# APPROACH TO PAIN IN THE GERIATRIC POPULATION

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# ABOUT ME

-Geriatrician and Assistant Professor in the Division of Geriatric Medicine, Queen's University.

-President, Medical Staff Association, Providence Care Hospital

-Associate Researcher, Providence Care Hospital

-My research interests include deprescribing and medication optimization, frailty and perioperative medicine particularly geriatric oncology.

# DISCLOSURES

- None.

# SESSION OBJECTIVES

By the end of this session you will:

- Have an understanding of some practical tips for approaching pain in older adults
  - Provide an introduction to the topic of pain management in the elderly
  - Increase knowledge and awareness of the effects of pain in the older adult
  - Review common pain assessment approaches
  - Understand and apply the basic concepts of pain management strategies in older adults

# WHAT IS PAIN?

- Pain is an unpleasant sensory and emotional experience due to sickness or injury.
- Subjective
- Pain can come from any part of the body:
  - skin, muscle, ligaments, joints
  - bones, tissue and nerves
  - organs inside the body

# FACTORS THAT INFLUENCE RESPONSE TO PAIN

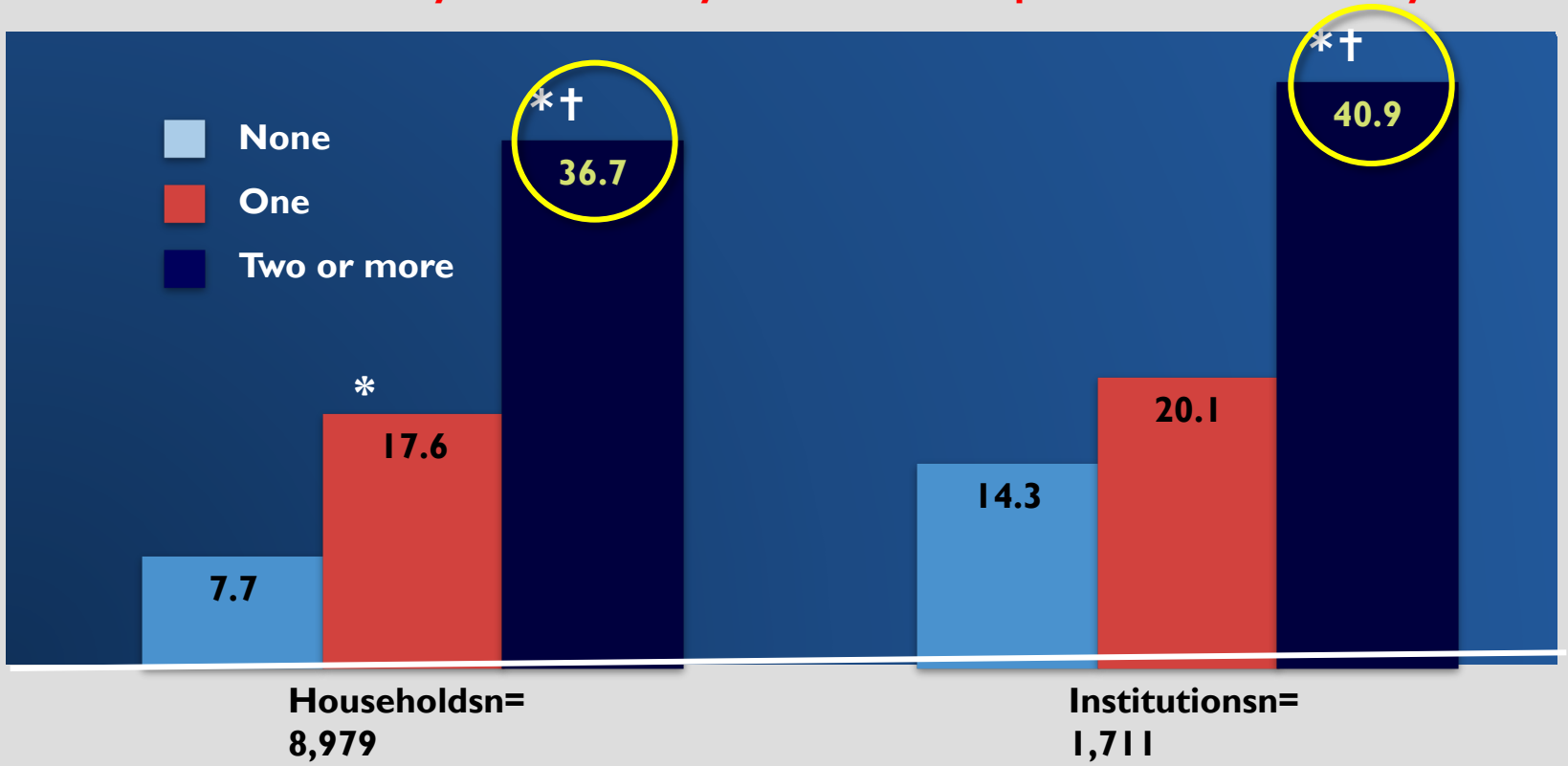
- The response to pain is influenced by:
  - Past pain experience
  - Culture
  - Gender
  - Significance of pain
  - Depression
  - Fatigue

# PAIN IN THE OLDER ADULT

- Pain in common in older adults 50%-75% of community dwellers
- Especially common in LTC: up to 80%
- Compared to younger people, older adults have higher prevalence of cancer, more surgery, longer stays in hospital, and more injury or disease.
- These events can lead to pain.
- Pain is not a normal part of aging.

