

SALA POLISSENA A
PIANETA DOLORE

Moderatori: Margherita Maragno – Daniela Pierluigi

Michele Domenico Spampinato

La terapia del dolore nel core
curriculum





XII congresso nazionale

simeu

RICCIONE 13-15 MAGGIO 2022

La terapia del dolore nel core curriculum

perché non c'è prendersi cura senza curare la sofferenza

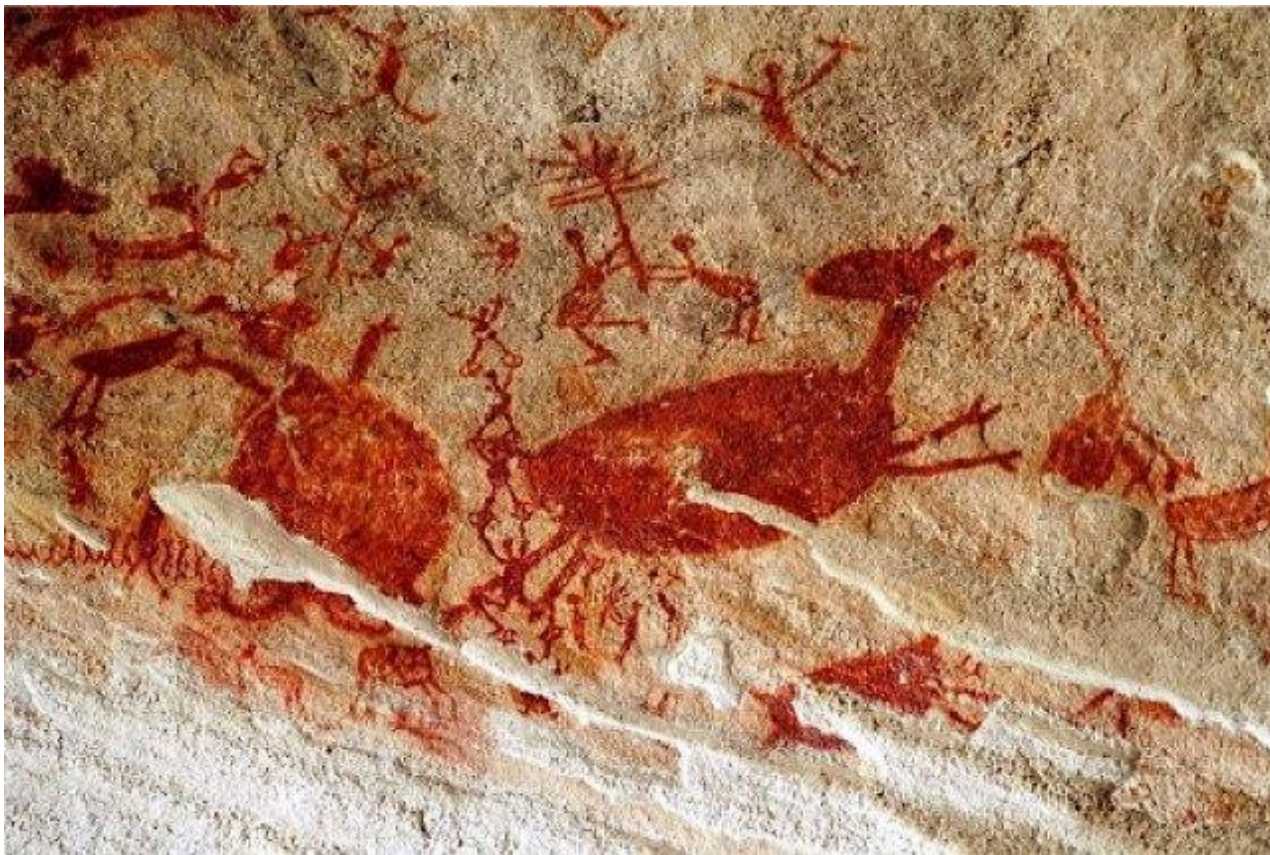


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Invocare, guarire, prevedere
Serra da Capivara; 25000 anni fa

