Queen's UNIVERSITY

PAIN AND THE OLDER ADULT

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Pain

"Pain is an unpleasant sensory and emotional experience which we primarily associate with tissue damage or describe in terms of tissue damage, or both. The inability to communicate verbally does not negate the possibility that an individual is experiencing pain and is in need of appropriate pain – relieving treatment."(IASP)

The concept of 'total pain' was defined by Dame Cicely Saunders as the suffering that encompasses all of a person's physical, psychological, social, spiritual and practical struggles

Outline

- The problem
- Brief review of pathophysiology
- Assessment – focus on the older adult
- Introduction to pain care

'Pain changes you completely… It just takes your life away. Your whole personality changes.'

The Problem

- Lindstron et al. (2012): N=1402 age 60-96 Sweden. 62% experienced pain previous 4 weeks
- Freund et al. (2012): N=1407, 80% had pain
- Mobily et al. (1994): N=3673 rural 65+
  - 86% of elderly experience significant pain
    - 59% had multiple pain complaints
    - Joint pain (66.3%); leg pain (56.4%); back pain 28.3%

‘Pain is frustrating because you can’t do things for yourself… Everything’s a challenge.

The Problem continues…

- Proctor & Hirdes (2001): N=3195 Nursing home residents
  - 50% had pain
  - 24% had daily pain
- Kassalainen et al. (1998): 64 cognitively impaired, 19 intact with pain
  - 25% of cognitively impaired had analgesics ordered

‘It does affect your self-esteem because you always think about – well, I know it’s negative thoughts really that you shouldn’t have, but it’s very difficult not to sometimes. But you think about the things that you did do and you were a very sociable person.’

Patient Experience

What is it like to have chronic pain as a senior?

‘Pain can make you feel lonely because you feel that you’re the only one that is suffering and can cope with it, and that is a lonely experience.’

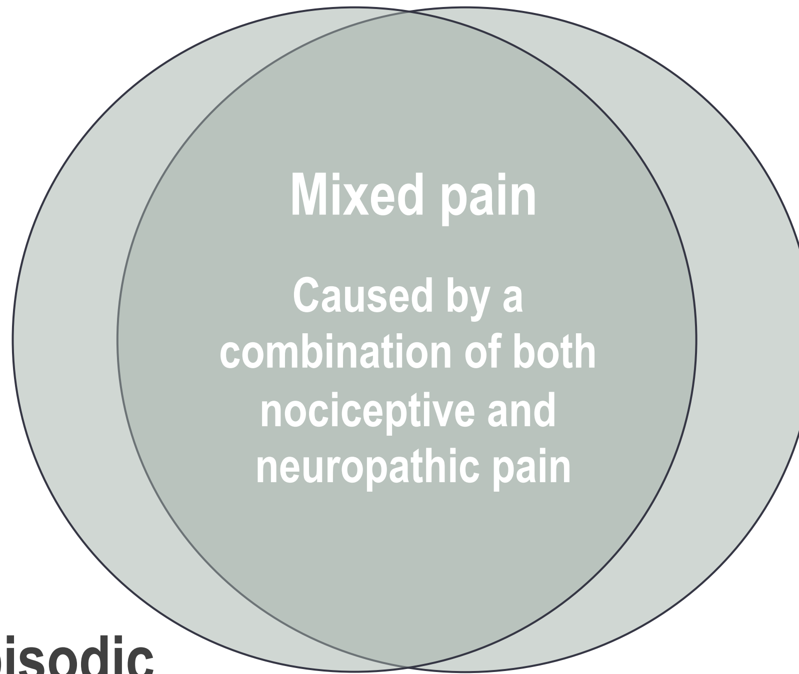
Case Study

Evelyn

- 70 years old, retired teacher, married with two grown sons
  - Slipped on ice 3 months ago: right femoral neck fracture
  - Right total hip arthroplasty – complicated recovery, occasional home physio
  - Still has pain! Taking Hydromorphone 1-2mg PO q3h PRN pain; acetaminophen 650mg PO q6h routinely
  - History includes: breast cancer (stage IV), chronic low back pain, osteoarthritis (knees, hips hands), chronic insomnia