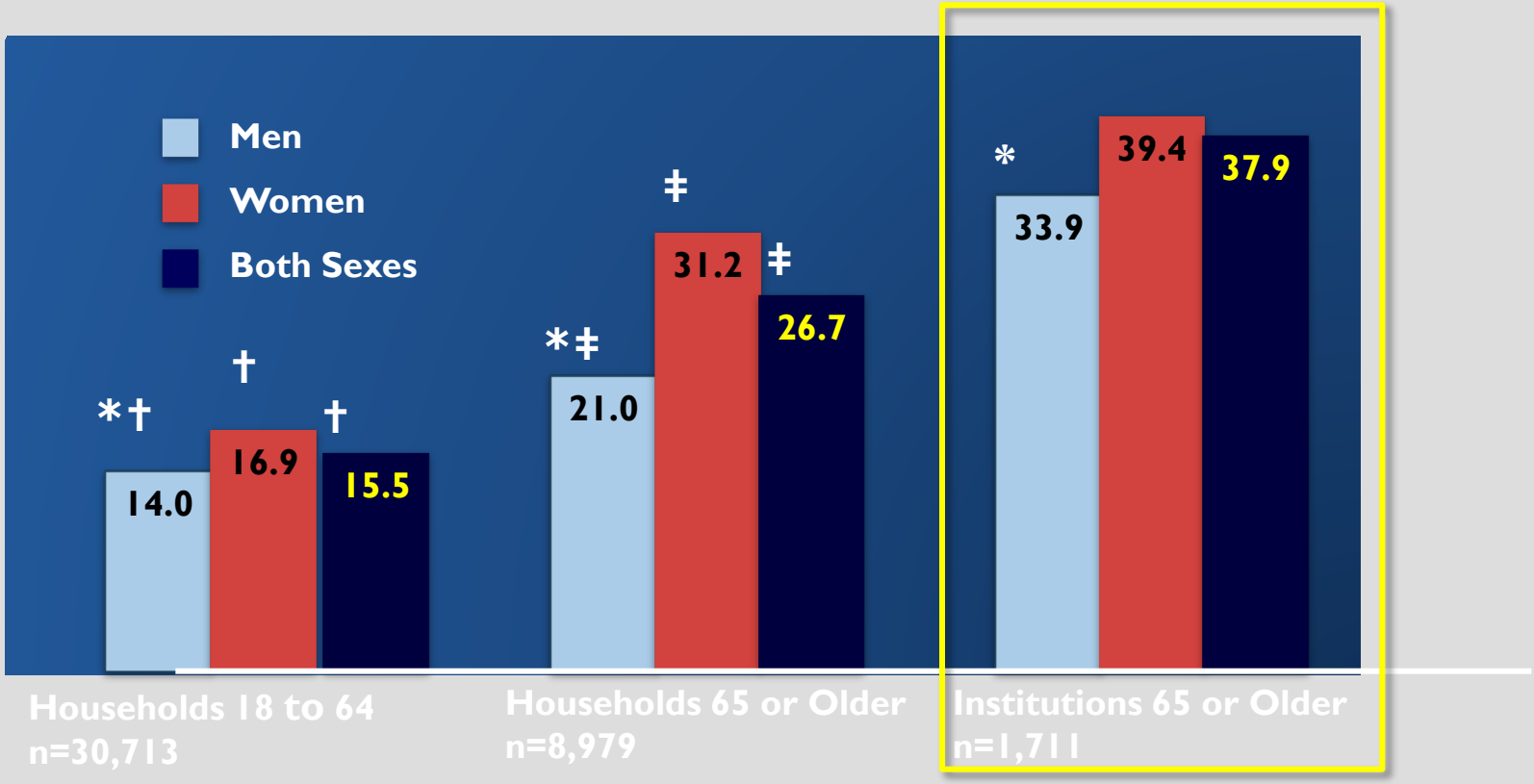
# INCREASED INCIDENCE OF CHRONIC PAIN ASSOCIATED WITH MEDICAL COMORBIDITIES

**Data from Canadian Community Health Survey and National Population Health Survey**




* significantly different from estimate for "None" ($p < 0.05$)
† significantly different from estimate for previous category ($p < 0.05$)

# INCIDENCE OF CHRONIC PAIN IN OLDER ADULTS




* significantly different from estimate for women ($p < 0.05$)
† significantly different from estimate for household population aged 65 or older ($p < 0.05$)
‡ significantly different from estimate for institutional population ($p < 0.05$)

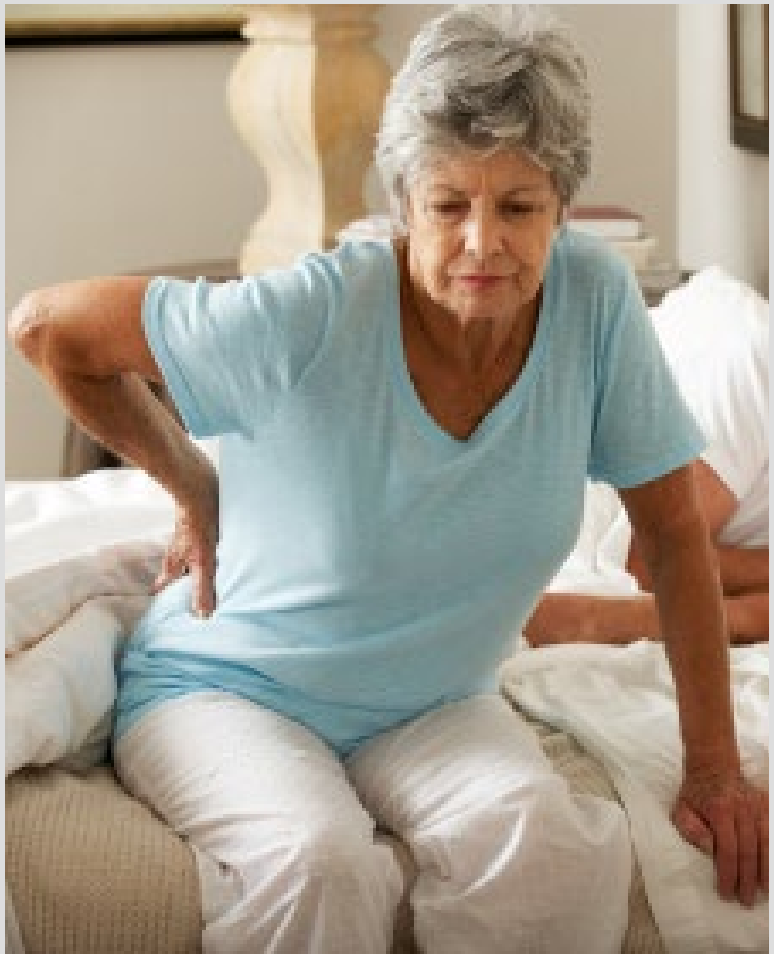
# CONSEQUENCES OF UNTREATED PAIN

- Untreated pain can lead to:
  - Poor health
  - Poor quality of life
  - Social isolation
  - Depression
  - Anxiety
  - A feeling of not being important
  - Need for help from others to complete tasks
  - Skin problems from sitting or laying down
  - Poor sleep
  - Weight loss from loss of appetite
  - Decreased mobility and Deconditioning
  - Difficulty concentrating
  - Increased healthcare costs

# REPORTING PAIN

- Many older adults do not report pain because they:
  - fear what will happen
  - do not know why they have pain
  - feel they need to be "brave"
  - do not want to complain
  - feel they will become a problem for their family
- Many people with communication or cognitive challenges have difficulty communicating pain.

# WHAT ARE THE TYPES AND SIGNS OF PAIN?



# TYPES OF PAIN

- **Acute pain** starts suddenly and goes away, such as pain from surgery, broken bones, cuts or burns. Usually weeks.

- **Chronic pain** long standing such as pain from arthritis, cancer, fibromyalgia or unclear/multifactorial aetiology. Usually months to years.

- Other types of pain:
  - **Soft tissue pain** when organs, muscles or tissues are damaged
  - **Nerve pain** when a nerve is damaged ie diabetes or post herpetic neuralgia
  - **Referred pain** felt in one part of the body from another part of the body
  - **Phantom pain** in a part of the body that has been removed
  - **Total pain** felt emotionally, socially and spiritually

# NOCICEPTIVE PAIN?

Reaction of peripheral pain receptors to noxious stimulus (thermal, chemical or mechanical). Pain is "proportional" and tends to be "protective" in seeking to reduce injury.

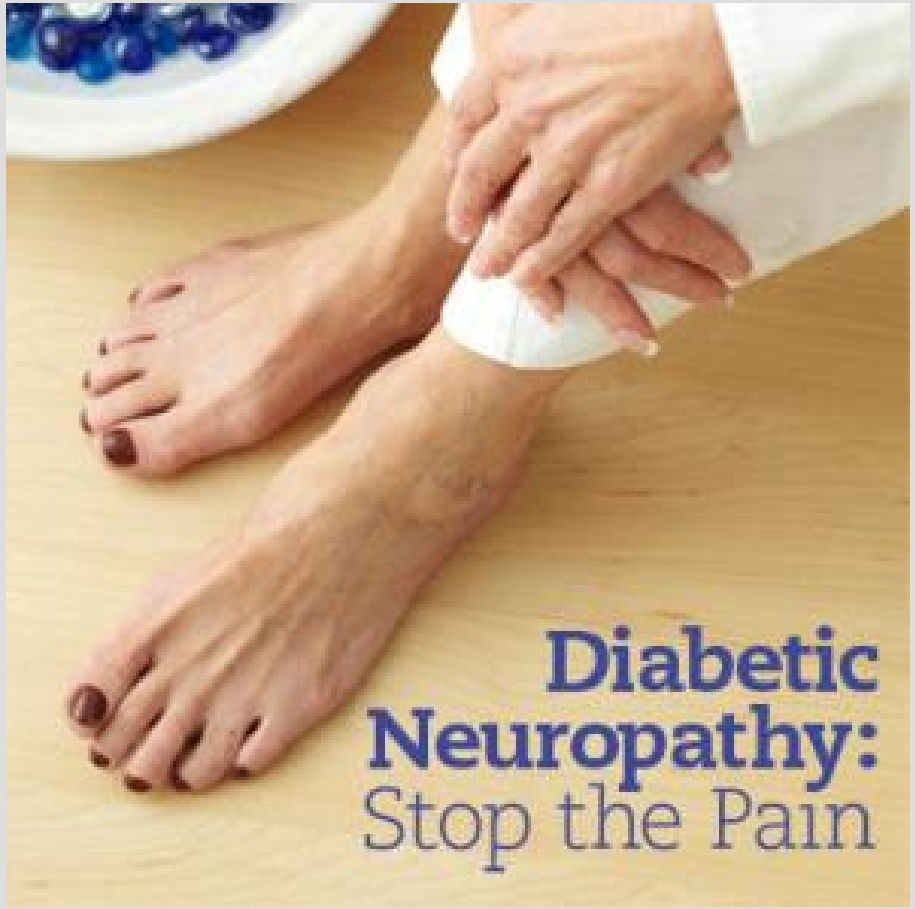
This pain can arise from:

a) The lining of body cavities (**visceral)** such as inflammatory bowel disease or a hiatus hernia. Pain may be described as *deep* and *aching*