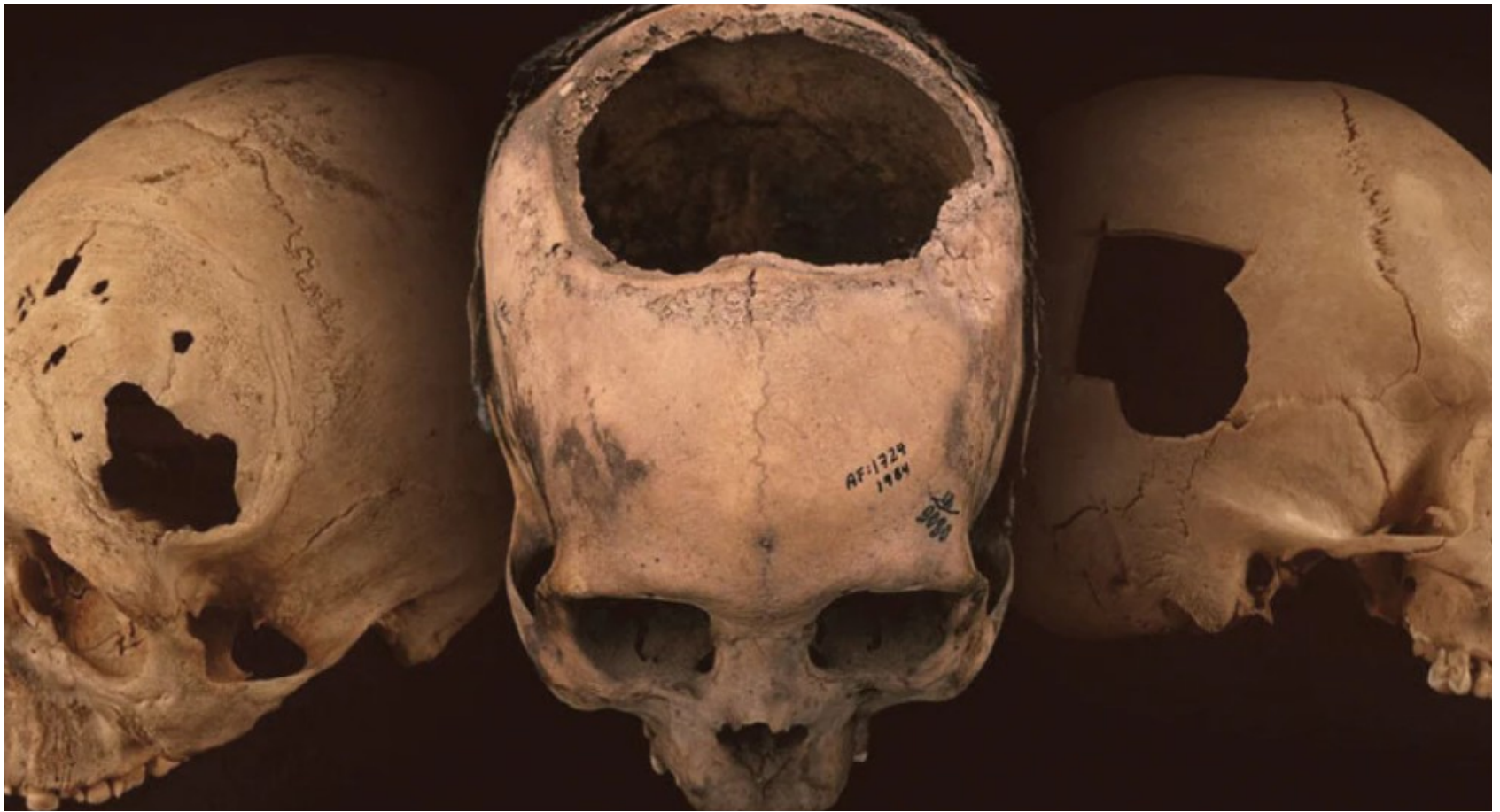


Sacerdote stregone mediatore tra Cielo e Terra
la grotta di Magura nel nord ovest della Bulgaria, 4000-8000 anni fa,



Cacciare il demone

Un teschio dell'Età del Bronzo da Gerico, Palestina, 2200-2000 a.C. Un primo esempio di trapanazione, la più antica forma di neurochirurgia, che consiste nel praticare, con un trapano, un foro nel cranio.



datati tra il 400 e il 200 a.C. (I gruppo), 1000 al 1400 d.C. (II gruppo), 1400 d.C. e la metà del 1500 d.C. (III gruppo).erù, altopiani di Cusco, la capitale dell'impero Inca, 1400 d.C. - 1500 d.C. (III gruppo). solo il **40%** del primo gruppo è sopravvissuto all'intervento, ma poi si passa **al 53%** per il secondo gruppo e **all'83%** durante il periodo Inca (III gruppo)



Terapia topica
La mummia di Similaun o “uomo di Similaun” o semplicemente Otzi, è conservato al Museo Archeologico dell’Alto Adige di Bolzano. 3300 e il 3100 a.C.



“Amo i Diecimila Popoli e le Cento famiglie e ricevo i loro tributi. Ho pietà di quelli che non possono dare e sono profondamente rattristato di vederli soggetti a ogni tipo di malattia. Non vorrei che usassero dei prodotti nocivi. Vorrei che venissero trattati con **i piccoli aghi che penetrano nei meridiani e nei tragitti dell'energia** e che armonizzano il sangue e i soffi, che regolano i movimenti energetici mettendo ordine nelle entrate e nelle uscite, nelle correnti e nelle controcorrenti. Di conseguenza dò ordine che si trasmetta alle generazioni future una ricetta che illumini, un modello molto chiaro, che sia per sempre e che non venga mai abolito, che sia facile da impiegare e difficile da dimenticare”
Huang Di, “L’Imperatore Giallo”- Nei Ching So Wen. 2690 a.C.



*Hul - Gil, pianta della gioia
Analgesia e sedazione peri-procedurale.
Regno di Hammurabi, 1792 al 1750 a.C, civiltà babilonese, Mesopotamia, III-II millennio a.c.*



