

Interprofessional Geriatrics Training Program

Pain Management of the Older Adult



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Acknowledgements

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Background: Pain

- The International Association for the Study of Pain (IASP) defines pain as an "unpleasant sensory and emotional experience associated with actual or potential tissue damage"
 - <http://www.iasp-pain.org/>
- Pain is the most common symptom that brings patients to see a provider, and it is frequently the first alert of an ongoing pathologic process
- Pain affects more Americans than diabetes, cancer, and heart disease combined
- Chronic pain is the most common cause of long-term disability, affecting about 50 million Americans annually

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(Berry et al., n.d.)

Learning Objectives

Upon completion of this module, learners will be able to:

1. Discuss the concept of pain management for the older adult by examining national guidelines and strategies for pain management
2. Identify the potential effects of pain on an older adult, including function and quality of life
3. Apply screening tools and pain management strategies available for the treatment of pain among older adults, based on age and health conditions and risks
4. Discuss pharmacologic and non-pharmacologic therapies for older adults with pain



Background: Pain

National Guidelines [not in narration]

- The American Geriatrics Society (AGS) updated its guidelines in 2009 around the management of persistent pain, with a focus on pharmacologic approaches; their 2002 non-pharmacologic approaches remain relevant
 - http://www.americangeriatrics.org/files/documents/2009_Guideline.pdf
- The American Pain Society publishes a series of evidence-based clinical practice guidelines on the management of pain; these guidelines include managing acute and chronic pain, opioid therapy, and drug dependence
 - <http://americanpainsociety.org/education/guidelines/overview>



Background: Pain and the Older Adult

- Pain affects approximately half of community-dwelling older adults (Matsou et al., 2016)
- Pain leads to:
 - Disability (Matsou et al., 2016; Eggermont et al., 2014)
 - Social isolation (Keefe et al., 2013)
 - Depression (Wood et al., 2016; Keefe et al., 2013)
 - Falls (Rubbio et al., 2014)



Background: Pain and the Older Adult

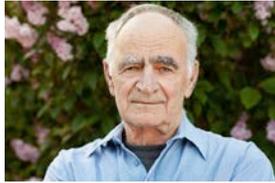
- The three most common sites of pain in older adults (> 65) are:
 - The back
 - Leg/knee or hip
 - Other joints



(Patel et al., 2013)

Background: Pain and the Older Adult

- Attitudes, beliefs, and culture influence the pain experience
- Negative malingering (stoicism) is particularly common with older adults



Background: Pathophysiology of Pain and the Older Adult

General Physiologic Changes

- It is important to consider the general physiologic changes of aging when managing pain
 - Particularly with pharmacologic management



Background: Pathophysiology of Pain and the Older Adult

General Physiologic Changes (Continued)

- The basal metabolic rate decreases
- The body's lean mass and total water decrease
- Whereas body fat increases
- Bones, viscera, and the brain shrink
- This effects
 - Volume distribution
 - Plasma concentration
 - Elimination of drugs
- There are changes in pain perception, particularly in patients with cognitive impairment



Background: Pathophysiology of Pain and the Older Adult

Changes by Body System

- Renal function declines, resulting in decreased clearance of drugs and may lead to the build-up of metabolites
- Increased susceptibility to volume depletion and decreased thirst may increase the risk of nephrotoxicity
- Commonly used medications are more likely to damage older kidneys, in particular nonsteroidal anti-inflammatory drugs (NSAIDs)
- Transit through the esophagus and colon may be slowed
- The stomach may atrophy and produce less acid



Background: Pathophysiology of Pain and the Older Adult

Changes by Body System (Continued)

- Pancreatic and liver function is usually well maintained, but the cytochrome P450 system may decline with age
- In particular, the decline in demethylation, the process by which benzodiazepines are metabolized, may necessitate dose adjustments
- Brain/CNS-pain perception changes [not in narration]



Assessment Question 1

Pain affects half of community-dwelling older adults and leads to increased incidence of:

- a) Diabetes
- b) Social engagement
- c) Depression
- d) Motor vehicle accidents



Assessment Question 1: Answer

Pain affects half of community-dwelling older adults and leads to increased incidence of:

