3. Geriatric Pain

11:15am – 12:00pm

History and Presentation:
Wendy Anderson

Assessing Pain in the Setting of Dementia
Patrice Villars

Pain Management in the Terminal Phase of Adult Illness
Wendy Anderson

Case 3 Panel Discussion

Case 3 | Geriatric Pain | Disclosure Statements

- Wendy Anderson
- Patrice Villars

Case 3 | Geriatric Pain | Pain Management in the Geriatric & End-of-Life Setting

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Objectives

- Discuss considerations of acute and chronic pain management for older adults and at end-of-life
- Detail practical approaches to assessing and treating pain in these populations

Case 3

You are clinic seeing Mrs. S. She is 82 years old, and has osteoarthritis in both knees, as well as renal failure, and mid-stage Alzheimer's.

She is accompanied by her daughter who is her caregiver.

Mrs. S and her daughter describe uncontrolled pain in her knees that limits the daily activities she enjoys: going to the market and playing with her grandchildren.

Chronic Pain in Geriatrics

- 60% to 70% report persistent pain
  - 45-85% in Nursing Homes or Assisted Living
  - 25% to 56% in community dwelling older adults
- 60% → moderate, 25% → severe
- Association with depression, poor sleep, decreased activity, social isolation→ risk of falls, poor health outcomes → pain
  - Molton & Terrell, *American Psychologist* 2014

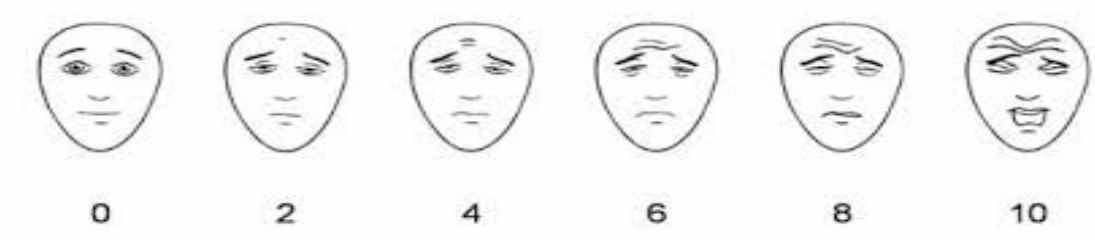
Assessing Pain in Older Adults

- Emphasize function/impact on daily activity, quality of life, mood
- Understand challenges
  - co-morbidities
  - Polypharmacy
  - Stoicism, 'it's part of getting old'
- Many cognitively impaired patients can report current pain levels
- In moderate to severe dementia, systematic treatment of pain decreases agitation

Husebo et al, BMJ 2011

Pain Assessment in patients with mild to moderate dementia

- Self report
- Faces Pain Scale



- Hicks, C, L., von Baeyer, C.L., Spafford, P.A., van Korlaarl., & Goodenough, B., (2001). The Faces Pain Scale–revised toward a common metric in pediatric pain measurement, *Pain 93* (2001); 173–183.

Pain Assessment in Advanced Dementia

ITEMS	0	1	2	SCORE
Breathing Independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low- level of speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying	
Facial expression	Smiling or inexpressive	Sad, frightened, frown	Facial grimacing	
Body language	Relaxed	Tense. Distressed pacing. Fidgeting	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out	
Consolability	No need to console	Distracted or reassured by voice or touch	Unable to console, distract or reassure	
		TOTAL*		

- **Total scores range from 0 to 10 (based on a scale of 0 to 2 for five items), with a higher score indicating more severe pain (0=”no pain” to 10=”severe pain”).**
- **PAINAD (Warden, Hurley, Volicer, 2003)**

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Non-Verbal Indicators of Pain

- Withdrawal, fatigue, grimaces, moans, and irritability, particularly in the patient unable to report his/her pain.
- Older adults: **confusion**, changes in behavior, **uncooperative/ resistance to care "combative",** and impaired mobility
- Any change from baseline

