Pain in the older adult- Assessment and Management

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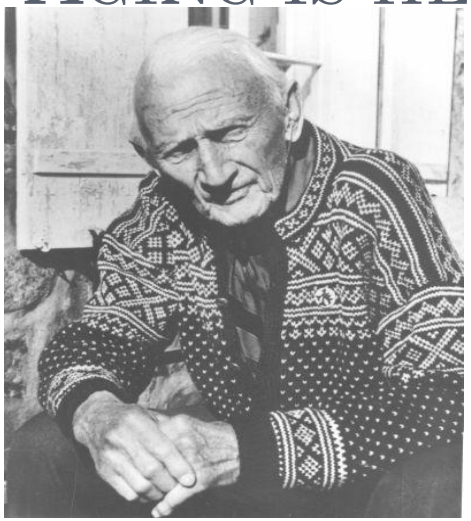
Outline

- Definitions and Prevalence
- General principles
- Multiple sources of pain
- Consequences of pain and under-treatment
- Assessment
- Therapy
- Elder friendly hospital program
- Resources
- Summary- video

Aging

"Aging is a process that converts healthy adults into frail ones with diminished reserves in most physiologic systems and with an exponentially increasing vulnerability to most diseases and to death"

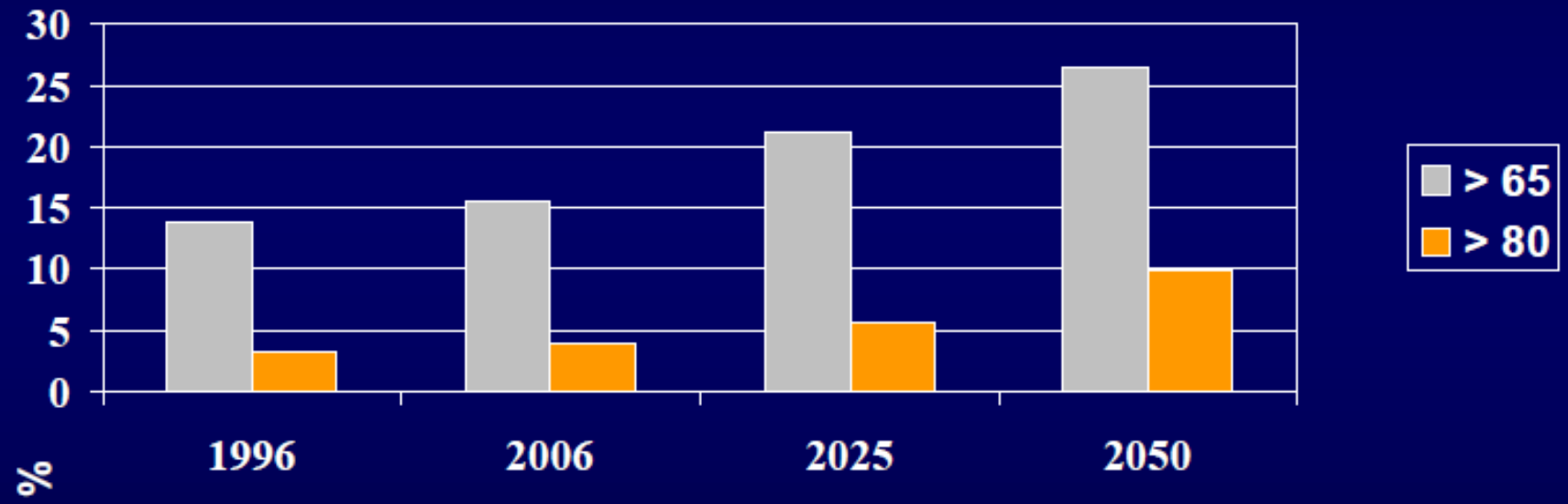
Aging is heterogeneous



What is pain?

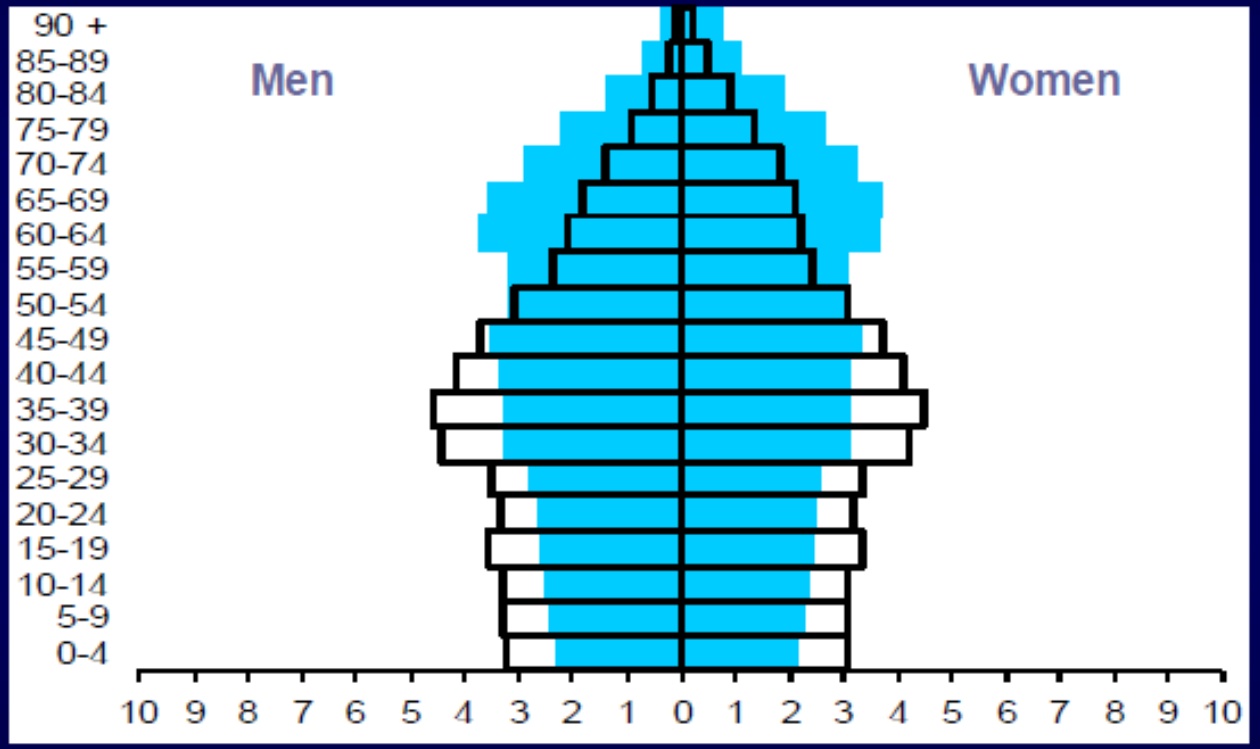
- PAIN is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage". (IASP)
- Pain is what the patient says it is and exists when the patient says it does (McCaffrey M. &Passero C Pain clinical manual 2nd edition1999)
- Pain is always subjective and each individual learns the meaning of pain through their experiences of injury or disease during life. (McCaffrey M. &Passero C Pain clinical manual 2nd edition1999)

