The Importance of Pain in the Elderly

- Pain is common
- Pain is under-treated
- Pain is multidimensional
- Presentation of pain is culturally based
- Pain assessment should be routine
- Pain is treatable
Objectives

- Understand how the management of pain affects the quality of life of the elderly patient.
- Develop an awareness of misconceptions and consequences of untreated pain.
- Recognize different types of pain and identify appropriate analgesics for each type.
- Utilize pain assessment tools as needed for facility residents.
- Understand how to determine correct doses of analgesics, as resident needs change.
- Understand that all team members have a role in assessment and treatment of pain.

Introduction

Responsibility for Effective Pain Relief

- Pain is **what a patient says it is**.
- Pain is **totally subjective**.
- The elderly do not always verbalize their pain but **express it is other ways**.
- Elderly patients often have more than one source of pain.
- The elderly are at increased risk of drug interactions.
Introduction
Responsibility for Effective Pain Relief

- Pain is common at end of life as a result of arthritis, circulatory disorders, immobility, neuropathy, cancer and other age-related conditions.
- Everyone experiences pain differently.
- Older patients report pain differently.
- Institutionalized elderly are often stoic about pain.

---

Introduction
Responsibility for Effective Pain Relief

- One person’s report of severe pain may seem like almost nothing compared to another.
- Caregiver’s challenge is to assess all relevant factors without imposing personal biases.
- **A person’s self-report of pain is the single most reliable indicator of pain.**
Introduction

Responsibility for Effective Pain Relief

- All geriatric care personnel and patient’s family share in the role of pain management.
- The elderly patient may not have pain when not moving and caregivers report pain when he or she is moving or doing ADLs.
- Everyone caring for the elderly must know to recognize and report pain.

Prevalence
Common Misconceptions about Pain

- The caregiver is the best judge of pain.
- A person with pain will always have obvious signs such as moaning, abnormal vital signs, or not eating.
- Pain is a normal part of aging.
- Addiction is common when opioid medications are prescribed.

Common Misconceptions about Pain

- Morphine and other strong pain relievers should be reserved for the late stages of dying.
- Morphine and other opioids can easily cause lethal respiratory depression.
- Pain medication should be given only after the elderly develops pain.
- Anxiety always makes pain worse.
Consequences of Untreated Pain

*What happens if pain isn’t properly treated in the elderly?*

- Poor appetite and weight loss
- Disturbed sleep
- Withdrawal from talking or social activities
- Sadness, anxiety, or depression
- Physical and verbal aggression, wandering, acting-out behavior, resists care
- Difficulty walking or transferring; may become bed bound

Consequences of Untreated Pain

*What happens if pain isn’t properly treated in the elderly?*

- Skin ulcers
- Incontinence
- Increased risk for use of chemical and physical restraints
- Decreased ability to perform ADL’s
- Impaired immune function
**Descriptions of Pain**

**Categories of Pain by Duration**

**Acute Pain**

*Brief duration, goes away with healing, usually 6 months or less.*

- Not necessarily more severe than chronic
- May be sudden onset or slow in onset
- Examples are broken bones, strep throat, and pain after surgery or injury

---

**Chronic Cancer Pain**

*Pain is expected to have an end, with cure or with death.*

- Aggressive treatment
- Addiction not a concern
Undertreatment of Pain in The Elderly

<table>
<thead>
<tr>
<th></th>
<th>AIDS*</th>
<th>Cancer**</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n=235)</td>
<td>(n=597)</td>
</tr>
<tr>
<td>Adequate analgesic medication</td>
<td>15%</td>
<td>58%</td>
</tr>
<tr>
<td>(P.M.I. = 0, +1, +2, +3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate analgesic medication</td>
<td>85%</td>
<td>42%</td>
</tr>
<tr>
<td>(P.M.I. = -1, -2, -3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Breitbart et al 1994  ** Cleland et al 1994

Categories of Pain by Duration

Chronic Non-Malignant Pain

*Pain has no predictable ending*

- Difficult to find specific cause
- Often can’t be cured
- Frequently undertreated
Pain Management

- Separate the indications for pain medications from the behavioral management of the patient
- Pain management requires a team approach which may require staffing to monitor, contain, and address addictive structures

Pain Syndromes
### Categories of Pain by Type

#### Somatic

<table>
<thead>
<tr>
<th>Source</th>
<th>Skin, muscle, and connective tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples</td>
<td>Sprains, headaches, arthritis</td>
</tr>
<tr>
<td>Description</td>
<td>Localized, sharp/dull, worse with movement or touch</td>
</tr>
<tr>
<td>Pain med</td>
<td>Most pain meds will help, if severe, need a stronger medication</td>
</tr>
</tbody>
</table>

