Characterization of pain in hospitalized patients: narrative review

Caracterização da dor em pacientes hospitalizados: revisão narrativa

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ABSTRACT

BACKGROUND AND OBJECTIVES: Pain can be influenced by the period of hospital stay, causing different losses to the patient. Professionals must properly collect and record this data to treat pain. The aim of this study was to investigate the different characteristics of pain in hospitalized patients.

METHODS: A systematic review was carried out in the Medline, LILACS and Pubmed databases, based on the descriptors "pain" AND "patients" AND "hospitalized" with their respective terms in Portuguese until October 2020. A total of 2,085 articles were found, of which 2,064 underwent careful evaluation and 20 were selected to compose this review based on the inclusion and exclusion criteria outlined.

RESULTS: Pain is more common and more severe in postoperative (90.8%) and palliative care wards, above all, it is frequently reported by young women. It lasts for more than three months in many patients and interferes with activities of daily living. Adequate analgesia is of great importance in this scenario. One-dimensional instruments are most commonly used to assess pain in hospitals. Attention is drawn to the absence or omission of non-pharmacological therapies for pain management, which can be considered a safe alternative without increasing the use of drugs.

CONCLUSION: Pain is very present and severe in hospitalized patients, demonstrating a failure in hospital analgesia protocols worldwide. Due to the work overload of professionals, pain is still under-evaluated.

Keywords: Inpatients, Hospitalization, Pain, Review.

RESUMO

JUSTIFICATIVA E OBJETIVOS: A dor pode ser influenciada pelo período de internação hospitalar, acarretando diferentes prejuízos ao paciente. Os profissionais devem coletar e registrar adequadamente esse dado para tratar a dor. O objetivo deste estudo foi investigar as diferentes características da dor em pacientes hospitalizados.

MÉTODOS: Foi realizada uma revisão sistematizada nas bases de dados Medline, LILACS e Pubmed, com base nos descritores "dor" *AND* "pacientes" *AND* "internados" com seus respectivos termos em inglês até outubro de 2020. Encontrou-se, no total, 2.085 artigos, dos quais 2.064 passaram por criteriosa avaliação e 20 foram selecionados para compor esta revisão com base nos critérios de inclusão e exclusão delineados.

RESULTADOS: A dor é mais comum e mais intensa em alas de pós-operatórios (90,8%) e de cuidados paliativos, sobretudo, é frequentemente relatada por mulheres jovens. Tem duração superior a três meses em muitos pacientes e interfere nas atividades de vida diária. Uma adequada analgesia representa grande importância nesse cenário. Os instrumentos unidimensionais são mais utilizados para avaliar a dor em hospitais. Chama atenção a ausência ou omissão de terapias não farmacológicas para o manejo da dor, a qual pode ser considerada uma alternativa segura sem aumentar o uso de fármacos.

CONCLUSÃO: A dor se mostrou muito presente e intensa em pacientes hospitalizados, demonstrando haver falha nos protocolos hospitalares de analgesia em todo o mundo. Por sobrecarga de trabalho dos profissionais, a dor ainda é subavaliada.

Descritores: Dor, Hospitalização, Pacientes internados, Revisão.

INTRODUCTION

Pain is defined as an unpleasant sensory and emotional experience associated with, or resembling that associated with, actual or potential tissue damage. A person's report of a painful experience must be respected, since pain is always personal and can be influenced by biological, psychological and social factors[1].

Pain is considered a universal health problem, being transversal to several diseases. Its subjectivity makes it difficult to be described and, if left untreated, it can lead to several adverse effects[2]. Considering the different forms of perception and appreciation of pain, which change from person to person, it is essential that

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HIGHLIGHTS

- Pain still does not receive the proper attention in the hospital environment. There are failures in the requisites of systematized, appropriate assessment and the professionals' trust in the patients' reports, especially the record in medical charts and adequate analgesic treatment.
- Pain is very present in hospitalized patients, regardless of the cause for hospitalization and, as a result, it limits the quality of life and daily activities, besides resulting in biopsychosocial changes.
- Training for interprofessional hospital staff is strongly recommended to improve pain management in this scenario.

