Pain Management and EOL Care in the Older Adult

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At the end of the presentation, the participant will:

- Demonstrate increased understanding of the specific pain management needs of the aging.
- Identify common cultural and social barriers to effective pain management in the older adult.
- Emphasize the importance of a focus on safety when prescribing pain medication for the older adult.
- Identify most common management needs of the dying older adult.

“ Persistent pain in older adults, particularly those who are frail or who have dementing illness, is at best under diagnosed and undertreated and, at worst, ignored.”

Weiner, Herr, & Rudy, 2002, p. 5

“The effects of aging on pain are less important than the effects of pain on aging.”

Weiner, Herr, & Rudy, 2002, p. 6

Pain Management in the Older Adult

- If left uncontrolled can:
  - Cause hypertension and tachycardia
  - Postpone healing
  - Cause respiratory complications
  - Increase confusion and restlessness
  - Root cause of delirium
  - Increase depression
  - Reduce peristalsis
  - Increase cortisol levels
  - Decrease socialization
  - Impact QOL

Pain Management Concerns for the Older Adult

- By 2030, 1 in 5 (20%) of our population will be over 65.
- After age 75, illness, mortality and social problems rise rapidly.
- Stoicism, and not wanting to complain.
- Belief that pain is a part of aging.
- Had pain so long think its normal.
- Cognitive and sensory impairment increases with pain.

Bruckenthal, Marino, & Snelling, 2016; Pasero & McCaffery, 2011

Geriatric patients commonly have:

- Multiple co-morbidities
- A variety of meds that can interact with opioids
- Altered metabolism and organ impairment
- Reduced ability to achieve homeostasis
- Altered pain perceptions
- Reduced ability to care for themselves
- Loss of muscle tone and strength

Fishman, Ballantyne, & Rathmell, 2010; McCleane & Smith, 2006

Common Sources of Pain in the Older Adult

- Musculoskeletal:
  - Arthritis, inflammation degenerative discs, ischemia, surgery, trauma, fibromyalgia, and vertebral compressions.
- Neuropathic:
  - Diabetic neuropathies, phantom limb pain, post CVA, and post-herpetic neuralgia.
- Osteoporosis, compression fractures, osseous fx.
- Pressure ulcers/wounds.

McCleane & Smith, 2006; Pasero & McCaffery, 2011

Alert, oriented and communicative is the NORM for the older adult.

- Confusion and disorientation may themselves be indicators of pain in a previously oriented patient.
- Learn the patient's pain history:
  - What underlying painful conditions/old injuries does the patient have?
    - Potential for acute-on-chronic pain.
  - What has helped them in the past?
    - Pharmacologic: OTC and prescription.
      - » What are they ACTUALLY taking?
    - Non-pharmacologic: positioning, distractive therapy, heat/cold packs, etc.