Papiro di Ebers

Trattato di farmacologia e terapia del dolore

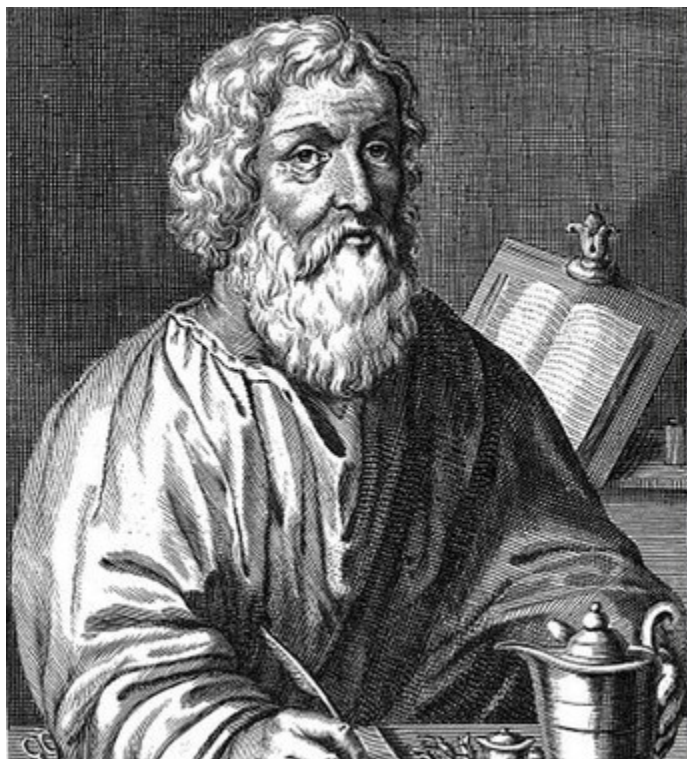
Festa dell'anno nuovo, 3° mese di shmu, 9° giorno, levata di Sodpu, 9° anno di regno di Amenhotep I., 1550 a.C. - 1530 a.C..



«di dolore è impregnata la vita perciò la liberazione dal dolore si ottiene solo liberandosi dal desiderio di vivere e raggiungendo uno stato di perfetta pace: il Nirvana»



Yahwéh la sola fonte della malattia e della guarigione perciò a Yahwéh il sacerdote, uomo scelto da Dio, si rivolgeva con preghiere per invocare protezione e guarigione. Ed è così che ha agito Isaia che ha curato Ezechia



HIPPOCRATIS
COI
OPUSCULA APHORISTICA
SEMEIOTICO-THERAPEUTICA VIII.
UNA CUM
JURE JURANDO,
Græcè & Latine
EX INTERPRETATIONE
ANUTII FOESII, ALIORUMQUE,
IN USUM
SACRÆ GENTIS ASCLEPIADEÆ
EXARATA.



“nessuna malattia è più divina o più umana di un'altra, poiché ogni malattia ha una causa naturale e non si produce senza di essa
“Primum non nocere, secundum purgare” ”
Ippocrate (460-377 a.C.).



Il dolore è malattia

“Sine opio medicina claudicat”, Galeno, 129-200 a. C.
Primo Maestro di Anagni, Ippocrate e Galeno, 1231-1255



“Infirmorum cura ante omnia et super omnia...”

“Aiuto ipnotico, cioè soporifero, è utile a coloro i quali si curano per mezzo della chirurgia, in maniera che, addormentati, non sentano il dolore del taglio. Si prendano queste cose: mezza oncia di oppio tebaico, 8 di succo di mandragora (tratto) dalle foglie spremute, mezza oncia di succo della verde erba di Matala, e di succo di verde giusquiamo, raccogli così, per mezzo di una spugna essiccata, un'unica pasta e diligentemente lascia asciugare; e quando vorrai farne uso a mezzo della stessa spugna per un'ora immergila in acqua calda e avvicinala alle narici ed avvertirai il paziente che da sé stesso assorba quella essenza per dormire a lungo e, quando lo vorrai risvegliare, applicherai alle sue narici un'altra spugna imbevuta di aceto caldo e potrai, così, scacciare il sonno”

San Benedetto da Norcia, 480-547 d.C..



“E’ da rilevare che l’oppio, il giusquiamo e la mandragora producono una profonda sonnolenza, a causa della loro grande umidità, se fate con esse un cataplasma e lo ponete sul luogo dell’incisione esso abolirà completamente la sensibilità per cui il dolore di qualunque specie non viene avvertito”

Scuola Salernitana e Salerno come “Civitas Hippocratica”, prima Università medica, Federico II, 1231.



“le particelle della fiamma poste vicino al piede, mettono in movimento parti di cute ed esercitano una trazione sul delicato filamento che è attaccato a questa zona di cute. In conseguenza di questo, si apre il poro sul quale termina il filamento, proprio come il tirare l'estremità di una corda che fa suonare il campanello che pende all'altra estremità: meccanismo inefficace se dissociato dalla mente e dall'anima”

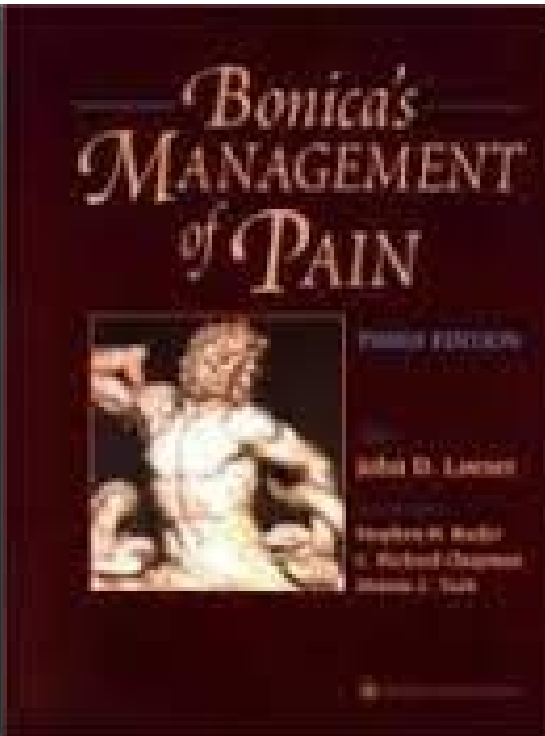
Cartesio, 1596-1650.



il 16 ottobre 1846 Morton si presentò al Massachussets General Hospital di Boston con una sfera di vetro munita di una via di ingresso e di una di uscita con dentro una spugna imbevuta di etere. Sotto la supervisione del chirurgo in carica dott. John Collins Warren ed alla presenza di numerosi colleghi, fece respirare al sig. Gilbert Abbott i vapori provenienti dalla sfera. Il dott. Warren asportò al paziente un grosso tumore del collo rapidamente e senza nessun dolore, poi si girò verso la platea e con gli occhi in lacrime disse: "signori non c'è nessun imbroglio". Era nata l'anestesia moderna
16 Ottobre 1846, dott. W.T.G. Morton.