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professionals pay attention to this phenomenon for the better assessment and comprehensive care of patients[3].

The lack of objective instruments to measure pain or possible errors that may arise from an underestimation may compromise the quality of care, in addition to contributing to morbidities and increased hospitalization time[4]. During hospitalization, patients are exposed to several situations and factors that can influence how pain is perceived, which can result in improvement or worsening of the complaint[5].

It is estimated that the worldwide prevalence of chronic pain (CP) is 10.1% to 55.5% and, according to the International Association for the Study of Pain (IASP), the average is 35.5%[6]. There are few epidemiological studies in Brazil, and that does not allow a precise and homogeneous estimate, however, some studies confirm that the incidence of CP is similar to that estimated by the IASP, varying between 29.3% to 73.3%, affecting about 40% of adults and seniors, with a predominance of women and of the dorsal/lumbar region[7,8]. It is also known that the main cause reported by patients in outpatient care is CP[9].

The present study contributes to the expansion of the knowledge about hospital pain. This investigation makes it possible to comprehend the heterogeneity of the subject in the different hospitals around the world. The lack of uniformity in the approach to pain in this context motivates exploration of the topic and guidance for readers towards the need of more robust discussions and clinical research with educational, evaluative and interventional actions, considering the particularities of the hospital environment.

The present study's objective was to determine the different characteristics of pain in hospitalized patients.

METHODS

A narrative review with a systematized search regarding pain in hospitalized patients, with the objective of gathering and synthesizing the evidence found in original articles on the subject. The review included only publications available in full in the Medline, LILACS and Pubmed databases. The descriptors defined in DeCS (*Descritores em Ciências da Saúde* - Descriptors in Health Sciences) and MeSH (Medical Subject Headings) were: "pain" AND "patients" AND "hospitalized" with their respective descriptors in Portuguese.

The inclusion criteria were original studies that portrayed pain in the hospital environment, that involved only adults with pain, without comorbidities, freely available in full in the selected databases and languages, published from 2015 to October 2020, to be evaluated by two independent authors. The exclusion criteria were repeated articles, other literature reviews, papers whose study population was composed of children or seniors, research on the efficacy of experimental treatments, articles published outside the time frame, and articles that cited pain in non-hospitalized patients.

RESULTS

A total of 2,085 articles went through three stages: (1) title analysis, (2) abstract analysis, and (3) objectives analysis. After this process, 1,037 publications remained, and were then filtered according to the established inclusion criteria: 1,017 publications were excluded, 11 for not having the full text available, 3 for being duplicates, 422 for not having been published within the established time frame, 278 whose research population was composed of children or seniors, 157 for researching treatments for pain and 94 for portraying pain in non-hospitalized patients. In addition, 52 review articles were also excluded. Finally, 20 studies met the inclusion criteria (Figure 1).

The studies vary widely in sample size. The smallest samples were 16 participants, while the largest is 88,000 pain scores. In addition, objectives and pain assessments also differ from one to another. The selected articles were organized and are shown in table 1.

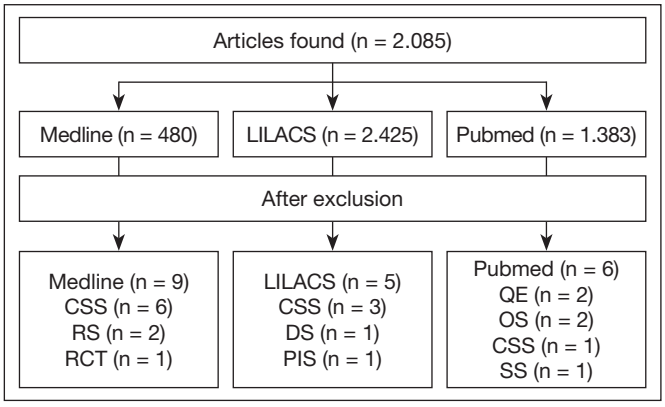

Figure 1. Flowchart of articles selection

CSS = cross-sectional study; RS = retrospective study; RCT = randomized controlled trial; DS = descriptive study; PIS = pilot intervention study; QE = qualitative study; OS = observational study; SS = experimental study.