- a) Diabetes
- b) Social engagement
- c) Depression (Correct Response)**
- d) Motor vehicle accidents



Approach to the Patient



Approach to the Patient

Remember

- Pain is subjective
 - Only patients know how much pain they are in, and only they can decide how far they want to go for treatment
- Pain is both a symptom and a disease
- Pain is a very personal issue



Approach to the Patient

Remember (Continued)

- Pain is hard to describe, hard to quantify
 - Eliminate dangerous and progressive diseases [not in narration]
 - Prevent centralization [not in narration]
- Pain is a sensation
 - What does blue look like? What does water feel like? What does coffee smell like? What do apples taste like?



Approach to the Patient

- Establish rapport with patient by developing empathy
 - Communicating that we want to understand our patients will comfort them and produce confidence that their treatments will work
- Find the source
- Treat both the primary source and the presenting symptoms



Approach to the Patient

- Screen for non-pain problems
- Focus on restoring function
- Patient education is required for informed consent
 - Patients need to understand where their pain is coming from and what to expect
 - They need to know what their treatment choices are and what the risks and benefits are



Approach to Patients in Clinic

Environmental Issues

- Keep clutter and noise to a minimum
- Keep lights as low as appropriate
- Keep rooms comfortable
- Keep crowds limited
 - Pain patients generally do better waiting in rooms rather than in the lobby if more than 1-2 other people are present



Assessment of Pain



Taking a Pain History

Pain History

- Acute and/or chronic
- Onset, duration
- Location
- Type of pain (e.g., sharp, dull, or stabbing)
- Intensity
- Contributing and ameliorating factors
- Impact on function and quality of life



Taking a Pain History

Psychosocial History

- Mood
- History of depression
- Substance abuse
- Abuse: physical, sexual, emotional, self-neglect

• Always consider the results of previous testing, pain evaluations, and treatments as well as their effectiveness and adverse events



Assessment of Pain

For the Patient

- Sharp = more
- Dull = less
- Be clear in YOUR definitions, so that your patients can be clear in their descriptions
 - Does it feel like you are getting poked with a pin? (sharp pain)
 - Does it feel like you got hit with a hammer? (dull pain)
 - “10 out of 10 means I could stick you with a needle for a blood draw and you would not feel more pain than you currently do”



Assessment of Pain

- If patients' answers do not seem to make sense, that may be the provider's fault for not helping them find the right words



 Engagement of Health Care Goals

Describing Pain: Types and Timing

Types of Pain (definitions not in narration)

Dysesthesia: An unpleasant abnormal sensation, whether spontaneous or evoked

Paresthesia: An abnormal sensation, whether spontaneous or evoked

Hyperalgesia: An increased response to a stimulus which is normally painful

Allodynia: Severe pain reaction to a non-painful stimuli

<http://americanpainsociety.org/uploads/education/references.pdf>

 Engagement of Health Care Goals (Berry et al., n.d.)

Describing Pain: Types and Timing

Timing of Pain (definitions not in narration)

Acute Pain:

- Self-limiting, usually lasts less than 6 months
- Protective function
- Nociceptive pain

Chronic Pain:

- Not a symptom, but a disease process of its own
- Pain that has persisted for > 6 months

Neurologic Centralization:

- Pain response that is initiated by the brain, generally in response to chronic pain

 Engagement of Health Care Goals (Berry et al., n.d.) <http://americanpainsociety.org/uploads/education/references.pdf>

Assessment of Pain in Older Adults	
Validated Pain Instruments	
The Faces Pain Scale • Licensing: Wong-Baker FACES Foundation (Wong et al., 2000)	http://wongbakerfaces.org/
The Numeric Rating Scale (Farrar et al., 2001) • Asks a patient to rate pain on a scale of 0 to 10	http://www.geriatricpain.org/Content/Assessment/Intact/Pages/NRScale.aspx
The Verbal Descriptor Scale (VDS) • Has the patient describe their pain as mild, moderate, or severe (Herr et al., 2007)	http://www.geriatricpain.org/Content/Assessment/Intact/Pages/VDS.aspx
The Visual Analog Scale (McCormack et al., 1988) • Use with patients who have difficulty speaking	https://www.painedu.org/downloads/nipc/pain%20assessment%20scales.pdf