**OR**

b) Subcutaneous tissue of the skin, muscles or bone (**somatic**) such as arthritis or a chronic ulcer.
Pain may be described as *throbbing* or *aching*

# NEUROPATHIC PAIN

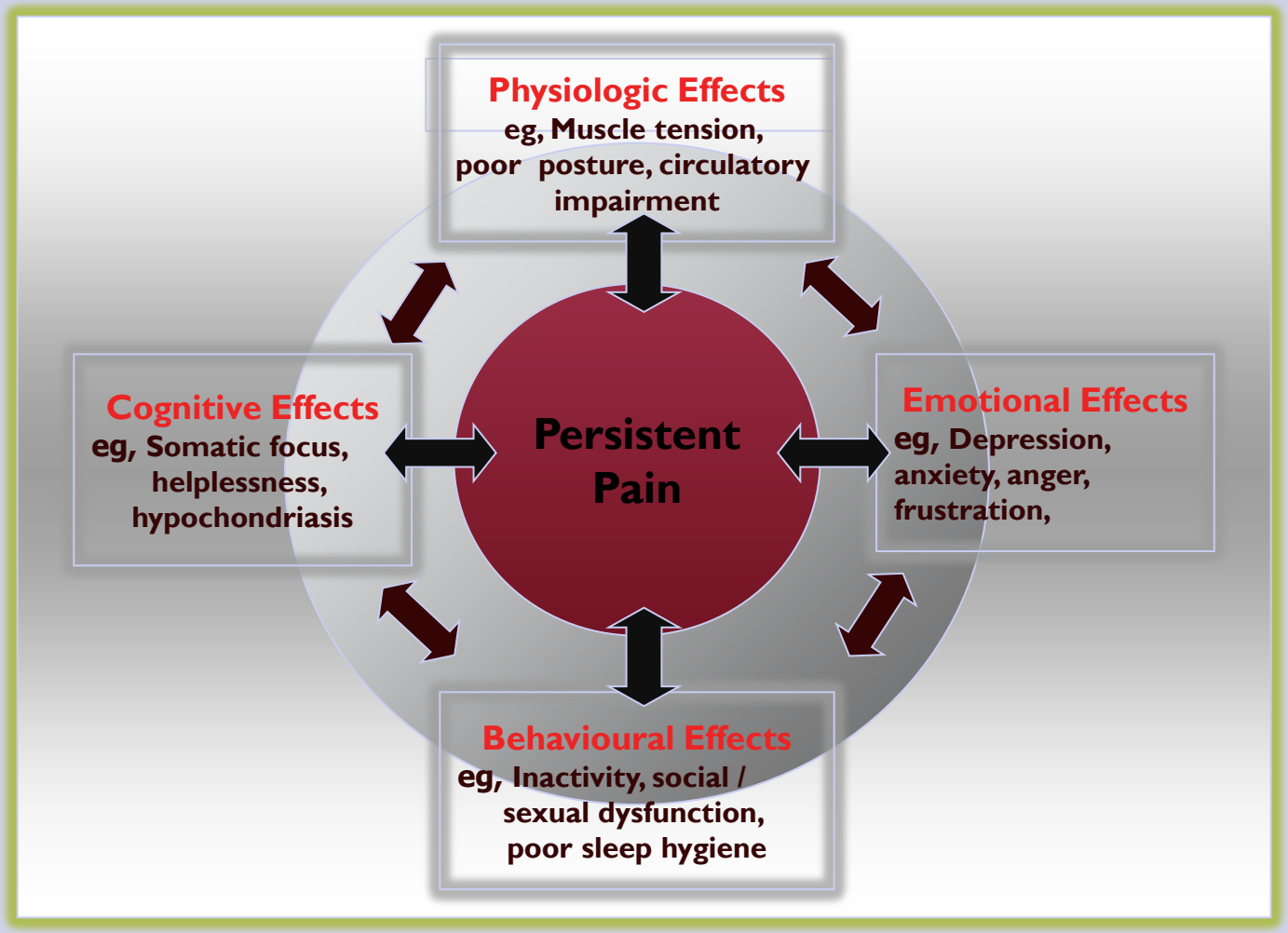



- This pain can arise from an injury to either the peripheral OR central nervous system. It may:
  - *shooting* pain, *electric* , *hot*, or *burning*
  - persist even after the injury resolves
  - even be triggered by a simple touch e.g. post herpetic neuralgia (not proportional)

# COMPLEX REGIONAL PAIN SYNDROMES

- Mixed pain
- Pain out of proportion to the severity of the injury and gets worse rather than better over time
- Often affects one of the arms, legs, hands, or feet
- Skin changes with intense burning pain, skin sensitivity, sweating, and swelling

# A BIO-PSYCHOSOCIAL APPROACH RECOGNIZES THE TOTAL PAIN EXPERIENCE



# IDENTIFICATION OF PAIN IN THE COGNITIVELY IMPAIRED ELDER

Elderly people with cognitive impairment may not formerly communicate they have pain.

Many people do not show signs of pain. Look for worsening behaviors.

**Look for:**

- Facial expressions

  (e.g. frown, sad, fearful, grimacing, closed eyes)
- Vocal Complaints

  (e.g. moaning, sighing, calling out, swearing, saying ouch)
- Interpersonal

  (e.g. resistive to care, lashing out, withdrawn)
- Body Movements

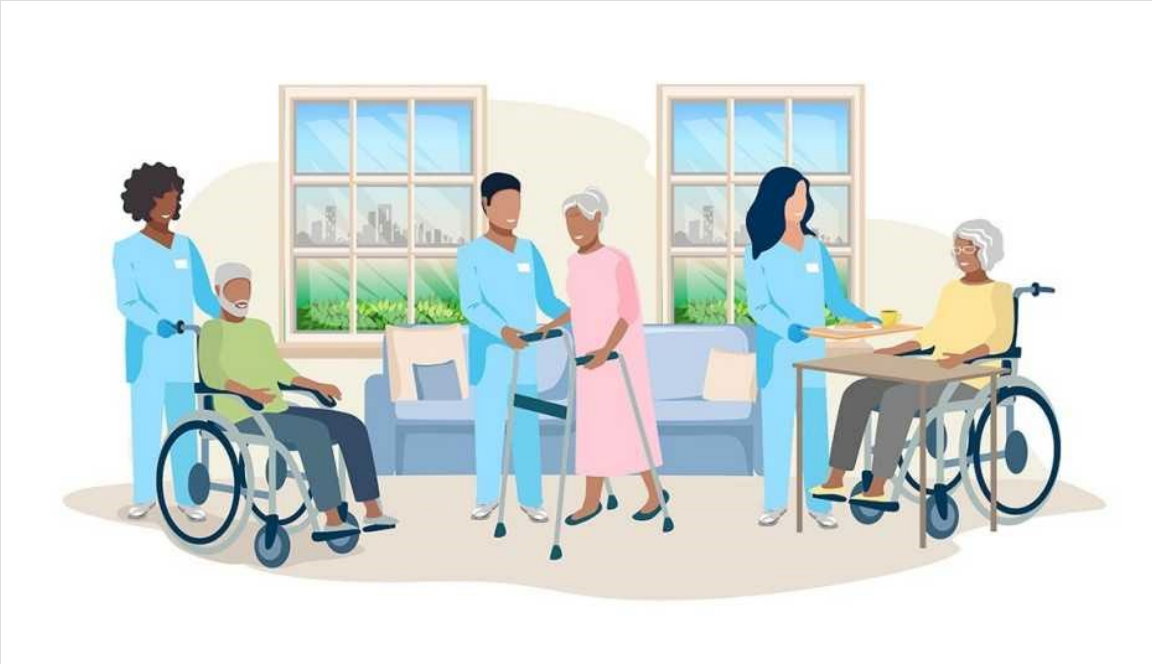
  (e.g. restless, pacing, rigid, fists clenched, knees pulled up)
- Change in patterns or routines

  (e.g. refusing food, personal care, more rest periods, distressed wandering)
- Behaviors/Mental status changes

  (e.g. crying, irritability, guarding painful areas)