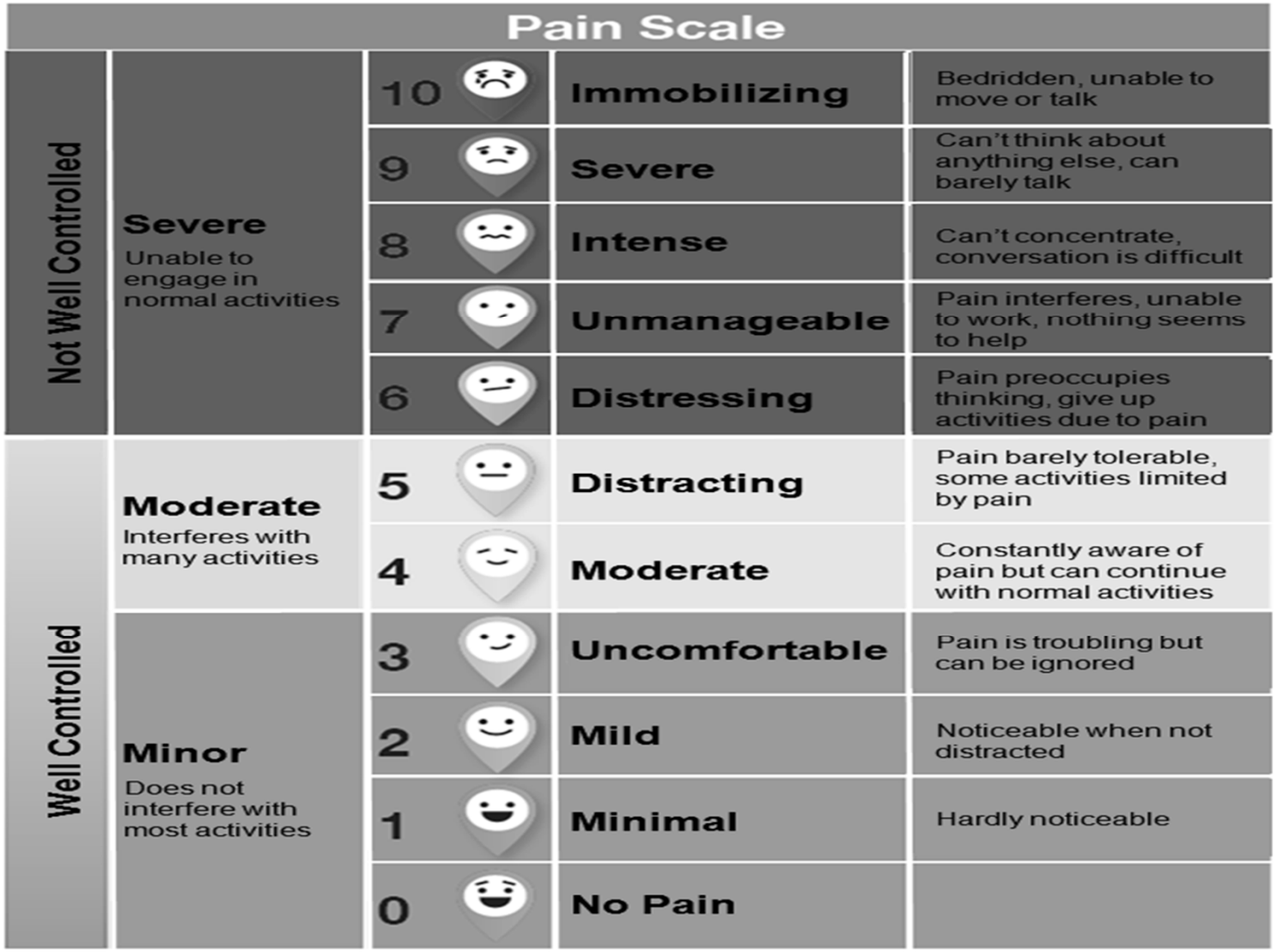
Pain Tools: Use and Misuse

Tool	Criteria
Wong Baker Face Scale	Children 3-18
N-PASS scale	Premature neonates and infants up to 2 months old
rFLACC scale	Children ages 3-7.
Verbal Descriptors	Pediatric through adult
UCLA Functional Pain Scale (Currently under validation assessment)	Pediatric through adult, a variation on numeric scale that equates pain with functional status.
PAIN AD	Patients with advanced dementia and End of Life
CPOT	Critical Care Pain Observation Tool, used with nonverbal patients primarily in ICU.

Utilizing pain assessment tools in the older adult

- Standard 0-10 Likert scale is challenging to many patients (including younger ones!)
- Verbal indicators such as mild-moderate-severe are useful, but highly subjective.
- “Faces” Pain Scale
  - Primarily validated in children
  - Variations created for elderly faces
  - ONLY works if the patient will truthfully point to the appropriate face.
    - Cultural bias

Geisinger Pain Scale



Medico et al, Am J Health-Syst Pharm. 2017; 74:528-33

But Not All of Our Patients Can Communicate…

UCLA Functional Pain Scale

PAIN SCALE				
Not Well Controlled	**Severe** **Unable to do normal activities** - hard or unable to think, talk, or move or do activities (examples: bathing, dressing, eating) - hard or unable to enjoy life because of pain	10		**Worst Possible**
		9		**Severe**
		8		**Intense**
		7		**Strong**
Well Controlled	**Medium / Moderate** **Hard to do normal activities** - able to do normal activities, but pain is often there with work, housework, socializing, and hobbies	6		**Nagging / Distressing**
		5		**Annoying / Distracting**
		4		**Moderate**
	Mild **Able to do normal activities** - pain is hardly there or can be ignored	3		**Uncomfortable**
		2		**Mild**
		1		**Slight**
		0		**No Pain**