Aging of the population



Source: U.S. Census Bureau, International Programs Center, International Data Base

Aging of the population

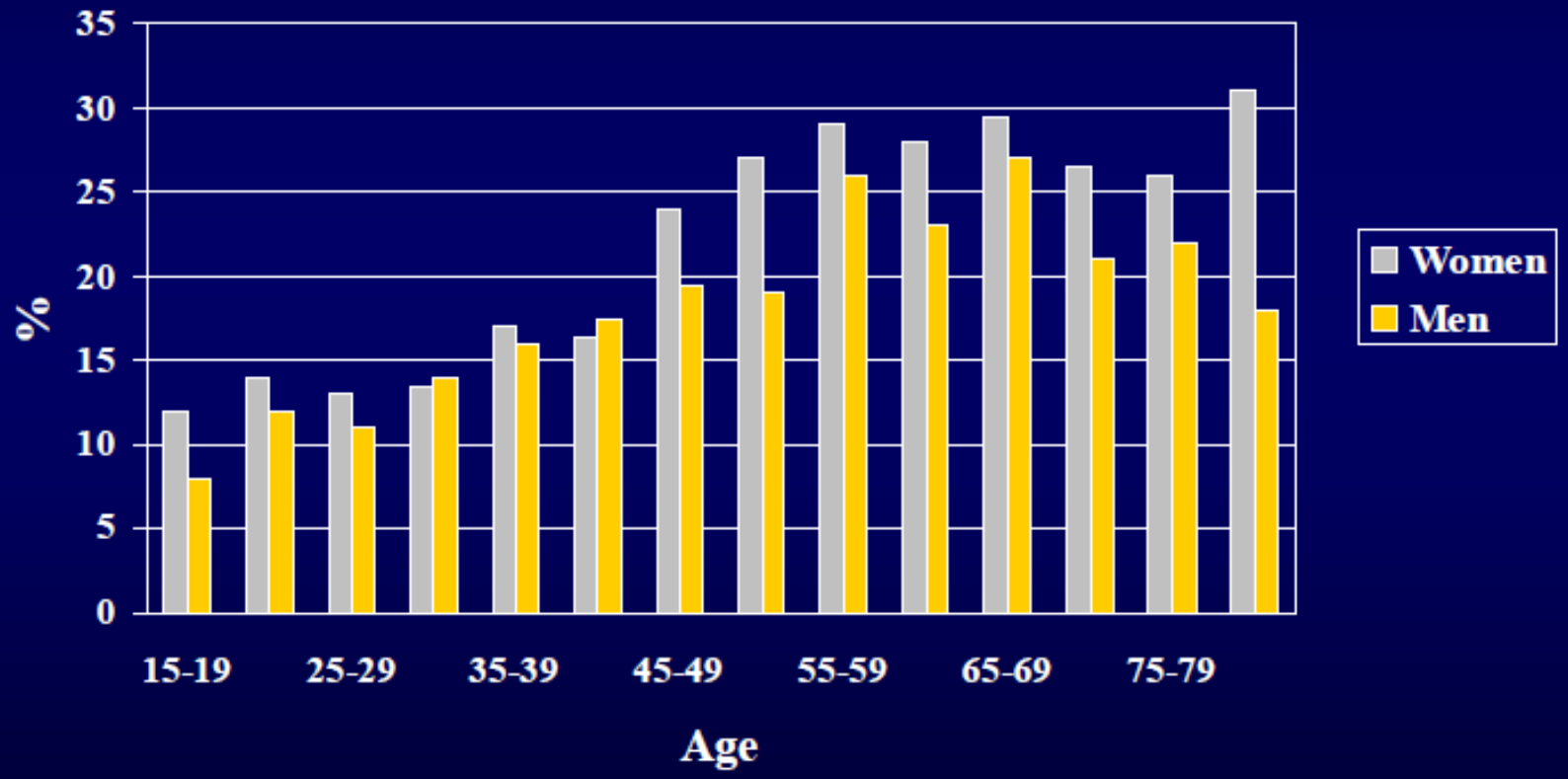


Quebec 1996, n = 7 246 896

Quebec 2026, n = 8 085 848

Source : *MSSS, SDI, 2005*
Institut de la statistique du Québec (ISQ), 2005

Prevalence of chronic pain



(Blyth et coll., 2001)

Prevalence- Pain in the elderly

- Common- more likely to suffer from cancer, bone and joint problems, and arthritis.
- Fractures are associated with morbidity and mortality
- Studies suggest that moderate to severe pain in community-based elderly population is 25-50%.
- Chronic pain in long-term care is more common with estimates at 45-80% of residents have significant pain.

