



Pain in HIV/AIDS

Pain is a very negative but common experience for patients with HIV/AIDS. It is often associated with significant psychological symptoms. In every case, it is a treatable problem that is all too often undertreated by physicians. Pain perception in patients is influenced by a number of cognitive-behavioral factors as well as sociocultural issues. HIV pain is often multifactorial in origin and the initial step in attempting to manage any pain complaint is a comprehensive assessment.

How common is pain for people with HIV?

The prevalence of pain in HIV-infected individuals varies, but estimates of the generally range from 30% to 80% with prevalence of pain increasing as disease progresses. HIV/AIDS patients with pain often feel two or three different types of pain simultaneously.

While still preliminary in nature, studies have shown that pain is dramatically undertreated in patients with HIV/AIDS. Specifically, research suggests that opioid analgesics (e.g. morphine, meperidine, oxycodone) are underused in the treatment of pain in HIV/AIDS. Research also shows that adjuvant analgesic agents such as antidepressants are also dramatically underutilized, despite the fact that such medications are recommended by the World Health Organization (WHO) for pain management. Even though the pain associated with HIV/AIDS is widely understood to be comparable to the pain of cancer, the undertreatment of pain in AIDS happens much more often than the undertreatment of pain in cancer.

A study at Memorial Sloan Kettering Hospital reported on the experience of pain in women with HIV/AIDS. The study suggested that women with HIV disease frequently experience pain more frequently than men with HIV disease, and report somewhat higher levels of pain intensity. This may in part be a reflection of the fact that women with HIV/AIDS-related pain are twice as likely to be under treated for their pain as men.

Why is HIV-related pain undertreated?

There are barriers to the effective treatment of pain that stem from all the parties involved: patient, provider, and even the healthcare system itself. Each potential barrier must be understood to ensure that a patient has effective treatment.

Patients often feel hesitant to report the pain they are feeling, believing it is part of the experience they must endure. Sometimes patients worry that pain medication will cause them to become addicted, or that side effects will be too serious. A patient might want to limit the total number of

pills or medications he must take, or may personally prefer a holistic and non-pharmaceutical approach to pain management. And some patients may simply be afraid of injections needed to administer pain medication. Finally, patients with HIV-related dementia may find their ability to communicate decreasing as the effects of dementia increase.

The biggest barrier to pain management on the part of providers is lack of knowledge. Many providers need greater knowledge of basic pharmacology and effective analgesic care, and all providers help their patients when they seek a greater understanding of behavioral, social and psychological aspects of pain.

Healthcare providers in some cases have an inadequate ability to assess pain, inadequate knowledge base of specific pain syndromes in HIV, a poor understanding of anatomy of pain, or inadequate knowledge of mechanisms of neuromediators of pain. And the legitimate fear of regulatory scrutiny of prescribing patterns may stop providers from offering truly effective pain management.

Health care system related barriers to pain management include lack of access to health care and specialized pain services; unavailability of opioid analgesics in many community pharmacies; cost of analgesics, lack of or low funding of drug benefits, state & federal regulatory practices which increase reluctance of physicians to prescribe opioid for severe pain because of scrutiny

What kinds of pain do people with HIV experience?

People with HIV/AIDS can experience a wide variety of types of pain, from a variety of causes. The most common pain syndromes reported in studies to date include painful sensory peripheral neuropathy, pain due to extensive Kaposi's sarcoma, headache, oral and pharyngeal pain, abdominal pain, chest pain, anorectal pain, arthralgias and myalgias, as well as painful dermatologic conditions. Arthritic pain and muscle pain is also common in people with HIV/AIDS. There are a number of anti-retroviral drugs, chemotherapy and several other HIV medications that can themselves cause pain.

Children with HIV infection also experience pain. HIV-related conditions in children that are observed to cause pain include meningitis and sinusitis (headaches); otitis media; shingles; cellulitis and abscesses; severe candida dermatitis; and dental caries; intestinal infections such as mycobacterium avium intracellular and cryptosporidium; hepatosplenomegaly; oral and esophageal candidiasis; and spasticity associated with encephalopathy that causes painful muscle spasms.



How should a clinician evaluate for pain?

In any assessment of pain, either initial or ongoing, it is important to bear in mind that only the patient knows when the pain is present or gone. Further, only the patient knows when there is not enough pain medication. While providers can usually tell when there is too much pain medication, they don't seem to be as attuned to whether there is enough pain medication; study after study shows that physicians consistently under-treat pain.

