

Sickle cell disease: managing acute painful episodes in hospital

Clinical guideline

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[nice.org.uk/guidance/cg143](https://www.nice.org.uk/guidance/cg143)

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This guideline is the basis of QS58.

Introduction

Acute painful sickle cell episodes

Sickle cell disease is the name given to a group of lifelong inherited conditions of haemoglobin formation. Most people affected are of African or African-Caribbean origin, although the sickle gene is found in all ethnic groups. Sickle cell disease can have a significant impact on morbidity and mortality.

It is estimated that there are between 12,500 and 15,000 people with sickle cell disease in the UK. The prevalence of the disease is increasing because of immigration into the UK and new births. The [NHS Sickle Cell and Thalassaemia Screening Programme](#) also means that more cases are being diagnosed.

Acute painful sickle cell episodes (also known as painful crises) are caused by blockage of the small blood vessels. The red blood cells in people with sickle cell disease behave differently under a variety of conditions, including dehydration, low oxygen levels and elevated temperature. Changes in any of these conditions may cause the cells to block small blood vessels and cause tissue infarction. Repeated episodes may result in organ damage.

Acute painful sickle cell episodes occur unpredictably, often without clear precipitating factors. Their frequency may vary from less than one episode a year to severe pain at least once a week. Pain can fluctuate in both intensity and duration, and may be excruciating. The majority of painful episodes are managed at home, with patients usually seeking hospital care only if the pain is uncontrolled or they have no access to analgesia. Patients who require admission may remain in hospital for several days. The primary goal in the management of an acute painful sickle cell episode is to achieve effective pain control both promptly and safely.

The management of acute painful sickle cell episodes for patients presenting at hospital is variable throughout the UK, and this is a frequent source of complaints from patients. Common problems include unacceptable delays in receiving analgesia, insufficient or excessive doses, inappropriate analgesia, and stigmatising the patient as drug seeking.

This guideline addresses the management of an acute painful sickle cell episode in patients presenting to hospital until discharge. This includes the use of pharmacological and non-pharmacological interventions, identifying the signs and symptoms of acute complications, skills and settings for managing an acute painful episode, and the information and support needs of patients.

This is an overarching guideline covering the principles of how to manage an acute painful sickle cell episode in hospital. Local protocols should be referred to for specific management plans, including drug choice and dosages. This guideline includes the management of acute painful sickle cell episodes in children and young people and in pregnant women. The guideline recommendations apply to all patients presenting with an acute painful sickle episode unless there are differences in management for these groups, in which case these are clearly outlined.

Drug recommendations

The guideline does not make recommendations on drug dosage; prescribers should refer to the 'British national formulary (BNF)' and 'BNF for children' for this information. The guideline also assumes that prescribers will use a drug's summary of product characteristics to inform decisions made with individual patients.

Who this guideline is for

This document is for healthcare professionals and other staff who care for people with an acute painful sickle cell episode in hospital. People with sickle cell disease and their family members and carers may also find it useful.

Patient-centred care

This guideline offers best practice advice on the care of adults, young people and children presenting at hospital with an acute painful sickle cell episode.

Treatment and care should take into account patients' needs and preferences. People with an acute painful sickle cell episode should have the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals. If patients do not have the capacity to make decisions, healthcare professionals should follow the [Department of Health's advice on consent](#) and the [code of practice that accompanies the Mental Capacity Act](#). In Wales, healthcare professionals should follow [advice on consent from the Welsh Government](#).

If the patient is under 16, healthcare professionals should follow the guidelines in [Seeking consent: working with children](#).

Good communication between healthcare professionals and patients is essential. It should be supported by evidence-based written information tailored to the patient's needs. Treatment and care, and the information patients are given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English.

If the patient agrees, families and carers should have the opportunity to be involved in decisions about treatment and care.

Families and carers should also be given the information and support they need.

Care of young people in transition between paediatric and adult services should be planned and managed according to the best practice guidance described in [Transition: getting it right for young people](#).