Bonica, John J. (John J. Bonica). 2008. Bonica, J.



Giovanni Giuseppe Bonica o John J. Bonica, 16 febbraio 1917 - 15 agosto 1994
italo-americano, padre fondatore della moderna terapia del dolore ed il primo a chiamarla con tale nome
"The management of Pain", 1953".



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The Global Emergency Medicine Wiki

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Exam Content

In This Section

Becoming Certified Initiative

For Residents

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Board Eligibility

Content Specifications

Oral Exams are developed from actual clinical cases. Exam editors are all clinically active emergency physicians who identify case topics that meet content specifications. These cases undergo a rigorous development and review process before they are ready for exam use.

ABEM selects cases based on how closely the clinical content aligns with the [EM Model](#). While these cases can originate from any content area within the model, some areas are routinely selected.

2019 Model of the Clinical Practice of Emergency Medicine

The Core Content Task Force II created and endorsed the 2001 Model of the Clinical Practice of Emergency Medicine (EM Model) as published in the June 2001 *Annals of Emergency Medicine* and *Academic Emergency Medicine*.

The 2019 EM Model Review Task Force conducted the eighth review of the EM Model. Their work is built on the original 2001 EM Model and the subsequent four revisions. The 2019 EM Model is published online in the May 2020 *Journal of Emergency Medicine*.

All changes that resulted from the 2019 EM Model Review Task Force are summarized in Figure 1. The three dimensions as revised in 2019 are presented in Tables 1-4.

Preamble of the Core Content Task Force II, Adapted for the 2019 EM Model

In 1975, the American College of Emergency Physicians and the University Association for Emergency Medicine (now the Society for Academic Emergency Medicine; SAEM) conducted a practice analysis of the emerging field of Emergency Medicine. This work resulted in the development of the Core Content of Emergency Medicine, a listing of common conditions, symptoms, and diseases seen and evaluated in emergency departments. The Core Content listing was subsequently revised four times, expanding from 5 to 20 pages. However, none of these revisions had the benefit of empirical analysis of the developing specialty but relied solely upon expert opinion.

1.0 SIGNS, SYMPTOMS, AND PRESENTATIONS

		Critical	Emergent	Lower Acuity
1.1	Abnormal Vital Signs			
1.1.1	Hypothermia	X	X	X
1.1.2	Fever	X	X	X
1.1.3	Bradycardia	X	X	X
1.1.4	Tachycardia	X	X	
1.1.5	Bradypnea/Apnea	X	X	
1.1.6	Tachypnea	X	X	
1.1.7	Hypoxia	X	X	
1.1.8	Hypotension	X	X	
1.1.9	Hypertension	X	X	X
1.2	Pain			
1.2.1	Pain (unspecified)	X	X	X
1.2.2	Headache (See 12.3)	X	X	X
1.2.3	Eye pain		X	X
1.2.4	Chest pain	X	X	X
1.2.5	Abdominal pain	X	X	X
1.2.6	Pelvic and genital pain	X	X	X
1.2.7	Back pain	X	X	X
1.2.8	Chronic pain			X
1.2.9	Extremity pain	X	X	X
1.2.10	Neck pain	X	X	X



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[Please donate!](#) Funds go solely to hosting and development costs that allow medical practitioners around the globe to freely access WikEM.

Emergency medicine residency programs

Background

This list and their [links](#) are a crowd-sourced presentation of emergency medicine residency programs throughout the world, for use as a central repository by applicants and other users. Included content often includes: history, curriculum, leadership, fellowships, and contact information. Please update the materials if you find old information. Programs and their residents, graduates, and faculty are responsible for keeping their information up to date.

United States

Alabama

- [University of Alabama](#)
- [University of South Alabama](#)

Arizona

- [Abrazo Health Network](#)
- [Maricopa Medical Center](#)
- [University of Arizona \(University Campus\)](#)
- [University of Arizona Combined Emergency Medicine and Pediatrics](#)
- [University of Arizona \(South Campus\)](#)

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 - 2.8 District of Columbia
 - 2.9 Florida
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 - 2.12 Indiana
 - 2.13 Iowa
 - 2.14 Kansas
 - 2.15 Kentucky



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Exam Content

The detailed [Critical Care Medicine Certification exam blueprint \(pdf\)](#) includes an outline of the content areas and their approximate percentages for a typical exam.

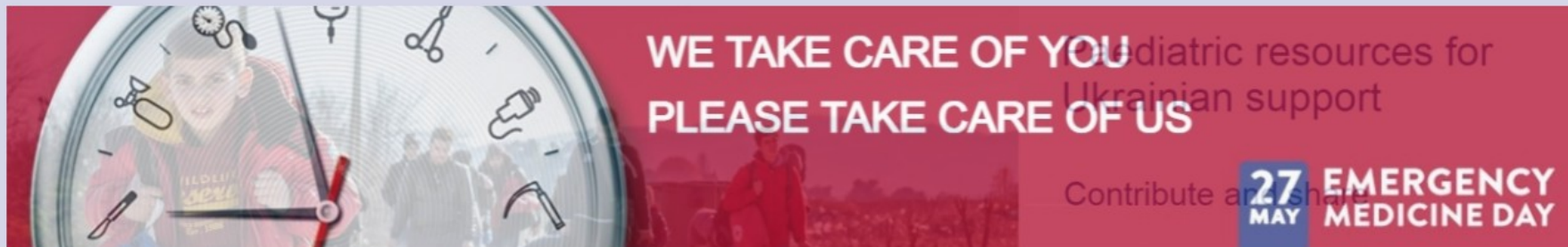
Exam Administration

Multiple editions, or “forms,” of the exam are used, and they may differ in question order and content. Some questions require the interpretation of illustrative materials such as electrocardiograms, radiographs and photomicrographs (e.g., blood films, Gram stains, urine sediments).

