



Hospice of the Twin Cities

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*“It is not what we get,
but who we become,
what we contribute...
that gives meaning to
our lives.”*
- Anthony Robbins

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Assessment and Management of Pain in Older Adults: A Review of the Basics

About 80% of long-term care residents experience chronic pain and a somewhat smaller number, about 25-50% of those older adults who live out in the community experience chronic pain.¹ It is reported that 28% of minority patients experience pain on a daily basis.² There are many predictors of chronic pain in minority populations: *being a Medicaid recipient; having two (2) or more comorbidities; low educational level; and psychological distress.*³

Usually people who experience pain seek relief for their pain. However, in the older adult only one (1) in five (5) seek relief for their pain. There are several possibilities of what the barriers may be: *Under-treatment by prescribers; financially unable to afford the medications; or a reluctance on the part of the older adult to take pain medications.* It is probably a combination of the above that keeps older adults from getting medical treatment for their pain.³

What are the effects of untreated pain in this population? The answer would be many, and far-reaching. They could be *depression; anxiety; decreased socialization; sleep disturbances; impaired ambulation; and increased healthcare utilization and costs.*³ Those who go untreated or under-treated are unable to live a full and functional life. Therefore, it is important professionals who work with the elderly make sure those suffering from pain are appropriately treated for their pain. This includes *careful prescribing, ongoing reevaluation, and a combination of treatments.*³

Clinical Assessment of Pain

Our goals for assessing pain in the elderly are the same goals we have for assessing pain in the young. However, the elderly are more reluctant to report pain for a number of reasons: *they think pain is a normal part of the aging process; they do not want to be a bother; and they fear there may be consequences to admitting their pain, like follow-up procedures and hospitalizations that can be costly for those on a fixed income.*³

Knowing the elderly may be reluctant to report pain, it is important for medical professionals to be diligent about assessing pain in this population. A thorough assessment includes *a detailed history, including characterization of the present pain complaint, pain-related history, and the impact of the pain on the patient's quality of life; a physical exam; and an appropriate diagnostic assessment.*³

The Medical History:

This history should include information about all known medical conditions and physical limitations. There are many different reasons for persistent pain in the elderly, including *peripheral vascular disease; diabetes; post-stroke syndrome; decubitus ulcers; oral/dental problems; contractions; degenerative joint disease; rheumatoid arthritis; previous fractures; and osteoporosis,* to name a few. It is also important to include a history on liver, GI, and kidney dysfunction because it could have a pharmacological

Assessment and Management of Pain in Older Adults (Cont.)

impact. A complete medication history is also important and should include prescription medications, over the counter drugs, and herbal remedies. A history of alcohol use is also a necessity because it may have a pharmacological impact regarding drug choices.³

Present Pain Complaint:

The pain an individual is experiencing should include all of the “pain’s characteristics”, including *type; quality; location; intensity; and etiology*. It is also important to evaluate what lessens the pain, increases the pain, effective treatments and the individual’s response to past treatments.

The type of pain described by the patient could be caused by damaging stimuli to tissue (skin, muscle, bone, organs) or nociceptive pain. If the pain is caused by the nervous system it is called neuropathic pain. Some patients suffer from a combination of different types or pain, and therefore, need a combination of treatments.³

Another important factor when assessing the pain in any individual, and especially in the elderly, is to use words they use in their vocabulary. They may not refer to pain as pain, but may refer to it as being “sore”, “achy”, “hurting”, etc. Once you understand the words they use to describe pain, continue to use those words. This method is very important when dealing with elderly individuals who may have some memory impairment.³ It is possible to get an accurate, self-report of pain from a memory impaired patient.

Assessment Tools:

There are several assessment tools available to evaluate the intensity of the pain being experienced by the patient. There are ***Numeric Scales; Verbal Rating Scales; Visual Analog Scale; and FACES pain rating scale***. The numeric scale can be vertical or horizontal, usually from values of 0 – 10, with 0 being “no pain” and 10 being the “worst pain imaginable”. Verbal rating scales also can be vertical or horizontal, but use words to describe the intensity of pain, instead of numeric values, and the FACES scale is actually a series of faces ranging from a “smiley face” to a face that is “sad with tears” and the different stages from smiling to sad, with tears, in-between. A multidimensional scale can be very useful because they usually contain a body map for the patient to mark where the exact location of the pain is. When patients have chronic pain the use of a multidimensional assessment tool is necessary.³

Assessment in the Cognitively Impaired:

When a patient has a cognitive impairment it is necessary to use behavioral indicators to assess the pain. They include: *Nonverbal cues (restlessness, agitation, guarding, diaphoresis, muscle tension, muscle rigidity); verbal cues (crying, moaning, calling out, acting out, sighing, groaning); and facial expressions (grimacing)*. Patients may also exhibit changes in behaviors, including activities. These behaviors may include *combativeness, resisting care, decreased social activities, acting out, increased wandering, difficulty sleeping and refusing to eat*. **Nursing Assistants are very important observers for the nurse. Listen to their observations and be proactive.**

Pain Management in Older Adults:

Pain management should include pharmacologic and non-pharmacologic techniques. The goals will be pain reduction and function improvement.