Pain: nociceptive, neuropathic, or mixed

Nociceptive pain:
Caused by activity in neural pathways in response to potentially tissue-damaging stimuli



Neuropathic pain:
Pain arising as a direct consequence of a lesion or dysfunction in the nervous system

Incident/episodic pain: **pain pathways are activated intermittently**

Woolf CJ. Ann Intern Med 2004;140:441. Treede RD, Jensen TS, Neurology 2008;70:1630. Portenoy R. Curr Med Res Opin 2006;22:1555

Pain mechanisms in older adults

- Homeostenosis Barili et al. (1998)
  - Cognitive reserves
  - Density of opioid receptors
  - Comorbidities
  - Impaired descending inhibition
  - Social isolation, loneliness, depression

'I get very depressed and anxious about it… it's frightening, especially when you live on your own'

Pain mechanisms in older adults

- Pain thresholds
  - CONTRAVERSY!!!!
    - Better and worse tolerance to heat pain (Gibson et al. 2001 vs. Gibson et al., 2004)
    - Reduced capacity to “down-regulate” (Ferrell & Gibson, 2007)
    - Better coping ability (Wittink et al., 2006)
    - Less and more “affective” pain (Scherder et al., 1999 vs. Porter et al., 1996)

‘Pain is deep in my side and when it’s really bad I’m not able to breathe deep, because when I breathe in deep it hurts.’

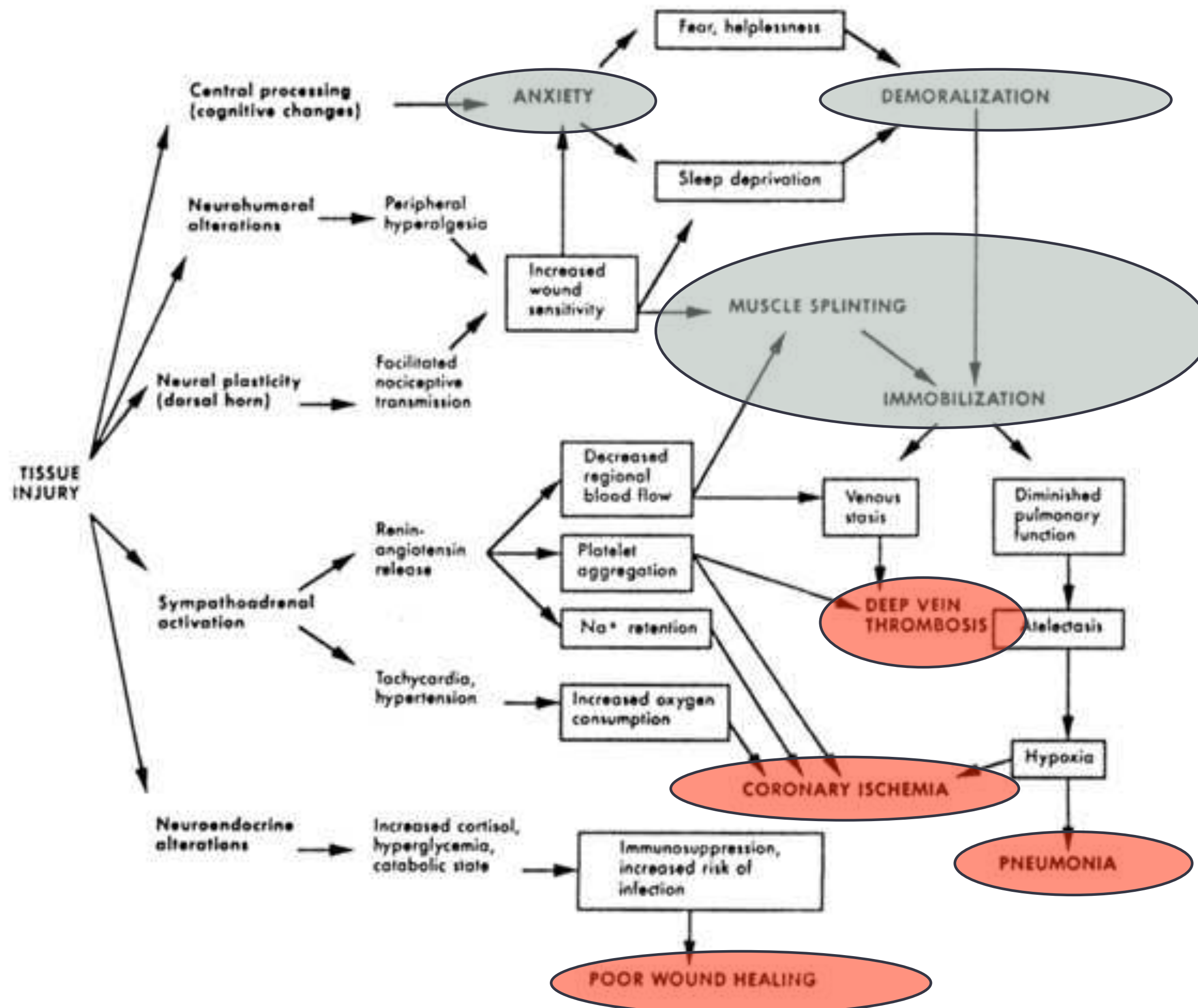
The "Why" of Comprehensive Pain Assessment

