Assessment and management of pain in infants

P J Mathew, J L Mathew

Infants, including newborn babies, experience pain similarly and probably more intensely than older children and adults. They are also at risk of adverse long term effects on behaviour and development, through inadequate attention towards pain relief in early life. However, the issue of analgesia in young babies has been largely neglected in most clinical settings, despite subjecting them to painful diagnostic and therapeutic procedures. Several therapeutic and preventive strategies, including systemic and local pharmacological and non-pharmacological interventions, are reported to be effective in relieving pain in infants. A judicious application of these interventions, backed by awareness and sensitivity to pain perception, on the part of the caregivers is likely to yield the best results. This article is a review of the mechanisms of pain perception, objective assessment, and management strategies of pain in infants.

Perception of pain in infants

Infants perceive pain in the same way as adults. The receptors of nociceptive stimuli are free nerve endings that are widely distributed all over the body. They are maximally present in the superficial layers of the skin and internal tissues such as peristomeum, arterial walls, and joint surfaces. Mechanical, chemical, or thermal stimuli excite the nociceptors and electrical impulses are transmitted to the dorsal horn of the spinal cord through two sets of nerve fibres—namely, large myelinated A-delta (A-δ) fibres and slower conducting, non-myelinated C fibres. The spinothalamic pathway transmits the impulses to the thalamus where pain is perceived. Third order neurons terminating in the sensory cortex and basal areas of the brain probably influence the appreciation of the quality of pain and the affective component. The neuronal pathways are modulated by neurotransmitters that amplify or attenuate transmission. Similarly, affective and emotional components of the painful stimulus are modulated through past experience and memory.

The periaqueductal grey and periventricular mesencephalic regions serve as an inherent analgesic system. Signals from these regions are transmitted through nuclei in the pons and medulla, to the dorsal horn of the spinal cord, to block the sensation of pain. The neurotransmitters involved in the suppression of pain are endogenous opiates that include β-endorphin, met and leu encephalins, and dynorphin. Other neurotransmitters such as serotonin and gamma-aminobutyric acid (GABA) also decrease the sensation of pain. Figure 1 summarises the mechanisms of pain perception and suppression in the human body.

The anatomical, physiological, and biochemical prerequisites for pain perception are present by the early part of intrauterine life. Therefore, even preterm infants can perceive pain comparable to older children. In addition, newborn babies have a well developed endocrine system that is able to release cortisol and catecholamines in response to painful stresses, resulting in biochemical and physiological alterations that make it possible to objectively assess response to pain. Nevertheless, there are some basic differences in the neurophysiology of pain perception in infants. Nociceptive impulses in babies travel to the spinal cord through unmyelinated rather than myelinated fibres, and there is also a relative paucity of inhibitory neurotransmitters in them. Babies also have larger receptive fields and possibly a higher concentration of substance P receptors. These factors are believed to make infants feel pain more severely than older persons.

Assessment of pain

Although self reporting of pain is the gold standard for assessment of the site, nature, and severity of pain, it is not precisely applicable in children below 3 years of age. Hence in infants, surrogate markers are used. Pain is associated with physiological, biochemical, behavioural, and psychological alterations that can be recorded and to some extent

Abbreviations: GABA, gamma-aminobutyric acid; NSAIDs, non-steroidal anti-inflammatory drugs
In order to introduce objectivity in the assessment of infant pain, various pain scales have been designed and validated. These are based either on physiological variations, behavioural changes, or a combination of both. A detailed description of these scoring systems is beyond the scope of this article. Box 3 lists some of the commonly used systems. While all these methods of pain assessment are exciting for accurate measurement in research settings, it must be emphasised that highly sensitive techniques may not always be necessary for effective management of pain. The mainstays of appropriate management include the physician’s awareness of infant pain, appreciation of situations wherein pain occurs, sensitivity to the need for controlling pain, and a generous measure of common sense.