Assessment of Pain in Older Adults
<ul style="list-style-type: none"> Look out for multiple factors and assess for: <ul style="list-style-type: none"> Nonverbal signs of pain <ul style="list-style-type: none"> Facial grimacing Rubbing Guarding Gait changes Changing position Loss of appetite


Assessment of Pain in Older Adults
<ul style="list-style-type: none"> Look out for multiple factors and assess for (continued): <ul style="list-style-type: none"> Behavioral signs that may indicate pain <ul style="list-style-type: none"> Wandering Pacing Withdrawal Aggression Agitation Crying


Assessment of Pain in Older Adults	
Assessment for Function Tools	
Range of Motion Scale	Active and passive range of motion tests of the joint and spine may include flexion, extension, rotation, lateral bending, supination, pronation, inversion, eversion, adduction, abduction (Stanley, 1976)
Physical Performance Test (PPT)	http://www.brightonrehab.com/wp-content/uploads/2012/02/Physical-Performance-Test-PPT.pdf
Timed Up and Go Test	https://www.cdc.gov/steady/pdf/tug_test-a.pdf
Katz Activities of Daily Living Scale (Katz, 1983)	https://consultgeri.org/try-this/general-assessment/issue-2.pdf (Shekely & Wallace, 2012)

Assessment of Pain in Older Adults	
Assessment for Function Tools (Continued)	
Lawton Instrumental Activities of Daily Living (Lawton & Brody, 1969)	http://micmrc.org/system/files/IADL.pdf (Graf, 2003)
Functional Independence Measure (FIM)	http://meteor.aihw.gov.au/content/index.phtml/itemId/495857
<ul style="list-style-type: none"> • Trademarked by the Uniform Data System of Medical Rehabilitation • Australasian Rehabilitation Outcomes Centre holds the territory license for use of FIM in Australia 	
	

Assessment of Pain in Older Adults	
Assessment for Mood	
The Geriatric Depression Scale Short Form, 15-item (Sheik & Yesavage, 1986)	https://consultgeri.org/try-this/general-assessment/issue-4.pdf (Greenberg, 2012)
<ul style="list-style-type: none"> • Depression often makes pain worse and vice versa • Screening and treating one without the other can lead to difficulty resolving both conditions 	
	

Assessment of Pain in Older Adults

Assessment of Quality of Life: Validated Tools

<p>Brief Pain Inventory</p> <ul style="list-style-type: none"> • Short version 9 items, long version 17 items • Copyright, Charles Cleeland, 1991 <p>The Geriatric Pain Measure <small>(Ferrill et al., 2000)</small></p>	<p>https://www.painedu.org/downloads/nipc/brief_pain_inventory.pdf</p> <p>http://www.palliativecareswo.ca/docs/Geriatric%20Pain%20Measure%20GP.M.pdf</p>
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Assessing Pain in the Older Adult

- There are challenges in assessing pain in older adults
- Addressed by the following simple changes:

Type of Impairment	Tools
Hearing impairment	<ul style="list-style-type: none"> • Visual scale type assessment tools • Assistive hearing devices
Visual impairments	Larger print tools
Cognitive impairment	Most tools have been validated

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Enhancement of Geriatric Care

Assessing Pain in the Older Adult

- Address challenges in assessing for pain in older adults (continued):

Type of impairment	Validated Tools
Severe impairment	<ul style="list-style-type: none"> • Pain Assessment Checklist for Seniors with Limited Ability to Communicate <small>(Fachs-Laetle & Hadjistavropoulos, 2004)</small> http://www.geriatricpain.org/Content/Assessment/Impaired/Pages/PACSLAC.aspx • Pain Assessment in Advanced Dementia <small>(Warden et al., 2002)</small> http://www.geriatricpain.org/Content/Assessment/Impaired/Pages/PAIDADTool.aspx • Doloplus-2 scale (Copyright) <small>(Lefebvre-Chapiro, 2001)</small> http://pre.coh.org/PainNOA/Doloplus%202 Tool.pdf

