

Q AND A



ASKQUIP

What is the relationship between obesity, back pain and arthritis?

The joints in the spine are called facet joints. Excessive body weight places unnatural stress on these joints. When excess weight is carried, the spine is forced to adapt to the burden, which is seldom successful and structural compromise and ultimately damage occurs—often arthritic damage. Over time the back, neck and shoulders develop increasing degrees of pain even at rest. Source: Silveri CP & Spinsanta S. Back pain and obesity: connection to back pain and development of obesity.

At: <http://www.spineuniverse.com>



"When excess weight is carried, the spine is forced to adapt..."

What is pain?

Although pain is a very complex phenomenon holding cultural, emotional and physical meaning, most experts agree that at the most basic level, pain is a completely subjective experience. In other words, pain is whatever the experiencing person says it is and exists whenever he or she says it does. Source: McCaffery M & Pasero C. *Pain: Clinical Manual*. St Louis: Mosby, 1999.

Describe respiratory depression and the obese patient...how can we prevent adverse outcomes?

Respiratory depression is a potentially life-threatening side effect among all patients, but can be especially serious among morbidly obese patients. It is critical to assess for sedation levels and respiratory status when starting opioids on a patient who has moderate to severe pain and has not been receiving opioids regularly. Literature suggests that the likelihood of respiratory depression decreases the longer the patient has been on opioids because tolerance to respiratory depression develops and information about the patient's response to opioids is known. Consider a semifowler position to improve respiratory function. Also consider the recently introduced implantable, non-narcotic, continuous infusion products, as these systems have been helpful in some categories of patients. Interested in more information on positioning? See: Burns SM, Egloff MB, Ryan B, et al. Effect of body position on spontaneous respiratory rate and tidal volume in patients with obesity, abdominal distension and ascites. *Am J Crit Care*. 1994;3:102-106.

Can you describe the resedation phenomenon?

I first became familiar with the resedation phenomenon reading an article published in *Obesity Surgery* that describes the dangers of anesthesia, postoperative pain medication administration and the obese patient. See: Callery CD & Davidson J. Care of the obese surgery patient requiring immediate-level care or intensive care. *Obesity Surg* 2001;11:93-97.

What is the relationship between emotional pain, and acute and chronic physical pain?

Many patients who experience long-term chronic pain become depressed and anxious. Depression and anxiety can be exacerbated if it is difficult to establish a clear physical cause for the pain. Assessment of chronic pain in the acute care setting where surgery or other experiences superimposed acute pain can be difficult for patients and clinicians. These patients may begin to question their judgment, fear they will be perceived as troublesome and worry that pain relief will be withheld because the pain is not considered real. These emotional responses may cause some health care providers to think that the pain is psychogenic or not of a physiologic nature. It then becomes important for clinicians who care for obese patients to understand that physiologically, the body adapts to pain after a period of time, and vital signs normalize. This return to equilibrium is necessary to prevent physical harm and undue stress on the body. It does not necessarily mean pain has been controlled adequately. Additionally, patients might exhibit a behavioral adaptation to both acute and chronic pain. They may minimize their expressions of pain for a number of reasons. A patient may wish to be seen as a good patient or may place a personal or cultural value on a stoic response to pain. The patient may become too exhausted to respond vigorously to pain. Sometimes patients use distraction techniques to move the focus away from pain, especially when intense and unrelieved. For more information on pain and depression, see The Mayday Pain Project at: www.painandhealth.org/dep-links.html.

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"Understanding Pain Management and The Obese Patient"



Understanding pain management among the obese patient is increasingly important for two reasons. The first is the increasing frequency of clinicians caring for larger patients. The second is the demand—legally and ethically—for adequate pain control among all patients, including those previously excluded from mainstream care. The challenge however, in caring for obese patients, is how to safely and effectively provide a level of pain control to ensure the patient's ability to participate in activity, mobility and general rehabilitative activities. This XTRAWise offers a review of pain management, and then seeks to answer some of the more common pain-related questions, a number of resources are provided along with the challenge to clinicians to consider research opportunities to improve the care of larger, heavier patients. A case study is included to frame some of the non-pharmaceutical options for pain management. I welcome your thoughts on this topic!