- Patients have the right to *the best possible evidence-based pain assessment and management including relevant bio-psychosocial components* (Guiding principles of BPG: RNAO, 2013. pp. 18)

- Establishes trust and improves satisfaction with care

- Patient-specific evaluation of interventions provided

Consequences of pain



Principles of Pain Assessment

- Self reporting is the "gold standard"
  - Affective components
  - Varies between individuals
  - Diurnal variation
- Systematic and frequent assessment is the most effective

'Pain is exhausting… You have to walk slowly. You have to stop and make an excuse or pretend to look in a shop window so that you can put your hand on the window and rest a moment. It's humiliating.'

The Adapted Pain Assessment Acronym

O - onset

P – provokes, palliates

Q – quality

R – region, radiation

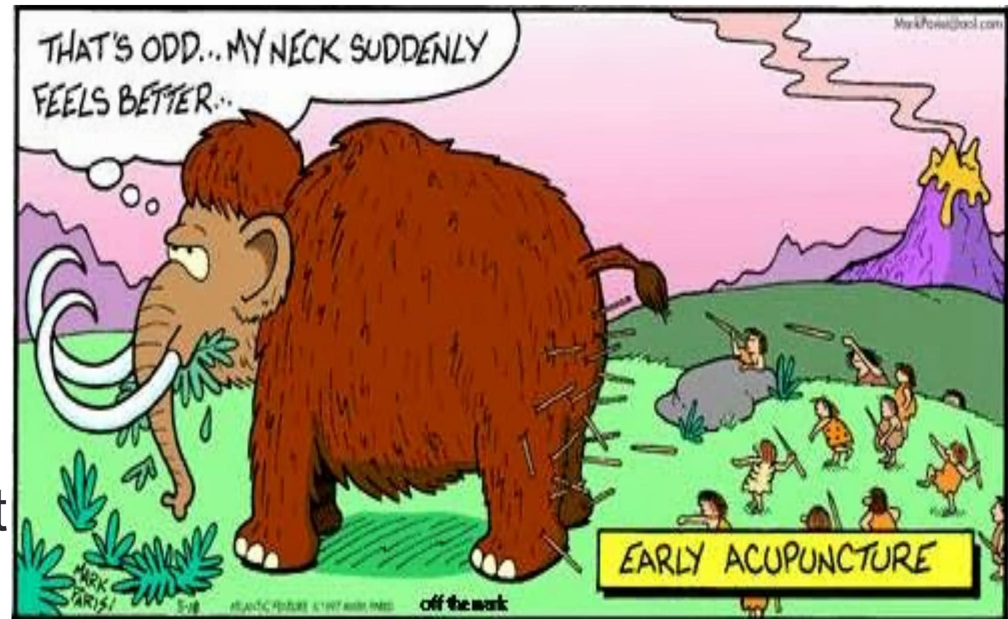
S – severity

T – timing/treatment

U – understanding/impact

V – values

…..and **C** – for communication!



