PAIN AND SEDATION SESSION 1
Assessment of Pain, sedation, withdrawal and delirium – putting it together.
Anne Sylvie Ramelet

Anne presented the ESPIC clinical what recommendations published in ICM; variation in quality across the world. Final common pathway of distress for untreated pain, agitation and delirium. Why put it together? Interrelated concepts improve patient outcomes. Some evidence in Kids. Use a pediatric-specific valid and reliable tool. Clues overlap. Measures what it measures. Perhaps use an electronic aggregated tool? Have a tool – but still need clinical judgment. Craig (Pain) 156(7) 1198+

Dick Tibboels – why do we monitor pain and do scores really help us treat it correctly?
Can we use biomarkers. EUROPAIN – nice review of analgesia practices. What is the outcome/goals? What is the valid data to ID Pain? Nociception, CNS, perception, behavior – is there a bio-psycho-social phenomena --- we don't have a perfect pain "instrument". ? Gap - ? modulation, impact of previous pain ; ? sensitive to change; lack of multidisciplinary approach. No scoring to one size fits all. No pain scoring means continued subjectively. We do have data to support its use (JAMA, 2013), lack of precision medicine. Solutions: training, structured interprofessional collaboration. Need to move on to neuropathic pan and to protocol based care.

K. Best: Risk factors for IWS in children.
Providing optional sedation is goal. IWS – automatic, GI, neurologic. No EBP guidelines. Treatment usually varies. What factors impact IWS in children using the RESTORE database. Conceptual Model: patient, process, system-tolerance as published in PCCM 2014. After meeting inclusion criteria N=1157; required 2 WAT-1 scores >3. 47% IWS, younger, MODS; > exposure; staffing 1:1 (p.=0.06); NEMS; needs further study.

Monique Van Dijk – Screening for Delirium
Delirium – hot topic. Used DSM-V criteria to define. Subtypes important: Hypoactive, Hyperactive, Mixed. I WATCH DEATH. Risk factors: Severity of illness, DD, LOS. Hot Topic – exponential increase in publications. Increasing 5-47% - differences in age groups. 3 tools – PCAM-ICU (5+)/PreSchool CAM-ICU, CAP-D (developmental anchor points) ; SOS-PD (translated, easy to transition from SOS); All instruments require training. Need a treatment algorithm. EMH makes it easier. Do we expect nurses to use 4 tools; maybe used a Mondriaan checklist embedded into the EMR. Need reassessments linked. Raise awareness, focus on prevention, support parents.

Corrine Balit: Understanding pharmacodynamics for decision making.
Choices we make are important. Case presentations --- cocktails; decision making. Need to integrate PK/PD principles; ?Goals pain (acute, chronic, neuropathic) sedation goals , receptors targets, ? Adverse Events (+- effects). Need to THINK about your goals and construct/deconstruct. ? mas out opioids -> adding non-opioid+opioid+alpha 2; treat itch –

diphenhydramine -> rotate opioids; Add ketamine? (emergence delirium + agitation) -> screen delirium/nonpharm; keep it simple – what are you treating??????? Tailor your plan.