A comprehensive pain assessment should be done whenever there is an indication from the patient that pain exists, and when a circumstance arises that is typically associated with pain. To assess pain, the clinician should inquire about pain in a clinical interview, and may also use a variety of pain assessment tools including the brief pain inventory (BPI) and the Memorial Pain Assessment Card (MPAC).

A physician should ask the patient what the pain feels like (e.g. burning, shooting, dull or sharp), how intense it is, when and for how long the pain has been present, and what actions or activities (e.g. taking any over the counter medications) either decrease or increase the pain.

Aside from asking questions about the pain itself, the physician should make a detailed medical, neurological, and psychosocial assessments (including a history of substance use or abuse). Where possible, family members or partners should be interviewed. Taking a careful history and physical examination can uncover a syndrome (e.g. herpes, bacterial infection, or neuropathy) that might be causing pain, and can then be treated in a standard fashion.

The Memorial Pain Assessment Card (MPAC) is a helpful clinical tool that allows patients to report their pain experience. Using the MPAC, a patient can easily and quickly refer to a visual scale to describe his pain intensity, pain relief and mood. Patients can complete the MPAC in less than 30 seconds. The Brief Pain Inventory is another pain assessment tool that a patient can respond to quickly and easily, using a 1-10 rating scale.

What psychosocial factors must be considered?

For any pain evaluation to be complete and accurate, certain psychosocial factors should be taken into account. Sometimes patients overstate or understate their pain, either intentionally or unintentionally. For example, a patient whose outward behavior seems cheerful might describe pain as an 8, on a scale of 0 to 10, or conversely, a patient in very clear physical discomfort (sweating, fever, etc.) might describe his pain level as a 2.

Some of this has to do with how effective the patient's coping skills are (e.g. distraction and relaxation techniques) A patient for whom stoicism is very important, or who is afraid that advancing pain means advancing illness might not admit being in severe pain. Or, a patient might figure out that by rating his pain level fairly high, he is more likely to receive pain medication. Physicians should be aware of these feelings and behaviors and sensitive to the anxieties they signify.

How is HIV-related pain managed or treated?

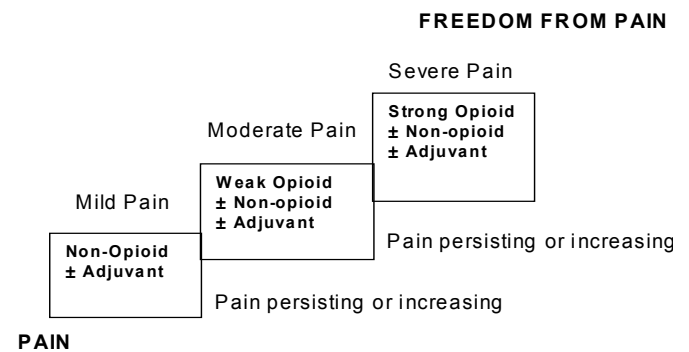
Although the best approach to treating pain in HIV/AIDS is multimodal (pharmacologic, psychotherapeutic, cognitive-behavioral, anesthetic, neurosurgical and rehabilitative approaches), analgesic pharmacotherapy is the first step and foundation in pain management.

When using medication to treat pain, clinicians should make the choice of analgesic based on severity and mechanism of pain. Opioids are the first choice of management of moderate to severe pain. NSAIDs, adjuvants, and nonpharmacologic modalities are important supplements to effective analgesia

When a patient is in chronic or persistent pain, physicians may prefer to use around-the-clock administration and long-acting opioids. Short-acting analgesics are useful for intermittent pain and as supplement for breakthrough pain.

The World Health Organizations provides recommendations for treating and managing pain in their analgesic ladder, below:

When pain is undertreated or poorly managed in people with HIV/AIDS, there may be serious negative consequences. A patient whose pain is not being attended to will lose trust in the doctor-patient alliance, and may have fear or anxiety that pain will not be adequately treated in the terminal phase. Pain is known to increase suicidal ideation



in patients struggling with those feelings. Careful and continuous pain assessment is critical in patients with HIV/AIDS, and complete pain management is crucial.

About this Fact Sheet. This fact sheet was written by Kerry Flynn Roy in collaboration with the APA Commission on AIDS. For more information contact American Psychiatric Association, Office of HIV Psychiatry, 1000 Wilson Blvd., Suite 1825, Arlington, VA 22209; phone: 703.907.8668; fax: 703.907.1089; or e-mail AIDS@psych.org. Visit our web site at www.psych.org/AIDS.