



Pain Assessment and Management for the elderly

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Outline

- What is pain
- Misconceptions and barriers to pain management
- Classification of pain
- Pain Assessment
- Factors affecting pharmacology in the elderly
- Analgesic ladder
- Opioids

Prepared by the Mid North Coast Rural Palliative Care Team 2004

What is Pain

“Pain is always subjective. Each individual learns the application of the word through experience in early life. It is unquestionably a sensation in a part of the body, but is also always and unpleasant and therefore an emotional experience...”

(Merskey, H 1979)

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Misconceptions

Related to pain in the elderly

- Pain is a natural outcome of growing old
- Pain perception decreases with age
- If the elderly patient does not report pain then they do not have pain
- Those with dementia or cognitive impairment do not feel pain, and their reports are probably invalid

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Barriers to effective pain management

- Evidence suggests that lack of knowledge of pain assessment among nurses and doctors is contributing to poor pain management
- Cultural beliefs
- Fear of Morphine
- Assessment tools (not used effectively)
- Pain is consistently under diagnosed and under treated in the aged

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Factors affecting pain perception

- Previous experience
- Cultural
- Prognosis
- Coping strategies
- Emotion - fear, anxiety, depression, anger
- Gender, age
- Up-bringing

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Types of Pain

- Visceral
- Soft Tissue
- Bone pain
- Nerve Compression
- Nerve destruction pain
- Muscle spasm
- Pleuritic pain
- Colic pain

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Classification of Pain

- Acute pain: result of injury or disease fractures, falls, cardiac pain, surgery
- Chronic Pain: malignant disease of an aging population therefore of greater incident with increased age
- Non malignant: degenerative, osteoarthritis, diabetic neuropathy, osteoporosis, CVA, shingles

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Pain Assessment

Principles:

- Ongoing assessment and documentation, not a single event
- Assess each pain separately
- Identification of the best proxy to ensure the patient's wishes are considered (if patient unable to communicate)
- Assess for psycho/social/spiritual factors
- Regular analgesia and PRN dosing
- WHO guidelines

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Pain Assessment Tools

- The primary use for pain rating scales is to provide a base line assessment and then to evaluate the effectiveness of the pain management plan
- Patient's self assessment most reliable tool
- Visual analogue scales, face scale, verbal numerical rating scales
- Pain diary
- Pain drawings
- Abbey pain scale

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Abbey Pain Scale

For measurement of pain in people who are ***cognitively impaired*** observe for:

- Vocalization
- Facial expression
- Change in body language
- Behavioural change
- Physiological change
- Physical change
- Pain can lead to Behavioural changes in residents

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Abbey Pain Scale

For measurement of pain in people with dementia who cannot verbalise

How to use the scale; While observing the resident score questions 1-6

Score Values Absent 0, Mild 1, Moderate 2, Severe 3

Q1. Vocalisation (eg whimpering, groaning, crying)

Q2. Facial Expression (eg looking tense, frowning, grimacing, looking frightened)

Q3. Change in Body Language (eg fidgeting, rocking, guarding part of body, withdrawn)

Q4. Behavioural Change (eg increased confusion, refusing to eat, alteration in usual patterns)

Q5. Physiological Change (eg temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pallor)

Q6. Physical Changes (eg skin tears, pressure areas, arthritis, contractures, previous injuries)

Add scores for Q1 to Q6 = Total Pain Score

Scores 0 - 2 = No pain; 3 -7 = Mild; 8 -13 = Moderate; 14+ = Severe

The type of pain; Chronic or Acute or Acute on Chronic

Abbey J. Piller N. De Bellis A. et. al. 2004. International Journal of Palliative Nursing. 10(1):p.12

Factors affecting Pharmacology in the elderly

- Cardiac impairment - slow circulation and longer onset
- Poor pulmonary function increases risk of respiratory depression
- Decreased renal function increases risk of build up of metabolites
- Impaired liver function affects the metabolism of drugs

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Pharmacology

- Analgesics are highly protein bound may pass the blood / brain barrier easily and increase CNS effects
- Poly pharmacy and drug interactions
- Changes in body composition can affect absorption and accumulation of analgesics

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Management of Pain

Most cancer pain can be effectively managed by WHO
“Analgesic Ladder”

Step 1 Mild Pain: non opioid +/- adjuvant

Step 2 Moderate pain: weak opioids + non opioid +/-
adjuvant

Step 3 Severe Pain: strong opioid + non opioid +/- adjuvant

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Pain Interventions

- Analgesia
- Heat and cold
- Massage
- Music
- Acupuncture
- Touch
- Repositioning
- Spiritual care
- TENS machine

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Non Opioids

- NSAIDs (non-steroidal anti-inflammatory drugs)
- Paracetamol
- Aspirin

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Opioids

- Tramadol (weak opioid)
- Panadeine (weak opioid)
- Oxycodone, Endone (strong opioid)
- Morphine
- Fentanyl
- Hydromorphone
- Methadone

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Adjuvant Drugs

- **NSAIDs** inhibit prostaglandin release, decreases inflammation
- **Corticosteroids** inhibit prostaglandin release, decreases swelling and inflammation in tumour mass
- **Tricyclic antidepressants** blocks descending pain pathway
- **Anticonvulsants** suppression of neuronal hyper excitability
- **Muscle relaxants** decrease myotonic activity in smooth muscle

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Myths regarding use of Opioids

- Opioids create addiction (psychological dependence, rare)
- Opioids cause respiratory depression (opioid naïve)
- Opioids hasten death and should not be used with the older person (doses must be titrated carefully)
- Used only at end stage of disease

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Opioids

- ***Start low go slow!***
- Opioids exist to be given not withheld
- The gold standard is morphine
- Start with 25-50% of the normal adult dose
- Breakthrough pain dose = 1/6 of daily dose
- Elderly or renal impaired, reduce starting dose and use smaller increases
- Not all pain responds to opioids

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Opioids cont...

- Morphine is metabolised in the liver
- First-pass metabolism reduces the bio-availability to approx 30% of the original dose
- Excreted by the kidneys
- Half-life is 2-3 hrs (time required for concentration of a drug in the body to decrease by 50%)
- Analgesic effect is approx 4hrs

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Summary

- ***“Pain is a more terrible lord than even death itself” - Albert Schweitzer.***
- A detailed assessment is the cornerstone of all symptom management
- Multi systems failure and poly pharmacy complicate medication management
- Review and reassess frequently

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