were non-Hispanic white patients. Results of one study showed that 57% of non-Hispanic white children, 64% of black children and 57% of Hispanic white children received some pain medication during the ED visit, whereas 37% of non-Hispanic white children, 25% of black children and 32% of Hispanic white children received opioid pain medication.10

Regional differences were also found. Patients in the South and the West received narcotics more often than children in the Northeast did, and children in the South received any analgesics more often than did their counterparts in the Northeast.10

A retrospective study looking at age, sex, race, mechanism of injury and fracture location found no statistical or clinically significant differences when these factors were compared between the analgesic and no-analgesic groups.11 This furthers the notion that race and ethnicity need more attention in the management of pain.

Discussion

Overall, the literature seems to indicate that pain in children who present to the ED with burns and long bone fractures is underassessed and undertreated. Assessment of pain level does not appear to be a routine part of many emergency departments’ history-taking protocol. At the most, 78% of older children received treatment while only 45% of younger children received treatment for displaced long bone fractures. Also it took about 86 minutes to receive analgesia for fractures and a mean time of 29 minutes for patients with burns. While this timing proves favorable, the majority of children were left untreated in this timeframe.

Statistically, a discrepancy appears to exist in the management of pain for different races and ethnicities, with 37% of non-Hispanic white children receiving opioid analgesics compared with 25% of black children and 32% of Hispanic white children. The bulk of pain in children who present to the ED with isolated painful injuries. Assessment of pain needs to be an early and critical part of all ED health care providers’ patient workup. A key factor to making this an effective part of management is to find a standard assessment method. To date, no one scale accurately or consistently measures pain in the pediatric population. Both the parents and the children need to be assessed as to the level of pain. No age is immune to pain, and emergency therapy can only improve in quality by recognizing that fact.

Results from one pediatric pain management study showed high analgesic use and high parental satisfaction and suggested that patient education may be a way to improve pain management. Simple explanation to patient and parents resulted in 96% of patients and parents being satisfied with the treatment.12 A little extra time at the bedside could save a lot of pain for the patient.

PAs can serve as the bridge between patient pain and fear and effective and timely treatment. As patient advocates, PAs have the personal skills and medical expertise to reduce pain. By making a point to assess pain in the initial examination, prolonged suffering can be eliminated.

The sooner pain is managed in the patient, the less anxiety he or she will experience during the ED visit. For a child, this could help make the experience less frightening.

These studies indicate the need for further research. EDs on a national scale could be reviewed for their management of pain in pediatric patients. Medications used, as well as the amount of time elapsed until administration of analgesics, could be recorded. More challenging will be research that attempts to find an effective tool to measure pain in children, since none exists. Data can then be used to develop a pain management protocol for pediatric patients presenting to the ED, if one is not already in existence.

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References