Adult and paediatric healthcare teams should work jointly to provide assessment and services to young people with an acute painful sickle cell episode. Diagnosis and management should be reviewed throughout the transition process, and there should be clarity about who is the lead clinician to ensure continuity of care.

1 Recommendations

The following guidance is based on the best available evidence. The [full guideline](#) gives details of the methods and the evidence used to develop the guidance.

Terms used in this guidance

Moderate pain Pain with a VAS (or equivalent) score typically within the range of 4 to 7 (this description should not be interpreted as a strict definition and will not apply to all patients, as pain is subjective).

Patient-controlled analgesia (PCA) A method of safely administering strong opioids which is controlled by the patient (or a nurse for nurse-controlled analgesia).

Severe pain Pain with a VAS (or equivalent) score typically above 7 (this description should not be interpreted as a strict definition and will not apply to all patients, as pain is subjective).

Individualised assessment at presentation

- 1.1.1 Treat an acute painful sickle cell episode as an acute medical emergency. Follow locally agreed protocols for managing acute painful sickle cell episodes and/or acute medical emergencies that are consistent with this guideline.
- 1.1.2 Throughout an acute painful sickle cell episode, regard the patient (and/or their carer) as an expert in their condition, listen to their views and discuss with them:
- the planned treatment regimen for the episode
 - treatment received during previous episodes
 - any concerns they may have about the current episode
 - any psychological and/or social support they may need.
- 1.1.3 Assess pain and use an age-appropriate pain scoring tool for all patients presenting at hospital with an acute painful sickle cell episode.
- 1.1.4 Offer analgesia within 30 minutes of presentation to all patients presenting at hospital with an acute painful sickle cell episode (see also recommendations 1.1.7 to 1.1.11).

- 1.1.5 Clinically assess all patients presenting at hospital with an acute painful sickle cell episode, including monitoring of:
- blood pressure
 - oxygen saturation on air (if oxygen saturation is 95% or below, offer oxygen therapy)
 - pulse rate
 - respiratory rate
 - temperature.
- 1.1.6 Assess all patients with sickle cell disease who present with acute pain to determine whether their pain is being caused by an acute painful sickle cell episode or whether an alternative diagnosis is possible, particularly if pain is reported as atypical by the patient.

Primary analgesia

- 1.1.7 When offering analgesia for an acute painful sickle cell episode:
- ask about and take into account any analgesia taken by the patient for the current episode before presentation
 - ensure that the drug, dose and administration route are suitable for the severity of the pain and the age of the patient
 - refer to the patient's individual care plan if available.
- 1.1.8 Offer a bolus dose of a strong opioid by a suitable administration route, in accordance with locally agreed protocols for managing acute painful sickle cell episodes, to:
- all patients presenting with severe pain
 - all patients presenting with moderate pain who have already had some analgesia before presentation.
- 1.1.9 Consider a weak opioid as an alternative to a strong opioid for patients presenting with moderate pain who have not yet had any analgesia.

1.1.10 Offer all patients regular paracetamol and NSAIDs (non-steroidal anti-inflammatory drugs) by a suitable administration route, in addition to an opioid, unless contraindicated^[1].

1.1.11 Do not offer pethidine for treating pain in an acute painful sickle cell episode.

Reassessment and ongoing management

1.1.12 Assess the effectiveness of pain relief:

- every 30 minutes until satisfactory pain relief has been achieved, and at least every 4 hours thereafter
- using an age-appropriate pain scoring tool
- by asking questions, such as:
 - How well did that last painkiller work?
 - Do you feel that you need more pain relief?

1.1.13 If the patient has severe pain on reassessment, offer a second bolus dose of a strong opioid (or a first bolus dose if they have not yet received a strong opioid).

1.1.14 Consider patient-controlled analgesia if repeated bolus doses of a strong opioid are needed within 2 hours. Ensure that patient-controlled analgesia is used in accordance with locally agreed protocols for managing acute painful sickle cell episodes and/or acute medical emergencies.