We know that…

- Prevalence of pain increases with age
- Majority of elderly have significant pain that is under-recognized and undertreated
- Pain assessment and management more difficult in patients with dementia – ++under-recognized, +++undertreated
- Elderly patients are reluctant to report pain
- Pain assessment can be complex given many elderly patients have either acute or chronic pain or both
- Generally, elderly patients present with multiple sources of pain
- They may have atypical presentation of pain
- Reluctance to use opioids
- Serious consequences to undertreating
- Serious consequences for medication SE and interactions

Multiple sources of pain the elderly

Site of Pain	Common Pain Syndromes- non-cancer
Head and neck	Trigeminal neuralgia Cluster headaches Cervical osteoarthritis
Joints	Shoulder and hip osteoarthritis Rheumatoid arthritis
Back/Spine	Osteoporosis Vertebral body collapse Disc disease, stenosis, osteoarthritis
Extremities	Peripheral neuropathy Peripheral vascular disease
Heart	Angina
Trunk	Postherpetic neuralgia Diabetic radiculopathy Persistent postsurgical pain
Gastrointestinal	Hiatus or inguinal hernia Chronic contipation Irritable bowel syndrome

Consequences of pain in the elderly

Diminished quality of life

- Functional and cognitive impairment
- Impaired gait and posture (falls)
- Slow rehabilitation
- Mood changes (depression, anxiety)
- Decreased socialization
- Sleep, appetite and sexual disturbances
- Increased healthcare use, costs

Under-treatment of pain in the elderly

Patient may underreport pain:

- Belief that pain is a natural consequence of aging
- Fear that the pain may herald serious illness
- Not using the word “pain” in their description of symptoms.

Sensory and cognitive impairments may reduce the reduce the individual’s ability to communicate suffering.

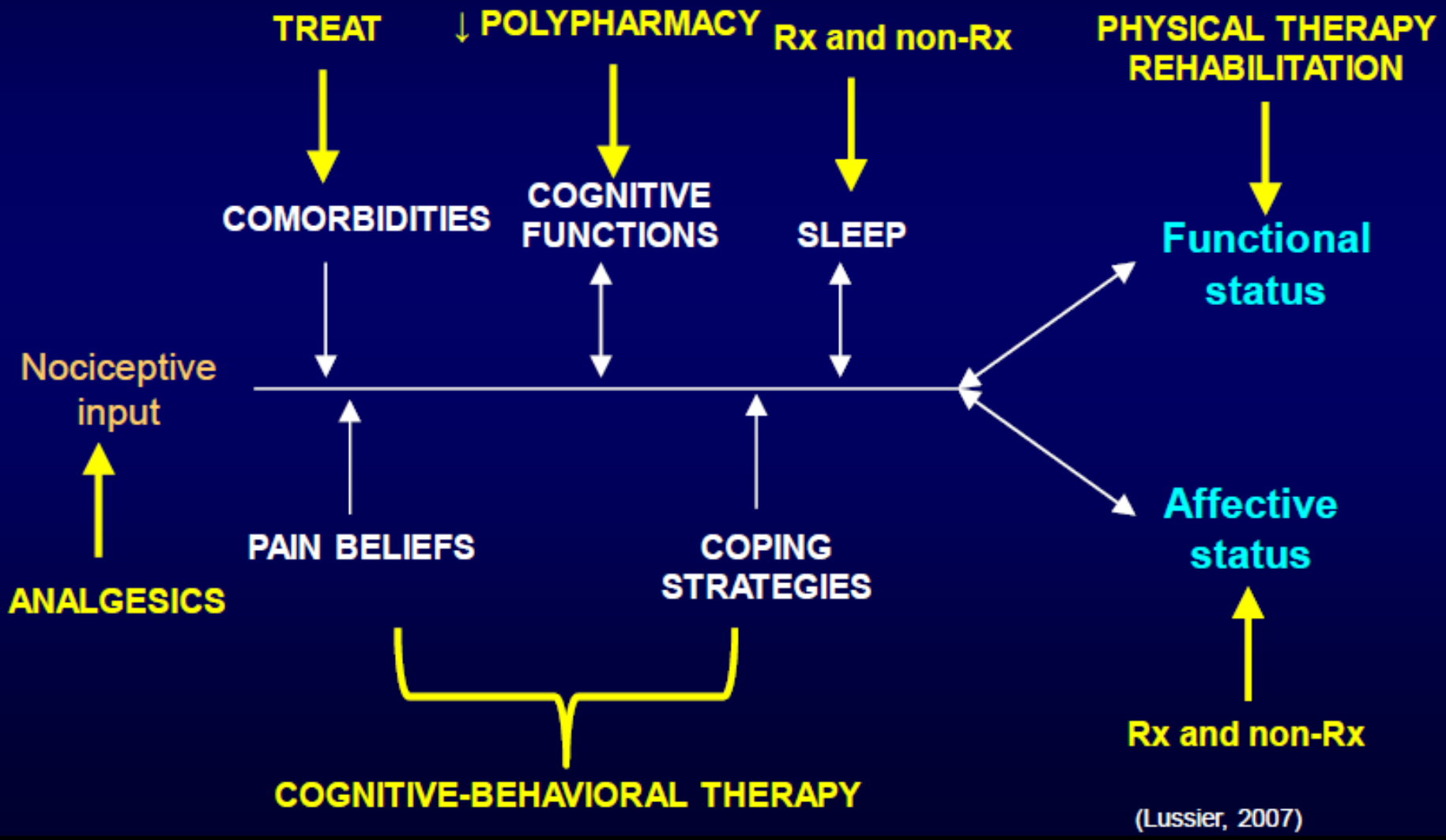
Health care professionals:

- May not be sufficiently knowledgeable of chronic and cancer pain illness, and mistake the changes of aging for reversible or treatable disorders.
- Fail to ask the patient or family about pain or discomfort, especially in the cognitively impaired.
- Reluctant to use opioids in the older adult for fear of causing confusion, delirium and other side effects of using opioids.

Age-related changes in the elderly

Absorption	Reduced	↑ gastric pH ↓ intestinal blood flow ↑ gastric emptying
Distribution	Delayed	↓ lean body mass ↑ body fat ↓ total body water ↑ plasma protein
Metabolism	Reduced	↓ Liver mass ↓ microsomal enzyme activity ↓ hepatic blood flow
Excretion and elimination	Reduced	↓ glomerular (kidney) filtration rate ↓ creatinine clearance ↓ renal blood flow

Geriatric Pain Model



(Lussier, 2007)