# IDENTIFICATION OF PAIN IN THE COGNITIVELY IMPAIRED ELDER

- Care providers and workers need to observe for and recognize changes in the person's behavior or condition
- Family members can generally inform care providers with cues and ideas about behaviours which may indicate pain or discomfort in their loved one



Tip: Identify and TREAT Pain before Treating BPSD

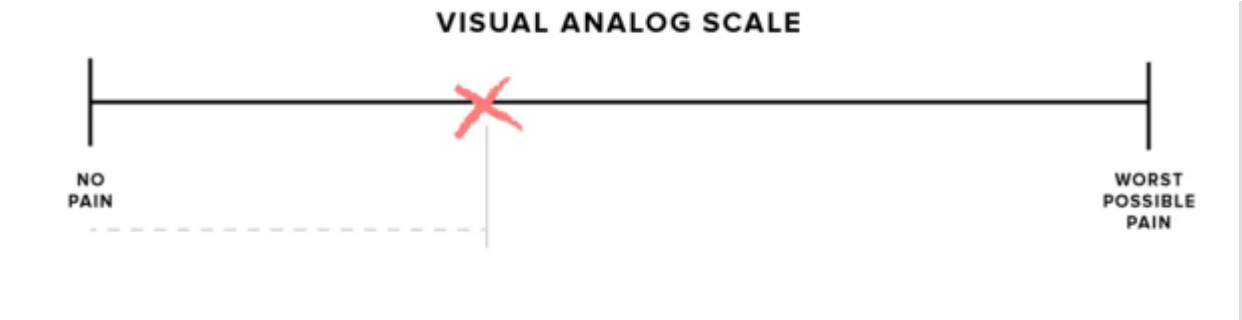
# GENERAL APPROACH TO IDENTIFY AND SCREEN FOR PAIN

- Ask the person to describe how they feel, using open ended questions to gather information. (e.g. How are you feeling today/now?)
- Be patient. Listen. Minimize distractions
- Use your observation skills - look for changes in function or behaviour, especially for people who have dementia
- Ask the family
- Check in with the person and family to make sure they understand the questions:
  - Use familiar terms
  - Encourage the use of glasses and hearing aides during assessment to support their vision and hearing needs

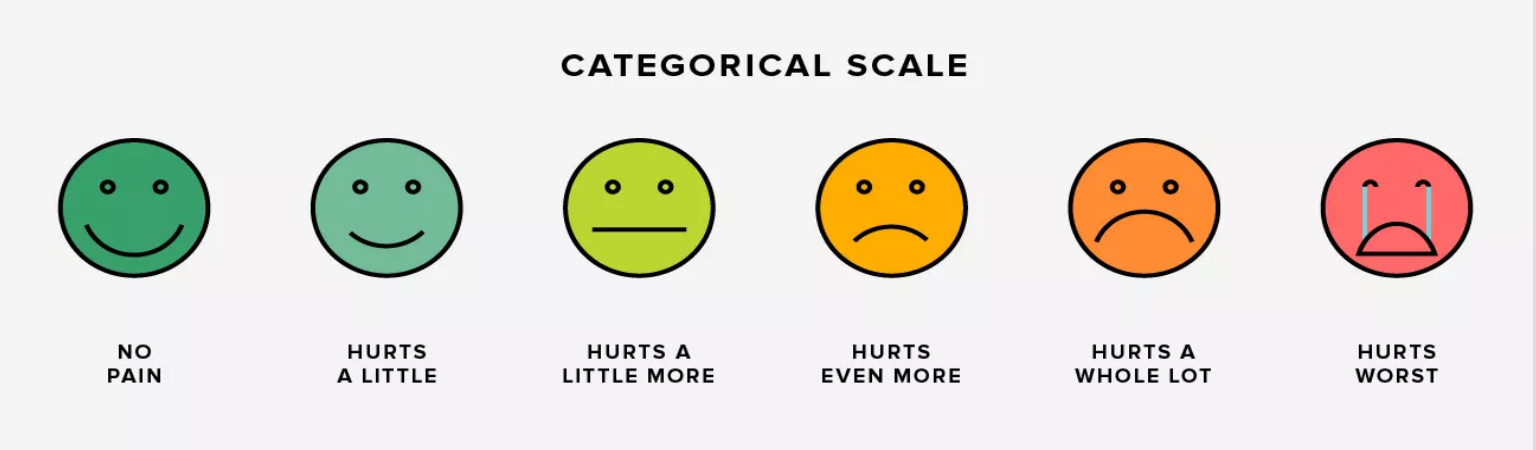
# HOW IS PAIN ASSESSED?

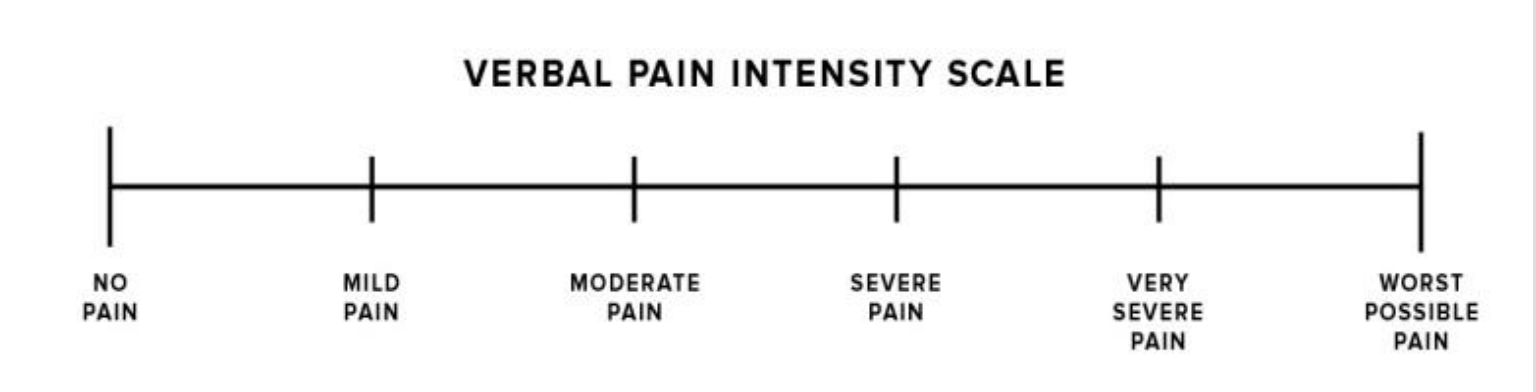
# ASSESSING PAIN

Health care providers may use one of the following scales to assess levels of pain.