Although the physiological and behavioural responses are very sensitive indicators of pain, they have poor specificity; and can occur with apprehension, stress related to disease, and discomfort. The responses may also be altered by the physiological state of the baby immediately preceding the painful stimulus, such as the stage of wakefulness, duration since last feed, restraint techniques used, etc. Despite these pitfalls, assessment of behavioural and physiological responses remains the most readily available, reliable, and feasible method of assessing pain in infants.

**CLINICAL SETTINGS FOR PAIN IN NEONATES AND INFANTS**

The clinical settings for pain in infants are extremely varied. They include painful disease conditions—both acute and chronic—as well as diagnostic and therapeutic procedures performed for the treatment of these conditions. It must be emphasised that procedures need not always be invasive in order to cause pain. Even simple actions such as removal of sticking tapes, limb compression during restraint, postural changes during ventilation, and physiotherapy manoeuvres can be intensely painful. Table 2 is a partial list of some of the situations wherein infants experience pain.
CONSEQUENCES OF PAIN

Pain is a dynamic experience that is often beneficial by warning of impending or actual injury, thereby preventing or restricting tissue damage. However, barring this aspect, pain has only damaging effects in terms of metabolic and behavioural responses induced by it. Box 4 lists some of the adverse effects on infant pain. In the long term, memory of painful experiences has effects on subsequent pain perception and response. The classical studies that demonstrated differences in response to vaccination among infants who underwent circumcision without anaesthesia and those who received anaesthesia, testify to this.19 20 It is believed that learning about pain starts with the first painful experience and it may have effects on subsequent pain perception and response. There is also some evidence that neonatal pain experience may have far reaching effects even up to the preschool age21 22 and beyond.23 Multiple influences, including infant factors as well as characteristics of the caregivers, together contribute to such events in development.8

From the point of view of those caring for neonates and infants, pain has two important deleterious consequences. The first is the mistrust and fear towards the caregiver, generated by failure to prevent or relieve pain. Secondly, inadequate analgesia for initial procedures can decrease the effect of adequate analgesic doses in subsequent procedures.

MANAGEMENT

The management of infant pain rests primarily on the tripod of (a) awareness of infants’ capacity to perceive pain, (b) sensitivity towards clinical situations wherein pain may be encountered, and (c) appropriate steps to prevent and treat pain. In this context, it is interesting that even in tertiary care centres, there is a wide variation in strategies for pain management, ranging from the absolute absence of use of pain assessment techniques24 to protocols wherein doses, regimens and routes of administration are not standardised.25 Box 5 reflects the basis of infant pain management.

Pharmacological interventions

Systemic administration of drugs

The opioids, including morphine, methadone, oxymorphone, codeine, fentanyl, alfentanil, and sufentanil are the most potent class of analgesic drugs. They have the added advantage of this group is that in the event of over dosage, the effects are easily reversed. However, these drugs have the potential for tolerance and dependence, the long term effects of which have not been studied in babies.32 They also have a

Table 1 Responses of infants to pain

<table>
<thead>
<tr>
<th>Physiological changes</th>
<th>Behavioural changes</th>
<th>Biochemical changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in:</td>
<td>Change in facial expression</td>
<td>Increased release of:</td>
</tr>
<tr>
<td>Heart rate</td>
<td>Grimacing</td>
<td>Cortisol</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Screwing up of eyes</td>
<td>Catecholamines</td>
</tr>
<tr>
<td>Respiratory rate</td>
<td>Nasal flaring</td>
<td>Glucagon</td>
</tr>
<tr>
<td>Oxygen consumption</td>
<td>Deep nasolabial groove</td>
<td>Growth hormone</td>
</tr>
<tr>
<td>Mean airway pressure</td>
<td>Curving of the tongue</td>
<td>Renin</td>
</tr>
<tr>
<td>Muscle tone</td>
<td>Quivering of the chin</td>
<td>Aldosterone</td>
</tr>
<tr>
<td>Intracranial pressure</td>
<td></td>
<td>Antidiuretic hormone</td>
</tr>
</tbody>
</table>