*This pain scale is intended to be used with verbal/adult patients. It has been adapted with permission from Geisinger's Pain Scale

UCLA Health

The Case:

- 88 year old woman with advanced dementia, diabetes type II, congestive heart failure, longstanding history of arthritis.
- Nonverbal, contractures to upper and lower extremities, PEG tube, lives in nursing home x 1 year, bedbound, incontinent urine and stool.
- Admitted with new onset cough, coarse ronchi throughout lung fields, thick pale yellow sputum.
- Third admission in five months (aspiration pneumonia x 2, UTI x 1).
- Code status: modified DNR/DNI

Assessment

- VS 100.1F, 110, 26, 100/40 SPO2 91% on 2l N/C O_2
- Pale w/flushed cheeks, facial affect flat but grimaces and recoils to touch, multiple skin tears and ecchymotic areas on arms. Cries out and resists when moved/turned.
- Stage II pressure areas on coccyx, Stage III on heels.
- Redness and excoriation around PEG tube bumper.
- Bowel sounds active to all quadrants, all pulses palpable.

Lab results:

- Na+ 141
- K+ 3.7
- Cl 92
- CO2 24
- BUN 1.2
- Creatinine 23
- Glucose 220
- H &H: 9.3 and 27
- WBC’s 17
- Albumin 3.2 g dL ,
- PreAlbumin 10 mg dL,
- Procalcitonin 1.9 mg/ml

Nursing Home Medications:

- Lasix 40 mg per Gtube bid
- Captopril 25 mg per Gtube tid
- Micronase 5 mg per Gtube qd
- Labetalol 100 mg per Gtube bid
- Pantoprazole 40 mg per Gtube qd
- Tylenol 650 mg per Gtube q 6 hours prn pain/fever
- MOM 30 ml per Gtube prn constipation
- Metaclopramide 10 mg per Gtube q 6 hours prn nausea/vomiting
- Haldol 5 mg per Gtube tid prn agitation

Could this patient be in pain?

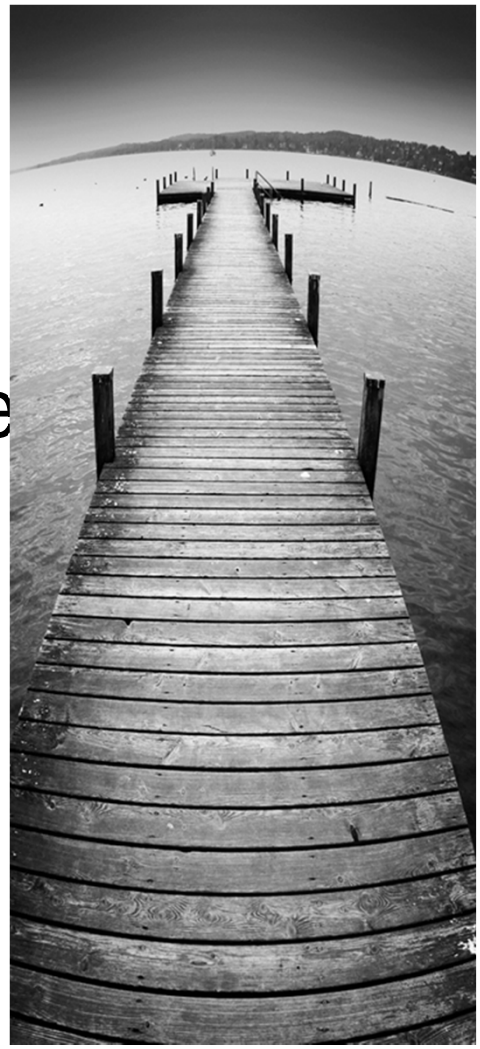
Communication may be Impaired, but Where is the Cognition/Comprehension?