Critical Care Medicine

Certification Examination Blueprint

Medical Content Category	% of Exam
Renal, Endocrine, and Metabolic Disorders	15.0%
Cardiovascular Disorders	17.5%
Pulmonary Disease	20.0%
Infectious Disease	12.0%
Gastrointestinal Disorders	5.0%
Neurologic Disorders	9.5%
Hematologic and Oncologic Disorders	5.5%
Surgery, Trauma, and Transplantation	7.0%
Pharmacology and Toxicology	4.5%
Research, Administration, and Ethics	2.0%
Critical Care Ultrasound Scanning	2.0%
	100%



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EUROPEAN CORE CURRICULUM FOR EMERGENCY MEDICINE

VERSION 2.0

This is the revised document of the ECCEM (European Core Curriculum for Emergency Medicine) revision group which consists of members of the **Educational Committee of EUSEM** (European Society for Emergency Medicine) and **EMERGE** (Emergency Medicine Examination Reference Group in Europe) on behalf of the **UEMS Section of Emergency Medicine**.

Cornelia Härtel
EMERGE member SWEDEN

Gregor Prosen
Education Committee EUSEM SLOVENIA

Ruth Brown
Chair of EMERGE UK

Eric Dryver
Chair of Education Committee EUSEM SWEDEN

7 Analgesia and Procedural Sedation

Pain and sedation assessment

Procedural sedation and analgesia

Local, topical and regional anaesthesia

8 Point-Of-Care Ultrasound

Focused cardiac ultrasound:

- Pericardial fluid/tamponade
- Dilated right ventricle
- Decreased contractility/left ventricular function
- Inferior vena cava assessment

Lung ultrasound:

- Pleural fluid
- Pulmonary consolidation
- Pneumothorax
- Interstitial syndromes

FAST (Focused Assessment with Sonography in Trauma)

Abdominal ultrasound:

- Hydronephrosis
- Distended urinary bladder
- Abdominal aorta measurement
- Gallstones

Approvazione della Scuola di specializzazione di "Medicina d'Emergenza-Urgenza"



Il Ministro dell'Istruzione dell'Università e della Ricerca

DECRETA:

Il decreto 1.8.2005, pubblicato sulla Gazzetta Ufficiale n.176 del 5 novembre2005 e'integrato nel senso che all'area medica, classe medicina clinica generale, e'aggiunta la seguente tipologia :
"Medicina d'Emergenza-Urgenza.", il cui ordinamento didattico e' allegato al presente decreto.

Il presente decreto sarà inviato ai competenti organi di controllo e sarà pubblicato nella Gazzetta Ufficiale della Repubblica Italiana.

Roma, 17 febbraio 2006

Il Ministro dell'Istruzione,
dell'Università e della Ricerca
F.to Letizia Moratti

SCUOLA DI SPECIALIZZAZIONE IN MEDICINA D'EMERGENZA-URGENZA
(SCUOLE DI AREA MEDICA - CLASSE DELLA MEDICINA CLINICA GENERALE)

La classe della MEDICINA CLINICA GENERALE e' integrata con la seguente tipologia:

Medicina d'Emergenza-Urgenza (accesso per laureati specialisti in Medicina e Chirurgia (classe 46/S) e ai laureati del vecchio ordinamento in Medicina e Chirurgia).

I profili di apprendimento della classe della MEDICINA CLINICA GENERALE sono i seguenti:

. Lo Specialista in **Medicina d'Emergenza-Urgenza** deve avere maturato conoscenze teoriche, scientifiche e professionali nei campi del primo inquadramento diagnostico (sia intra che extraospedaliero) e il primo trattamento delle urgenze mediche, chirurgiche e traumatologiche; pertanto lo specialista in Medicina d'Emergenza-Urgenza deve avere maturato le competenze professionali e scientifiche nel campo della fisiopatologia, clinica e terapia delle urgenze ed emergenze mediche, nonché della epidemiologia e della gestione dell'emergenza territoriale onde poter operare con piena autonomia, nel rispetto dei principi etici, nel sistema integrato dell'Emergenza-Urgenza.

OBIETTIVI FORMATIVI

Obiettivi formativi integrati (ovvero tronco comune): lo specializzando deve avere acquisito una soddisfacente conoscenza teorica e competenza professionale nel riconoscimento e nel trattamento, anche in condizioni di emergenza-urgenza, delle più diffuse patologie nei seguenti ambiti:

Allergologia e immunologia clinica: conoscenza delle malattie allergiche, delle immunodeficienze prevalenti, delle malattie autoimmuni; competenza nella diagnosi e trattamento delle allergie da farmaci, alimentari e respiratorie e delle malattie immunomEDIATE.