#### Visceral

<table>
<thead>
<tr>
<th>Source</th>
<th>Internal organs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples</td>
<td>Tumor growth, gastritis, chest pain</td>
</tr>
<tr>
<td>Description</td>
<td>Not localized, refers, constant and dull, less affected with movement</td>
</tr>
<tr>
<td>Pain Med</td>
<td>Stronger pain medications</td>
</tr>
</tbody>
</table>
### Categories of Pain by Type

**Bone Pain**

<table>
<thead>
<tr>
<th>Source:</th>
<th>Sensitive nerve fibers on the outer surface of bone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
<td>Cancer spread to bone, fx, and severe osteoporosis</td>
</tr>
<tr>
<td>Description:</td>
<td>Tends to be constant, worse with movement</td>
</tr>
<tr>
<td>Pain Med:</td>
<td>Stronger pain meds, opiates with NSAIDS as adjunct</td>
</tr>
</tbody>
</table>

**Neuropathic**

<table>
<thead>
<tr>
<th>Source:</th>
<th>Nerves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples:</td>
<td>Diabetic neuropathy, phantom limb pain, cancer spread to nerve plexis</td>
</tr>
<tr>
<td>Description:</td>
<td>Burning, stabbing, pins and needles, shock-like, shooting</td>
</tr>
<tr>
<td>Pain Meds:</td>
<td>Opioates+tricyclic antidepressants or other djuvant</td>
</tr>
</tbody>
</table>
Pain Assessment

Asking about pain is an important part of ALL assessments!!

- Everyone caring for the elderly is to know to report pain.
- Nurses must assess all reports of pain.
- Assessments to identify and treat pain must be ongoing.
- Elderly patients require frequent monitoring for pain.

Patients with Dementia or Communication Difficulties

Consider the following when assessing elderly patients with dementia or communication problems:

- Ask the patient if he or she is having pain.
  - Consider the disease condition and procedures that may be causing pain.
  - Think “if I were that patient, would I want something for pain?”
Patients with Dementia or Communication Difficulties

- Use proxy pain reporting-family, staff
- Be alert for behaviors that may indicate pain
  - Facial expressions
  - Physical movements
  - Vocalizations
  - Social changes
  - Agitation

Psychological Aspects of Pain in the Elderly
Factors That Influence Under-treatment of Pain in the Elderly

- Gender: women with pain are twice as likely to be undertreated as men
- Education: those with less education are significantly likely to be under-treated
- Substance abuse history: patients with injection drug use history are significantly more likely to be under-treated
- Unusual medical circumstances:
  - Weaning post-op in COPD patient
Assessment

Comprehensive Pain Assessment

- Inquire about pain
- Self-report is the only means for gathering history
- Psychosocial assessment
- Physical and neurological exam
- Use of brief pain assessment tools
- Reassess after interventions
Pain Characteristics

- Pain Intensity
- Pain Quality
- Pain Distribution
- Factors that increase or decrease the pain
- Temporal characteristics
- Inferred pathophysiology

Pain Intensity* and QOL in Elderly Pain Patients

Functional Impairment** is Significantly Correlated With Pain Intensity (P < .0001)

*BPI – Numerical rating scale Pain Intensity Ratings for “worst” pain
**BPI – Functional Interference Subscale (Range 0-8, score of 5 or more = significant impairment)
**Instruments for Pain Measurement**

- **Pain Intensity Measures:**
  - **Examples:**
    - Categorical scale
    - Visual analog scale
    - Numerical scale
    - Scales for children (e.g. faces, poker chips)

- **Multidimensional pain measures:**
  - **Example:**
    - McGill pain questionnaire

- **Pain drawings**

- **Measures of pain and its impact:**
  - **Examples:**
    - Brief pain inventory
    - Memorial Pain Assessment Card

---

**Pain Scale**

<table>
<thead>
<tr>
<th>Least</th>
<th>Moderate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Just Noticeable</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mild</td>
<td>Excruciating</td>
</tr>
<tr>
<td></td>
<td>No Pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Severe</td>
<td>Weak</td>
</tr>
</tbody>
</table>

**Relief Scale**

<table>
<thead>
<tr>
<th>No</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relief of Pain</td>
</tr>
</tbody>
</table>

**Mood Scale**

<table>
<thead>
<tr>
<th>Worst</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mood</td>
</tr>
</tbody>
</table>

**Memorial Pain Assessment Card (MPAC)**

* Breitbart et al 1994  ** Cleland et al 1994*
Treatment and Management of Pain in the Elderly

Barriers to Effective Pain Management

- Patient barriers
- Provider barriers
- System barriers
Health Care System-related Barriers to Pain Management

