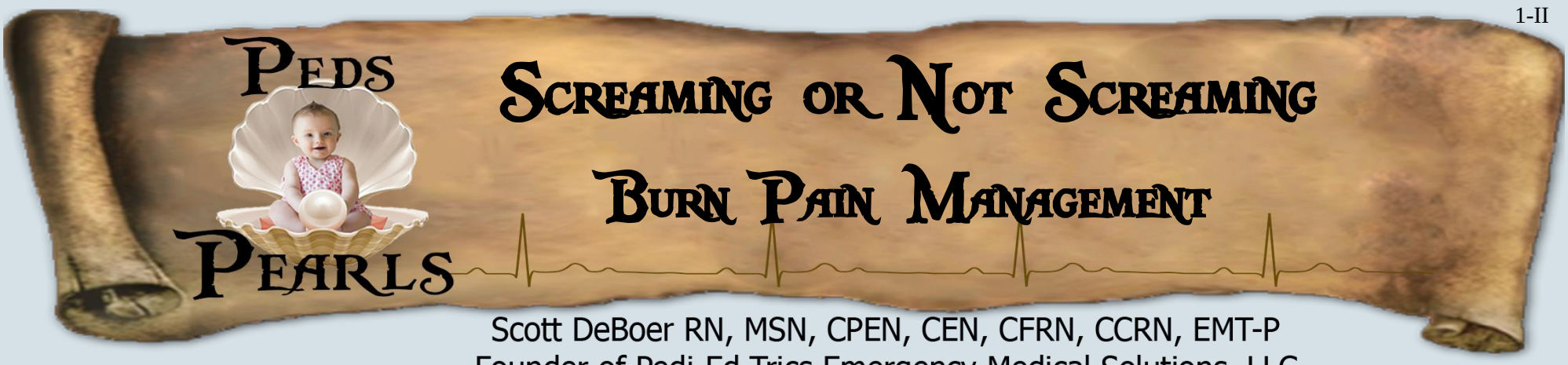
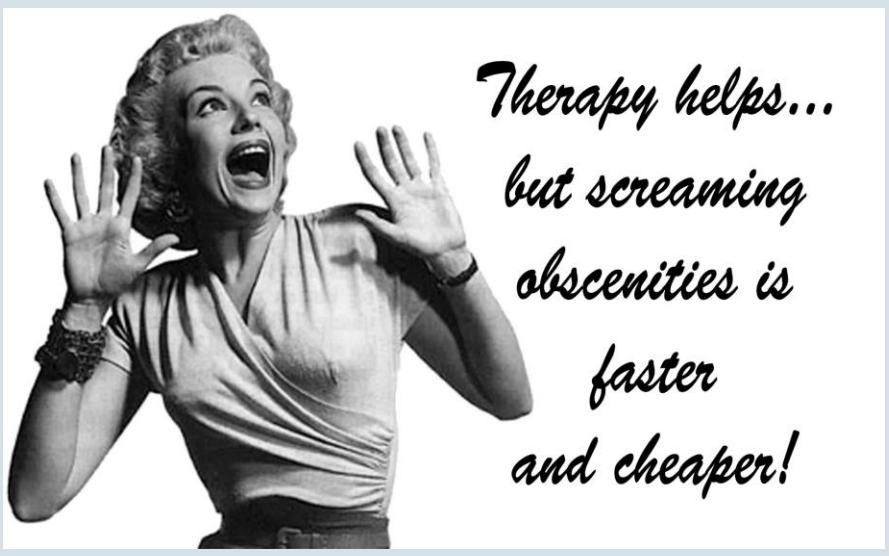


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Uncomfortable Situations

We often feel uncomfortable with that which is not familiar to us. Unless you work in a pediatric emergency department, it's unlikely that you are very familiar with (and by extension, very comfortable with) true pediatric emergencies. And unless you work in a dedicated burn unit, it's unlikely that you are very familiar with (and by extension, very comfortable with) caring for patients with significant burns. Combine these two situations and you have what is perhaps the most uncomfortable (and perhaps the most dreaded) patient to care for, the pediatric burn patient. From fluids, to infections, to families... caring for these patients can be very challenging. Additionally, there is another aspect to the care we can provide, and that is pain management. And when it comes to burn pain management, just remember, "Screaming or Not Screaming."



Non-pharmacological measures should certainly be considered for burn patients, but it is extremely likely that pain meds, and strong ones at that, will be called for. But there are questions that come up about the administration of strong pain medications. First of all, we are concerned about giving enough of the medication, and then, we are often worried about giving too much. And what is it about giving too much that we really worry about? The answer to that question is simple… we worry that the patient is going to stop breathing. While this is always a good thing to watch for, we can remember from basic anatomy and physiology classes that there are several stimuli to keep you breathing; these include oxygen, carbon dioxide, and PAIN!

Pain is God's not so subtle reminder that you are still alive.

In all too many situations, and in all too many emergency departments, it is way too easy to find the pediatric burn patient. Regrettably, all you have to do is follow the screams. In EMS or the Emergency Department, you can only give as much pain medication as your medical director or NP/PA/physician orders. However, in most cases, you are the eyes (and ears) of the ordering provider, and as such, you are in a uniquely important position to request and administer a whole lot more.

Think about morphine for a minute…

The dose is 0.1 mg/kg. That means a 10 kg child should get 1 mg of morphine and a 100 kg adult should receive 10 mg <u>each</u> dose. Now, <u>how often</u> they get dosed is the real issue. The personal feeling and experience of many of us is that if you exercise appropriate care and monitoring (and aren't stupid), you can continue to give more medication safely. *Stupid would be pushing 10 mg to the little child or 100 mg of morphine at a time to an adult. That's just stupid as it's 10X the dose and decimal points really do make a difference.* However, pushing an appropriate mg/kg dose every few minutes until the patient <u>stops</u> screaming, but is <u>still</u> breathing, is probably a good indication that the medication is working. There's a point at which your patient will <u>stop</u> screaming and start sleeping. That's when you <u>stop</u> pushing. If you keep pushing, then yes, they will stop breathing and that may or may not be what you want. If they are intubated with a good blood pressure, no worries. They have an endotracheal tube in place. The airway is protected and you are controlling the breathing. And to withhold the pain medication needed to provide relief is inhumane at best!

On a side note, how can you give the pain meds? Trauma courses teach the IV or IO route and appropriately so. The bloodstream to brain time is short and patients deserve pain relief fast and often. However, can you give these meds IM? Sure, but we don't recommend it. Remember if you are in shock, blood goes to the core; meaning heart, lungs, and brain. And where does that blood not go? To put it bluntly, it doesn't go to the butt. So if you give them a shot of morphine in the butt, when does it go to the brain? Honestly, we don't know what the butt to brain time is in burn patients. So, IV/IO (or short term intranasally with ketamine or fentanyl until IV/IO access is obtained) is what's best for your patient!

Screaming Or Not Screaming

Imagine, if you can, what it would be like if you were horribly burned. Would you want to be screaming or not screaming? You wouldn't want to be screaming, and your patients deserve nothing less!

Pediatric Emergency Medicine & Critical Care Physician Insights



There is a very fine line and you always want to make sure that you give enough time between doses. If the patient is starting to settle down, I might wait a little longer before giving another dose. Reversing with Narcan (naloxone) can not only counteract the respiratory depression, but it can block the receptors for pain relief for a while and that would be really bad!



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Contact us to have Scott DeBoer or one of our other pediatric experts present at your next conference.

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