Cardiologia: conoscenza delle più diffuse malattie cardiovascolari, capacità nella raccolta della storia clinica essenziale e nel trattamento; competenza specifica nella valutazione dei pazienti con dolore toracico acuto, interpretazione delle alterazioni maggiori dell'elettrocardiogramma, diagnosi e trattamento dell'infarto miocardico acuto, diagnosi e trattamento delle aritmie minacciose, trattamento dell'arresto cardiaco, rianimazione cardiorespiratoria, trattamento dello shock, dell'asma cardiaco e dell'edema polmonare, trattamento della trombosi venosa profonda e dell'embolia polmonare, trattamento dell'ipotermia.

Ematologia: conoscenza delle più diffuse malattie dell'apparato emopoietico, capacità nella raccolta della storia clinica essenziale e nel trattamento; competenza specifica nel trattamento dell'anemia grave, della leucopenia grave, della trombocitopenia grave, nella diagnosi e nel trattamento delle condizioni suscettibili di dare gravi emorragie.

Endocrinologia: conoscenza delle più diffuse malattie endocrine, capacità nella raccolta della storia clinica essenziale e nel trattamento; competenza specifica nel trattamento della chetoacidosi diabetica, dell'ipoglicemia, dell'ipercalcemia e degli altri disordini dell'equilibrio idro-elettrolitico.

Farmacologia clinica: conoscenza della farmacologia clinica dei farmaci d'uso più comune, delle loro interazioni, degli effetti avversi e del rapporto costo/beneficio; competenza per la diagnosi e il trattamento degli avvelenamenti più comuni e del sovradosaggio dei farmaci psicotropi.

The High Prevalence of Pain in Emergency Medical Care

WILLIAM H. CORDELL, MD,* KELLY K. KEENE,* BEVERLY K. GILES, RN,*
JAMES B. JONES, MD, PHARM D,* JAMES H. JONES, MD,*
AND EDWARD J. BRIZENDINE, MS†

Although there is a widely held belief that pain is the number 1 complaint in emergency medical care, few studies have actually assessed the prevalence of pain in the emergency department (ED). We conducted an analysis of secondary data by using explicit data abstraction rules to determine the prevalence of pain in the ED and to classify the location, origin, and duration of the pain. This retrospective cross-sectional study was conducted at an urban teaching hospital in Indianapolis, IN. Charts from 1,665 consecutive ED visits during a 7-day period were reviewed. *Pain* was defined as the word pain or a pain equivalent word (including aching, burning, and discomfort) recorded on the chart. Of the 1,665 visits, 61.2% had pain documented anywhere on the chart, 34.1% did not have pain, and 4.7% were procedures. Pain was a chief complaint for 52.2% of the visits. This high prevalence of pain has important implications for the allocation of resources as well as educational and research efforts in emergency medical care. (Am J Emerg Med 2002;20:165-169. Copyright 2002, Elsevier Science (USA). All rights reserved.)

METHODS

This study was conducted in the emergency department of Methodist Hospital, Indianapolis, IN. The institution is an urban, tertiary-care referral center with an annual ED census of 90,754. The institutional review board approved the study. We identified the study population by developing a master encounter list from the electronic ED database. Consecutive ED charts for the 7-day period were photocopied for data abstraction. Three physicians and 2 nurses abstracted data from the photocopied charts, and a single investigator entered the data into a spreadsheet.

We defined *pain* as the word pain or a pain equivalent word recorded on the chart (Table 1). Pain equivalent words included aching, burning, cramping, discomfort, dysuria,

TABLE 2. Multiple-Axis Classification of Pain for the Encounters When Patients Reported Pain.

	Frequency	%
Region (N = 1019)		
1 region of pain	819	80.4
2 regions of pain	139	13.6
3 or more regions	61	6.0
For those who had 1 or 2 regions of pain (N = 958), the location was:		
Head, face, mouth	225	23.5*
Cervical	46	4.8
Upper limbs, shoulder, and clavicle	104	10.9
Thoracic (including anterior chest, scapulae, and thoracic spine)	176	18.4
Abdominal pain (including pelvic pain)	235	24.5
Lower back, lumbar spine, sacrum, and coccyx	126	13.2
Lower limbs	144	15.0
Pelvis	11	1.2
Anal, perineal, and genitalia	30	3.1
Etiology (N = 1019)		
Neoplasm and malignancy	8	0.8
Sickle cell crisis	6	0.6
Trauma	317	31.1
Migraine and other headache	29	2.8
Colic (renal or biliary)	19	1.9
Infectious	178	17.4
Inflammatory	60	5.9
Specific chronic pain syndromes	11	1.1
Dental pain	19	1.9
Other	163	16.0
Unknown	209	20.5
Duration (N = 1018)		
< 48 hours	576	56.6
48 hours up to 1 month	312	30.6
1 month up to 6 months	20	2.0
≥ 6 months	32	3.1
Not recorded or not known	78	7.7

DECLARATION OF MONTREAL

Declaration that Access to Pain Management Is a Fundamental Human Right

We, as delegates to the International Pain Summit (IPS) of the International Association for the Study of Pain (IASP) (comprising IASP representatives from Chapters in 64 countries plus members in 129 countries, as well as members of the community), have given in-depth attention to the unrelieved pain in the world,

And, recognizing the intrinsic dignity of all persons and that withholding of pain treatment is profoundly wrong, leading to unnecessary suffering which is harmful; we declare that the following human rights must be recognized throughout the world:

Article 1. The right of all people to have access to pain management without discrimination (Footnotes 1-4).

Article 2. The right of people in pain to acknowledgment of their pain and to be informed about how it can be assessed and managed (Footnote 5).

Article 3. The right of all people with pain to have access to appropriate assessment and treatment of the pain by adequately trained health care professionals (Footnotes 6-8).