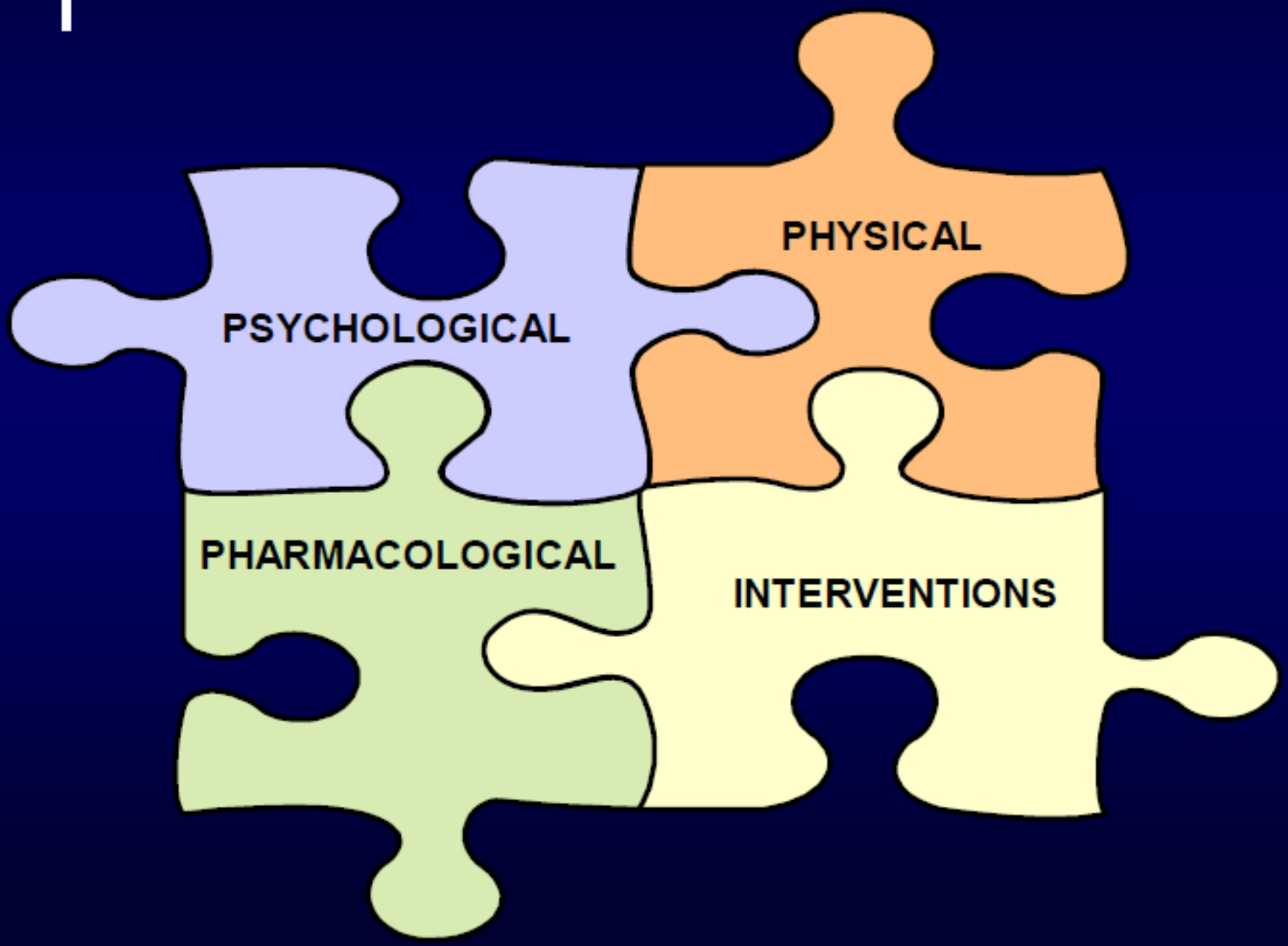
Assessment of pain

- Review of medical history, physical exam, and laboratory and diagnostic tests in order to understand sequence of events contributing to pain.
- Assess cognitive and functional status and coping.
- Assess present pain using PQRSPUV
- Assess pain history, including injuries, illnesses, and surgeries; pain experiences; and pain interference with daily activities.
- Review medications, including current and previously used prescription drugs, over-the-counter drugs, and home remedies. Determine which pain control methods have previously been effective for the patient. Assess attitudes and beliefs about use of analgesics, adjuvant drugs and non-pharmacological treatments.

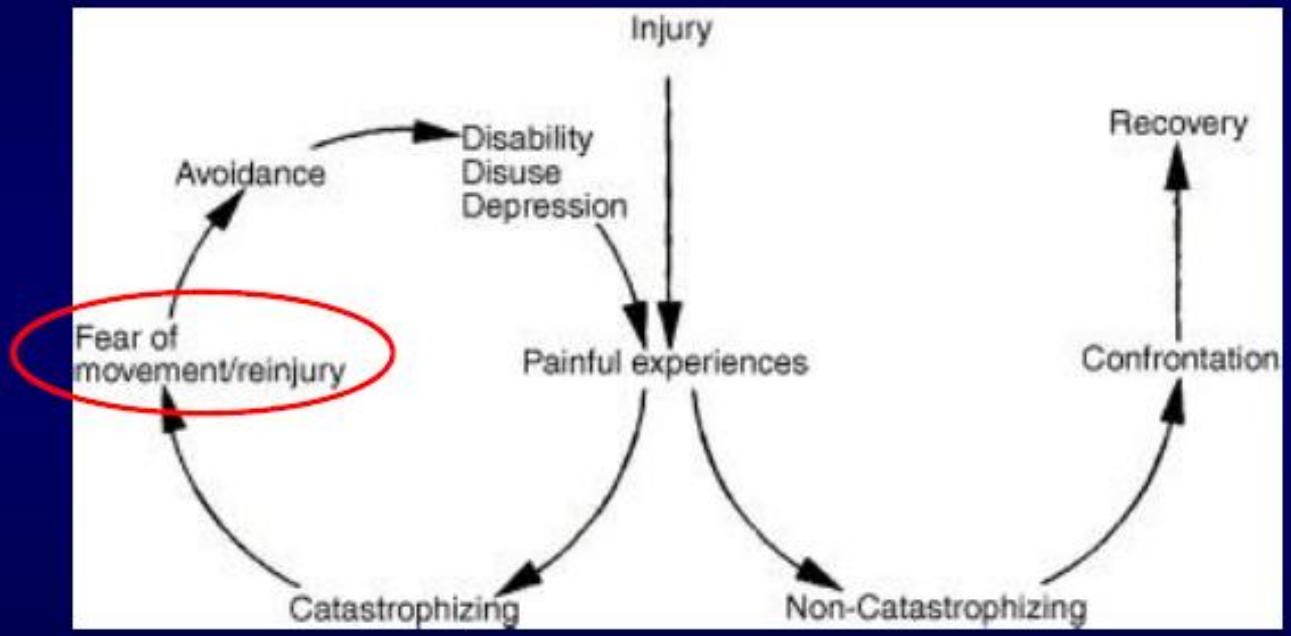
Assessment of pain con't

- Use a standardized tool to assess self-reported pain (0-10, PainAD)
- Monitor pain intensity (at rest and with activity) after management strategies have been started (diary to evaluate effectiveness)
- Observe for nonverbal and behavioural signs of pain, including changes in the patient's usual patterns.
- Gather surrogate information (caregivers, family members) about the patient's pain experiences.

