STROKE AND RNAO BEST PRACTICES: PAIN

Presented by:

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Objectives

To understand:

- Types of post stroke pain
- Prevention
- Assessment
- Management
Bernie is a thin 80 year old gentleman who experienced a Left MCA stroke. This left him with weakness in his right upper and lower extremity, impaired ability to sense touch on that side and trouble planning his movements as well as difficulty communicating. Bernie has trouble paying attention and lacks insight into his actual capabilities post-stroke. He suffers from shoulder pain on his right side after an improper transfer from the bed to the chair while his weaker side was not supported properly.

Bernie completed 6 weeks of in-patient rehab. He is now moving in to a LTC facility.
Post-Stroke Pain

“a sensation in your body that causes acute discomfort or suffering”

(Heart & Stroke Foundation, 2013, p 4.2)
Duration of Pain

Pain can be either:

- Acute Pain
- Chronic Pain

(Heart & Stroke Foundation, 2013)
Sources of Pain

Pain can be due to tissue or nerve damage:

- **Tissue damage** leads to a pain that can be sharp, dull, or aching.

- **Nerve damage** can be described as sharp, burning, aching, tingling, cutting, piercing, stabbing, or numbness.

(Heart & Stroke Foundation, 2013)
Post-Stroke Pain: Facts

Pain is very common in stroke survivors

(Heart & Stroke Foundation, 2013)
Post-Stroke Pain Facts

Pain affects quality of life

(Heart & Stroke Foundation, 2013)
Types of Post-Stroke Pain

- Central Post-stroke Pain
- Spasticity (High Tone)
- Shoulder or Hand Syndrome
- Orthopaedic Conditions
- Hemiplegic shoulder pain
  - Shoulder subluxation
Central Post-Stroke Pain

- “Burning/tingling/stabbing/acid under skin”
- Pain can be constant or intermittent
- Caused by damage to the brain or spinal cord from a stroke
- Less than 10%

(Heart & Stroke Foundation, 2013)
Central Post-Stroke Pain

➢ Worsened by:
  • Physical Activity
  • Light touch
  • Stress
  • Cold
  • Change in weather

➢ May complain of pain:
  • Where there is no visible tissue damage
  • From light touch
  • That is unusually severe

(Heart & Stroke Foundation, 2013)
Managing Central Post-Stroke Pain

- Difficult to treat
- Prescribed medications
- Early identification
- Watch for symptoms
- Acknowledge their pain
- Report pain to the appropriate person

(Heart & Stroke Foundation, 2013)
Spasticity

- Abnormally high muscle tone
- Shortens muscles
- Prevents normal movement
- Results in stiff and painful joints
- ‘Muscle cramp’

(Heart & Stroke Foundation, 2013)
Spasticity Management

- Doctor, Physiotherapist, Occupational Therapist

(Heart & Stroke Foundation, 2013)
Shoulder or Hand Syndrome

- May begin with shoulder pain
- Develop stiff, swollen, and painful hand and wrist
- Decreased range of motion in shoulder and hand

(Heart & Stroke Foundation, 2013)
Shoulder or Hand Syndrome Management

- Pain management specialist consult
- Use recommended positioning to protect
- Use prescribed exercises
- Team approach (Doctor/PT/OT)

(Heart & Stroke Foundation, 2013)
Orthopaedic Conditions

- **Rotator Cuff Tear**
  - Muscles that hold the shoulder in place

- **Tendonitis**
  - Inflammation of the tendon

- **Bursitis**
  - Inflammation of a bursa

(Heart & Stroke Foundation, 2013)
Risk Factors of Post-Stroke Shoulder Pain

- Functional status
- Self-perceived health
- Arm motor function
- Sensory Disturbance
- Subluxation

(Lindgren et al., 2007)
Shoulder Subluxation
Shoulder Subluxation Cont’d

How can you help:

- Handle the shoulder carefully
- Support the shoulder joint.
- Talk to members of the interdisciplinary team

(Heart & Stroke Foundation, 2013)
Best Practice Guidelines: Prevention

- Joint protection strategies
- No overhead pulleys
- No movement past 90 degrees flex/abduction unless the scapula and humerus are mobilized
- Education regarding correctly handling the involved arm

(Dawson et al., 2013)
“The assessment of the painful hemiplegic shoulder should include evaluation of tone, strength, changes in length of soft tissues, alignment of joints of the shoulder girdle and orthopedic changes in the shoulder”

Evidence Based Recommendations for:
• Assessment
• Planning Goals of Care and Treatment strategies with the resident, family and Interdisciplinary team.
• Implementing the Care
• Monitoring and Evaluation of the effectiveness of the pain management strategies
• Educational Resources
RNAO’s related Best Practice Guidelines
www.rnao.ca

Client Centred Care 2002
Revised Supplement 2006

Stroke Assessment Across the Continuum: developed in partnership with the Heart and Stroke Foundation of Ontario.
2005 Revised Supplement 2011
Best Practice Guidelines: Management

- Consult with Interdisciplinary Team (PT/OT/Physician)
- Consult with a pain consultant in your area
- Medications as prescribed

(Dawson et al., 2013)
Identifying Pain in Persons Post-Stroke

- **Verbally**
  - “Pain Words” – burning/itching/throbbing
  - Sounds – moans/groans, cries
  - Exclaiming/Cursing – “Ouch!”

- **Physically**
  - Rubbing, bracing, holding or guarding
  - Frequent shifting, restlessness

- **Through Facial Expressions**
  - Frowning/wincing

- **Through Behaviour Changes**
  - Change in appetite

(Heart & Stroke Foundation, 2013)
How you can help

- Ask yes or no questions
- Use simple words to help identify the problem
- Point to areas that may be painful when asking questions
- Ask about pain during or after movement
- Be patient and take time
- Use a pain assessment scale regularly
- Discuss the pain and management with the team

(Heart and Stroke Foundation, 2013)
Case Study

Bernie’s shoulder pain could potentially have been prevented by:

- Utilizing joint protection strategies
- Providing education to resident, family and interdisciplinary team members regarding handling the involved arm

“Treatment is difficult and may be even more difficult after the pain is established”
- Best form of treatment is prevention!
Questions and Discussion