- Present, even though communication is lost?
- Uncertain?
- Completely gone?

Just because the patient cannot communicate (or cannot communicate in the practitioner's language) does NOT mean the patient does not have comprehension.

Populations and Diagnoses: When the Voice is Lost…

- Advanced Dementia
- Neurological Deficits
- Language and/or Cultural Barrie
- Sedated/Intubated
- *End of Life*



Dementia:
The Progressive Loss

- Patients with dementia experience pain sensation similarly to those without dementia…BUT…
- Central Nervous System damage effects memory, language and higher order cognitive processing, thereby impairing the ability to communicate.
- Although those with dementia may be able to use conventional reporting techniques early in the disease, this ability worsens over time.

Neurological Deficits and Conditions: Examples Include:

- Cerebral Vascular Attacks (Stroke)
  - Cognitive ability may vary with degree of injury
    - Ability to communicate may be impaired, but cognition may remain intact (aphasia, dysphasia)
- Sensory challenges (blindness, deafness, inability to speak)
  - Once again: is cognition present?
  - Are tools available to assist the individual in communicating, or can they be obtained?
  - Have significant others developed a communication method?

Language and Cultural Barriers

- Attempt to communicate with the ***patient*** first!
  - Face-to-face INDEPENDENT MEDICAL INTERPRETER is the “gold standard”.
  - Translation phones are a valuable tool, but some patients struggle with their use.
    - Difficult to hear over medical equipment
    - Concept of the phone can be challenging.
  - Significant other as interpreter is the last resort.

Language and Cultural Barriers

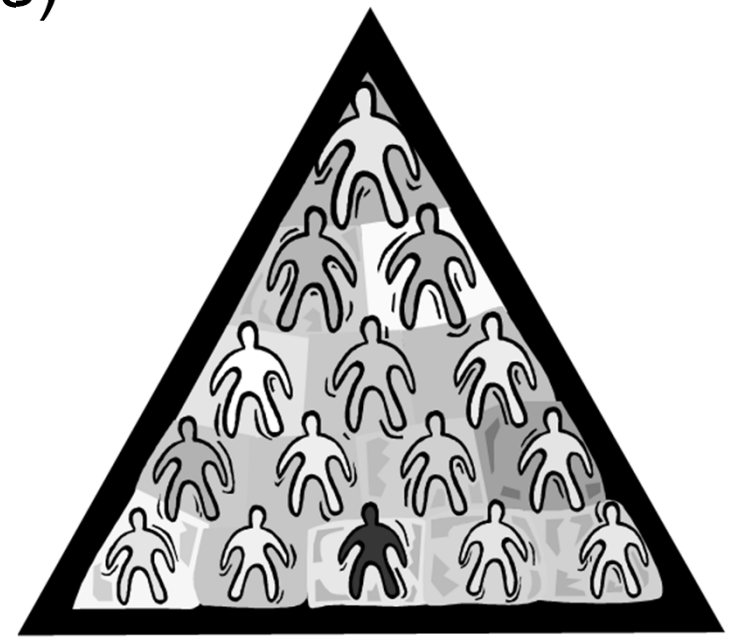
- If communication with the patient is not possible
  - The person remains “who he is” intrinsically.
    - Traits such as stoicism may be cultural.
- Significant others as a source of information
  - Pros:
    - Know the individual well and may share familial/cultural background
    - Know the patient’s pain history.
    - May recognize nonverbal indicators that would not be noticed by the practitioner.
      - Very valuable in the Developmentally Delayed patient.
  - Cons:
    - May carry their own beliefs and biases
      - Fear of pain medication or addiction
      - “Grandpa is tough/has high pain tolerance/is a fighter.”
      - Or...May “over report” pain in fear that their loved one could be suffering.