Pain management

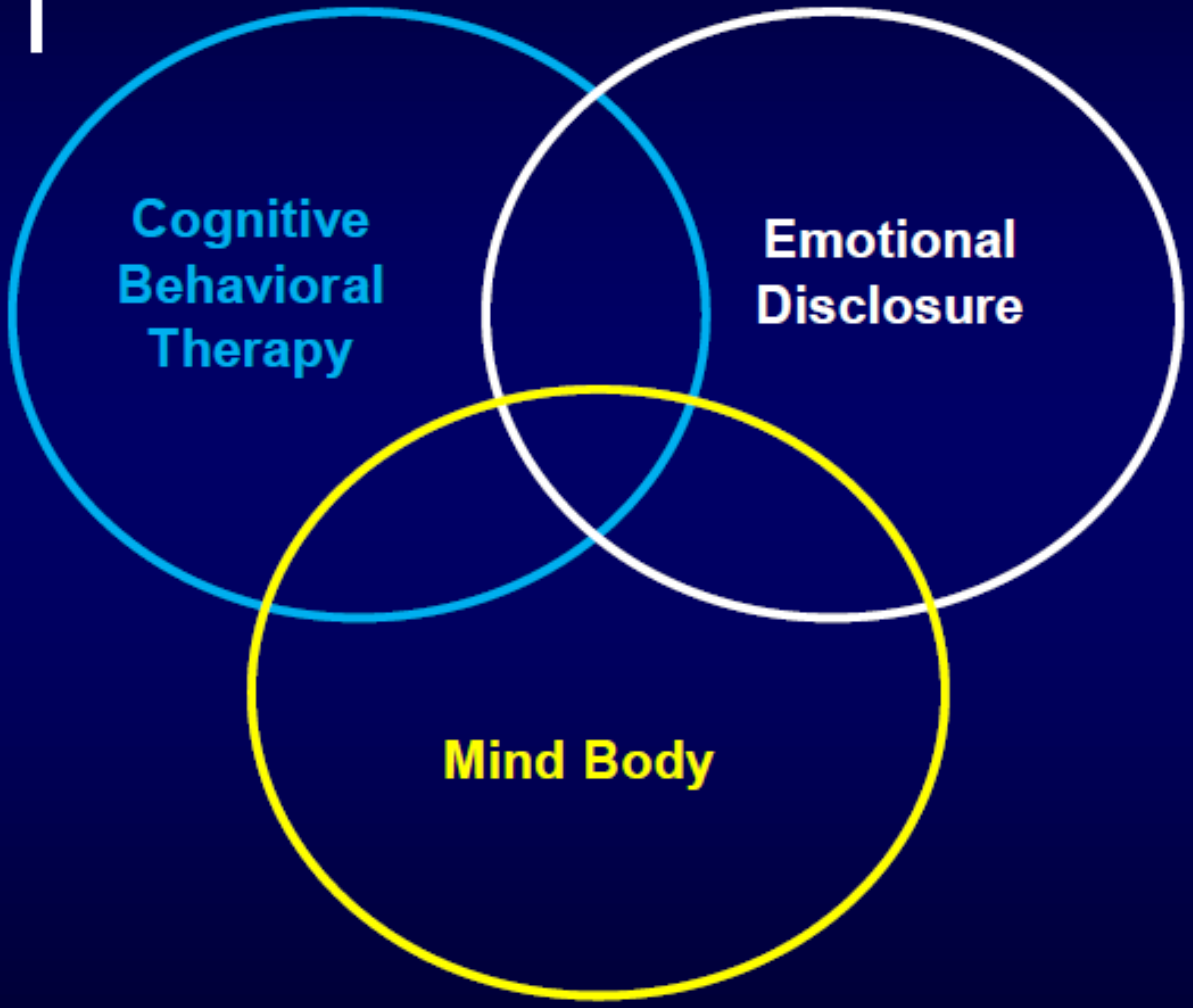


“Fear of movement”