Autonomic changes:10 11
- Mydriasis
- Sweating
- Flushing
- Pallor

Body movements:12 13
- Finger clenching
- Thrashing of limbs
- Writhing
- Arching of back
- Head banging

Decreased secretion of:
- Insulin

Box 2: Case study

An 18 month male baby with a diagnosis of Guillain-Barré syndrome was mechanically ventilated for neuromuscular paralysis in the intensive care unit of a teaching hospital. Intubation was performed under cover of 0.01 mg/kg intravenous midazolam. He was also being given bolus doses of 0.01 mg/kg morphine intravenously every six hours. Despite respiratory stabilisation and normal arterial blood gas analysis, the baby had persistent tachycardia, borderline hypertension, excessive sweating, and marked restlessness. These findings were interpreted as autonomic instability associated with the primary clinical condition. Propranolol in the dose of 1 mg/kg every eight hours was started; the blood pressure showed a slight decline, but the other features of sympathetic overactivity did not subside. On the advice of one of the authors, morphine bolus doses and were replaced by infusion of 0.01 mg/kg/hour, which led to resolution of the symptoms and the omission of propranolol.

The case study highlights the importance of:
- Being sensitive to infants’ perception of pain.
- Recognition of infants’ responses to pain, which may be misinterpreted.
- Benefit of continuous infusion of morphine over intermittent bolus doses to relive infant pain.15

Box 3: Pain assessment scales in infants

Based on behavioural changes
- Neonatal Facial Coding System (NFCS).
- Infant Body Coding System (IBCS).
- Neonatal Infant Pain Scale (NIPS).
- Pain assessment in Neonates (PAIN).
- Liverpool Infant Distress Scale (LIDS).
- Modified Behavioural Pain Scale.
- Children’s Hospital of Eastern Ontario Pain Scale (CHEOPS).
- Neonatal Assessment of Pain Inventory (NAPI).
- Behavioural pain score.
- Clinical scoring system.

Combination of physiological and behavioural changes
- CRIES (acronym for crying, change in transcutaneous oxygen saturation, heart rate, blood pressure, facial expression and alteration in sleep pattern).
- Pain Assessment Tool (PAT).
- Premature Infant Pain Profile (PIPP).
- Scale for Use in Newborns (SUN).
- COMFORT Score.
variable half life period that often depends on the gestational age; hence dose and frequency of administration must be titrated against clinical effects. Although there is plenty of scientific evidence to support the use of opioid drugs in infants, the risk of adverse effects, particularly of respiratory and central nervous system depression, often hampers the rational use of these agents, especially in young babies. These effects can be reduced by modifying the route and method of administration as well as meticulous monitoring.

Non-steroidal anti-inflammatory drugs (NSAIDs) are generally used to treat pain of lesser intensity and as an adjunct to the risk of adverse effects, particularly of respiratory and central nervous system depression. They are often hampers the rational use of these agents, especially in young babies. These effects can be reduced by modifying the route and method of administration as well as meticulous monitoring. 

Non-steroidal anti-inflammatory drugs (NSAIDs) are generally used to treat pain of lesser intensity and as an adjunct to the pain of infants. They are often hampers the rational use of these agents, especially in young babies. These effects can be reduced by modifying the route and method of administration as well as meticulous monitoring.

Before any analgesic or anaesthetic drug is systematically administered to infants, the pharmacokinetic and pharmacodynamic properties of the drug must be studied. This is because most of these drugs are handled differently in babies compared with adults. In addition, the clinical status of the baby with special reference to drug metabolism and excreting capacity must be thoroughly understood. Young babies, especially those who are premature and of very low birth weight, have immature drug handling capabilities that necessitate reduction in dosage or increasing the interval between doses. Another aspect that must be looked into before administration of these agents is the type of medication the baby is already receiving for the clinical condition, so that undesirable interactions do not occur.