Managing Chronic Pain in Older Adults

- Negotiate goals of treatment in terms of function (physical, psychosocial)
- Acetaminophen preferred to NSAIDs
- Opioids should be considered for patients with refractory pain
  - Start low, go slow
  - Balance btwn side effects/function
- Manage side effects, esp constipation!
  - Patience – most SE resolve w/n 72 hours

Challenges to Pain management in Older Adults

- Multiple co-morbidities
- Polypharmacy
  - Beers List: Potentially Inappropriate Drugs for Elderly
    - On the list: ibuprofen, naproxen
    - Not on the list: opioids, acetaminophen
- Use of OTC meds
- Stoicism – “it’s part of growing old…”
- Fear of opioids (narcotics!) and side effects

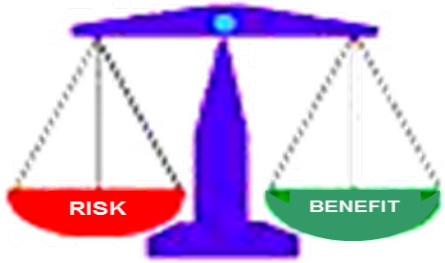
Case 3, continued

Mrs. S's chronic pain improved with scheduled acetaminophen. Yet you now hear that she has been admitted to the hospital after a traumatic fall in which she fractured her hip.

After surgery for her hip fracture, she becomes very confused. Her inpatient providers worry that opioids may be worsening her confusion.

Acute Pain in the Elderly - Challenges

- Reluctance by providers to due fears of precipitating side effects
  - Delirium
  - Sedation
  - GI changes
- Stoicism
- Not wanted to be a burden
- “Good patient” syndrome



Managing Acute Pain in Geriatrics

- Untreated pain is associated with longer hospital length of stay after hip fracture
  - Muscle atrophy → dec function
  - Inc risk for thromboembolism
  - Longer stays, inc costs
- Treating pain leads to better short- and long-term functional outcomes
  - Increased physiological workload
- Appropriate administration of opioids for acute post-operative pain *decreases* delirium in older adults

Morrison et al *J Gerontol* 2003 & *Pain* 2003

Managing post-op pain

- Always include concurrent treatment of pre-existing chronic pain
- Start opioids at 25-50% of the adult dose and titrate until pain is reduced to a mild & tolerable level
- Monitor closely for side effects from opioid accumulation (risk of toxicity increased w/morphine in pts with renal insufficiency)
- Regularly use a consistent pain scale appropriate to the level of understanding of the older adult

Case 3, continued

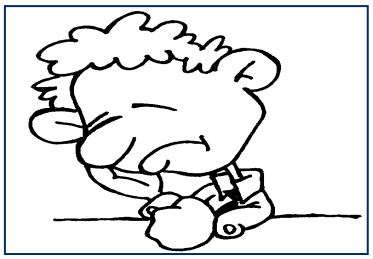
With your assistance in excellent pain management after her hip fracture and surgery, Mrs. S recovers and returns to her home with her daughter.

Over the years, her dementia has worsened. With your support and hospice, her daughter continues to care for Mrs. S. at home.

As she nears the last days of her life, her daughter asks you whether she should be taking morphine.

Assessing Pain at End-of-Life

- Many patients become somnolent or unresponsive in last days/weeks
- Not all patients have pain at end-of-life
- Pain assessment based on facial expression, non-purposeful movements
- Dyspnea can be assessed with observational scales, respiratory rate
- Consider trial of opioids, treating past or presumed pain



Managing Pain at End-of-Life

- Not all dying patients need morphine
- As patients become more somnolent, opioid-related sedation is less of a concern
- Counsel families about how opioids are being used, equivalent doses
- For patient transitioning to hospice care, consult hospice medical director for recommended regimen

Opioids in Last Days of Life

- Opioids are mainstay of pain and dyspnea management
- Bolus / PRN doses should be used to achieve comfort; drip or scheduled dosing is to maintain comfort
- Concentrated medications (e.g. morphine 20mg/mL) given SL are very useful when patients cannot swallow

Discussion

Questions / Comments / Challenges

with pain assessment and management in the geriatric & end-of-life setting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