INTRODUCTION

Over the last two decades research into the nature, assessment, and treatment of children's pain has grown exponentially **[(lidow 2002), (Merskey et al. 2005)]**.

Surgery is one of the most terrifying medical procedures, generating eating disorders, sleep disturbances, regression to earlier levels of behavior, depression, and stressful reactions in children which include states of anxiety and worry, and somatizations such as loss of voice after tonsillectomy. Usually anxiety and other symptoms disappear quickly after the operation. Nevertheless, surgery aftereffects persist in vulnerable children even after they are discharged or in cases in which complications arise **(Mendez et al. 2001)**.

Nursing goals when caring for surgical children are to minimize children's anxiety, prepare them for surgery, and assist in their speedy, uncomplicated recovery **(Timby and Smith 2003)**.

Surgical procedures are classified as their emergency or elective procedures. Elective procedures can be scheduled in advance e.g. hernia repair, while emergency procedures usually are a result of a life threatening situation such as hemorrhage, intestinal obstruction, malignancy or body system disruption and require immediate surgical attention. Procedures are also termed major or minor according to the degree of risk to the patient. Major surgical procedures involve a risk of bleeding and loss of organs or bodily parts, while minor surgical procedures usually involve less risk of bleeding and fewer complications.**[(Smeltzer and Bare 2000), (Taylor et al. 2001), (Smith et al. 2004)]**.

All children normally experience pain from sources such as minor bumps, cuts, bruises, occasional headaches, toothaches, growing pains, fractures, and dental procedures **(International association for the study of pain 2006)**. Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage **(Mclntosh et al. 2003)**.

The under treatment of postoperative pain in children may also trigger biochemical and physiologic stress response and cause impairments in pulmonary, cardiovascular, neuro-endocrinal, gastrointestinal, immunological, and metabolic functions **(Gehdoo 2004)**.

Pain in children is multidimensional and is affected by gender, genetic variations, emotional status, temperament, developmental level, culture and ethnicity, previous pain experiences, type and duration of pain, and parental response to the child's pain **(James et al. 2002)**. Preschool children's response to pain may be in the form of low frustration level, active physical resistance, and striking out when hurt **(Hamilton 2005)**.

In Egypt many researches has been done to investigate causes of pain in children. Some researchers found that acute or recurrent abdominal pain are the most common causes of pain in children **(Salah El Din 2000)**. In Benha children hospital, according to the year 2004, it was found that postoperative abdominal pain represents 42% of total pain problems in admitted children to the surgical unit **(Benha children hospital 2004)**.

Children's pain can be measured by many different methods like self-report measurement "what children say", biological markers "how their bodies react)", and behavioral measurements "what children do"

(Tovar 2005). Children's Hospital of Eastern Ontario Pain Scale (CHEOPS) is recommended as a valid, reliable, and practical tool in measuring children's postoperative pain as it yielded the best agreement with the routine decision to treat pain among other pain measuring tools **[(Suraseranivongse et al. 2001), (Rourke 2004**)].

Pediatric pain management is achieved by combining multi-modalities including pharmacological and non-pharmacological interventions **(Yenbut et al. 2005)**. Pharmacological interventions include opioids, non-opioids analgesics, non-steriodal anti-infllammatory drugs, and adjuvant therapy, while non-pharmacological interventions include distraction and relaxation strategies, cutaneous stimulation, and parental involvement. Through the use of these techniques both anxiety and pain can be reduced **[(James et al. 2002), (Munden et al.. 2003)]**.

Distraction is defined as "the deployment of attention away from a particular stimulus or experience and towards an alternative stimulus" **(Piira et al 2003)**. Preschool children can be distracted through playing with toys, engaging in therapeutic play, and listening to short stories **(National Association of Hospital Play Staff NAHPS 2005)**.

Play is a key to every child's well-being as it increases motor skills, release tension, advances intellectual development, and increases chances of children speaking **(Hoffman 2005)**.

Toys play a vital role in every day life of children, and they are no less important in the hospital setting. Toys controlled by capability switches help the child to develop sense of control over his or her environment and increase self-esteem **[(Wong et al. 1999), (Hoffman 2005)]**.

Significance of the Study:

Since pain is a common phenomenon that occurs in every child's life, so the role of the nurse is to evaluate actual or anticipated pain, and to apply simple and appropriate pharmacological and nonpharmacological pain measures that can help in the reduction of pain in children.