Oligoanalgesia in the Emergency Department

JAMES E. WILSON, MD,*† JILL M. PENDLETON, BS†

A review of the charts of 198 patients who were admitted through the emergency department with a variety of acutely painful medical and surgical conditions revealed that 56% received no analgesic medication while in the emergency department. In the 44% of patients who received pain medication, 69% waited more than 1 hour while 42% waited more than 2 hours before narcotic analgesia was administered. In addition, 32% initially received less than an optimal equianalgesic dose of narcotic when compared with morphine. This study demonstrates that narcotic misuse, in the form of oligoanalgesia, is prevalent and is the shared responsibility of both emergency physicians and housestaff consultants. (Am J Emerg Med 1989;7:620-623. © 1989 by W.B. Saunders Company.)

eastern Ohio Universitics College of Medicine. The ED has a yearly volume of 60,000 patients, of whom 40% are privately insured, 40% are covered by Medicare/Medicaid, and 20% are indigent. The ED is staffed 24 hours a day by board-certified emergency medicine faculty and residents of its residency program in emergency medicine. Seven other residencies exist within the hospital with a total of 132 residents in various medical and surgical teaching programs. Junior- and senior-level residents from these programs serve as consultants for patients in the ED when requested by the emergency medicine faculty. All patients presenting to the ED are initially examined and

MAY 2011



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Access to Palliative Care as a Human Right

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Emergency Department Crowding Is Associated With Poor Care for Patients With Severe Pain

Jesse M. Pines, MD, MBA,
MSCE
Judd E. Hollander, MD

From the Department of Emergency Medicine (Pines, Hollander), the Center for Clinical Epidemiology and Biostatistics (Pines), University of Pennsylvania School of Medicine, and the Leonard Davis Institute of Health Economics, University of Pennsylvania, Philadelphia, PA.

Study objective: We study the impact of emergency department (ED) crowding on delays in treatment and nontreatment for patients with severe pain.

Methods: We performed a retrospective cohort study of all patients presenting with severe pain to an inner-city, teaching ED during 17 months. Poor care was defined by 3 outcomes: not receiving treatment with pain medication while in the ED, a delay (>1 hour) from triage to first pain medication, and a delay (>1 hour) from room placement to first pain medication. Three validated crowding measures were assigned to each patient at triage. Logistic regression was used to test the association between crowding and outcomes.

Results: In 13,758 patients with severe pain, the mean age was 39 years (SD 16 years), 73% were black, and 64% were female patients. Half (49%) of the patients received pain medication. Of those treated, 3,965 (59%) experienced delays in treatment from triage and 1,319 (20%) experienced delays from time of room placement. After controlling for factors associated with the ED treatment of pain (race, sex, severity, and older age), nontreatment was independently associated with waiting room number (odds ratio [OR] 1.03 for each additional waiting patient; 95% confidence interval [CI] 1.02 to 1.03) and occupancy rate (OR 1.01 for each 10% increase in occupancy; 95% CI 0.99 to 1.04). Increasing waiting room number and occupancy rate also independently predicted delays in pain medication from triage (OR 1.05 for each waiting patient, 95% CI 1.04 to 1.06; OR 1.18 for each 10% increase in occupancy; 95% CI 1.15 to 1.21) and delay in pain medication from room placement (OR 1.02 for each waiting patient, 95% CI 1.01 to 1.03; OR 1.06 for each 10% increase in occupancy, 95% CI 1.04 to 1.08).

Conclusion: ED crowding is associated with poor quality of care in patients with severe pain, with respect to total lack of treatment and delay until treatment. [Ann Emerg Med. 2008;51:1-5.]

Table 2. Adjusted models using ED crowding measures, adjusting for patient-level factors to predict primary outcomes (n=13,758).

Adjusted models	Adjusted OR (95% CI)
No analgesia in the ED	
Waiting room number*	1.03 (1.02–1.03)
Occupancy rate [†]	1.01 (0.99–1.04)
Age ≥65 y	1.61 (1.40–1.86)
Female sex	1.30 (1.20–1.41)
White race	0.89 (0.80–0.98)
More severe triage level (1 or 2)	1.10 (1.02–1.18)
Delay >1 h in analgesia from triage	
Waiting room number*	1.05 (1.04–1.06)
Occupancy rate [†]	1.18 (1.15–1.21)
Age ≥65 y	1.47 (1.22–1.77)
Female sex	1.37 (1.25–1.50)
White race	0.84 (0.75–0.94)
More severe triage level (1 or 2)	0.57 (0.52–0.62)
Delay >1 h in analgesia placement in room	
Waiting room number*	1.02 (1.01–1.03)
Occupancy rate [†]	1.06 (1.04–1.08)
Age ≥65 y	1.61 (1.39–1.87)
Female sex	1.26 (1.16–1.36)
White race	0.90 (0.81–0.99)
More severe triage level (1 or 2)	0.89 (0.83–0.95)

*For an increase in waiting room number of 1 patient.

[†]For an increase in occupancy rate of 10%.

LEGGI ED ALTRI ATTI NORMATIVI

LEGGE 15 marzo 2010, n. 38,

Disposizioni per garantire l'accesso alle cure palliative e alla terapia del dolore.