### Local techniques

Local anaesthetic agents block the transmission of impulses from receptors to the spinal cord. Theoretically speaking, they can be administered in any one of three ways—infiltration into the local area, nerve blockade, or intravenous regional block. The latter two methods demand a high degree of technical expertise and may not be feasible during routine diagnostic and therapeutic procedures. The safety and efficacy of infiltration of local anaesthetic drugs have been well documented for short surgical procedures such as circumcision and diagnostic procedures like bone marrow aspiration, biopsies, etc. Nevertheless, they are not widely used, for two major reasons. The first is the real or supposed risk of side effects of local anaesthetic, which includes anaphylaxis, hypotension, and other less serious effects. This is a risk that has to be taken into account. However, the more common reason probably is the temptation on the part of the physician to perform a “quick in, quick out” procedure and “spare” the baby the pain of two needle pricks. Such an attitude must be vigorously discouraged, particularly as the pain of local anaesthetic infiltration can be substantially minimised or even obviated by using narrowest available needles for infiltration, neutralising the pH of the local anaesthetic, warming the drug to body temperature before use, and injecting as slowly as possible. It is also recommended to infiltrate the subcutaneous space before raising a wheal, as epidermal stretching is very painful.

The various local anaesthetic agents used are lignocaine, available as injectable, spray and gel preparations, bupivacaine, amethocaine gel, and ropivacaine. Mixing the local anaesthetic with adrenaline increases the duration of action; however this must never be used in regions supplied by end arteries such as the penis, fingers, and toes. Local anaesthetic

### Table 2: Clinical settings wherein infants experience pain (a partial list)

<table>
<thead>
<tr>
<th>Disease conditions</th>
<th>Diagnostic procedures</th>
<th>Therapeutic procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Otitis media</td>
<td>Heel puncture</td>
<td>Intravenous cannulation</td>
</tr>
<tr>
<td>Pharyngitis and oral infections</td>
<td>Venous and arterial puncture</td>
<td>Intramuscular injection</td>
</tr>
<tr>
<td>Aphthous ulcers</td>
<td>Suprapubic bladder puncture</td>
<td>Umbilical catheterisation</td>
</tr>
<tr>
<td>Chest pain associated with coughing</td>
<td>Lumbar puncture</td>
<td>Insertion or removal of infant feeding tube</td>
</tr>
<tr>
<td>Infantile colic</td>
<td>Ventricular puncture</td>
<td>Urinary bladder catheterisation</td>
</tr>
<tr>
<td>Headache due a variety of causes</td>
<td>Endotracheal suction</td>
<td>Endotracheal intubation and suction</td>
</tr>
<tr>
<td>Injury due to trauma</td>
<td>Bronchoscopy</td>
<td>Circumcision</td>
</tr>
<tr>
<td>Hydrocephalus</td>
<td>Paracentesis thoracis</td>
<td>Wound dressing</td>
</tr>
<tr>
<td>Intracranial bleeding</td>
<td>Ascitic fluid aspiration</td>
<td>Incision and drainage procedures</td>
</tr>
<tr>
<td>Necrotising enterocolitis</td>
<td>Gastrointestinal endoscopy</td>
<td>Postoperative state</td>
</tr>
<tr>
<td>Intestinal obstruction</td>
<td>Cystoscopy</td>
<td>Insertion/removal of drainage tubes</td>
</tr>
<tr>
<td>Spasticity</td>
<td></td>
<td>Endoscopic sclerotherapy</td>
</tr>
<tr>
<td>Thrombophlebitis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In addition, the clinical status of the baby with special reference to drug metabolism and excreting capacity must be thoroughly understood. Young babies, especially those who are premature and of very low birth weight, have immature drug handling capabilities that necessitate reduction in dosage or increasing the interval between doses. Another aspect that must be looked into before administration of these agents is the type of medication the baby is already receiving for the clinical condition, so that undesirable interactions do not occur.