Table 1. Synthesis of selected studies

Autores	Type of study and sample	Objective	Results
Hoogervorst-Schilp et al.[10]	Retrospective study n = 3,895 participants	To examine compliance with postoperative pain assessment in patients after the implementation of a national safety program.	In 12% of the patients, during the postoperative period, pain was measured 3 times a day, all 3 full days after surgery. In 53% of patients, pain was measured once a day for the same period. Compliance was higher in general hospitals compared to tertiary and academic teaching hospitals.
Van Hecke et al.[11]	Cross-sectional study n = 351 patients and 304 nurses	To assess pain intensity and examine its association with patient, nurse, and related to the barriers/facilitators system for pain management.	The mean pain for all patients on all nurse wards was 2.2. A significant independent association was found between higher pain intensity and younger age.

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Table 1. Synthesis of selected studies – continuation

Autores	Type of study and sample	Objective	Results
Peng et al.[12]	Cross-sectional study n = 2,293 participants	To clarify the epidemiological characteristics of pain and related factors in hospitalized patients in southwestern China.	The incidence of pain was 57.4% in all hospitalized patients at rest, with 62.1% being acute pain and 37.9% being persistent and chronic. Among surgical patients, 90.8% complained of acute pain during rest and 97.1% during motion, occurring predominantly (95.2%) at surgical areas. Age, lower schooling level, surgery, and smoking history were factors associated with increased duration and severity of postoperative pain as well as non-surgical pain.
Mikan et al.[13]	Cross-sectional study n = 404 participants	To clarify the association between pain and QoL of Japanese patients using a cancer-specific QoL scale in three settings: an outpatient oncology service, an oncology nurse ward, and palliative care hospitalization units.	The results show that pain has an association with QoL, having moderate influence on aspects such as physical functioning, fatigue, insomnia, dyspnea, and on emotional functioning. The association with pain was lower for patients in the palliative care unit compared to outpatients and patients hospitalized in the nurse ward.
Wang et al.[14]	Retrospective cohort study n = 88,133 pain scores	To characterize the trends of CSP among cancer patients and examine their differences in prevalence in repeat hospitalizations.	There was a downward trend from the 1st to the 18th hospitalization. There was a robust decrease in the prevalence of CSP from the 1st to the 5th hospitalization. The prevalence of worse pain intensity was significantly higher during the 1st than during the 5th hospitalization.
Porta-Sales et al.[15]	Cross-sectional study n = 1,064 participants	To evaluate the frequency, type, and characteristics of cancer pain in adult patients, including hospitalized and outpatients.	The frequency of pain was 55.3%. Pain was less frequent in outpatients (41.6%) than hospitalized patients (64.7%), although the median duration of pain was longer in outpatients (20 versus 6 weeks).
Jabusch et al.[16]	Cross-sectional study n = 88 participants	To quantify the prevalence of pain among adult hospitalized patients and the degree to which pain interferes with daily activities.	The prevalence of pain was 70.4%, and the mean intensity was 3.76. The pain interference in daily activities mean score was 4.56. The most frequently identified area of pain was the lower extremities (28%).
Valkering et al.[17]	Randomized controlled clinical trial n = 46 participants	To investigate the effect of hospitalization versus outpatient care after ACL reconstruction on functional outcome, postoperative pain experience, and readmission rate.	Outpatient care after ACL reconstruction produces postoperative pain experience and functional outcomes comparable to hospitalized care and is a safe option. A simple analgesic protocol proves to be sufficient. No readmissions related to pain were recorded.
Ambrogi et al.[18]	Cross-sectional study n = 938 participants	To assess the prevalence, characteristics, management, and determine factors linked to the severity of CRP in a Paris teaching hospital.	59% of patients reported pain in the previous 24 h and 58% experienced CRP in the previous 15 days. In addition, 37% of procedures resulted in severe pain. Severity of CRP was associated with long hospitalization, non-vascular invasive punctures, catheterization, mobilization, radiological examination or pain (previous 24 h) due to surgery or treatment. Only half of the patients received information about the painful procedure and treatment for pain was delivered in less than a quarter of the cases.
Bernhofer et al.[19]	Qualitative phenomenological study n = 16 participants	To develop an understanding of the unique pain experience in hospitalized patients with an admission diagnosis of IBD and related care or surgery.	Hospitalized IBD patients feel discredited and misunderstood, have a desire to dispel the stigma of chronic pain and "neediness" associated with the disease, feel frustration and constant pain, have a need for a caregiver with knowledge and comprehension about the disease in addition to reporting that the nurse is like a connection between the patient and the doctor.
Dequeker et al.[20]	Cross-sectional study n = 35 nurses and 351 patients	To assess agreement between nurses and hospitalized patients regarding pain intensity and patient-related barriers for the management of pain.	At the individual level, moderate agreement in the assessment of pain intensity was found between patients and nurses, being higher for patients with mild pain and with severe pain compared to no pain and moderate pain. A higher level of agreement was also found when nurses used a validated scale to assess pain intensity compared to nurses using only experience.
Erol et al.[21]	Qualitative descriptive study n = 16 participants	To explore the pain experiences of patients with advanced cancer and how they cope with pain, and to present insight into pain management done by nurses' approaches from the patients' perspective.	Advanced cancer patients with pain experienced anxiety, abandonment, hopelessness, and many restrictions in daily life, as well as inability to cope with pain. Almost half of the patients were not satisfied with the nurses' care regarding pain and pain management.