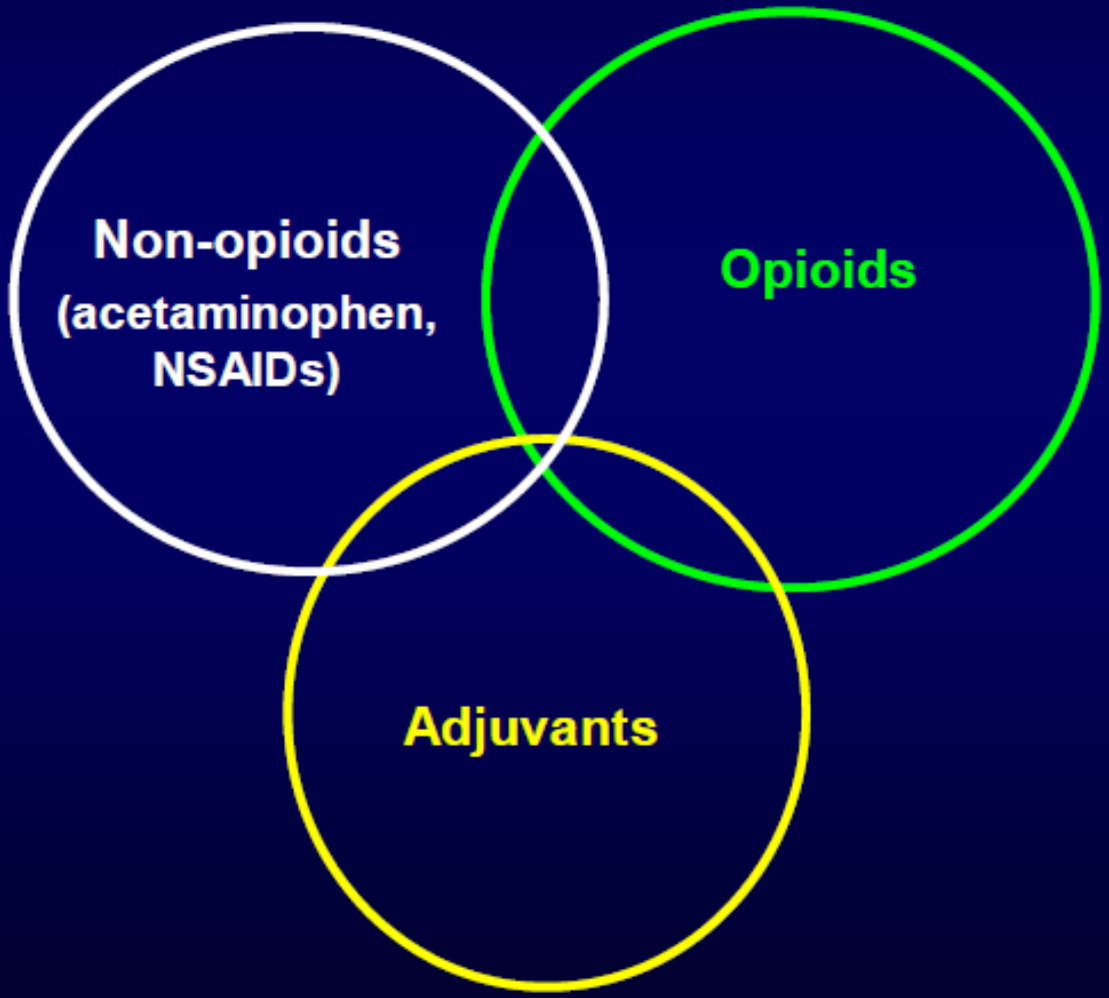


Andrew J. Cook , Peter A. Brawer , Kevin E. Vowles
The fear-avoidance model of chronic pain: Validation and age analysis using structural equation modeling
Pain, Volume 121, Issue 3, 2006, 195 - 206