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Assessment Question 2

There are several validated pain instruments for assessing pain in the older adult. These include all of the following EXCEPT:

- a) The Numeric Rating Scale
- b) The Verbal Descriptor Scale (VDS)
- c) The Faces Pain Scale
- d) The Mini-Mental State Exam (MMSE)



Assessment Question 2: Answer

There are several validated pain instruments for assessing pain in the older adult. These include all of the following EXCEPT:

- a) The Numeric Rating Scale
- b) The Verbal Descriptor Scale (VDS)
- c) The Faces Pain Scale
- d) The Mini-Mental State Exam (MMSE) (Correct Answer)**



Management of Pain



Pain Pathology: Sources of Pain

Find the Source: First Eliminate Threats to Life and Limb

- Myocardial infarction (MI)
- Infection
- Musculoskeletal conditions that could worsen (e.g., tendon tear)
- Bone
- Muscle
- Tendon
- Ligament
- Intervertebral discs
- Nerves
- Organ pain from pathology to organ system (i.e., IBS, UTI, URI) (not in narration)
- Centralized pain



Assessment of Pain

Acute Pain

- Normal sensation triggered in the nervous system to alert of possible injury

Chronic Pain is Different

- Chronic pain persists
 - Pain signals keep firing in the nervous system for weeks, months, even years
 - There may have been an initial or an ongoing cause of pain (i.e., arthritis, cancer), but some people suffer chronic pain in the absence of any past injury or evidence of body damage



Assessment of Pain: Chronic Pain

Chronic Pain is Different (Continued)

- Many chronic pain conditions affect older adults
 - Older adults may have two or more co-existing chronic pain conditions
 - Neurologic centralization
 - Increased emotional and psychological response to pain
 - These may require treatment independent of the pain
 - Overall increased pain levels
 - Refractory to most interventions
 - Longer treatment course, but have poorer results
 - Treatment typically requires both antidepressant and anti-seizure as well as opioid medications



Assessment of Pain

Care Coordination

- Pharmacologic interventions
- Behavioral interventions
- Community resources across settings and providers

Develop Plan of Care

- Integrate acute needs
 - Preventive care and health promotion
 - Provide list of local community-based resources, such as exercise and nutrition classes, chronic disease self-management education classes, and lay-led empowerment workshops for preventive care and health promotion



Assessment of Pain

Develop Plan of Care (Continued)

- Promote mental health services as essential components of the plan of care
 - This is especially effective if mental health professionals are included as part of the care team
- Refer to community-based mental health and social services, as needed



Management: Treat the Source

Treat the Source of the Pain

- Identify if pain is acute or chronic
- Specify the tissue responsible for the generation of the pain
- Use these distinctions to guide treatment:
 - Anti-inflammatory medications
 - Nerve-modifying medications
 - Central pain control



Management: Treat the Source

Resolving Pain as a Process

- Symptom control
 - Decrease inflammation
 - Decrease intensity and frequency
- Decrease psychological or social symptoms, such as depression, anxiety, or an inability to sleep

Return to Normal Life

- Improve functional ability
- Improve or maintain quality of life



Non-Pharmacologic Strategies



Management of Pain: Non-Pharmacologic Approaches

- It is important to tailor the treatment to the individual attitudes and beliefs and preferences for and experience with non-pharmacological pain treatment strategies
 - This will help tailor the non-pharmacological techniques to the individual

Cognitive Behavior Strategies

- Focus on changing the person's perception of pain (e.g., relaxation therapy, education, or distraction)
- May not be appropriate for cognitively impaired persons



Management of Pain: Non-Pharmacologic Approaches

Physical Pain Relief Strategies

- Focus on promoting comfort and altering physiologic responses to pain (e.g., heat, cold, transcutaneous electrical nerve stimulation [TENS] units)
- Generally safe and effective
- Can be very important tool for your patients



Management of Pain: Physical Pain Relief Strategies

Modalities

- Energy sources that provide pain relief and reduce inflammation:
 - Heat
 - Ice
 - Transcutaneous electrical nerve stimulation (TENS)
 - Ultrasound