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Pain management One of the greatest challenges in health care today is to ensure the physical, emotional and spiritual comfort of our patients. Management of pain is an important factor in patient comfort, and all patients—regardless of size—are entitled to the best pain relief that can safely be achieved. Pain can interfere with patient mobility, and ultimately patient care, for a number physiologic and psychologic reasons. In most cultures, pain serves as a warning that something is wrong. Patients experiencing pain might respond with reluctance to move or to participate in activity and mobility—this is especially problematic among obese patients who often encounter numerous threats to immobility. Patients may be reluctant to allow repositioning or to repositioning themselves because of sustained discomfort. Often this reluctance is misinterpreted as non-compliant or health-defeating behavior, further confounding care; and may even threaten the therapeutic relationship. The problem of pain is pervasive and the myths and misconceptions surrounding the pain experience, and the assessment of pain, often preclude adequate comfort and quality care. This is especially true among bariatric patients where little evidence-based practice is available to make decisions about patient care and pain management. In addition to the challenges that all patients face, bariatric patients have additional concerns. More questions than answers arise when dealing with pain in patients whose bodies are a greater percentage of adipose tissue. For example, is the medication of choice water or fat soluble, and what are the clinical consequences of either? Will a 1½ inch needle deliver a medication into the muscle or into the fatty tissue and should intramuscular injection even be attempted? What is the effect of opioids on sensorium or already compromised pulmonary function? Finally, is postoperative nausea among morbidly obese due to the type of surgery performed or a side effect of the medication? These largely unanswered questions further serve to complicate pain management among the obese patient. In many cases, pain can lead to behaviors that appear to be health-defeating activities. The challenge to clinicians is to be aware of the differences between patients based simply on size and adiposity. The value of an interdisciplinary team in addressing these complexities cannot be overlooked as each expert brings a unique and different perspective to the patient. Recovery can be affected by uncontrolled pain and the patient is best served when managed by a team that understands the special needs of larger patients. The pain specialist, pharmacist, physician, physical/occupational therapist, WOC nurse, bariatric CNS, and other interested professionals are important members of the team.



Obesity and the back Most experts agree that in many cases, obesity leads to diabetes, heart disease, hypertension, sleep disorders, cancer and other health problems. However, obesity is more recently associated with chronic back pain. One of the regions most vulnerable to obesity is the lumbar spine. Lack of exercise and physical conditioning leads to poor flexibility and weakness in the back, legs and thighs. This consequently increases the curve of the lower back causing the pelvis to tilt too far forward, which results in poor posture, and ultimately, pain along the entire spine from the neck to the hips. Being overweight significantly contributes to osteoporosis, osteoarthritis, rheumatoid arthritis, degenerative disc disease, spinal stenosis and spondylolisthesis—and ultimately added pain. Source: Silveri CP & Spinsanta S. Back pain and obesity: connection to back pain and development of obesity. At: <http://www.spineuniverse.com>

Article review... Davidson J Callery C. Care of the obesity surgery patient requiring immediate-level care or intensive care. *Obes Surg* 2001;11:93-97

Selecting the most appropriate level of postoperative care is a challenge to clinicians who are forced to balance cost and quality. This article not only describes the goals of postoperative triage but addresses the resedation phenomenon, which serves as a threat to safe, appropriate postoperative pain management. Gallagher S. Ethical dilemmas in pain management. *Ostomy/Wound Management* 1998;44(9):18-21. This article argues that pain management is fast becoming an increasingly important component of chronic care. Choices for the best approach in managing the complex patient can pose ethical dilemmas. Ethical principles of autonomy, beneficence and non-maleficence are explored through case study presentation. Suggestions for addressing ethical dilemmas are examined.

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"The hospital had made a lot of changes based on input from larger, heavier patients."