1.1.15 Offer all patients who are taking an opioid:

- laxatives on a regular basis
- anti-emetics as needed
- antipruritics as needed.

1.1.16 Monitor patients taking strong opioids for adverse events, and perform a clinical assessment (including sedation score):

- every 1 hour for the first 6 hours

- at least every 4 hours thereafter.

1.1.17 If the patient does not respond to standard treatment for an acute painful sickle cell episode, reassess them for the possibility of an alternative diagnosis.

1.1.18 As the acute painful sickle cell episode resolves, follow locally agreed protocols for managing acute painful sickle cell episodes to step down pharmacological treatment, in consultation with the patient.

Possible acute complications

1.1.19 Be aware of the possibility of acute chest syndrome in patients with an acute painful sickle cell episode if any of the following are present at any time from presentation to discharge:

- abnormal respiratory signs and/or symptoms
- chest pain
- fever
- signs and symptoms of hypoxia:
 - oxygen saturation of 95% or below or
 - an escalating oxygen requirement.

1.1.20 Be aware of other possible complications seen with an acute painful sickle cell episode, at any time from presentation to discharge, including:

- acute stroke
- aplastic crisis
- infections
- osteomyelitis
- splenic sequestration.

Management of underlying pathology

- 1.1.21 Do not use corticosteroids in the management of an uncomplicated acute painful sickle cell episode.

Non-pharmacological interventions

- 1.1.22 Encourage the patient to use their own coping mechanisms (for example, relaxation techniques) for dealing with acute pain.

Settings and training

- 1.1.23 All healthcare professionals who care for patients with an acute painful sickle cell episode should receive regular training, with topics including:
- pain monitoring and relief
 - the ability to identify potential acute complications
 - attitudes towards and preconceptions about patients presenting with an acute painful sickle cell episode.
- 1.1.24 Where available, use daycare settings in which staff have specialist knowledge and training for the initial assessment and treatment of patients presenting with an acute painful sickle cell episode.
- 1.1.25 All healthcare professionals in emergency departments who care for patients with an acute painful sickle cell episode should have access to locally agreed protocols and specialist support from designated centres.
- 1.1.26 Patients with an acute painful sickle cell episode should be cared for in an age-appropriate setting.
- 1.1.27 For pregnant women with an acute painful sickle cell episode, seek advice from the obstetrics team and refer when indicated.

Discharge information

1.1.28 Before discharge, provide the patient (and/or their carer) with information on how to continue to manage the current episode, including:

- how to obtain specialist support
- how to obtain additional medication
- how to manage any potential side effects of the treatment they have received in hospital.

^[1] The use of NSAIDs should be avoided during pregnancy, unless the potential benefits outweigh the risks. NSAIDs should be avoided for treating an acute painful sickle cell episode in women in the third trimester. See the 'British National Formulary' for details of contraindications.

2 Notes on the scope of the guidance

NICE guidelines are developed in accordance with a scope that defines what the guideline will and will not cover.

3 Implementation

NICE has developed [tools to help organisations implement this guidance](#).

4 Research recommendations

The Guideline Development Group has made the following recommendations for research, based on its review of evidence, to improve NICE guidance and patient care in the future.

4.1 *Pain management for patients with an acute painful sickle cell episode*

For patients with an acute painful sickle cell episode, what are the effects of different opioid formulations, adjunct pain therapies and routes of administration on pain relief and acute sickle cell complications?

Why this is important

Limited evidence is available on the effectiveness of different opioid formulations, routes of administration and adjunct therapies in the treatment of an acute painful sickle cell episode. A series of RCTs should be conducted that compare the effects of different opioid formulations, adjunct pain therapies and routes of administration. These RCTs should be conducted separately in adults and children, and cover the duration of the acute painful episode. Outcomes should include pain and adverse events such as acute chest syndrome.