- Lack of access to health care and specialized pain services
- Unavailability of opioid analgesics in many community pharmacies
- Cost of analgesics, defunding of drug benefits
  - Being in the “hole”
- State & federal regulatory practices which increase reluctance of physicians to prescribe opioids for severe pain because of scrutiny

Health Care Provider-Related Barriers to Pain Management in the Elderly

- Lack of knowledge regarding pain management principles
  - Inadequate ability to assess pain
  - Inadequate knowledge base of specific pain syndromes in the elderly
  - Poor understanding of anatomy and chemistry of pain
  - Lack of knowledge regarding basic pharmacology
  - Lack of understanding of effective analgesic care
  - Lack of knowledge and inability to understand behavioral, social, and psychological aspects of pain
Pain Management

- Establish protocols
  - Clearly identify purpose and use of analgesic
  - Identify your prescription policies
  - Patient care contracts
  - Relationship with pharmacists
Multimodal Management of Pain in the Elderly

- Pharmacotherapies
- Anesthetic interventions
- Psychotherapy
- Cognitive-behavioral therapy
- Rehabilitation
- Neurosurgical approaches
- Neurostimulation (TENS)

Clinical Pearls: Lessons Learned from Patients

- Remember the principles of pain assessment
  - pain is subjective
  - the patient alone can measure pain

- Remember the principles of pain medication
  - easy to tell when there is too much medication,
    impossible to tell when there is enough

- Eligibility for sainthood is not inversely proportional to the amount of narcotics prescribed in the lifetime of a physician
Treatment of Pain

- **Rules of thumb, common sense rules with elderly:**
  - Use the lowest effective dose by the simplest route
  - Start with the simplest single agent and maximize it’s potential before adding other drugs.
  - Use scheduled, long-acting pain medications for constant or frequent pain, with prn, short-acting medication available for breakthrough.
  - Treat breakthrough pain with one-third the 12 hours scheduled dose.

Treatment of Pain

- If three or more prn doses are used in a day, increase the scheduled dose.
  Increase by \(\frac{1}{4} - \frac{1}{2}\) of the prior dose.
  - Increase the prn dose when you increase the scheduled dose.

- Be vigilant at assessing the side effects of medication.
  - Treat or prevent side effects, such as constipation and nausea.

- Change medication as necessary.
Treatment of Pain

- Use the WHO’s step-wise approach, also called WHO Analgesic Ladder, Subsection 2.7 in Manual.
- Reevaluate and adjust medications at regular intervals and as necessary.
- Do not stop pain medication in terminal patients.
  - Change the route if needed.
Consequences of Undertreating Pain in the Elderly

- Disruption of doctor-patient alliance
- Increased “drug seeking” or “pseudo-addiction” behavior
- Increased fear and anticipatory anxiety that pain will not be adequately treated in the terminal phase
- Increased suicidal ideation/depression and demoralization

Pain Management in the Elderly

*Elderly present several pain management problems:*

- Little attention in the literature for physicians or nurses on topic of pain in the elderly
- Elderly report pain differently due to changes in aging-physically, psychologically, culturally
- Institutionalized elderly often stoic about pain
- Cognitive impairment, delirium, and dementia present barriers to pain assessment
Pain Management Risk for Elderly

- Frail elderly at risk for both under and over treatment of pain.
- NSAIDS and acetaminophen are effective and appropriate for a variety of pain complaints.
  - NSAIDS risk gastric and renal toxicity
- Unusual drug reactions more common in the elderly.
- Treater must be aware of side effects and there must be an effective communication method for staff to recognize adverse drug reactions.

What Everyone Can do to Manage Pain

- Show that you care.
- Talk to the patient, even if he/she doesn’t understand.
  - Talk to, not around, the patient.
- Take care of the basics-glasses, hearing aides, dry clothes toileting, food, fluids.
- Communicate with your team
  - If something worked, let others know what works.
What Everyone Can do to Manage Pain, cont.

- Always report pain. Pain IS NOT a normal part of aging.
- Understand the care plan for pain-management is a team approach.
- Use relaxation methods to decrease anxiety and muscle tension.
- Use tactile strategies like stroking and massage.
- Music, art and meditation can be very helpful.
- Don’t forget the team
  - PT for mobility and safety
  - OT for positioning and splints.