http://rachelwentzbooks.blogspot.ca/2013_09_01_archive.html

RNAO (2013). *Clinical Best Practice Guidelines: Assessment and management of pain,* (3rd ed.). http://rnao.ca/sites/rnao-ca/files/AssessAndManagementOfPain2014.pdf

IMMPACT Recommendations

Core domains for clinical trials of chronic pain efficacy and effectiveness

- Pain: *MPQ, BPI, VAS/NRS*
- Physical functioning: *HRQoL, BPI, disease specific (e.g. WOMAC)*
- Emotional functioning: *POMS, BDI*
- Participant ratings of global improvement: PGIC
- Symptoms and adverse effects
- *Participant disposition*

www.immpact.org

Turk et al. Core outcome domains for chronic pain clinical trials: IMMPACT recommendations. 2003 Pain 106, 337-345.
Dworkin et al. Core outcome measures for chronic pain clinical trials: IMMPACT recommendations. 2005 Pain ;113: 9-19.

Measures of Pain Intensity: Uni-dimensional tools

- Quick and easy assessment of intervention efficacy
- Common metric of 0-10 adopted by many centres
- Standard tools – reliability/validity well documented
  - Visual Analogue Scale (VAS)
  - Numeric Rating Scale (NRS): 0 to 10
  - Verbal Rating Scale (VRS): No pain, mild, moderate, severe, very severe
    - Present Pain Intensity (PPI): No pain, mild, discomforting, distressing, horrible, excruciating
  - Faces Pain Scale – revised (FPS-R)

Pain assessment in the cognitively impaired

- Hadjistavropoulos et al. (2000)
  - Assess for ability to use self-report tools
    - Observational tools (i.e.PACSLAC:Fuchs-Lacelle & Hadjistavropoulos, 2004)
  - Physical exam and history, caregiver report
  - Consistency
  - Collected over time
  - Observation of response to interventions

Common Pain Behaviours in Cognitively Impaired Older Adults

AGS Panel on Persistent Pain in Older Persons (2002)

Facial Expressions

- Slight frown; sad, frightened expression
- Grimacing; wrinkled forehead; closed or
- tightened eyes
- Any distorted expression
- Rapid eye blinking

- **Verbalizations, Vocalizations:**
  - Sighing, moaning, groaning
  - Grunting, chanting, calling out
  - Noisy breathing
  - Asking for help
  - Verbal abuse

Common Pain Behaviours in Cognitively Impaired Older Adults

Body Movements:

- Rigid, tense body posture; guarding
- Fidgeting
- Increased pacing, rocking
- Restricted movement
- Gait or mobility changes

Changes in Interpersonal Interactions:

- Aggression, combativeness, resistance to care
- Decreased social interactions
- Social inappropriateness, disruptiveness
- Withdrawn

Common Pain Behaviours in Cognitively Impaired Older Adults

Changes in Activity Patterns or Routines

- Refusal of food, appetite change
- Increased rest periods
- Sleep, rest pattern changes
- Sudden cessation of common routines
- Increased wandering

Mental Status Changes:

- Crying or tears
- Increased confusion
- Irritability or distress

Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)

DATE: ______________ TIME ASSESSED: ___________ NAME OF PATIENT/RESIDENT: ____________________________

PURPOSE: This checklist is used to assess pain in patients/residents who have dementia and are unable to communicate verbally.

INSTRUCTIONS: Indicate with a checkmark, which of the items on the PACSLAC occurred during the period of interest.
Scoring the Sub-Scales is derived by counting the checkmarks in each column.
To generate a Total Pain Score sum all four Sub-Scale totals.

Comments: ____

Sub-scale Scores:

Facial Expressions	
Activity/Body Movement	
Social/Personality Mood	
Other	
Total Checklist Score	

* "Other" sub-scale includes physiological changes, eating and sleeping changes and vocal behaviours.