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Table 1. Synthesis of selected studies – continuation

Autores	Type of study and sample	Objective	Results
Işlekdemir and Kaya[22]	Randomized controlled clinical trial n = 138 participants	To determine the effects of family presence on pain and anxiety levels during invasive nursing procedures.	The experimental and control group members did not differ regarding pain and anxiety scores during the intervention, concluding that family presence has no influence during invasive nursing procedures.
Harada, Tamura and Ota[23]	Prospective observational study n = 220 participants	To determine the prevalence of NP in cancer patients receiving palliative care.	The prevalence of NP in terminal cancer patients in Japanese palliative care units was 18.6%. As for the cause, in 78% of patients NP was due to tumor growth, in 14.6% to chemotherapy, and in 4.9% to radiotherapy.
Bellido-Vallejo et al.[24]	Longitudinal observational validation study n = 73 participants	To evaluate the psychometric properties and sensitivity for measuring change in pain level of the Spanish version of the PLO when assessing acute pain in hospitalized patients.	The study provides evidence of reliability, validity and sensitivity to the Spanish version of the PLO which was shown to be a well-structured multidimensional instrument to evaluate pain intensity and associated behavioral, emotional and physical aspects.
Rosa, Mendoza and Pontin[25]	Descriptive study n = 50 participants	To trace the epidemiology profile and identify the in-hospital outcomes of patients undergoing surgical correction of neuromuscular scoliosis.	The average length of stay was 10.8 days and 52% of patients had some complication, such as constipation. Surgical site infection was present in 12% of the sample, 42% had moderate to severe pain and 2% did not meet the proposed mobility goals.
Fermiano et al.[26]	Pilot intervention study n = 22 participants	To evaluate pain levels in adult ICU patients who are sedated, under invasive mechanical ventilation, before, during and after a respiratory physiotherapy intervention.	There were no significant differences in hemodynamic variables and pain assessment of the critically ill patients at any of the evaluated time points.
Panazzolo et al.[27]	Cross-sectional study n = 336 participants	To evaluate the use of analgesics in the immediate postoperative period of patients assisted in a post-anesthesia recovery room, according to the type of surgery performed.	A total of 42.8% of the patients used some type of analgesic. The most used class of drugs was the opioid analgesics, specially fentanyl and remifentanil for surgeries with general anesthesia and morphine (0.2mg) for subarachnoid anesthesia.
Bertoncello et al.[28]	Descriptive cross-sectional study n = 24 participants	To comprehend the evolution of acute pain in patients admitted to the Emergency Unit of a Teaching Hospital in the South of Brazil, using the vNRS, as well as to evaluate and control the patient's acute pain, using the instrument proposed by McCaffery and Beebe.	In the first evaluation, 62.5% of patients presented severe pain and 37.5% moderate pain. In the second evaluation, there was a predominance of moderate pain (54.17%) and an important increase of patients who scored mild pain (33.3%). The instrument helped the nurse to register the occurrences and evolution related to pain. However, weaknesses were observed in its use.
Sousa-Muñoz et al.[29]	Cross-sectional observational study n = 115 participants	To evaluate the prevalence of pain and the adequacy of analgesic therapy administered to patients in a university hospital, as well as to assess the agreement between self-report of pain and data recorded in medical records regarding pain manifestations.	It was verified that 52.2% of patients had severe pain and 33.9% had moderate pain. In only 39.1% and 36.1% of the medical records, at the time of admission and hospitalization development, respectively, information on pain was recorded. A negative pain management index was found in 82.6% of the patients. Inappropriate prescription was observed in 78.3% of patients. Non-opioid analgesics and non-hormonal anti-inflammatory drugs were used in 87.8% of the patients, while opioids were used in only 14.7%.