La Camera dei deputati ed il Senato della Repubblica hanno approvato;

IL PRESIDENTE DELLA REPUBBLICA

Commentary

Pain as the Fifth Vital Sign: Exposing the Vital Need for Pain Education

Natalia E. Morone, MD, MS^{1,2,3}; and Debra K. Weiner, MD^{1,3,4,5,6}

¹Geriatric Research Education and Clinical Center, Veterans Affairs Pittsburgh Healthcare System, Pittsburgh, Pennsylvania; ²Division of General Internal Medicine, Center for Research on Health Care, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; ³Clinical and Translational Sciences Institute, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; ⁴Division of Geriatrics, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; ⁵Department of Psychiatry, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania; and ⁶Department of Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

ORIGINAL RESEARCH

Open Access



Increased analgesia administration in emergency medicine after implementation of revised guidelines

Geesje Van Woerden¹, Crispijn L. Van Den Brand¹, Cornelis F. Den Hartog², Floris J. Idenburg³,
Diana C. Grootendorst⁴ and M. Christien Van Der Linden^{1*}

Abstract

Background: The most common complaint of patients attending the emergency department (ED) is pain, caused by different diseases. Yet the treatment of pain at the ED is suboptimal, and oligoanalgesia remains common. The objective of this study is to determine whether the administration of analgesia at the ED increases by implementation of revised guidelines in pain management.

Methods: We conducted a prospective pre-post intervention cohort study with implementation of a revised guideline for pain management at our ED, in which nurses are allowed to administer analgesia (including low-dosage piritramid (opioid) intravenous) without doctor intervention. Numeric Rating Scales (NRS) were measured, and administration of medication (main outcome) was documented. We included every adult patient presenting with pain (NRS 4–10) at the ED.

Results: A total of 2107 patients (1089 pre-implementation phase and 1018 post-implementation phase) were included in our study. During pre-implementation, 25.4 % of the patients with NRS between 4 and 10 received analgesia. After implementation, 32.0 % of these patients received analgesia ($p < 0.001$).

Conclusions: After implementation of the revised guidelines in pain management at the ED, the administration of pain medication increased significantly. Nevertheless, the percentage of patients in pain receiving analgesia remain low (32 % after implementation).

Keywords: Analgesics, Pain management, Acute pain, Emergency department

Table 1 Patient characteristics pre- and post-implementation

	Pre-implementation (n = 1089)	Post-implementation (n = 1018)	p value
	Mean years (lowest-highest)	Mean years (lowest-highest)	
Age	42 (16–101)	43 (18–94)	0.86
	Median (std. dev.)	Median (std. dev.)	
NRS at entrance ED (std. dev.)	5.0 (1.7)	5.0 (1.6)	0.086
	N (%)	N (%)	
Male	526 (48.3)	482 (47.3)	0.66
Dutch	472 (43)	403 (40.0)	0.39
Other	452 (42)	419 (41.2)	
Surgical specialty	386 (35.4)	405 (39.8)	0.045
Non-surgical specialty	700 (64.3)	613 (60.2)	
Triage category high	171 (15.7)	153 (15.0)	0.003
Triage category middle	509 (46.7)	547 (53.7)	
Triage category low	409 (37.6)	318 (31.2)	
Use of analgesia pre-hospital	150 (13.8)	113 (11.0)	0.001
NRS 4–6	698 (64.1)	697 (68.5)	<0.001
NRS 7–10	391 (35.9)	321 (31.5)	

P-values printed in italic are statistically significant



S I M E U

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d'emergenza-urgenza

Sedazione
Analgesia
Urgenza

Raccomandazioni Intersocietarie Italiane (SIAARTI, SIMEU, SIS 118, AISD, SIARED, SICUT, IRC) sulla gestione del dolore in emergenza

Messaggi Chiave

I percorsi diagnostico-terapeutici sul dolore in emergenza richiedono un approccio di tipo multidisciplinare.

Queste raccomandazioni evidenziano la necessità di incrementare le conoscenze relative alla gestione del dolore in emergenza e promuovono l'utilizzo della titolazione con oppioidi e l'utilizzo di tecniche loco-regionali.

Livelli A di evidenza sono limitati al controllo del dolore procedurale nella popolazione pediatrica (Tabella 5)

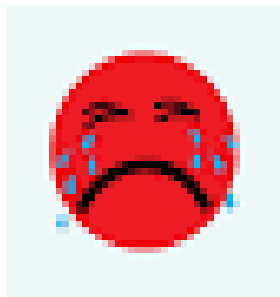


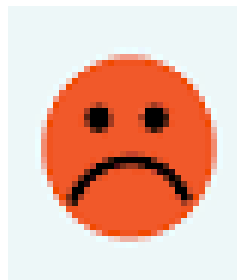
Multimodal oral analgesia for non-severe trauma patients: evaluation of a triage-nurse directed protocol combining methoxyflurane, paracetamol and oxycodone

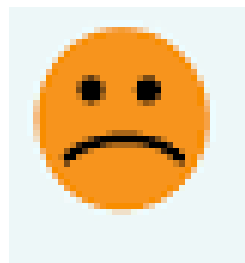
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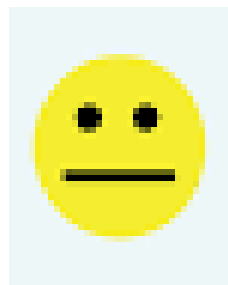
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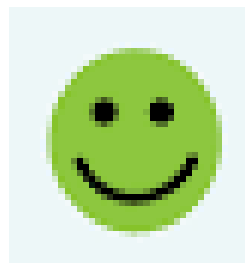
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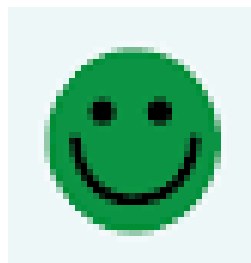












La terapia del dolore nel core curriculum

perché non c'è prendersi cura senza curare la sofferenza



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