Saroyan J, Schechter W, Tresgallo M, Pica A, Erlich M, et al. Balancing Knowledge Among Resident Specialties: Lecture-based Training and the OUCH Card to Tread Children's Pain. *J Grad Med Educ.* 2010;2 (1):73-80.

"OUCH" Card

Department of Anesthesiology
College of Physicians and Surgeons, Columbia University

To page pediatric pain service from hospital phone: dial X-XXXX then press X-XXXX

Opioid dosing

Intravenous	Dose *(mg/kg)*	Route	Interval	Comment
Morphine	0.05-0.1	IV	q2-4h	Cont SpO2
Hydromorphone	0.015	IV	q2-4h	monitor
Oral				
Oxycodone	0.05-0.1	PO	q4h	max 5-10 mg/dose
Hydromorphone	0.03	PO	q4h	max 2-4mg/dose
Morphine	0.3	PO	q4h	max 15-30 mg/dose

Opioid equivalency

Ratio is approximately: 3 mg PO morphine = 1mg IV morphine = 0.2 mg IV hydromorphone *(conversion must be followed by a 50% reduction if the patient is tolerant to the opioid i.e.used for greater than five days)*

Non-steroidal anti-inflammatory agents

Obtain primary attending approval prior to initiation. Relative contraindications to Cox1/Cox2 inhibitors: concomitant steroid usage, nephropathy, gastropathy, hepatopathy, or coagulopathy

Drug	Dose *(mg/kg)*	Route	Interval	Comment
Ketorolac *(Toradol)*	0.5	IV	q6h	max of 30 mg/dose for no more than 5 days
Ibuprofen *(Motrin or Advil)*	10	PO	q6h	max 600 mg/dose
Acetaminophen *(Tylenol)*	10-15	PO	q4h	max 30 mg/kg/day in newborn 60 mg/kg/day in infants 90 mg/kg/day in children 3 gm/day in adults

Figure 1.
The Faces Pain Scale Revised (FPS-R) scale has been reproduced with permission of the International Association for the Study of Pain® (IASP®). The figure may not be reproduced for any other purpose without permission.

Pediatric Pain Assessment

Numeric rating scale ≥ 8 years old: 0=no pain—10=worst pain
FLACC[1,2] For child less than 3 years old *or* cognitively impaired child

Categories	*Scoring* 0	1	2
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant quivering chin, clenched jaw
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back	Arched, rigid or jerking
Cry	No cry *(awake or asleep)*	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consolability	Content, relaxed	Reassured by occasional touching, hugging or being talked to, distractable	Difficult to console or comfort

*Each of the five categories, **F**ace, **L**egs, **A**ctivity, **C**ry and **C**onsolability, is scored from 0–2, which results in a total score between zero and ten.*

References
[1] Merkel S, 1997
[2] Voepel-Lewis T, 2002
[3] Hicks CL, 2001

Faces Pain Scale-Revised[3] (FPS-R) ~ 3-7 years old

In the following instructions, say "hurt" or "pain," whichever seems right for a particular child.
"These faces show how much something can hurt. This face *[point to left-most face]* **shows no pain. The faces show more and more pain** *[point to each from left to right]* **up to this one** *[point to right-most face]* - **it shows very much pain. Point to the face that shows how much you hurt** [right now]." *Score the chosen face 0, 2, 4, 6, 8, or 10, counting left to right, so '0' = 'no pain' and '10' = 'very much pain.' Do not use words like 'happy' and 'sad'. This scale is intended to measure how children feel inside, not how their face looks.*

0 2 4 6 8 10