QoL = Quality of Life; CSP = Clinically Significant Pain; ACL = Anterior Cruciate Ligament; CRP = Care-Related Pain; IBD = Inflammatory Bowel Disease; NP = Neuropathic Pain, PLO = Pain Level Outcome Scale; ICU = Intensive Care Unit; NVS = Numerical Verbal Scale.

DISCUSSION

There is a growing consensus that pain is the fifth vital sign, determining that it must be investigated, analyzed and recorded with the same importance given to the other vital signs. Pain perception is multidimensional, presenting diversity as to sensory quality and intensity, in addition to affective-emotional variables, and for this reason it is full of subjectivity[30]. A common burden associated with any disease is pain. Study[12], involving patients from 17 hospitals in China, observed acute pain complaint in 90.8% of the participants at postoperative rest, concluding that postoperative analgesia still needs to be improved. Surgical pain is an important factor in the hospital environment because it is more severe than non-surgical pain and should be taken into consideration.

In addition, the study[16] showed that the prevalence of pain in hospitalized adults occurred at unacceptable rates. Of the 88 patients interviewed, 70.4% reported pain present at the time of the survey, of these, 30% reported a duration of pain less than 7 days and 26% a duration that exceeded three months.

The results also showed an important relationship between pain and its interference in daily activities.

The prevalence of postoperative pain has remained consistently high (39%) during the last two decades, even after a dose of an analgesic drug[9], and one of the contributing factors to this finding is the insufficient measurement of pain in hospitals. When the patient's pain experience is fully comprehended, better treatment becomes possible. Hospitalized patients with inflammatory bowel disease (IBD) experience physical and psychological complications of pain (acute and chronic), thus the authors[19] interviewed 16 patients of different age, gender, length of hospital stay, and length of IBD diagnosis in order to understand these patients' pain and related care or surgery.

The outcome was that these patients have complex physical and emotional needs, have daily pain and frustration with pain control, and report feeling discredited about their pain by nurses and physicians. In addition, several reports of unnecessary suffering were collected[19] because the nurse or doctor was not familiar with effective pain control techniques. In contrast, when the complaint was heard and attended to properly, there were reports of comfort experienced by patients after the drug application.

In addition to that, the authors[27] studied patients in the immediate postoperative period and found that analgesics such as tramadol and dipyrone were the most prescribed and used to ease the pain complaints reported by patients in post-anesthetic recovery. They also verified an association between the use of some opioid drug in the postoperative period and no pain, once more reinforcing the importance of the anesthetic practice for the well-being of the recently operated patient.

In parallel, nursing records were analyzed[31] in an oncology hospital, noting the presence of pain in more than 71% of the medical records that comprised the sample. Furthermore, the prevalence of neuropathic pain (NP) in Japanese terminal cancer patients in a palliative care unit was 18.6%, according to the authors[23]. NP was diagnosed by the authors according to the IASP algorithm.

In order to examine the pain experience of 16 hospitalized patients with advanced cancer, the authors[21] allowed patients to speak freely, using their own words to describe their perception of pain. The results showed that these patients experience anxiety, abandonment, hopelessness, and many restrictions in daily life, as well as an inability to cope with pain. The study also showed that they need more attention from nurses, since most of the sample was not satisfied with the care received regarding the coping of pain[21].