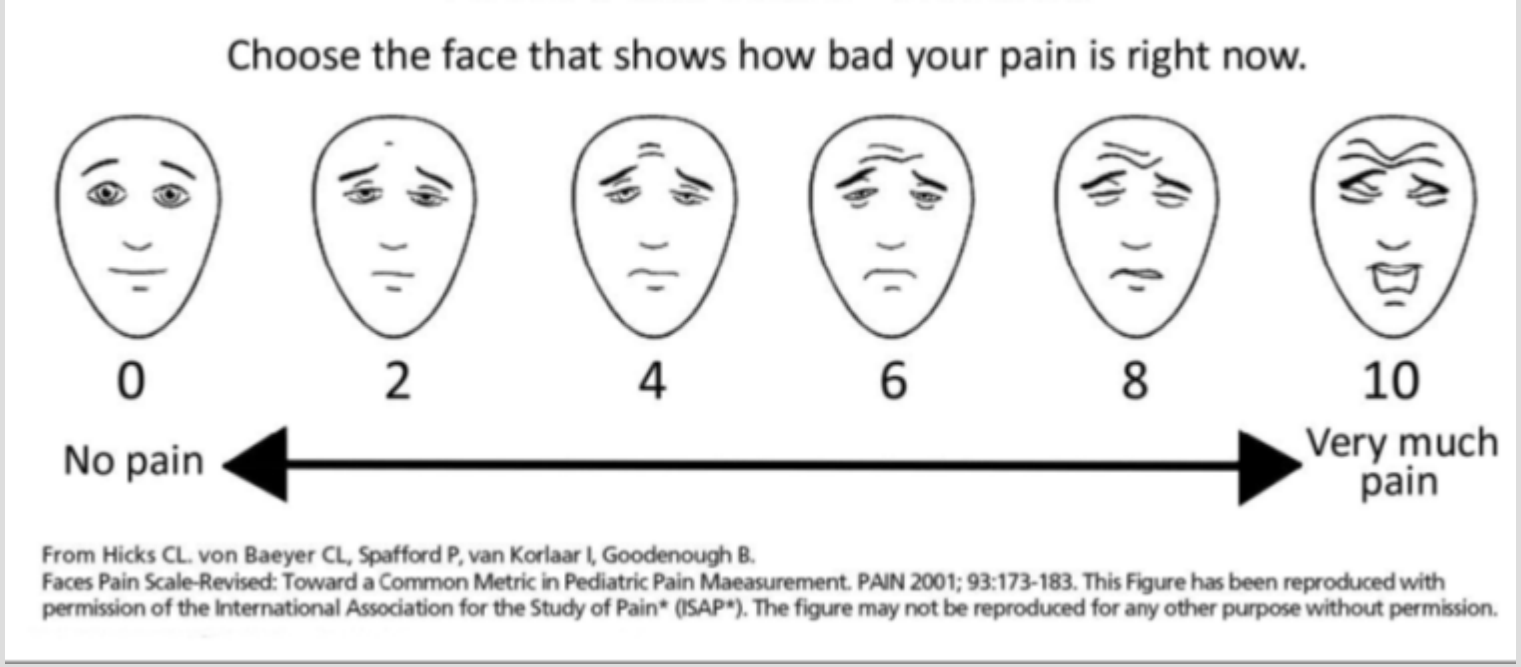



# ASSESSING PAIN



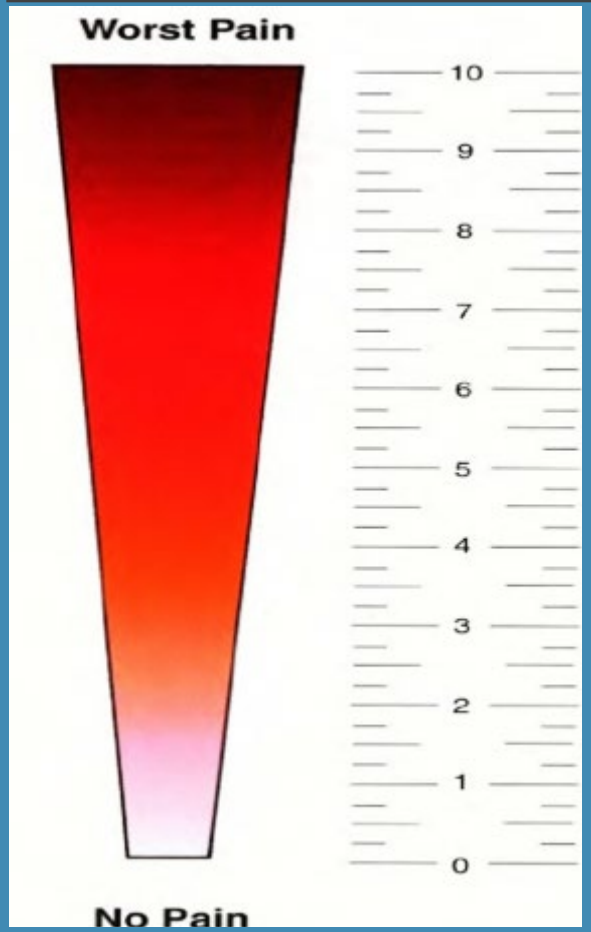
# FACES PAIN SCALE – REVISED (FPS-R)




This tool is used to assess pain intensity in persons who are able to self report, but unable to use a numeric rating scale (NRS). Some studies show African Americans and Asians prefer the FPS-R

**NOTE**: This tool is **not meant** to be used by the health care provider to look at the resident's facial expression and pick a face

# COLOUR VISUAL ANALOGUE SCALE (VAS)




Description: It is a continuum scale that provides a visual alternative to the Numeric Rating Scale (NRS)

It should be explained to the person as follows:

- The light coloured area at the bottom is no pain at all and the dark red colour at the top is the worst pain imaginable
- Ask the person to point to the part of the scale that best describes their pain at rest "R" and with activity "A"

Document

# PAIN ASSESSMENT SCALE IN ADVANCED DEMENTIA (PAINAD) CONTINUED

- Developed to assess pain in people who are cognitively impaired, unable to communicate or suffer from dementia and are unable to report or describe pain
- Observe individual during their activity and record behavioral indicators of pain: breathing, negative vocalization (e.g. no, no), facial expression, body language, and ability to be consoled
- Can be used with people who have advanced dementia
- Tool can be used for screening and follow-up
- Can be completed in 1-3 min

# PAINAD Scale

**The Pain Assessment in Advanced Dementia (PAINAD) Scale***

| Items | 0 | 1 | 2 | Score |
|---|---|---|---|---|
| **Breathing independent of vocalization** | Normal | Occasional labored breathing. Short period of hyperventilation. | Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respirations. | |
| **Negative vocalization** | None | Occasional moan or groan. Low-level speech with a negative or disapproving quality. | Repeated troubled calling out. Loud moaning or groaning. Crying. | |
| **Facial expression** | Smiling or inexpressive | Sad. Frightened. Frown. | Facial grimacing. | |
| **Body language** | Relaxed | Tense. Distressed pacing. Fidgeting. | Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out. | |
| **Consolability** | No need to console | Distracted or reassured by voice or touch. | Unable to console, distract or reassure. | |
| | | | **Total** | |

**This is a 5-item scale that assesses the following:**

- **Breathing**
- **Vocalization**
- **Facial expression**
- **Body language**
- **Consolability**

**Each item is scored on a 0-2 scale, with higher scores indicating greater pain intensity.**

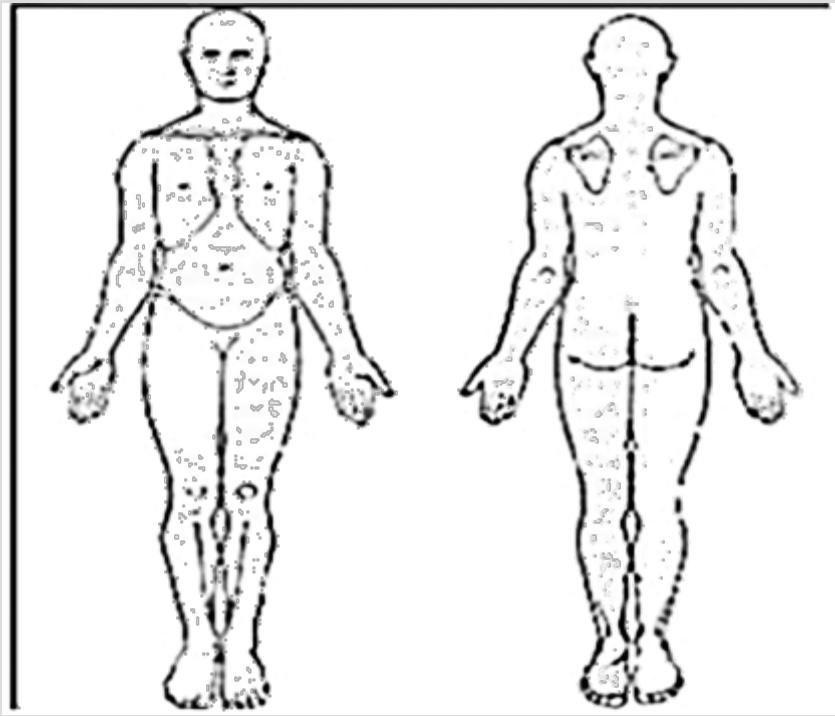
PAINAD = Pain Assessment in Advanced Dementia

**The total score ranges from 0-10 points. Scores may be interpreted as follows:**

- **1-3=mild pain**
- **4-6=moderate pain**
- **7-10=severe pain**

# PRINCIPLES OF DOCUMENTATION

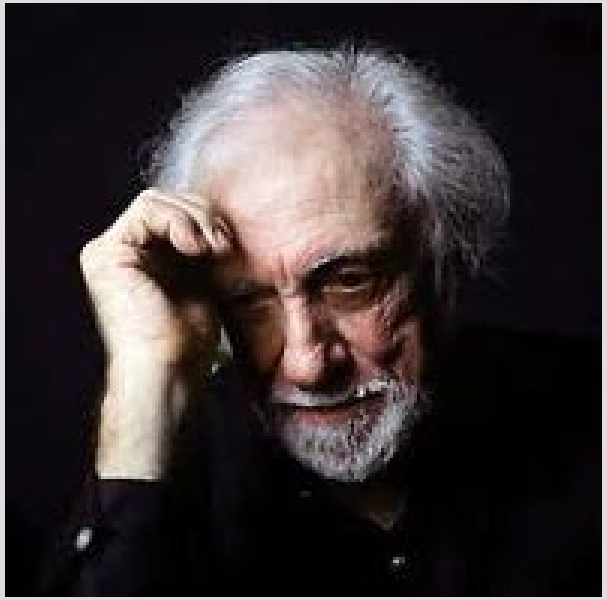
Documentation communicates information to others about the person in your care and provides a permanent legal record. In some sectors (i.e. Long Term Care), documentation provides required information for the organization's funding.