First person – non-pharmaceutical options for pain management Last year I was in the hospital for surgery—I was just miserable. I was in the hospital for seven days and did not sleep for more than one hour at a time. And most surprising to me was the fact that my pain was not from the surgery. The bed was uncomfortable, the hospital was noisy and chaotic, I felt that my body smelled bad, I needed to have my hair washed and my back hurt so badly. I had a terrible time walking and I know the nurses thought I was uncooperative, but I had trouble balancing myself—the gown would open in the back and I felt like my belly was "falling". I mean it was the weirdest sensation, but I kept imagining my incision would open and there would be a catastrophe. Three weeks ago, I had a 23 pound panniculus removed. I was very concerned about the surgery because of the experience last year. I spoke with the nurse who completed my admission forms, he explained that the hospital had made a lot of changes based on input from larger, heavier patients. This time I had a bed that lowered such that I could easily get out of bed with the help of a walker that fit my width and girth perfectly. A special air mattress was on the bed—and it was so comfortable I had no problem sleeping. I used very little pain medication and I was more active during the day. I never experienced back pain the entire time I was in the hospital. The nurse fit me with a binder that helped me feel more secure around my belly, and I was given a gown that completely covered my back. Because of my added mobility, I was able to use the shower, which changed my disposition. This is my advice to patients and clinicians...share with one another. Clinicians need to help patients feel comfortable sharing their concerns, and patients have a responsibility to share with clinicians, this is how we can best meet the needs of all stakeholders.

Obesity and cancer pain Cancer is diagnosed in over one million Americans annually and one of five deaths in the United States—about 1400 daily—result from cancer. Research suggests the incidence of certain cancers is associated with obesity. The cost of cancer pain in suffering, disability and quality of life is high. Cancer pain needs to be treated aggressively by pharmacologic and non-pharmacologic methods. Leaders in the field appeal to clinicians to consider an interdisciplinary approach to pain—including 1) analgesics and adjuvant drugs; 2) cognitive/behavioral strategies; 3) physical modalities; 4) palliative radiation and antineoplastic therapies; 5) nerve blocks; and 6) palliative and ablative surgery. Adapted from: Management of Cancer Pain. US Department of Health and Human Services. AHCPR Pub No. 94-0592

CANCER FAQS - Obesity and Cancer

What have scientists learned about the relationship between obesity and cancer?
 In 2001, experts concluded that cancers of the colon, breast (postmenopausal), endometrium, kidney and esophagus are associated with obesity. Some studies have also reported links between obesity and cancers of the gall bladder, ovaries and pancreas. Obesity and physical inactivity may account for 25 to 30 percent of several major cancers—colon, breast (postmenopausal), endometrial, kidney and cancer of the esophagus. Preventing weight gain can reduce the risk of many cancers. Experts recommend that people establish habits of healthy eating and physical activity early in life to prevent overweight and obesity. Those who are already overweight or obese are advised to avoid additional weight gain and to lose weight through a low-calorie diet and exercise. Even a weight loss of only five to ten percent of total weight can provide health benefits.
 Vainio H, Bianchini F. *IARC handbooks of cancer prevention*. Volume 6: Weight control and physical activity. Lyon, France: IARC Press, 2002.

How many people are thought to be diagnosed with cancer by being overweight or obese? What is the morbidity?
 In 2002, about 41,000 new cases of cancer in the United States were estimated to be due to obesity. This means that about 3.2 percent of all new cancers are linked to obesity. A recent report estimated that, in the United States, 14 percent of deaths from cancer in men and 20 percent of deaths in women were due to overweight and obesity.
 Polednak AP. Trends in incidence rates for obesity-associated cancers in the U.S. *Cancer Detection and Prevention* 2003; 27(6):415-421.
 Calle EE, Rodriguez C, Walker-Thurmond K, Thun MJ. Overweight, obesity, and mortality from cancer in a prospectively studied cohort of U.S. adults. *New England Journal of Medicine* 2003; 348(17):1625-1638.