### Local techniques

Local anaesthetic agents block the transmission of impulses from receptors to the spinal cord. Theoretically speaking, they can be administered in any one of three ways—infiltration into the local area, nerve blockade, or intravenous regional block. The latter two methods demand a high degree of technical expertise and may not be feasible during routine diagnostic and therapeutic procedures. The safety and efficacy of infiltration of local anaesthetic drugs have been well documented for short surgical procedures such as circumcision and diagnostic procedures like bone marrow aspiration, biopsies, etc. Nevertheless, they are not widely used, for two major reasons. The first is the real or supposed risk of side effects of local anaesthetic, which includes anaphylaxis, hypotension, and other less serious effects. This is a risk that has to be taken into account. However, the more common reason probably is the temptation on the part of the physician to perform a “quick in, quick out” procedure and “spare” the baby the pain of two needle pricks. Such an attitude must be vigorously discouraged, particularly as the pain of local anaesthetic infiltration can be substantially minimised or even obviated by using narrowest available needles for infiltration, neutralising the pH of the local anaesthetic, warming the drug to body temperature before use, and injecting as slowly as possible. It is also recommended to infiltrate the subcutaneous space before raising a wheal, as epidermal stretching is very painful.

The various local anaesthetic agents used are lignocaine, available as injectable, spray and gel preparations, bupivacaine, amethocaine gel, and ropivacaine. Mixing the local anaesthetic with adrenaline increases the duration of action; however this must never be used in regions supplied by end arteries such as the penis, fingers, and toes. Local anaesthetic
agents are regarded as having a relatively poor safety margin, and hence resuscitation equipment should be available before use. A eutectic mixture of 2.5% lignocaine and 2.5% prilocaine, designated EMLA (eutectic mixture of local anaesthetics) is becoming increasingly popular. The eutectic combination is a mixture of the two local anaesthetic drugs in a 1:1 weight ratio, whereby the crystalline powders melt at a lower temperature than they do separately, hence they constitute a liquid at room temperature. This combination increases the concentration of the drugs in the emulsion droplets and is more effective than using both drugs together. Applied about 60 minutes before the intended procedure, it penetrates up to a depth of 5–10 mm, providing good anaesthesia for several minutes. The penetration can be increased by applying occlusive dressings onto the smeared surface. However, EMLA must not be used on abraded skin surfaces or mucous membranes. The major drawbacks of EMLA are vasoconstriction and risk of methaemoglobinaemia. A mixture of tetracaine, amethocaine, and cocaine abbreviated as TAC, is another popular local anaesthetic in some parts of the world.

Adjunctive drugs

These are drugs with little analgesic or anaesthetic effect, but useful as adjuncts with analgesics, by virtue of their sedative and/or hypnotic properties. However, they are not replacements for analgesics. In fact, they can suppress some of the behavioural responses associated with pain, thereby interfering with assessment and appropriate management. With appropriate monitoring of heart rate, respiratory rate and transcutaneous oxygen saturation, these agents can be safely and efficaciously used to advantage.

Non-pharmacological interventions

These are interventions that enhance activity in descending inhibitory systems and thereby decrease pain perception. Attenuation of transmission of impulses to the spinal cord can be achieved by stimulation of large sensory nerve fibres mediating sensations of touch and heat/cold. The non-pharmacological interventions may also modulate pain sensation and response to pain through changes in attention and decreasing apprehension. Some of the strategies are listed in box 6. It must be re-emphasised that non-pharmacological interventions practised in isolation are unlikely to relieve pain. They are more useful as complementary strategies to pharmacological methods of relieving acute pain.

The non-pharmacological interventions have the allure of being easy to administer and require no intensive monitoring. Although there are no adverse effects reported with their use, a recently published double blind, randomised, controlled trial has noted that the repeated use of sucrose analgesia in infants less than 31 weeks’ gestation may put them at risk for poorer neurobehavioural development and physiological outcomes in later weeks of life.

**Box 6: Non-pharmacological interventions to relieve infant pain**

- Positioning and restraining the infant in a relatively flexed posture.
- Stimulation of nerve fibres transmitting tactile and thermal sensations.
- Combining these methods with soothing vocal stimulation.
- Breast feeding.
- Feeding of sweet compounds such as sucrose, glucose, saccharine.
- Non-nutritive sucking on pacifiers.