Use of a pain drawing documentation tool can provide a visual resource for the person experiencing pain and the care provider. Areas of pain can be identified and marked to show the location of pain

# PAIN ASSESSMENT CHECKLIST FOR SENIORS WITH LIMITED ABILITY TO COMMUNICATE (PACSLAC)

Total Pain Score sum all four Sub-Scale totals.



| 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 | |
| Decreased activity | |
| Refusing medications | |
| Moving slow<br>Impulsive Behaviour (e.g., repetitive movements) | |

| Activity/Body Movement | Present |
|---|---|
| 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 | |
| Upset | |
| Agitated | |
| Cranky/Irritable | |
| Frustrated | |
| **Other*** | |
| Pale Face<br>Flushed, red face | |
| Teary eyed | |
| Sweating | |

| Other continued | Present |
|---|---|
| Shaking/Trembling | |
| Cold & clammy | |
| Changes in sleep (please circle):<br>Decreased sleep or<br>Increased sleep during day | |
| Changes in Appetite (please circle):<br>Decreased appetite or<br>Increased appetite | |
| Screaming/Yelling<br>Calling out (i.e. for help)<br>Crying | |
| A specific sound or vocalisation<br>For pain 'ow', ouch' | |
| Moaning and groaning | |
| Mumbling | |
| Grunting | |

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.

# HOW IS PAIN ASSESSED?

- LOOK AT FLOW SHEET: BOWELS, BLADDER, SLEEP
- LOOK AT MAR INCLUDING PRNS
- DOS CHARTING LOOK AT BEHAVIORS AND PATTERNS OF BEHAVIOR
- PROGRESS NOTES/CHART- Ie are behaviors always around personal care? May be secondary to pain or discomfort

# HOW IS PAIN ASSESSED?

TAKE A HISTORY

- **O**nset
- **L**ocation
- **D**uration
- **C**haracter
- **A**ggravating Factors
- **R**elieving factors
- **T**iming
- **S**everity

# HOW IS PAIN ASSESSED?

- DO A PHYSICAL EXAM
- VITALS: TEMPERATURE, BLOOD PRESSURE, PULSE, RESPIRATORY RATE, O2 SATURATION, GLUCOSE!

# ACUTE PAIN

- Typically well described and localized
- Associated with:
  - ↑ blood Pressure
  - ↑ pulse
  - ↑ breathing rate
  - sweating
  - large pupils
- Tends to be time limited
- Person is often restless, anxious, unable to concentrate
- Usually responds to analgesics and other pain management approaches

# CHRONIC PAIN

- Generally we do **not** see changes in vital signs (pulse rate, high blood pressure  or ↑ breathing)
- Poorly localized and described
- Rarely subsides on its own; can be progressive and debilitating
- Is frequently unrecognized, untreated or under-treated
- In the older adult, chronic pain is often a symptom of a disease process or other condition(s)

# HOW IS PAIN MANAGED?

Your Guide to

## PAIN MANAGEMENT

*Consult with your Physician*

*Over-the-counter pain relievers*

*Implement mind-body practices*

*Physical Therapy*

*Counseling*

*Educate yourself*

*Exercise*

*Nutrition*

Home Healthcare Professionals

## PATIENT BASED APPROACH

| *Patient's perception* | *Assessment* | *Tailored approach* | *Interative evaluation* | *Education* | *Non-pharmacological approach* | *Team* |
|---|---|---|---|---|---|---|
| P | A | T | I | E | N | T |
| •Listen to your patient<br>•Consider all the factors affecting patient's experience of pain and symptoms reporting<br>•Believe your patient | •Answer the 4 W (where, when, what, why)<br>•Identify pain pathophysiology (nociceptive, neuropathic, nociplastic)<br>•Perform a meticulous physicals examination, require appropriate instrumental exams, and evaluate their correlation<br>•Use validated scales to measure pain | •Follow-up visits are mandatory to evaluate treatment efficacy and to tailor therapy<br>•Timing is strictly dependent on type of pain and therapy<br>•Consider telemedicine in selected cases | •Program the follow up, strictly for the opioid and new cure<br>•Remember: telemedicine is also a good way | •Education involves both patients and caregivers<br>•Provide information about all the factors influencing pain (sleep, nutrition, physical activity, mood, social life, flare-ups, medications)<br>•Use the educational tool that best fits your patient's characteristics (brochures, videos, audios, websites) | •Always consider non-pharmacological treatment (spinal cord stimulation, radiofrequency, intrathecal drug delivery device, neurolysis, acupuncture, physical therapy, cognitive-behavioral interventions)<br>•Do not consider non-pharmacological approach as the last chance but as the first choice in selected cases | •Pain is a multidimensional problem: it needs a multidisciplinary approach<br>•Team composition is extremely dynamic based on pain etiology and patient's characteristics |

# PAIN MANAGEMENT THERAPIES

- ***What's the Target?***
  - ***Comfort*** may mean different things to different people: one person may be satisfied with feeling less pain, while another asks to be free of pain

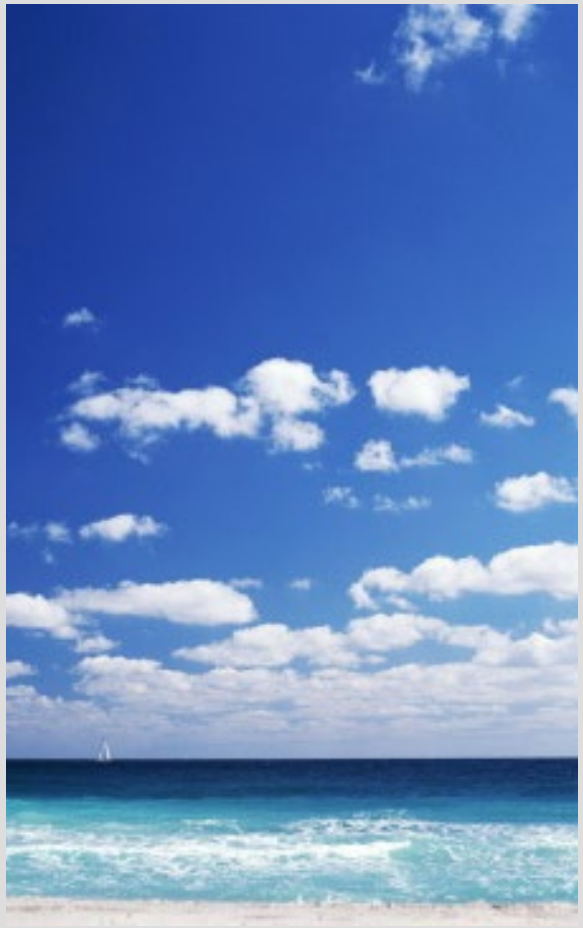
- The use of a collaborative team approach will provide and maximize therapy and pain management in the elderly
- Non-pharmacologic and Pharmacologic strategies

# HOW IS PAIN MANAGED? NON-PHARMACOLOGIC STRATEGIES

- Approaches which can help reduce the need for medications and / or compliment pain medication therapy
- These may include physical, psychological, psychosocial and spiritual care

  - Hot/Cold Compress
  - Positioning
  - Offloading/Immobilization (splint, brace, rest)
  - Massage
  - Acupuncture
  - Relaxation, meditation and mental imagery
  - Progressive muscle relaxation
  - Distraction
  - Biofeedback
  - Physiotherapy
  - TENS (Trans-electrical Nerve Stimulation)

