When the solution is not on the tip but under the tongue

Erika Poggiali,[1] Lorenzo Ghiadoni,[2] Sossio Serra[3]

[1]Emergency Department, Guglielmo da Saliceto Hospital, Piacenza; [2]Department of Clinical and Experimental Medicine, University of Pisa, Pisa; [3]Emergency Department, Maurizio Bufalini Hospital, Cesena, Italy

In the recent letter by Pucciarelli *et al*.,[1] the authors comment on an observation reported by Fabbri *et al*.[2] that the pain is treated correctly only in a very small percentage of patients (3%), even those who experienced severe pain, suggesting as a possible solution of this important unsolved issue the introduction (implementation) of sublingual sufentanil use for pain treatment of trauma patients in the pre-hospital setting. As reported by Janati *et al*.,[3] pain management remains a challenge for many emergency clinicians for several reasons, which can be summarized in the lack of knowledge about the available pain control medications and opioid dosages, of experience with the drug's use in the emergency department (ED) and pre-hospital settings, and proper supervision by the senior residents along with clinician's fear regarding the drug's side effects. By the Italian Law 38/2010 all Italian citizens, including adults and children, have the right to access palliative care and antalgic centers in case of either oncologic or non-oncologic pain.[4] This law represents in a single phrase "the right of not suffering", thus incorporating and formalizing the provisions of the Charter of Rights on unnecessary pain brought by the Tribunal for Patients' Rights in 2005 and leading to a crucial "cultural transformation" for pain management by fostering the dignity and autonomy of the patient in the process of care. Accordingly, we have a problem with effective pain management if only 3% of patients with pain, including 77% of those with severe pain, received the right treatment in the emergency setting. It is well known that inappropriate pain management can cause acute and chronic consequences, which include dysregulation of the neuroendocrine system with increased blood pressure and heart rate, the development of coagulation disorders, pulmonary edema, and heart attack, psychological consequences, such as anxiety, insomnia, depression, and social isolation, which are common causes for referral to the ED, and of increased costs for the health system.[5-7] As a result, we must support educational interventions, including mandatory training for medical and nursing staff to treat pain correctly and appropriately in all emergency settings, both ED and pre-hospital. In 2020, the EUSEM Guidelines for the Management of Acute Pain in Emergency Situations stated that no more than 20–25 minutes should elapse from the initial assessment to the provision of pain relief (if appropriate).[8] Working in an emergency setting, it is evident that inserting an intravenous (IV) access is frequently unpleasant, time-consuming, and, in some cases, limited. On the other hand, oral drugs start to act slowly and take time to achieve their effect, whereas intramuscular treatments have a harsh, unpredictable onset.[9] Thus, the development of non-parenterally delivered analgesics with faster onsets as an alternative to the IV route is a potentially effective technique for ensuring earlier analgesia. Intranasal fentanyl[10] and inhaled methoxyflurane[11] are two valid alternatives for pain management, both in ED and pre-hospital settings, as they are simple to administer, quick, and effective, making analgesia more efficacious and faster. Sublingual sufentanil can also be a new excellent tool to achieve the goal of rapid and effective analgesia without resorting to the venous route, due to its characteristics such as ease of administration, high potency, and extended duration of action. A single 30 mcg dose dissolves sublingually within 5 min and showed an average bioavailability of 52% with plasma concentrations reaching therapeutic levels within 30 min, peaking by hour 1, and decreased below therapeutic levels by hour 3.[12] A multicenter study of 76 patients presenting to the ED with moderate-to-severe pain secondary to trauma showed that a single-dose sublingual sufentanil 30 mcg was effective at significantly improving pain scores within 15 min and maintaining adequate analgesia at 2 hours without significant adverse events.[13] In addition, the lack of requirement for IV placement, the easy administration route, and the faster analgesic onset of sublingual sufentanil when compared to IV opioids make it a reasonable alternative to IV opioids in the ED setting.[13]

Another strategy to ensure early analgesia is certainly the development of nurse-guided analgesia protocols, which have been proven to be safe and effective in both ED and pre-hospital

Correspondence: Erika Poggiali, Emergency Department, "Guglielmo da Saliceto" Hospital, Via Giuseppe Taverna 49, Piacenza, Italy.
Tel.: +39.0523.303044
E-mail: E.Poggiali@ausl.pc.it

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settings, although to date some legal restrictions limit their use to only certain medications in Italy.[13] As reported in the study by Viglino *et al*., a nurse-directed protocol for multimodal analgesia combining inhaled methoxyflurane, paracetamol, and an oral opioid, initiated on admission to the ED, effectively reduces pain in patients with non-severe trauma within the first 15 min.[14] Based on these observations, sublingual sufentanil could be used in the emergency setting by the nursing staff, having a safe side-effect profile and low risk of respiratory depression.[15]

For this reason, we appreciated the authors' effort to promote sublingual sufentanil in the pre-hospital setting as the right choice for moderate/severe pain in trauma patients.[1]

Adequate management of pain is a moral and ethical imperative for emergency clinicians and nurses.[16,17] Treating pain as soon as possible, avoiding delays, and using the right medication for each patient according to the work setting should be a duty and the primary endpoint for all emergency personnel, both medical and nursing. To achieve this goal, we must all work together using standardized protocols to avoid under- and over-treatment, particularly in the pre-hospital setting, and encourage the direct role of nurses in administering therapies, ideally promoting the creation of a national network to spread the culture of pain management to "leave no one — *doctors, nurses, patients* — behind", quoting a powerful UNESCO slogan.[18]

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