Physical Medicine

Use Physical Medicine to Aid in Pain Management

- Treat the source
 - Return patient to normal function using manual medicine



Physical Medicine

Use Physical Medicine to Aid in Pain Management (Continued)

- **Physical therapy** (such as stretching and strengthening activities) and low-impact exercise (such as walking, swimming, or biking) can help reduce the pain; other therapies include heat and massage
- **Occupational therapy** teaches how to pace activities and how to do ordinary tasks differently
- **Chiropractic manipulations** massage and manipulation may give relief of pain



**Non-Pharmacologic Pain Relief:
Complementary and Alternative Medicine**

Complementary and Alternative Medicine to Aid Pain Management

- **Guided imagery** A relaxation technique involving imagining yourself at your favorite relaxing location (e.g., beach)
- **Progressive muscle relaxation** Starts at the feet and moves up the body until the entire body feels relaxed
- **Relaxation breathing** Helps relax the body and reduce anxiety



**Non-Pharmacologic Pain Relief:
Complementary and Alternative Medicine**

Complementary and Alternative Medicine to Aid Pain Management (Continued)

- **Acupuncture** This ancient Chinese practice uses very thin needles at very specific points on the skin to interfere with nerve impulses; can be used for both acute and chronic pain
- **Biofeedback** Uses visual or sound cues to help people control their response to pain; they can learn to relax muscles and stay calm



**Non-Pharmacologic Pain Relief:
Complementary and Alternative Medicine**

Complementary and Alternative Medicine to Aid Pain Management (Continued)

- **Herbal supplements** are often useful and powerful, but may interact with other medications
 - *Referral Cue: Add pharmacist to the care team to check if herbal supplements may have adverse effects akin to prescribed medications*



Non-Pharmacologic Pain Relief

Psychological Support is an Important Aspect of Non-Pharmacologic Pain Relief

- Psychological counseling can help with stress management (e.g., cognitive behavioral therapy or biofeedback)
- Group counseling for couples or families to decrease interpersonal stress
- Screening for adjustment disorder and depressive disorders
 - Helps to manage secondary symptoms such as insomnia
- Some psychological approaches have been found to be particularly useful for the older population, including guided imagery, biofeedback training, and relaxation (Abdalla et al., 2013)



Assessment Question 3

Match the following types of non-pharmacologic therapies:

Psychological Support	Low-impact exercise (such as walking, swimming, or biking)
Physical Therapy	Acupuncture
Occupational Therapy	Counseling for stress management
Complementary and Alternative Therapy	How to pace ordinary daily tasks and activities



Assessment Question 3: Answer

Correct Matched Responses:

Physical Therapy	→	Low-impact exercise (such as walking, swimming, or biking)
Complementary and Alternative Therapy	→	Acupuncture
Psychological Support	→	Counseling for stress management
Occupational Therapy	→	How to pace ordinary daily tasks and activities



Pharmacologic Strategies



Pharmacological Strategies

- Non-pharmacological approaches may not be enough to help your patients' experience of pain

Pharmacology and the Older Adult

- Older adults are at increased risk for adverse drug reactions due to age- and disease-related changes in pharmacokinetics and pharmacodynamics
- Monitor medication effects closely to avoid overmedication or undermedication and to detect adverse effects
 - Assess hepatic and renal functioning



Medication Management

Long-Acting Pain Medication

- Prescribe when your patient is in constant pain
- Typically lasts 12 hours
- Breakthrough pain occurs when people are being treated with long-acting pain medications
- Breakthrough pain occurs randomly, but may peak right before it is time to take their next dose of long-acting pain medication

Short-Acting Pain Medication

- Used for pain that comes and goes
- Typically lasts 2-4 hours



Medication Management

- Older adults are at higher risk for adverse drug reactions
 - Monitor their prescriptions for adherence, effectiveness, overdose, and adverse events
- Empower your patient to work with you on this task
 - Educate and activate the patient to understand and report all medication-related problems
 - Include your patient in all the decision-making about their care plan
 - Follow up on prescribing decisions to maintain, change dose, change frequency, discontinue, substitute, or add a drug