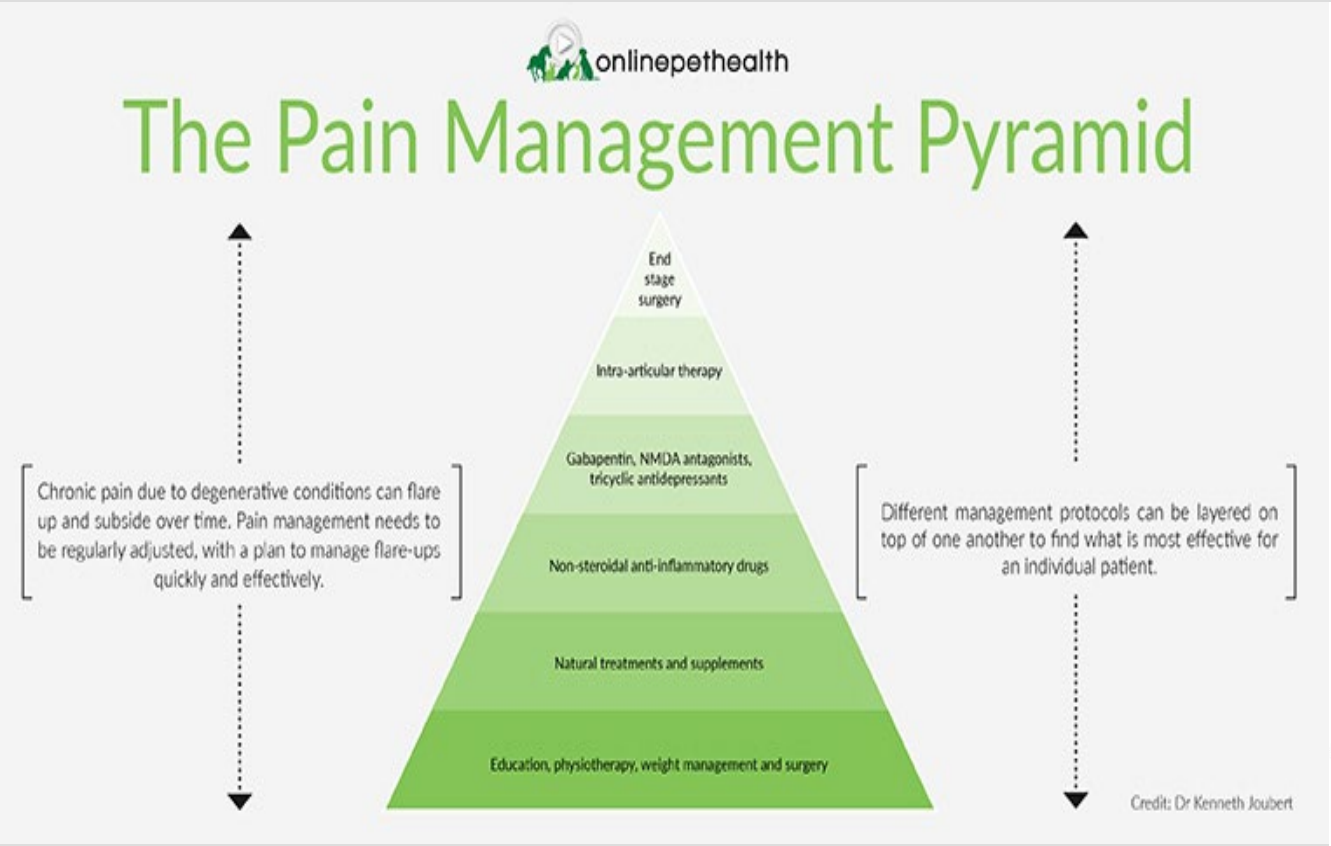
# HOW IS PAIN MANAGED?
## Non-pharmacologic strategies

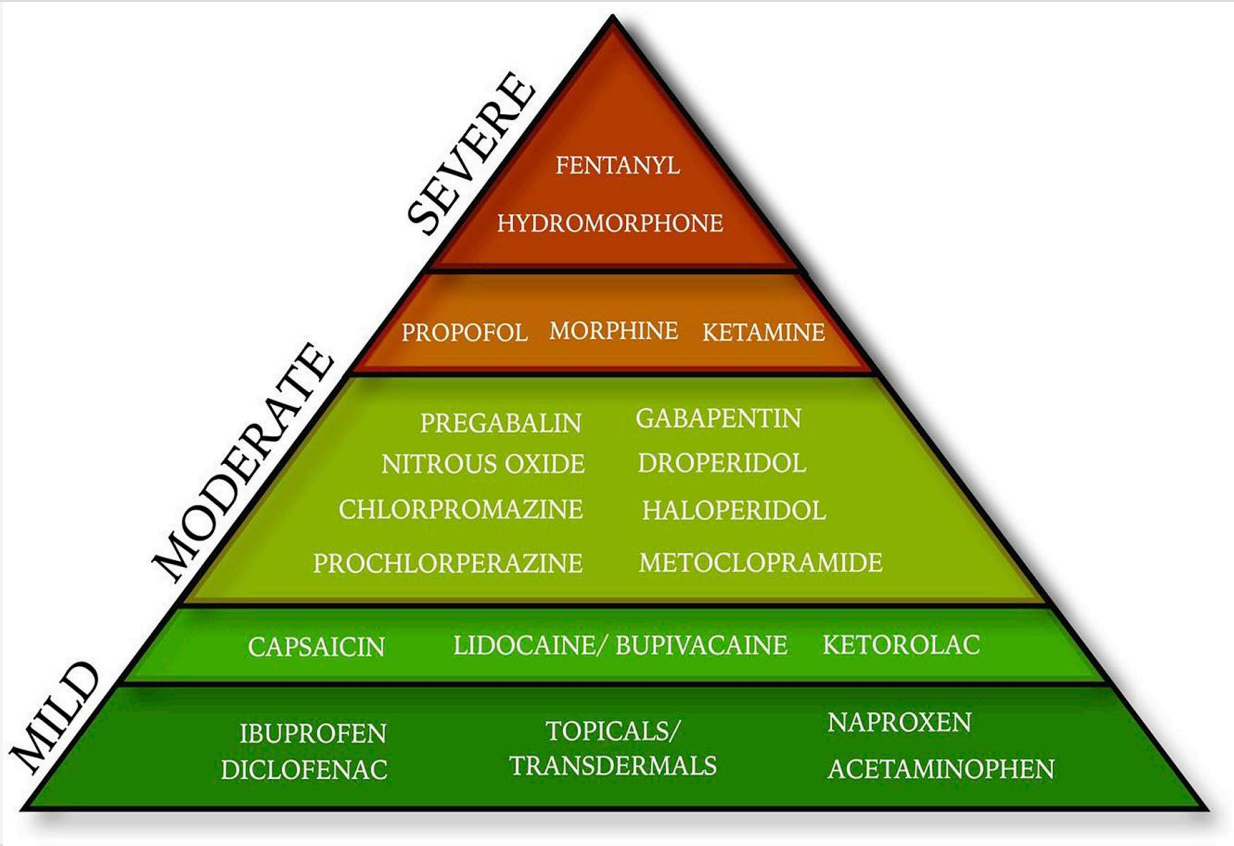


(Quinlan-Colwell, 2012)