It is important to highlight that the professionals responsible for the direct care of the sensations of pain are the nurses, since they stay for a longer period of time close to the patient and must, therefore, assume the correct pain management, that is, make pain assessment a priority, in order to provide relief from suffering and improvement in the quality of life (QoL) to the oncologic patient[33].

The association between pain and QoL was investigated in the study[13] in three oncology care settings: the outpatient clinic, the nurse ward, and the palliative care unit. The results for "average pain" or "worst pain" were similar when associated with the main aspects of QoL, while for "least pain" the association was relatively small. Pain has an association with physical and emotional QoL, being lower in cancer patients in the palliative care unit than in outpatients or hospitalized patients[3].

An individual generally prefers to have a family member present during medical or nursing interventions, so it was assumed that the presence of family reduced patients' anxiety and pain levels. However, the authors[22] surveyed 138 patients randomly assigned to an experimental group (which had family members present) and a control group (which remained with no family members) and observed that anxiety and pain states during invasive nursing procedures did not differ from one group to the other; therefore, family presence does not influence these scores, meaning that this factor could be based purely on patient preferences.

In addition, pain intensity was evaluated[11] in order to examine its association with patients, nurses and the barriers/facilitators system. The prevalence of pain found in patients of the nurse wards included in the research was 64.4%, of which most (36.7%) presented mild pain. Of the nurses who answered the questionnaire, more than half (66.8%) estimated their knowledge about pain as "moderate"[11].

The main barriers perceived by the patients were reluctance to take opioid drugs (51%), fear of adverse effects (47%) and not wanting to be a burden to the nurses (47%). As for nurses, the majority perceived pain as a priority (92.4%) and reported that there are painkillers on the ward (84.6%). The barrier perceived by 30.6% of the nurses was insufficient time to listen to the patient[11].

The results indicate that 12.1% of the variation in pain intensity reported by patients can be explained at the ward level, meaning that improvements in pain management should focus on both patients and health care professionals, as both contributed to this variation. This study[11] identified two barriers that explained 10.7% of all variance, namely the nurses' educational level and nurses' fear of adverse effects, leaving only a small proportion of variance unexplained.

The study[20] investigated patient-related barriers for the management of pain; 40.7% report difficulty with its assessment and 37.9% reluctance to report pain. However, in the perception of nurses, these percentages were 12.6% and 10.5%, respectively, showing that nurses significantly underestimate pain management by patients.

To improve these flaws, nurses should be trained and more encouraged to actively explore patient-related barriers for pain management. By doing so, patients can be educated in order to reduce them. Routine pain intensity assessments should also be encouraged, as many patients only report pain when asked. Finally, patients should be educated on how to use pain assessment scales in the nurse wards and hospitals[20].

A study[29] with the objective of evaluating the prevalence of pain in hospitalized patients characterized that the mean duration of the painful condition is 8.8 months, and the presence of acute pain is present in 50.4% of the sample. A differential of this study[29] was the observation of the predominance

of females, both for acute (65.5%) and chronic pain (57.9%). Twenty-eight participants (24.3%) reported pain as the main complaint that caused hospitalization. The abdominal (34.8%) and pelvic (33%) areas were most frequently noted for acute and chronic pain in this study.

Reports of more severe levels of pain predominated, with 7.3 being the average intensity for the entire sample. Severe pain was presented by 60 patients, representing 52.2%, while 39 reported pain of moderate intensity (33.9%). The evaluation of the agreement between the pain self-report and the data recorded in the medical records showed that only 45 (39.1%) of them recorded information on pain at admission and 42 (36.1%) during the development[29]. Finally, inappropriate prescription of analgesics was observed for 78.3% of the patients; 13 therapeutic strategies were adequate for mild pain, nine for moderate pain and two for severe pain. The use of monotherapy with non-opioid analgesics and non-hormonal anti-inflammatory drugs prevailed (87.8%)[29].

