

Original Article

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Pain in People with HIV/AIDS: An Update

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Abstract

This review article addressed the emphasis on pain in people living with HIV/AIDS (PLWHA) through a literature overview. There was a high prevalence of pain in PLWHA, associated with psychiatric comorbidities and post-traumatic stress disorder, thus adversely impacting quality of life. Treatments including anti-retroviral therapy, analgesic therapy when provided along a multidimensional approach, together with alternative therapies would combat pain in PLWHA. The evidence presented in this study included assessment studies that reported about pain in PLWHA and treatments for pain in PLWHA. Despite the under-reporting of HIV/AIDS in palliative care literature, researchers and clinicians need to realize the under-estimation and under-treatment of pain in PLWHA along a multidisciplinary biopsychosocial model to improve their health-related quality of life.

Keywords: Palliative Immunology; Immuno-anesthesiology; Immuno-analgesia; HIV/AIDS.

This review article addressed the emphasis on pain in people living with HIV/AIDS (PLWHA) through a literature overview.

Prevalence

Nair et al [1] assessed the prevalence of pain in 140 HIV/AIDS patients and the type, site, severity, management of pain and impact of pain on quality of life in an ART centre. The following findings were reported; "About 66.7% in-patients and 24.5% out-patients complained of pain. Of the 52 patients who reported pain, 32% reported neuropathic pain and

68% reported noci-ceptive pain. Headache was most common followed by pain in the soles of feet and low back. Only 26.9% received any form of analgesic. Pain severity significantly affected the quality of life.

Prevalence, Intensity, Associated factors, and Effect

Namisangoet al [2] determined the prevalence, intensity, associated factors, and effect of pain among 302 adult ambulatory HIV/AIDS patients. The following results were reported; "Forty-seven percent reported pain in the 7 days prior to the survey and pain was a symptom at the time of diagnosis for 68%. 53% reported mild pain, 20% reported moderate pain while 27% reported severe pain. Gender was not associated with pain intensity, but reduced functional performance, increasing number of symptoms, advanced HIV disease, physical symptom distress (MSAS-SF), and number of health comorbidities were significantly associated with pain intensity. Increasing pain intensity was associated with greater functional ability impairment (BPI functional interference index) and poorer Quality of Life (QOL). Pain is a common symptom among ambulatory HIV/AIDS patients and has a debilitating effect on QOL".

Validity of Measures

Pappas et al [3] investigated the construct validity of measures of reported pain, pain control, symptoms and symptom control and had following findings; "The HIV persons who reported chronic illness were much more likely to report pain and symptoms compared to those not chronically ill. When controlling for the degrees of pain, pain control did not differ between the chronically ill and non-chronically ill.

Pain as a Symptom

Wahab and Salami [4] studied the frequency of pain as a symptom and determined the body regions often affected among a cohort of patients attending the antiretroviral (ARV) clinic in 79 respondents. The study had the following findings: "Pain was present in 22 (27.8%) of the respondents. The major regions affected by pain were lower limbs (40.9%), head and neck (31.8%), and abdomen (31.8%). Only 40% of those with moderate to severe pain intensity reported being on any form of analgesia".

Pain Experience

Laschinger and Fothergill-Bourbonnais [5] used a phenomenological design to explore the experience of pain caused by HIV from 21 men and 1 woman through open-ended interviews. "The phenomenon of pain was understood under four themes: physical pain, painful losses, the pain of not knowing, and social pain."

Pain in Women

Gray and Berger [6] explained that women experienced pain differently from men due to biological, psychological, and social factors. Knowledge of HIV-related pain into either nociceptive or neuropathic; prescribing concomitant medication or antidepressants, the weak public health infrastructure with its limited human resources and inadequate drug supplies are the issues that make high-quality palliative and end-of-life care virtually impossible.

Psychiatric Aspects

Douaihy et al [7] discussed the psychiatric components and their impact on pain in the HIV population. Psychological assessment issues, psychosocial barriers to treatment, and psychotherapeutic approaches need to be understood so that an integrated, flexible, and interdisciplinary team approach model could be implemented for treating HIV/AIDS-related pain.

Douaihy et al [8] discussed mood, anxiety, and substance abuse assessments; barriers to care; and psychiatric treatments in the context of HIV/AIDS-related pain and provided recommendations for an interdisciplinary comprehensive approach to managing pain in HIV disease.

Post-traumatic Stress Disorder (PTSD)

Smith et al [9] assessed the relationship of PTSD to pain intensity and pain-related interference in 145

HIV-infected persons suffering from persistent pain. "On average, participants reported being exposed to 6.3 different types of trauma over the course of their lifetime, of which receiving an HIV diagnosis was rated as being among the most stressful. Over half (53.8%) had features of PTSD and those with PTSD reported higher pain intensity and greater pain-related interference in performance of daily activities (i.e., working, sleeping, walking ability and general activity), and affect (i.e., mood, relations with other people, enjoyment of life) over time than those who did not.