Management of Pain: Medications

- Decide with your patient what medicines to include – both prescriptions and over-the-counter aspirin pain relievers, such as
 - Non-aspirin pain relievers such as acetaminophen can relieve headaches and minor pain, but do not reduce swelling
- Anti-inflammatory drugs are used to relieve pain, inflammation, swelling, and fever
- Aspirin and non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen and naproxen
 - There are also prescription steroidal drugs (like prednisone) that are used for more serious inflammatory conditions such as chronic arthritis
- Tramadol is used for mild to moderate pain



Management of Pain: Medications

NSAID Adverse Effects

- **Gastritis:** May need a medication such as a proton pump inhibitor (e.g., esomeprazole or pantoprazole) to protect the stomach from ulcers
 - NSAIDs should be taken with food to minimize or prevent gastritis
- **Bleeding:** Monitor for frequent bleeding gums, nose bleeds, or cuts that bleed longer than normal
- **Vascular:** All NSAIDs have a relative risk of MI and CVA; stronger NSAIDs generally carry a larger risk; the longer your patients takes NSAIDs the larger the risk
- **Renal:** NSAIDs may also cause acute kidney injury/pre-renal nephrotoxicity, especially if the older adult is dehydrated
- May cause fluid retention/ heart failure exacerbation [not in narration]



Management of Pain: Opioid Analgesics

- Note: Always prescribe opioids with careful consideration and caution

<p>Mild Pain</p> <ul style="list-style-type: none"> • Codeine-containing medications <p>Mild to Moderate Pain</p> <ul style="list-style-type: none"> • Hydrocodone • Tramadol [not in narration] 	<p>Moderate Pain</p> <ul style="list-style-type: none"> • Oxycodone <p>Severe Pain</p> <ul style="list-style-type: none"> • Fentanyl transdermal • Hydromorphone • Morphine • Methadone – requires specific DEA licensing and training
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Management of Pain: Opioid Analgesics

Adverse Effects

- Nausea
- Vomiting
- Constipation
- Itching
- Jerky muscular movements
- Sedation
- Confusion
- Respiratory depression
- Each of these adverse effects should be monitored and managed as part of your re-evaluation of the plan of care



Management of Pain: Adjuvant Analgesics

- The following FDA approved antidepressants, anti-seizure medications, and muscle relaxants do not have an FDA indication for pain, but may be effective for pain management:

Antidepressants

- May help relieve neuropathic pain and help to improve sleep
- Examples: desipramine, duloxetine

Anti-Seizure Medications

- Medications used to relieve nerve type pain described as "shooting" pain
- Examples: gabapentin, pregabalin, carbamazepine

Muscle Relaxants

- Treat muscle spasms, and may be sedating
- Examples: cyclobenzaprine, baclofen



Management of Pain: Adjuvant Analgesics

- These agents are "adjuvant analgesics" for co-administration with non-opioid and opioid analgesics unless the older adult has purely neuropathic pain
- However, most older adults have degenerative and inflammation-based pain
- These agents pose a risk in older persons that add to the CNS drug burden and should be used judiciously



Pain Medications May Cause Xerostomia (Dry Mouth)

Pain Medications May Cause Dry Mouth

- Constant thirst
- Dysphagia
- Altered speech
- Difficulty wearing dentures
- Oropharyngeal infections
- Difficulty moving food around the mouth
- *Referral Cue: Dentists, Registered Dietitians, and Speech Therapists*



Pain Medications May Cause Xerostomia (Dry Mouth)

Pain Medications May Cause Dry Mouth (Continued)

- Mucous and plaque accumulation
- Food retention
- Changes in oral flora
- Mucosal tissue changes
- Taste alterations
- Dental caries



Educate Patients

Minimize Side Effects

- Avoid sugary snacks between meals
- Consider using oral lubricants, saliva substitute products, ice chips, sugarless candies, etc. (not in narration)
- Ask their dentist about prescription fluoride toothpastes



Management of Pain: Topical Agents

Over-the-Counter

- Menthol, camphor, salicylates, and anesthetic-based options

Prescription Products

- Topical NSAID (e.g., diclofenac) (not in narration)
- Opiates (not including medications prepared for systemic use, like fentanyl)
- Other: lidocaine patch (not in narration)