Non-Pharmacologic Techniques:

There are some very simple techniques that can be used to reduce pain. They may include *listening to music, soft touch, and warm packs to help relax patients* who are open to non-traditional, non-pharmacologic techniques. Another suggestion is sensory stimulation such as *pet therapy and folding warm clothes* or cognitive therapy that includes *reading or reminiscing to reduce pain*. Regular physical activity is not only a pain reducer, but improves functional capacity and mood. Because of these outcomes, it is important that physical activity is included for all patients. These programs should be individualized not only to meet the needs and preferences of the individual, but also to adhere to their limitations. Remember, sometimes non-pharmacologic approaches may work alone, or in conjunction with pharmacologic interventions.³

Pharmacologic Pain Management Techniques:

Using medications to manage pain is the most common treatment for pain control in older adults. There are many different medications that can be used and it is important to be aware of the specific properties of drugs and the common age-related changes that can influence how drugs are metabolized and absorbed. Pain meds should be titrated up slowly and balanced with intolerable side effects or toxic reactions. **ALWAYS**, use the least invasive route of administration.³

Basic End-Stage Indicators:

- ◆ Overall physical decline
- ◆ Life limiting condition
- ◆ Clinical progression of the disease as evidenced by
 - Multiple ER visits
 - Inpatient hospitalizations
 - Serial physician assessment
 - Laboratory studies
 - Radiologic or other studies
- ◆ Impaired nutritional status
 - Decrease in appetite; increase in weight loss
 - Serum albumin <2.5mg/dl not to be used in isolation)
- ◆ Multiple co-morbidities
- ◆ Decline in functional status (ADLs)

Specific Guidelines for determining Prognosis for

Liver Disease

- ◆ Factors 1 and 2 must be present; documentation of factor 3 will add supporting documentation:
1. The patient should show BOTH a and b
 - a. Prothrombin time prolonged more than 5 seconds over control, or International Normalized Ratio (INR) >1.5;
 - b. Serum albumin <2.5gm/dl.
 2. End-stage liver disease is present and the patient shows AT LEAST ONE of the following:
 - Ascites, refractory to treatment or patient non-compliant;
 - Spontaneous bacterial peritonitis;
 - Hepatorenal syndrome (elevated creatine and BUN with oliguria <400 ml/day and urine sodium concentration < 10 mEq/1;
 - Hepatic encephalopathy, refractory to treatment, or patient non-compliant;
 - Recurrent variceal bleeding, despite intensive therapy.
 3. Documentation of the following factors will support eligibility for hospice care.
 - Progressive malnutrition
 - Muscle wasting with reduced strength and endurance
 - Continued active alcoholism (>80gm Ethanol/day)
 - Hepatocellular carcinoma
 - HBsAg (hepatitis B) positivity
 - Hepatitis C refractory to interferon treatment

Assessment and Management of Pain (Cont.)

Acetaminophen is a good first line of treatment for people with mild to moderate pain. The daily cap on dosage is 4 grams (8 extra-strength Tylenol) unless the patient has liver disease or renal disease and then the daily dosage must be lowered by 50 – 75%. If acetaminophen does not work, it is suggested the patient be switched to a NSAID (non-steroidal anti-inflammatory drug). GI toxicity, platelet dysfunction, renal dysfunction, and sodium retention limit their usefulness in some patients.³

Opioid medications can be used to relieve moderate-to-severe pain. The greatest benefit to using opioids is they have no ceiling effect, in other words, you can continue to titrate up in an effort to manage the patient's pain without causing organ damage. There are some common side effects, which can be dealt with very easily. Those side effects are *nausea, vomiting, itching, sedation, and constipation*. Most of these side effects will come to be tolerated, except for constipation. Every patient on an opioid drug also needs to be on a bowel regimen.³

There are other medications that are not "pain medications" but are used in conjunction with the pain medications to help relieve specific kinds of pain, and they are referred to as "adjuvant medications". These drugs are used to manage neuropathic pain most often. The use of lidocaine 5% patches and

capsaicin have been found beneficial in treating post-herpetic and diabetic neuropathy. Some antidepressants and anticonvulsant meds have been useful in treating nerve-related pain, as well.³

When all is said and done, it takes a team to accomplish successful pain management in the elderly. It is necessary for the physician, nurse, patient, and patient's family to work together to ensure optimal pain relief, and the treatment should be dependent on the patient's *diagnosis, preference for treatment, and tolerance of the interventions* chosen.³ This is not an easy process, but is a necessary one. By 2030, about 20 percent of the population in the United States will be older than 65~it is the perfect time for a review of the basics in pain assessment and pain management in older adults.

¹AGS Panel on Persistent Pain in Older Persons. **The management of persistent pain in older persons.** J Am Geriatric Society 2002;50:S205-@224. Abstract.

²Reyes-Gibby cc, Aday LA, Todd KH, Cleland CS, Anderson KO. **Pain in aging community-dwelling adults in the United States: non-Hispanic whites, non-Hispanic blacks, and Hispanics.** J Pain. 2007;8:75-84. Abstract.

³ **Assessment and Management of Pain in Older Adults: A Review of the Basics,** Bruckenthal, P., D'Arcy, YM. <http://www.medscape.com/viewarticle/556382>



Hospice of the Twin Cities
10405 6th Avenue North
Suite 250
Plymouth, MN 55441

(763) 531-2424

We're on the Web!
www.hospiceofthetwincities.com

Mission Statement

Hospice of the Twin Cities' mission is to enhance the quality of the lives of our patients and their families by providing respectful care based on maintaining dignity, alleviating physical, psychosocial, and spiritual suffering, advocating for fundamental rights, and affirming the sacred value of life.