes (max total dose 50 mcg) if necessary to relieve pain.

    b) Fentanyl can be administered **1-2 mcg/kg Intranasal** (max of .5 cc / nostril) and repeated once in 15 minutes if unable to obtain IV access.

    NOTE: Use only one nostril at a time. Start with left nostril and may use the right nostril for second dose.

NOTE: Pain alone is not a sufficient indicator for the placement of an intraosseous (IO) line.

MCP

2. Severe pain management in children ≤1 year of age.

3. Additional dose(s) of Fentanyl.

Pain can be assessed in children using either the 1-10 rating scale or the Wong-Baker "Faces" pain scale.