This version of the scale does not include the items "sitting and rocking", "quiet/withdrawn", and "vacant blank stare" as these were not found to be useful in discriminating pain from non-pain states.

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Note on Scoring: There is no recommended cut off score at this time. Scores all depend on the person and context (e.g., whether they are assessed over a shift or during a transfer). The authors recommend an individualized approach whereby a baseline series of scores is collected for each resident and then the nurse observes deviations from the score (also examining whether pain treatments result in decline in scores).
Email correspondence from Thomas Hadjistavropoulos May 28, 2007

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Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)

Facial Expressions	Present
Grimacing	
Sad Look	
Tighter face	
Dirty look	
Change in eyes (squinting, dull, bright, increased movement)	
Frowning	
Pain expression	
Grim face	
Clenching teeth	
Wincing	
Opening mouth	
Creasing forehead	
Screwing up nose	
Activity/Body Movement	
Fidgeting	
Pulling Away	
Flinching	
Restless	
Pacing	
Wandering	
Trying to leave	
Refusing to move	
Thrashing	

Activity/Body Movement	Present
Decreased activity	
Refusing medications	
Moving slow	
Impulsive Behaviour (e.g., repetitive movements)	
Uncooperative/Resistant to care	
Guarding sore area	
Touching/holding sore area	
Limping	
Clenched fist	
Going into foetal position	
Stiff/Rigid	
Social/Personality/Mood	
Physical aggression (e.g., pushing people and/or objects, scratching others, hitting others, striking, kicking)	
Verbal aggression	
Not wanting to be touched	
Not allowing people near	
Angry/Mad	
Throwing things	
Increased confusion	
Anxious	

Social/Personality/Mood	Present
Upset	
Agitated	
Cranky/Irritable	
Frustrated	
Other*	
Pale Face	
Flushed, red face	
Teary eyed	
Sweating	
Shaking/Trembling	
Cold & clammy	
Changes in sleep (please circle):	
Decreased sleep or	
Increased sleep during day	
Changes in Appetite (please	
Decreased appetite or	
Increased appetite	
Screaming/Yelling	
Calling out (i.e. for help)	
Crying	
A specific sound or vocalisation	
For pain 'ow', ouch'	
Moaning and groaning	
Mumbling	
Grunting	

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Issues related to pain: *Polypharmacy*

- Onder et al. (2012): N=4023 Nursing home residents
  - 49.7% polypharmacy (4-9 drugs)
  - 24.3% excessive polypharmacy (<10 drugs)
  - Residents with pain 2.31 times more likely to have polypharmacy

Discussion: Treatment/ Pain Care

- Interdisciplinary care
- Pharmacology
- Non pharmacological approaches
  - Psychological
  - Social
  - Educational
  - Complementary

Evelyn’s comprehensive pain assessment

- Risk?
- Previous pain history
- Current pain symptoms & characteristics
  - OPQRSTUV and C
  - Unidimensional and multidimensional tools
  - Effectiveness of interventions
- Functional impact
  - BPI-I, sleep quality, engagement in postoperative activities
- Psychosocial impact
  - Useful tools: PHQ-9 (screening for depression), PGIC, IEQ

Resources for clinical practice

- IASP: Pain in the Elderly
  - http://www.iasp-pain.org/AM/Template.cfm?Section=IASP_Press_Books2&Template=/CM/HTMLDisplay.cfm&ContentID=6379
- RNAO BPG
  - http://www.rnao.org/Storage/29/2351_BPG_Pain_and_Supp.pdf
- Canadian Pain Coalition
  - http://www.canadianpaincoalition.ca/index.php/en/about-us/media-room/2006/11/6/12
- RNAO LTC Best Practices Toolkit
  - http://ltctoolkit.rnao.ca/resources/pain

Empathy is really the opposite of spiritual meanness. It's the capacity to understand that every war is both won and lost. And that someone else's pain is as meaningful as your own.

Barbara Kingsolver