Management of Pain: Topical Agents

Advantages of Topical Agents

- Generally, smaller systemic effect
- Decreased addiction potential

Disadvantages of Topical Agents

- Smaller systemic effect
- Depth of penetration may be limiting
- May struggle with application of medication



Assessment Question 4

Pharmacological management of pain with the older adult patient includes consideration that:

- Different types of medications are for different types of pain
- Pharmacological strategies cannot be combined with non-pharmacological strategies
- Older adults are at a decreased risk for adverse drug reactions due to their age
- It is uncommon to see an older adult on multiple pain medications



Assessment Question 4: Answer

Pharmacological management of pain with the older adult patient includes consideration that:

- Different types of medications are for different types of pain (Correct Answer)**
- Pharmacological strategies cannot be combined with non-pharmacological strategies
- Older adults are at a decreased risk for adverse drug reactions due to their age
- It is uncommon to see an older adult on multiple pain medications



Pharmacologic Strategies



Addiction and Pain

- A person with a history of addiction has lost control over the use of a drug
- They may still develop acute or chronic pain that needs to be managed
- Differentiate between: *(not in narration)*
 - Drug tolerance: A decreasing response to repeated constant doses of a drug or the need for increasing doses to maintain a constant response
 - Pseudotolerance: A need to increase dosage due to factors other than tolerance
 - Drug dependence: A psychological craving for, habituation to, abuse of, or physiological reliance on a chemical substance
 - Addiction: Persistent compulsive dependence of a substance
 - Pseudoaddiction: A drug-seeking behavior that stimulates true addiction in patients with pain who are receiving inadequate pain medication



(TheFreeDictionary, 2017)

Addiction and Pain

Discussing With Your Patient

- A health care provider may ask patients to sign an opioid agreement and
 - Obtain prescription from only one provider
 - Use only one pharmacy
 - Bring medication to appointment to be counted
 - Have periodic urine drug testing
 - Older adults may not be compliant with medication regime for fear of addiction



(American Pain Foundation, n.d.)

Care Planning: Person-Centered Care

Develop a Person-Centered Care Plan

- Identify and prioritize patient's preferences, needs, and values
- Use shared decision-making techniques to select preference-sensitive treatment options
- Get to know your patients
 - Include life context and social and cultural determinants of health when discussing the goals and plans of his or her care



Care Planning: Person-Centered Care

- Assist patients/families/caregivers in reaching their identified lifestyle, management, and treatment goals
- Employ behavior-change techniques to assist in reaching identified lifestyle goals



Care Planning: Person-Centered Care

Patient Education Is Essential

- Patients should understand:
 - What is hurting?
 - Why it hurts?
 - What can help?
 - Why it can help?
 - What the time course is for treatment and alleviation?
 - And what if any, there other options are?
- You can empower your patient through information and create a collaborative care plan



Self-Care Strategies: Lifestyle Changes

Let Your Patients Know

- Lifestyle changes are an important part of management of their care plan
- Lifestyle changes are an important part of management of chronic pain
- Get regular sleep at night and avoid taking naps during the daytime
- Regular physical activity can increase strength and flexibility
- Good nutrition will make a person feel better and help prevent some side effects



Self-Care Strategies: Lifestyle Changes

Let Your Patients Know (Continued)

- Stop smoking
 - The nicotine in cigarettes can make some medicines less effective
 - Smokers also tend to have more pain than nonsmokers; this is a result of narrowing blood vessels causing a decrease in blood flow to a painful area
- Decrease alcohol use
 - Minimize adverse effects of medications and decrease depressive symptoms



Self-Care Strategies: Pain Prevention

Help Your Patients Prevent Pain

- Develop a written pain treatment plan upon admission to the hospital or prior to surgery or treatments
 - Help your patients to set realistic pain treatment goals, and document those goals and plans
- Assess their pain regularly and frequently to facilitate appropriate treatment
- Anticipate and aggressively treat for pain before, during, and after painful diagnostic and/or therapeutic treatments
 - Administer analgesics 30 minutes prior to activities



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