4.2 *Use of low-molecular-weight heparin to treat patients with an acute painful sickle cell episode*

Are therapeutic doses of low-molecular-weight heparin (LMWH) effective, compared with prophylactic doses of LMWH, in reducing the length of stay in hospital of patients with an acute painful sickle cell episode?

Why this is important

Moderate-quality evidence from one RCT suggested a significant benefit of treating patients with an acute painful sickle cell episode with LMWH. This was supported by exploratory health economic analyses suggesting a large reduction in length of stay and associated costs. An RCT should be conducted that examines the effect of therapeutic doses of LMWH, compared with prophylactic doses, on the length of stay in hospital of patients with an acute painful sickle cell episode. The RCT should be conducted separately in adults and children, and cover the duration of the painful episode.

4.3 *Psychological interventions for patients with an acute painful sickle cell episode*

For patients with an acute painful sickle cell episode, are psychological interventions, in conjunction with standard care, effective in providing pain relief?

Why this is important

There was a lack of evidence on the benefits of psychological interventions for managing pain during an acute painful sickle cell episode. An RCT should be conducted in patients with an acute painful sickle cell episode that compares the effectiveness of psychological interventions plus standard care against standard care alone. The RCT should cover the duration of the painful episode, and should assess outcomes such as pain, mood and health status.

4.4 *Non-pharmacological interventions for patients with an acute painful sickle cell episode*

For patients with an acute painful sickle cell episode, are non-pharmacological interventions, such as massage, effective in improving their recovery from the episode?

Why this is important

There was a lack of evidence on the potential benefits of supportive interventions for patients with an acute painful sickle cell episode. An RCT should be conducted that examines the effect of providing rehabilitation interventions that are aimed at improving a patient's recovery after an acute painful sickle cell episode. Such interventions could include massage and physical therapy. The intervention should be provided within the hospital setting, and patients should be followed up 7 days after the episode. Data should be collected to inform outcomes such as length of stay, health-related quality of life and coping strategies.

4.5 *Cost effectiveness of daycare units for treating patients with an acute painful sickle cell episode*

Are daycare units cost effective compared with emergency settings for treating patients with an acute painful sickle cell episode?

Why this is important

There was a lack of evidence on the cost effectiveness of daycare units for treating patients with an acute painful sickle cell episode in the UK. A trial should be carried out that compares treating patients with an acute painful sickle cell episode in an emergency department setting and in a specialist sickle cell daycare unit. Outcomes should include health-related quality of life (HRQoL). Data should be collected using validated measure(s) of HRQoL, including EQ-5D

5 Other versions of this guideline

5.1 *Full guideline*

The full guideline, [Sickle cell acute painful episode: management of an acute painful sickle cell episode in hospital](#), contains details of the methods and evidence used to develop the guideline.

5.2 *NICE pathway*

The recommendations from this guideline have been incorporated into a [NICE pathway](#).

5.3 *Information for the public*

NICE has produced [information for the public](#) explaining this guideline.

We encourage NHS and voluntary sector organisations to use text from this information in their own materials about acute painful sickle cell episodes.

6 Related NICE guidance

Published

- [Opioids in palliative care](#). NICE clinical guideline 140 (2012).
- [Patient experience in adult NHS services](#). NICE clinical guideline 138 (2012).
- [Depression in adults with a chronic physical health problem](#). NICE clinical guideline 91 (2009).
- [Antenatal care](#). NICE clinical guideline 62 (2008).
- [Intrapartum care](#). NICE clinical guideline 55 (2007).
- [Acutely ill patients in hospital](#). NICE clinical guideline 50 (2007).

7 Updating the guideline

NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations. Please see our website for information about updating the guideline.

Appendix A: The Guideline Development Group, Internal Clinical Guidelines Technical Team and NICE Centre for Clinical Practice

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About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the Centre for Clinical Practice at NICE, which worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#). This guideline was developed using the [short clinical guideline process](#).

The recommendations from this guideline have been incorporated into a [NICE pathway](#). We have produced [information for the public](#) explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also [available](#).

Changes after publication

October 2012: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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