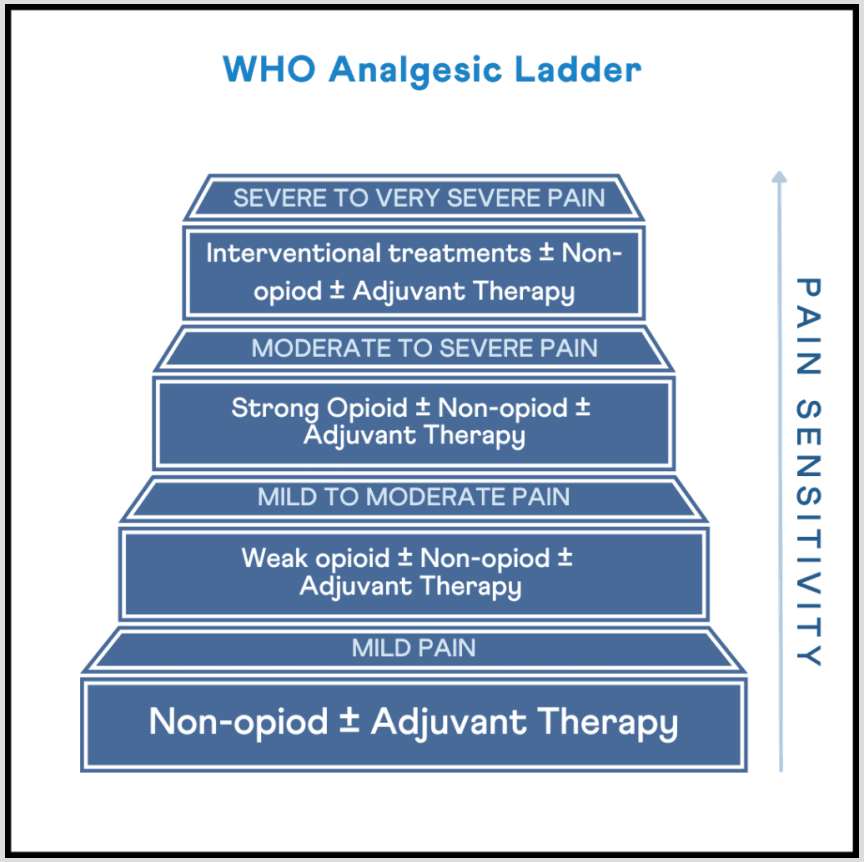
- Cognitive-behavioural therapies:
  - Mental imagery (thinking about a comforting place or situation)
  - Relaxation through deep slow breathing, progressive muscle relaxation
  - Music, singing
  - Prayer, meditation
  - Distraction
  - Hypnosis
  - Using humour
- Education including their loved ones and caregiver(s)
- Support groups
- Counseling

# HOW IS PAIN MANAGED? PHARMACOLOGIC APPROACH



# WHO PAIN PYRAMID




•**First Step -** Mild pain: non-opioid analgesics such as nonsteroidal anti-inflammatory drugs (NSAIDs) or **acetaminophen (3 g/day)** with or without adjuvants

•**Second Step -** Moderate pain: weak opioids (hydrocodone, codeine, tramadol) with or without non-opioid analgesics and with or without adjuvants

•**Third Step -** Severe and persistent pain: potent opioids (**morphine,** methadone, fentanyl, oxycodone, buprenorphine, tapentadol, **hydromorphone**, oxymorphone) with or without non-opioid analgesics, and with or without adjuvants.

# ADJUVANT THERAPY

- Adjuvant therapy can help to enhance the effectiveness of other medications

- Adjuvant therapy may include:
  - NSAID's (non-steroidal anti-inflammatories) (i.e. Ibuprophen) to reduce inflammation
  - Tricyclic anti-depressants (i.e. Nortriptyline) can be useful to treat neuropathic pain
  - Anticonvulsant medications (i.e. Gabapentin) can relieve shooting, electrical pain of peripheral nerve dysfunction

# PAIN MANAGEMENT CONSIDERATIONS

- Beers List
- STOPP-START

# COMMON PAINS I ENCOUNTER

- Depression/Dementia (Somatization)
- Osteoarthritis
- Musculoskeletal
- Neuropathic pain
- Shingles/Post-herpetic neuralgia
- Restless leg syndrome
- Cancer pain
- Cardiac related pain (morphine can have vasodilatory effect)
- COPD
- PVD
- Urinary retention/Bladder Spams
- Pressure ulcer pain (positioning)

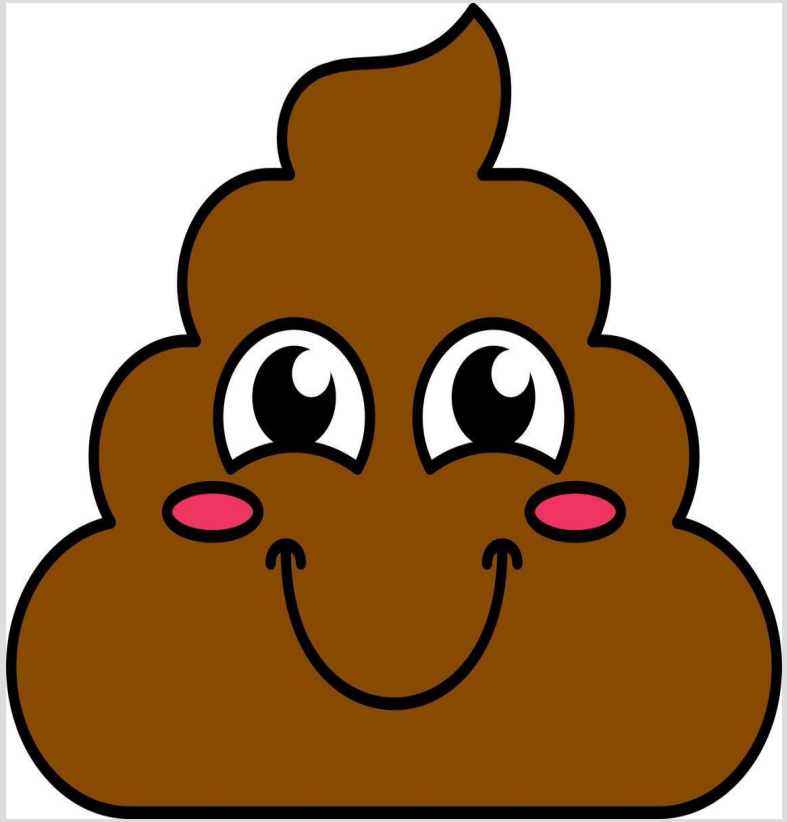
# PAIN MANAGEMENT

**TOP TIPS:**

-Check if PRNS are being GIVEN in patients who are cognitively impaired

-Start low go slow with narcotics

-The hand that prescribes the narcotic should also prescribe the bowel regimen



# SIGNIFICANT SIDE EFFECTS

- **Constipation** is a major side effect of opioids / narcotics such as codeine and morphine. Check on bowel habits, maintain an adequate fluid intake and check for stool consistency and frequency. Mild laxative preparations are usually used to help prevent constipation

- **Nausea** & **vomiting** is another common side effect of opioids. Antiemetic's may be considered and / or assessment of drug dosages

# OTHER POTENTIAL SIDE EFFECTS

As a care provider, be on the lookout for and report any possible side effects such as:

- increased drowsiness
- unsteady gait
- dizziness
- dry mouth
- change in appetite (nausea, vomiting, refusing to eat)
- increased heart rate
- signs of delirium (sudden, temporary onset of confusion that causes changes in how people think and behave)
- change in breathing pattern (shallow, slow respiratory rate)

# SUMMARY

- ☑ Pain is very common in older adults particularly institutionalized seniors.
- ☑ Pain Management strategies must be tailored to the needs of the individual, their lifestyles and goals of care.
- ☑ Pain Management in the elderly requires a collaborative team approach. We must always remember that the person experiencing the pain is the expert and needs to be an active member of the team
- ☑ Regular ongoing assessments are key factors to evaluate and monitor treatment effectiveness. Observe and report positive and negative effects of treatment therapies
- ☑ Pain management therapies may include non-pharmacological and pharmacological strategies

# THANK YOU! COMMENTS? QUESTIONS?

# REFERENCES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# ADDITIONAL RESOURCES

- Overview for Caregivers - Pain http://sagelink.ca/pain_overview_senior_family_caregiver_2014

- There are a number of Resources and links available on pain on sagelink.ca

- Cavalieri, T. (2005). Management of Pain in Older Adults. JAOA, Supplement 1, 105(3), S12-S17. Retrieved from:

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# ADDITIONAL RESOURCES

- BSO Assessment Tools: Assessment-Tools_Updated-April-2024.aspx (brainxchange.ca)

- PACSLAC for pain assessment: Pain-Assessment-Checklist-for-Seniors-with-Limited-Ability-to-Communicate-PASLAC.pdf (gerocentral.org), but there are other tools listed.

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- BSO DOS is the recommended direct observation tool to collect data on the frequency, trends and contributing factors when people living with Dementia are experiencing responsive behaviours. Behavioural Supports Ontario – Dementia Observation System (BSO-DOS©) | brainXchange The Mobile Team staff would use the BSO DOS to track responsive behaviours then cross reference the medication administration record to identify trends and possibilities for intervention.
- There is a new BSO Integrated Teams Poster (Print Legal Size) (brainxchange.ca) which explains how internal (embedded) and external (mobile team) members work together to support a person with responsive behaviours.