**Modification of techniques**

The basic principle behind modifying operational techniques is to reduce the incidence and frequency of stimuli that may be perceived as noxious. This encompasses minimal handling of sick babies, avoiding sampling and painful procedures during sleep cycles, not sticking adhesive tapes onto hair, moistening tapes before removal, reducing harsh noise and light in treatment areas, and controlling thermal stress.

Often, a change in procedural practice may help in reducing pain of neonates and infants. For example, infants show significantly fewer signs of pain during heel puncture with the use of mechanical lancets as opposed to manual lancets. Similarly, venous puncture for blood sampling is reportedly less painful than heel puncture. One may also consider insertion of central venous catheters in babies requiring frequent blood sampling or intravenous medications, as against repeated venous and heel punctures. Naturally, such an option must be weighed in the light of expected duration of cannulation and risks of infection and thrombosis. However, there are data showing that infection rate in centrally cannulated babies is not higher than in those undergoing multiple punctures. In neonatal circumcisions, use of the Mogen clamp is preferred to the Gomco clamp because it is associated with less pain.

**CHRONIC PAIN**

There are certain conditions that result in pain over prolonged periods, either as repeated short episodes or as a continuous phenomenon. A frequently encountered situation is the infant with a malignant condition. In such situations, the goals of pain relief are to provide maximum comfort for prolonged periods of time. Hence analgesics and anaesthetic agents with a long duration of action but few systemic side effects are desired. Butamben is a local anaesthetic agent that can produce sensory blockade for several months when injected epidurally. Its added advantage is the sparing of motor neurones, though this aspect is controversial at present. An alternate method of increasing the duration of anaesthetic activity may be to use slow release preparations of local anaesthetic. There is some progress towards preparation of liposomess and sustained release microspheres containing local anaesthetic. Another option may be to consider nerve blocks.56 Alternatively, one may consider nerve blocks used in conjunction with ketamine, which is a dissociative anaesthetic that can be administered intramuscularly or epidurally. It is a non-opioid analgesic and hence useful in children who are not to be treated with opioids.57 The intrathecal route is also under consideration.

The World Health Organisation has suggested a protocol of a four step graded approach to pain management in cancer. This involves starting with non-opioid analgesics, then using opioids orally, followed by parenteral use of potent opioids, and lastly more invasive treatment such as intrathecal or epidural administration of drugs, nerve blockade, etc. It is the opinion of some experts that such treatment is likely to be inferior to using a multipronged attack in the management of chronic pain.

**PRE-EMPTIVE ANALGESIA—PREVENTION IS BETTER THAN CURE**

The general tendency among those caring for young babies is to treat pain after it has occurred. However, prevention being better than cure, it is appropriate to administer appropriate dosages of analgesics with or without sedatives whenever pain is anticipated in babies. Such an approach is not only more humane, reducing the distress of infants, their parents and caregivers, but it also has the added benefit of making management of the child’s clinical condition as well as diagnostic or therapeutic procedures easier to perform.

**CONCLUSION—PAIN IN PERSPECTIVE**

The physician caring for neonates and infants has to be sensitive to the fact that babies perceive pain as much as adults,
although their expression of this may be subject to misinterpre-
tation. Pain experience in young babies may have far reaching
csequences not only in the short term, but in the long term as well.
Appropriate assessment and management of pain is not only good
cclinical practice, but is also necessary to prevent adverse effects in
sick babies. There is a wide vari-
ey of therapeutic approaches to choose from; and the ideal
may be to use a combination strategy. It may also be worth-
to develop institutional protocols for the specific purpose of pain management in infants.