Pain is poorly evaluated and undertreated in nurse wards. In addition, there are discrepancies between self-reported pain and medical records; the therapeutic strategies implemented were inadequate[29], an error caused mainly by lack of knowledge and skill on analgesic control, followed by concern about the effects and possibility of drug abuse, in addition to the reluctance to comprehend pain complaints. All these findings highlight the need for greater pharmacological knowledge on the part of the health teams.

It was observed that, despite the advances in health care, pain still is a problem that is not enough investigated and it is even underestimated by health care professionals during their care. The most frequent obstacles are lack of knowledge and ability to obtain analgesic control, concern with the adverse effects of opioids, fear of the possibility of drug addiction, and the reluctance to comprehend the painful complaints as human responses in which there could be intervention. The conclusion is that the professional has difficulty in routinely assessing and documenting pain[32].

Acute pain is a valuable symptom when investigating and defining the patient's diagnosis. A study[28] that followed the pain evolution of 24 patients admitted to the Emergency Unit using the Verbal Numerical Rating Scale (vNRS) and the instrument proposed by McCaffery and Beebe to evaluate and control acute pain found that severe pain is more present in the complaints reported by patients.

The pain process is most often preceded by pain in the lower back, abdominal area, lower limbs and headache according to the prevalence of care seeking in the emergency unit, which are relieved mostly by simple analgesics that have a good effect on pain control, followed by opioids and, finally, non-hormonal anti-inflammatory drugs. The use of VNS to measure pain positively helped the interaction between patient and nurse at the moment of pain scoring, although some patients still find it hard to quantify it. In addition, it is already known that pain caused by procedures is common in hospitalized patients and that care-related pain (CRP) is undervalued and little is known about the care directed to it, besides the fact that it is neither considered nor properly managed. In order to improve this, the authors[18] suggest that health professionals should be trained specifically to improve management of CRP and that special attention should be paid to hospitalized patients at risk of severe CRP.

More than a symptom, pain was perceived as a disease, a subjective organic event, difficult to measure, whose control must be included in the patient's treatment, given its ability to cause biological, psychosocial and psychosomatic changes. Among the most common organic symptoms are loss of sleep, impaired work, movement, and walking, changes in mood, in the ability to concentrate, and in family relationships, as well as changes in sexual activity and other mental health issues[34].

Respiratory, hemodynamic and metabolic alterations can be caused by uncontrolled pain, predisposing the patient to cardiovascular instability, higher energy and protein consumption, difficulty in early ambulation which favors the appearance of deep vein thrombosis, especially in seniors, also causing insomnia, higher metabolic wear, fatigue and less cooperation with treatment[35].

Studies show that pain is still present in hospitalized patients, meaning that there is a failure in the analgesia protocols in hospitals in several parts of the world. The use of correct instruments and methods to evaluate pain facilitates the identification of its genesis, which is necessary for an individualized treatment focused on the patient's need for comfort and well-being. The main barrier for an adequate pain management is a good assessment done by the professional, which requires time and trust in the patient's report, because only then can therapies be instituted to minimize the complaint.

More discussion and deepening on the subject are needed. Interprofessional teams must be involved with the purpose of developing methods of treatment and pain relief directed to the profile and characteristics of the patients of each hospital. Finally, considering the hospital environment, the absence or omission of non-pharmacological therapies for pain management draws attention, in addition to the lack of studies on physical therapy resources used to treat and relieve pain in hospitalized patients.

The main limitations of the present review are the lack of methodological rigor of the original articles that composed it, this was due to the small number of articles found on the subject and the short period of time established for the search of the articles in the databases.

CONCLUSION

The study observed that pain is more common in postoperative and palliative care wards, where it was also more severe, besides being more frequently reported by young women. The prevalence of inappropriate prescription of drugs to treat pain is still high. Pain is still poorly evaluated in the hospital scenario due to lack of time and the professional's difficulty in adequately questioning the patient and documenting pain.

AUTHORS' CONTRIBUTIONS

Bárbara Bernardes Lobo
Conceptualization, Project Management, Methodology, Writing - Review and Edition
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Project Management, Methodology, Writing - Review and Editing, Supervision

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