

SECTION: PM-8

PROTOCOL TITLE: PEDIATRIC PAIN CONTROL AND SEDATION

REVISED: January 28, 2010

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**GENERAL COMMENTS:** This Protocol supplements Protocol M-12 (Adult Pain Control and Sedation).

**BLS SPECIFIC CARE:** See General Pediatric Care Protocol PM-1

- Splint fractures as necessary
- Ice packs as necessary for swelling
- Determine patient's color category on length based resuscitation tape (Broselow Tape)

**ILS SPECIFIC CARE:** See General Pediatric Care Protocol PM-1

**ALS SPECIFIC CARE:** See General Pediatric Care Protocol PM-1

*Analgesia*

- Morphine Sulfate
  - IV/IM/IO: 0.1-0.2 mg/kg repeated every 5-10 min. PRN to a max of 15 mg
- Fentanyl Citrate (Sublimaze)
  - IV/IO/IM: 2-3 mcg/kg IVP every 5-10 min
  - Repeat to a max of 100 mcg

*Sedation for painful procedures and injuries*

- Midazolam (Versed)
  - IV/IM: 0.05-0.1 mg/kg every 5-10 min (over 2-5 minutes if IV). Maximum dose of 2.5 mg
- Diazepam (Valium)
  - IV/IO: 0.2-0.3 mg/kg every 5-10 min PRN.
  - Max of 10 mg

*Spasm*

- Midazolam (Versed)
  - IV: 0.1 mg/kg every 5-10 min (over 2-5 minutes if IV) Maximum dose of 2.5 mg
- Diazepam (Valium)
  - IV: 0.2-0.3 mg/kg every 5-10 min PRN to a max of 10 mg

# Protocol PM-8

## PED PAIN CONTROL AND SEDATION

*Adjunctive medications:* These medications are given for potentiation of other medications or for the prevention/treatment of certain side effects (nausea, EPS, etc) of medications used in pain control or sedation.

*Anti-emetics*

For nausea and vomiting associated with analgesic administration.

- Zofran (ondansetron) IV/IM/IO
  - 0.1 mg/kg to a maximum of 4 mg
- Benadryl (diphenhydramine) IV/IM/IO
  - 1 mg/kg to a maximum of 25 mg

**PHYSICIAN PEARLS:**

Providers at all levels should take a multi-faceted approach to pain control and sedation.

Assessment should be on the 0 → 10 scale when ever possible, using OPQRST as an assessment tool, to provide a quantitative level of discomfort and allow accurate documentation.

ALS Providers may decrease the dosage of any medication with sedative properties when doing so would decrease adverse effects and still potentially obtain a clinical goal.

Narcotic analgesia used to be considered contraindicated in the prehospital setting for abdominal pain of unknown etiology. It was thought that analgesia would hinder the ER physician or surgeon's evaluation of abdominal pain. It is now becoming widely recognized that severe pain actually confounds physical assessment of the abdomen and that narcotic analgesia rarely diminishes all of the pain related to the abdominal pathology. It would seem to be both prudent & humane to "take the edge off of the pain" in this situation, with the goal of reducing, not necessarily eliminating the discomfort. Additionally, in the practice of modern medicine the exact diagnosis of the etiology of abdominal pain is rarely made on physical examination alone, but also includes laboratory tests, x-ray, ultrasound, and CT scan as essential elements in the diagnosis of abdominal pain. Therefore providing analgesia for abdominal pain is both humane and appropriate medical care.

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