Impact of Pain

Sibanda [10] examined studies on socioeconomic, cultural, political, and psychological factors determining high-risk sexual behaviors leading to heterosexual HIV infection in the African context. The author contended that "the focus of HIV/AIDS prevention programs should be on a myriad of socioeconomic, cultural, political, and behavioral factors instead of just on women and prostitutes—groups that have the least negotiating power within the context of sex and reproduction in a patriarchal society such as Zimbabwe."

Biopsychosocial Model

Marcus et al [11] reviewed the literature on pain in HIV/AIDS, including prevalence, pathophysiology, substance abuse, treatment issues, and psychosocial contributions and explained, "In light of the high prevalence of pain among individuals with HIV/AIDS, attention is paid to the negative psychosocial impacts of pain in this population and to psychosocial barriers to optimal HIV/AIDS-related pain treatment". The author conceptualized HIV/AIDS pain as chronic pain and subsequently, a biopsychosocial model of chronic pain assessment and treatment is applicable along a multidimensional framework.

Pain Management

O'Hara and Czarniecki [12] emphasized the need for improved understanding on pain in HIV-infected children and the need to overcome disease-related, pain-related and treatment-related myths so that effective analgesic prescription for children according to the World Health Organization guidelines on the use of analgesics according to a pain ladder.

Pharmacologic Management

Breitbart and McDonald [13] expressed concern over the underuse of opioid analgesics. The authors

suggested comprehensive measure of pain symptoms followed by a multifaceted program utilizing a combination of pharmacologic, psychotherapeutic, cognitive-behavioral, anesthetic, neurosurgical, and rehabilitative (physical interventions, such as bed rest, massage, ultrasound, and transcutaneous electrical nerve stimulation) approaches.

Drug Therapy

Harding et al [14] identified drug availability and prescribing practices in 12 sub-Saharan African countries and examined the barriers and potential facilitators for use of opioids and other drugs in their cross-sectional survey of facilities within ministries of health in 12 African countries. The study had following findings; "Of 62 responding facilities, problems were reported in accessing named nonopioids, with a small number of facilities unable to dispense them. Less than half the facilities were currently prescribing opioids of any strength. Further problems were identified in terms of the availability and supply continuity of named antiemetics and anxiolytics. The data identified a number of systemic problems, suggesting that opioid supply issues are similar to less controlled drugs, such as antiemetics. Among competent authorities, there was no agreement on whether further opioid expansion was possible. Integration of data from care facilities and competent authorities highlighted a disparity in the understanding of the availability of specific drugs, with competent authorities naming drugs that were not listed by any responding facility in their respective country".

Palliative Care

Coughlan [15] listed the barriers facing PLWHA for obtaining adequate pain relief and palliative care that include few care and support services, lack of recognition and acknowledgement of pain in HIV/AIDS by health care professionals, widespread stigma and discrimination especially towards vulnerable groups such as injecting drug users, government regulatory mechanisms which make access to opioids even more difficult for the care services which have developed and a lack of understanding of or advocacy for pain relief and palliative care in the literature on HIV/AIDS care and support.

Newshan and Sherman [16] explained the assessment and management of pain, fatigue and weakness, dyspnea and cough, anorexia and weight-loss, nausea and vomiting, sleep disorders, dry mouth, diarrhea, itching, and fever and night sweats.

Hypnosis

Langenfeldt et al [17] studied the effects of hypnosis-based pain management approach on AIDS-related pain symptoms in 5 adult patients using a A-B time-series analysis design. The study found that all 5 patients showed significant improvement on at least 1 of the 3 dependent variables as a result of the hypnotic intervention. Four of the 5 patients also reported less pain medication use during the treatment phase.

Competing Therapeutic Goals

Taylor [18] explained the utility of Un'anga (the traditional system of health and healing), as an alternative model for the diagnosis and management of illness. The author opined, "Through the use of highly charged symbols and ritualized communication, n'angas (traditional healers) seek to transform patients' understandings and experiences of HIV-related illness".

There was a high prevalence of pain in PLWHA, associated with psychiatric comorbidities and post-traumatic stress disorder, thus adversely impacting quality of life. Treatments including anti-retroviral therapy, analgesic therapy when provided along a multidimensional approach, together with alternative therapies would combat pain in PLWHA.

The evidence presented in this study included assessment studies that reported about pain in PLWHA and treatments for pain in PLWHA. Despite the under-reporting of HIV/AIDS in palliative care literature, researchers and clinicians need to realize the under-estimation and under-treatment of pain in PLWHA along a multidisciplinary biopsychosocial model to improve their health-related quality of life.

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