Analgesics Prescribed for “Severe” Pain

(BPI*-NRS= 8 - 10) in ambulatory patients, n = 114

<table>
<thead>
<tr>
<th>Treatment</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>26%</td>
</tr>
<tr>
<td>NSAID</td>
<td>41%</td>
</tr>
<tr>
<td>Anti-depressant</td>
<td>8%</td>
</tr>
<tr>
<td>Weak opioid</td>
<td>26%</td>
</tr>
<tr>
<td>Strong opioid</td>
<td>8%</td>
</tr>
</tbody>
</table>

WHO analgesic ladder would suggest that 100% of patients with “severe” pain would receive a strong opioid.
Pain Management Index (PMI):
A Measure of Adequacy of Analgesic Therapy

<table>
<thead>
<tr>
<th>Potency of Analgesic Prescribed</th>
<th>Level of Pain Patient Reports</th>
<th>= PMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = No Analgesic</td>
<td>0 = no pain</td>
<td>Range of –3 to +3</td>
</tr>
<tr>
<td>1 = A Non-opioid</td>
<td>1 = mild pain (1-3)</td>
<td></td>
</tr>
<tr>
<td>2 = A Weak Opioid</td>
<td>2 = Moderate pain (4-7)</td>
<td></td>
</tr>
<tr>
<td>3 = A Strong Opioid</td>
<td>3 = Severe pain (8-10)</td>
<td></td>
</tr>
</tbody>
</table>

P.M.I. = 0, +1, +2, +3 = adequate analgesic therapy
P.M.I. = -1, -2, -3 = inadequate analgesic therapy

General Principles of Pharmacotherapy in Pain

- Choice of analgesic based on severity and mechanism of pain
  - Opioids are the first choice of management of moderate to severe pain
  - NSAIDs, adjuvants, and nonpharmacologic modalities are important supplements to effective analgesia
- Preference for around-the-clock (ATC) administration and long-acting opioids for chronic or persistent pain
- Short-acting analgesics useful for intermittent pain and as supplement for breakthrough pain
- Increase dose of long-acting opioid if frequent rescue doses needed
Opioid Use in the Elderly

Educating your staff is essential!!

- Opioids produce higher plasma concentrations in older persons
- Greater sensitivity in both analgesic properties and side effects
- Smaller starting doses required
- Consider duration of action, formulation availability, side-effect profile, and patient preference.
- Review for drug interactions

Opioid Use in the Elderly, cont.

- Older persons may have fluctuating pain levels and require rapid titration or frequent breakthrough medication.
- Long-acting are generally suitable once steady pain levels have been achieved.
- Once steady pain relief levels are achieved, controlled-released formulas can be used.
- Fentanyl patches should not be placed on areas of the body that may receive excessive heat. Patches may be contraindicated with exceptionally low body fat.
Adjuvant Analgesic Drugs for Pain in the Elderly

- Tricyclic antidepressants
- Heterocyclic and non-cyclic antidepressants
- Serotonin reuptake inhibitors
- Psychostimulants
- Neuroleptics
- Benzodiazepines
- Anticonvulsants
- Mexileine
- Steroids
- Antihistamines
- Baclofen

Local Therapies for Pain in the Elderly

- Local anesthetics and other agents have been used for pain 2nd to intraoral ulceration and peripheral neuropathy:
  - Lidocaine
  - EMLA Cream
- Capsaicin cream
- Sucralfate and local anaesthetic “slurry”
- Colchicine, levamisole and oral steroids
Physical Modalities for Pain in Elderly

• Heat / Cold
• Massage
• Counterstimulation
• Exercise / Physical Therapy

Cognitive-Behavioral Techniques Used by Elderly Pain Patients

Psycho-education
• Preparatory Information

Cognitive Therapies
• Cognitive restructuring

Behavioral Therapies
• Self monitoring
• Modeling
• Behavioral Rehearsal
• Graded Task Management
• Contingency Management
### Cognitive-Behavioral Techniques Used by Elderly Pain Patients (Cont’d)

<table>
<thead>
<tr>
<th>Relaxation</th>
<th>Distraction</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Passive breathing</td>
<td>• Focusing</td>
</tr>
<tr>
<td>• Progressive muscle relaxation</td>
<td>• Controlled mental imagery</td>
</tr>
<tr>
<td></td>
<td>• Cognitive distraction</td>
</tr>
<tr>
<td></td>
<td>• Behavioral distraction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Combined Relaxation &amp; Distraction Techniques</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Passive relaxation with mental imagery</td>
</tr>
<tr>
<td>• Progressive muscle relaxation with mental imagery</td>
</tr>
<tr>
<td>• Systemic Desensitization</td>
</tr>
<tr>
<td>• Meditation</td>
</tr>
<tr>
<td>• Hypnosis</td>
</tr>
<tr>
<td>• Biofeedback</td>
</tr>
<tr>
<td>• Music Therapy</td>
</tr>
</tbody>
</table>

---

### Summary

- Pain must be a focus of care in the elderly patient
- Pain in the elderly is often undertreated, especially in women and substance abusers
- Principles guiding the management of pain in the elderly are similar to those developed in cancer pain
- A multidisciplinary approach to pain management in the elderly is optimal
“The good news is, you have my favorite disease.”