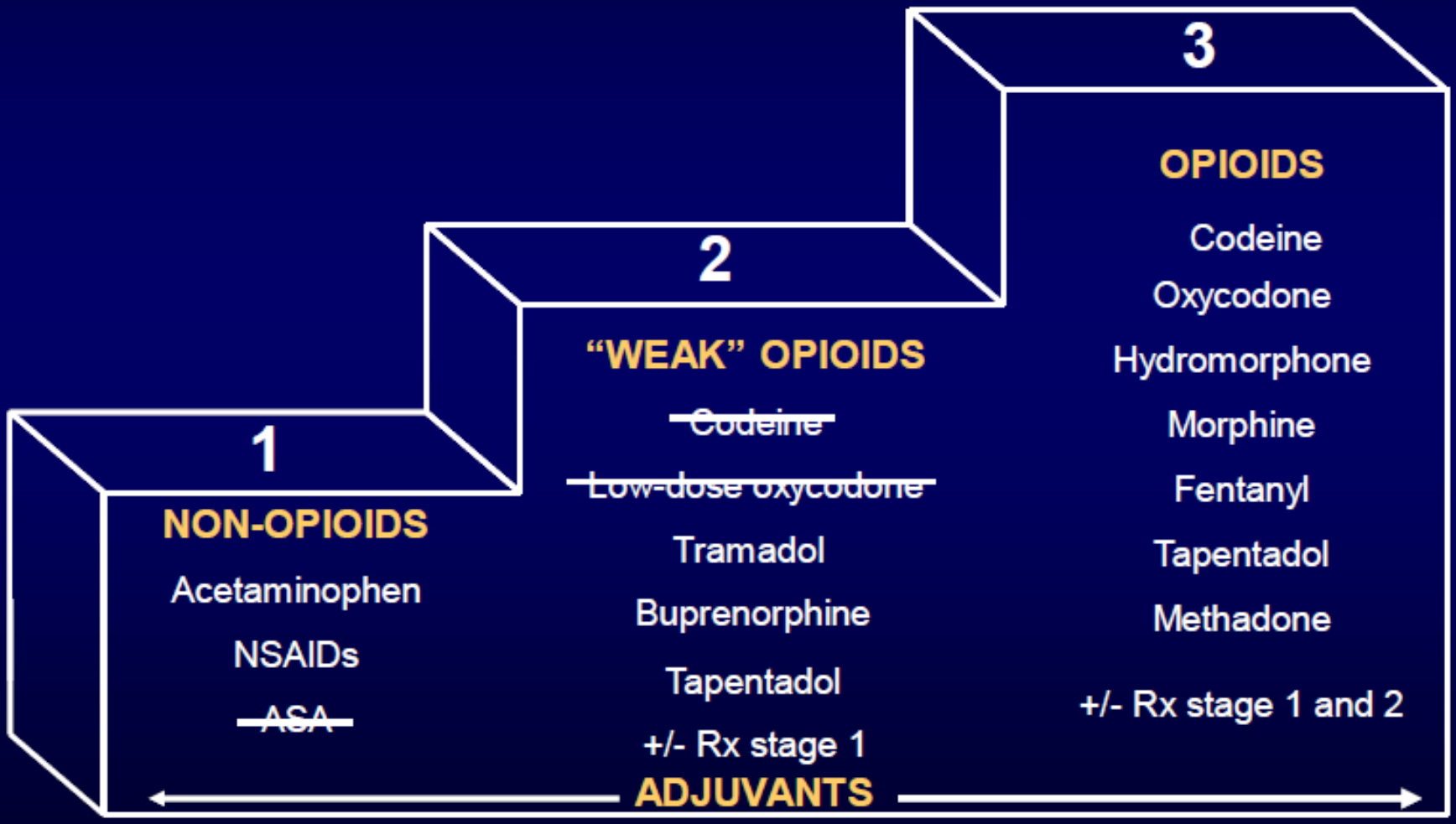
Psychological approaches



Pharmacological treatment



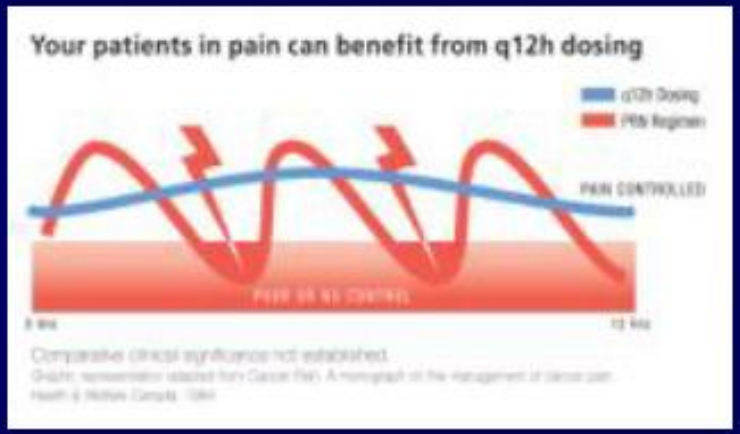
WHO Analgesic Ladder



Goal: optimize balance between analgesia and adverse effects

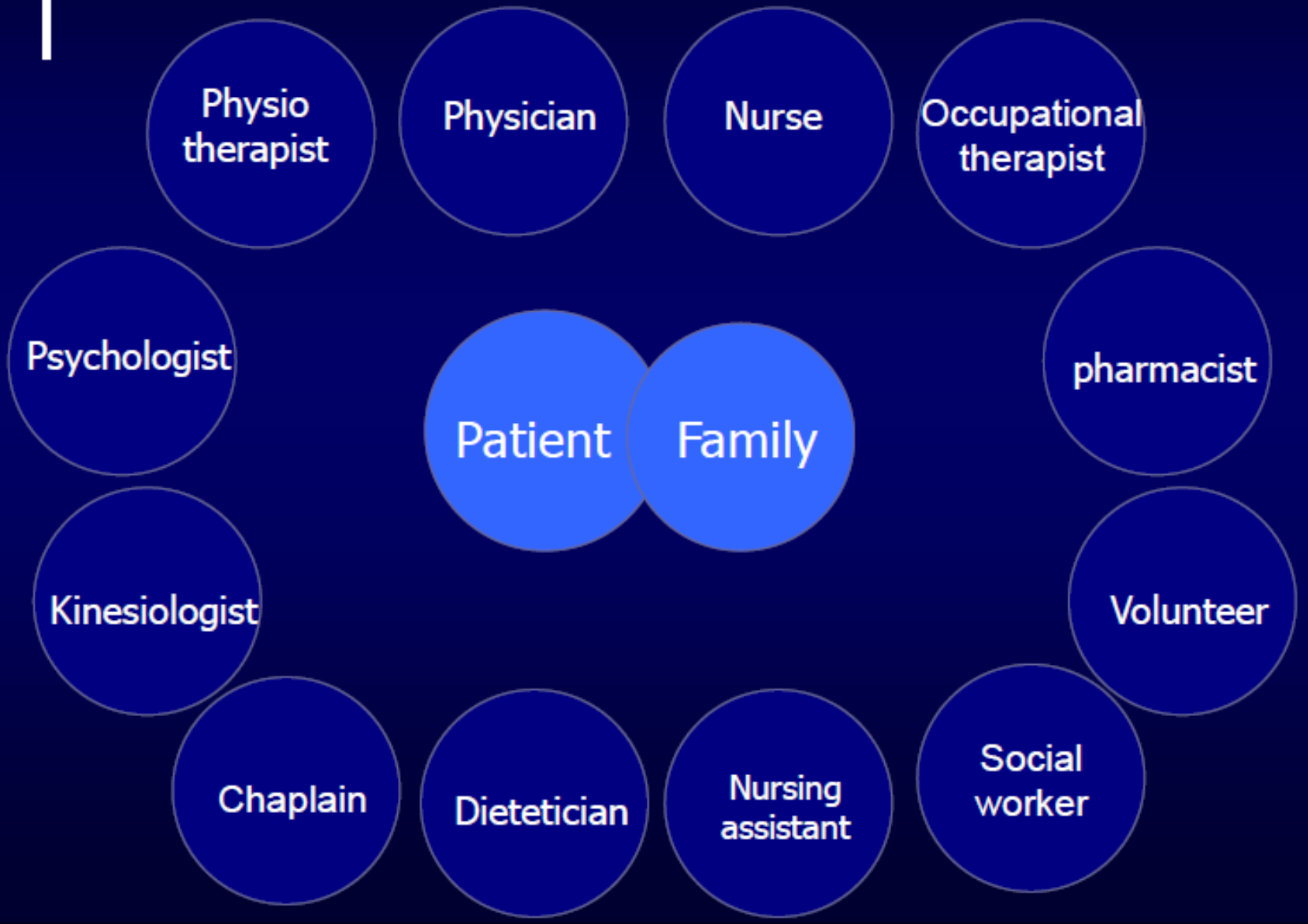
Long-acting opioids

- Avoid fluctuations of pain intensity and adverse effects secondary to variations of plasma levels



- ↓ number of daily tablets
  - ↑ compliance
  - ↓ dependency on nursing staff and family
- Better sleep

Interdisciplinary management



MUHC Elder Friendly Hospital Program

Approche adaptée à la personne âgée (AAPA)

