Pain in wound care

REFERENCES

Marucha PT, Kiecolt-Glaser JK, Favagehi M (1998) Mucosal wound healing is impaired by examination stress. *Psychosom Med*. 60(3): 362–5

Pare A (1840) *Oevres Completes D'Ambroise Pare, Precedees d'une Introduction sur l'origine et les Progres de la Chirurgie en Occident du Seizieme Siecle, et sur la Vie et les Ouvrages d'Ambroise Pare. Par J F Malgaigne.* J-B Balliere, Paris (3 volumes)

Pinker S (2011) T*he Better Angels of our Nature*. Viking, New York, NY

Solowiej K, Mason V, Upton D (2009) Review of the relationship between stress and wound healing: part 1. *J Wound Care* 18(9): 357–66

Upton D, Solowiej K (2010) Pain and stress as contributors to delayed wound healing. *Wound Practice and Research* 18(3): 114–22

White R J (2008) A multinational survey of the assessment of pain when removing dressings. *Wounds UK* 4(1): 1–6.

Reddy MR, Kohr RK, Queen DQ et al (2003) Practical treatment of wound pain and trauma: A Patient-centered approach. *Ostomy Wound Manage* 49(4A): 2–15

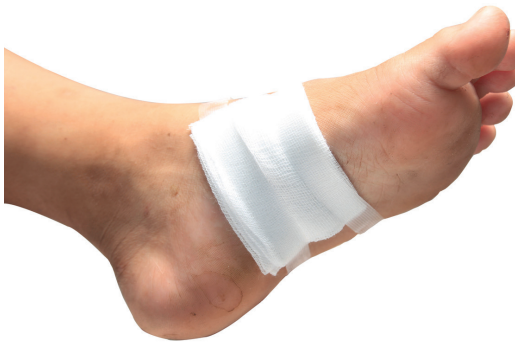
EDWARD WHITE
Freelance Medical Writer, British Columbia, Canada

As per historical records detailing most aspects of mankind's turbulent existence, a look through the annals of wound care and surgery reveals a progressive trend from the dark, early days of unspeakable barbarism and eye-watering brutality, to a civilised, humane age; one in which individuals act with compassion and care for themselves and others. Indeed, the famed cognitive psychologist and linguist Steven Pinker (2011) has argued that violence in world has declined over time, claiming that this decline "may be the most significant and least appreciated development in the history of our species" (Pinker 2011). It could also be argued that this decline in violence in the wider world has been matched with an increase in the concern for patient welfare within the healthcare world, especially as regards pain.

There is no hiding it; for individuals requiring medical attention, be it in civilian life or on the battlefield, the prospects used to be dark. Boiling oil cautery, wound salves prepared from boiled puppies and worms, beating donor sites with wooden shoes to elicit swelling, or even packing wounds with donkey faeces to seal them off from evil spirits; the life of a patient in days gone by could scarcely have seemed better than death in some cases. Even today, the use of woven gauze on wounds still persists, only to cause desiccation of the wound bed, followed by a thoroughly unpleasant ripping out of eschar when the enmeshed 'dressing' is removed. Hardly the compassionate approach to patient care, especially in an age of technologically advanced, non-adherent wound dressings!

Even from the days of the Roman physician Celsus, who described the four fundamental signs of infection (rubor, tumor, calor, dolor) in his 1st century work De Medicina, there is the explicitly recorded observation of patient pain as an indicator of wound status, 2000 years ago.

But what of the pain itself? In the problem-solving game of healing wounds, identifying aetiology, applying treatments, and recording progress are always in danger of being prioritised above monitoring and controlling pain levels. In recent years, the increasing influence of health economics has resulted in numerous papers questioning the real cost of pain, quite literally, in terms of both financial burden and quality of life (QoL).



Even today, the use of woven gauze on wounds still persists, only to cause desiccation of the wound bed and pain when the enmeshed 'dressing' is removed.

Upton and Solowiej (2010) suggested that pain be described as a "biopsychosocial concept that can be viewed by the patient as a stressor". This can be from the wound itself, or crucially, from wound treatments themselves. Dressing change, wound cleaning, debridement, and inappropriate dressing selection can all contribute to wound-related pain (Solowiej et al, 2009).

Predictably, pain can lead to increased stress, which has been shown to delay wound healing (White 2008), in some cases by 40% (Marucha et al, 1998). Patient welfare aside, this comes at huge cost to the caregiver and the healthcare system as a whole; more pain, especially at dressing change, can result in decreased trust in caregivers, and longer healing times obviously result in a whole catalogue of additional costs being borne by the healthcare system; additional nursing time, bed time, dressing costs, to name but a few.

Despite how crucial pain is as a determinant of wound status, the effect of pain on patient welfare appears to remain a secondary consideration, and the underlying costs of pain remain largely unknown and unquantified. According to Reddy et al (2003), one of the failures of modern medicine is the inadequate assessment and treatment of pain. Is this still the case?