Authors’ affiliations
P J Mathew, Department of Anaesthesia and Critical Care, All India
Institute of Medical Sciences, New Delhi, India
J L Mathew, Department of Pediatrics, Postgraduate Institute of Medical
Education and Research, Chandigarh, India

REFERENCES
definitions and notes on usage. Recommended by the ISAP
3. Anand KJ, Sippell WG, Aynsley-Green A. Randomized trial of fentanyl
anesthesia in preterm neonates undergoing surgery: effects on the stress
cortisol and beta-endorphin response to intrauterine needling. Lancet
6. Fitzgerald M, McIntosh N. Pain and analgesia in the newborn. Arch Dis
8. Fitzgerald M, Beggs S. The neurobiology of pain: developmental
9. Larsson BA. Pain and pain relief during the neonatal period. Early pain
experiences can result in negative late effects. Jarkantniden
10. Anand KJS, Carr DB. The neuroanatomy, neurophysiology and
neurochemistry of pain, stress and analgesia in newborns and children.
12. Grunau RVE, Craig KD. Pain expression in neonates: facial action and
postoperative infants: intermittent bolus dosing versus targeted continuous
15. Craig KD. The facial display of pain in infants and children. Pain
pain in the hospitalized infant. J Obster Gynecol Neonatal Nurs
17. Stevens B, Johnson CC, Horton L. Factors that influence the behavioral
18. Wiltsen H, Annika P. Analgesic efficacy of tramadol 2 mg kg\(^{-1}\) for
ketamine, alfentanil and ketamine plus alfentanil administration for
multidisciplinary protocol for neonatal circumcision pain management. J
21. Jain A, Rutter N. Local anesthetic effect of topical amethocaine gel in
neonates: randomized controlled trial. Arch Dis Child Fetal Neonatal Ed
967–70.
23. Mantzkes US, Bramblik AM. Paracetamol in childhood. Current state of
knowledge and indications for a rational approach to postoperative
24. Bolton P, Bridge HS, Montgomery CJ, et al. The analgesic efficacy of
preoperative high dose [40 mg kg\(^{-1}\)] oral acetaminophen after
bilateral myringotomy and tube insertion in children. Paediatr Anaesth
25. Gradin M. Need for a reliable pain evaluation scale in the newborn in
Neonatologists. Pain management in French neonatal intensive care units.
27. Taddia A. Opioid analgesia for infants in the neonatal intensive care
non-pharmacologic comfort measure for pain in preterm infants. J Obster
feeding in term neonates: randomised controlled trial. BMJ
32. Ramenghi L, Evans, Leevene ML. Sucrose analgesia: absorptive
mechanism or taste perception? Arch Dis Child Fetal Neonatal Ed
33. Noerr B. Sucrose for neonatal procedural pain. Neonatal Network
efficacy of glucose and pacifier in very preterm neonates during
35. Deshmukh LS, Udani RH. Analgesic effect of oral glucose in preterm
infants during venipuncture—a double-blind, randomized, controlled trial. J
procedural pain relief in preterm and term neonates. Nurs Res
2002;51:375–82.
37. Pinelli J, Symington A, Ciliska D. Nonnutritive sucking in high-risk
infants: benign intervention or legitimate therapy? J Obster Gynecol
the first week of life in neonates younger than 31 weeks’
39. McIntosh N, van Weel L, Bрамeуer H. Allievation of the pain of heel
prick in preterm infants. Arch Dis Child Fetal Neonatal Ed 1994;70:
F177–81.
40. Harkin VA, Rutter N. Making heel pricks less painful. Arch Dis Child
41. Larsson BA, Tannfeldt G, Lagercrannik H, et al. Venepuncture is more
effective and less painful than heel lancing for blood tests in neonates.
42. Taddia A. Pain management for neonatal circumcision. Paediatr Drugs
43. Fewtrall MS, Sapsford DJ, Herrick MJ, et al. Continuous axillary nerve
44. Aram L, Krane EJ, Kozloski LJ, et al. Tunnelled epidural catheters for
prolonged analgesia in pediatric patients. Anesth Analg 2001;92:
1432–8.
45. Tobias JD. Applications of intrathecal catheters in children. Paediatr
46. Schechter NL, Blankson V, Pachter LM, et al. The oclusell place: no
47. Kost-Beyer S. New concepts in acute and extended postoperative pain
115–35.