Summary – content & structure of AAPA

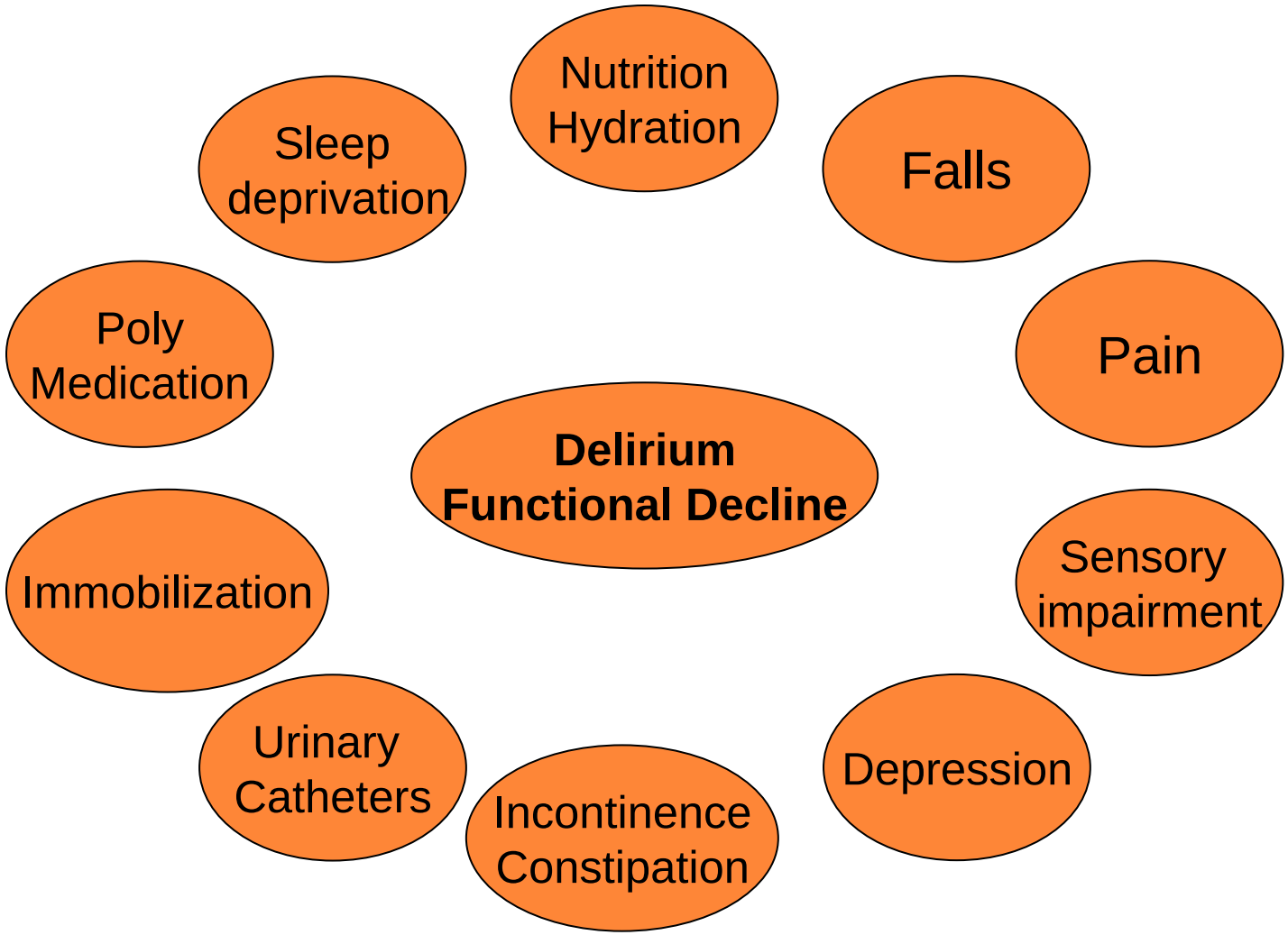
Focus –

- Patient 75 y.o. and older
- Known risks of hospitalization:
  - Functional Decline
    - Immobilization syndrome
  - Delirium
- All clinical processes
  - Esp. D/C planning (FSAG)
- Multiprofessional
- Multidepartmental

MUHC Elder Friendly Hospital Program

Approche adaptée à la personne âgée (AAPA)

Factors impacting Delirium & Functional Decline



MUHC Elder Friendly Hospital Program

Approche adaptée à la personne âgée (AAPA)

AAPA Goals

- Decrease **iatrogenic complications** for 75+ -
  - Screen to identify at-risk patients
  - Evaluate pt's baseline upon admission
  - Intervene to prevent or correct complications
- Measure the impact of our interventions on:
  - ALOS
  - readmission rate
  - need for long term care
  - hospitalization costs

AINEES

- **A**- autonomy - in ADLs, mobility
- **I**- skin integrity- wounds, incisions
- **N**- nutrition and hydration
- **E**- "etat cognitif" dementia, delirium
- **E**- elimination- continence, constipation, catheter
- **S**- sleep hygiene

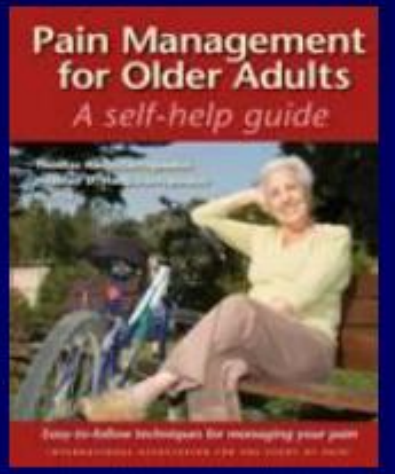
For more information …

Gibson SJ, Weiner DK, eds. *Pain in Older Persons*, IASP Press, 2005

Beaulieu P, ed. P*harmacologie de la douleur*. Montréal, Qc : Presses de l'Université de Montréal, 2005

Lussier D. Douleur chronique. Arcand M, Hébert R, eds. *Précis pratique de gériatrie*. Montréal, Qc: Edisem Maloine, 2007

Beaulieu P, Lussier D, Porreca F, Dickenson AH, eds. *Pharmacology of Pain*. Seattle, USA: IASP Press, 2010



Hadjistavropoulos T, Hadjistavropoulos H, eds. *Pain management for older adults: a self-help guide*, IASP Press, 2007

Summary

- Video
- Stay active
- Know your medical and surgical history
- Carry a list of your medications
- Do you have a general practitioner?
- Questions?

Thank you

NSAIDs in older patients

Pharmacological Management of Persistent Pain in Older Persons

American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons

II) Non-selective NSAIDs and COX-2 selective inhibitors may be considered rarely, and with extreme caution, in highly selected individuals

(A) *Patient selection*

- other (safer) therapies have failed
- Evidence of continuing therapeutic goals not med
- ongoing assessment of risks and complications outweighed by therapeutic benefits

VII) All patients taking nonselective NSAIDs and COX-2 selective inhibitors should be routinely assessed for

- G-I toxicity
- renal toxicity
- hypertension
- heart failure
- other drug-drug and drug-disease interactions