Sedated/Intubated

- SEDATIVE/ANTIPSYCHOTIC MEDICATION IS *NOT* FOR *PAIN*!!!
- Heavily sedated/paralyzed patients will not be able to communicate pain in standard ways.
  - Risk for PTSD.
- Intubation and suctioning themselves are painful.
- Pre-medicate for potentially painful treatments (i.e. inserting lines, repositioning, etc…).
- Agitation scores *do not* measure pain.
  - Although agitation may be, and frequently is, an indicator of pain.
- Pain increases oxygen demand.
  - Holding pain medications during “sedation vacation” and “ventilator weaning trials” may worsen likelihood of earlier extubation.

The Hierarchy of Pain Assessment Techniques*

- Self-Report
- Search for Potential Causes of Pain (Presumptive pain indicators)
- Observe Patient Behaviors
- Surrogate Reporting
- Attempt an Analgesic Trial



*McCaffery & Pasero, 2011, Herr et al 2006.

If no method of meaningful communication can be found, nonverbal patient pain assessment tools should be utilized.

PAINAD

Pain Assessment IN Advanced Dementia
PAINAD

	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

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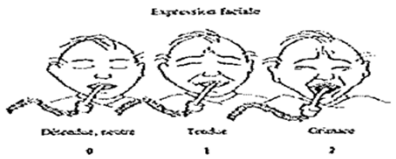
The Critical-Care Pain Observation Tool (CPOT)

(Gélinas et al., 2006)

Indicator	Score		Description
Facial expression  Caroline Arbour, RN, B.Sc., PhD(student) School of Nursing, McGill University	Relaxed, neutral	0	No muscle tension observed
	Tense	1	Presence of frowning, brow lowering, orbit tightening and levator contraction or any other change (e.g. opening eyes or tearing during nociceptive procedures)
	Grimacing	2	All previous facial movements plus eyelid tightly closed (the patient may present with mouth open or biting the endotracheal tube)
Body movements	Absence of movements or normal position	0	Does not move at all (doesn't necessarily mean absence of pain) or normal position (movements not aimed toward the pain site or not made for the purpose of protection)
	Protection	1	Slow, cautious movements, touching or rubbing the pain site, seeking attention through movements
	Restlessness/Agitation	2	Pulling tube, attempting to sit up, moving limbs/thrashing, not following commands, striking at staff, trying to climb out of bed
Compliance with the ventilator (intubated patients)	Tolerating ventilator or movement	0	Alarms not activated, easy ventilation
	Coughing but tolerating	1	Coughing, alarms may be activated but stop spontaneously
	Fighting ventilator	2	Asynchrony: blocking ventilation, alarms frequently activated
OR **Vocalization (extubated patients)**	Talking in normal tone or no sound	0	Talking in normal tone or no sound
	Sighing, moaning	1	Sighing, moaning
	Crying out, sobbing	2	Crying out, sobbing
Muscle tension Evaluation by passive flexion and extension of upper limbs when patient is at rest or evaluation when patient is being turned	Relaxed	0	No resistance to passive movements
	Tense, rigid	1	Resistance to passive movements
	Very tense or rigid	2	Strong resistance to passive movements or incapacity to complete them
TOTAL	___ / 8		

Presumptive Causes of Pain (Examples)

- Contractures
- Pressure Ulcers or other open lesions
- Ecchymosis
- Endotracheal tubes
- Invasive procedures
- Recent surgery
- Position changes/range of motion (look for stiffness, grimacing).

Pain Behaviors

- Pain behaviors may be more difficult to assess

the palliative setting:

- Acute Pain: Elevated vital signs may occur with sudden onset and severe pain; usually does not occur with ongoing and persistent pain when the body reaches “persistent equilibrium”.
- Chronic Pain: Absence of involuntary cues **or vital sign changes** does not mean the patient is not experiencing pain.
- Allodynia: pain due to a stimulus that does not normally invoke pain.

  A feature of many painful conditions, such as neuropathies, post-herpetic pain, fibromyalgia, complex regional pain syndrome and migraine.

Vital Signs: Their Own Conundrum…

- For acute, sudden and severe pain, elevations in HR and blood pressure are often present BUT...
- For patients with chronic or longstanding pain, changes in HR and blood pressure frequently do not occur.
- Vital signs can be affected by factors other than pain.
    - BP medications, beta blockers, critical illness.

The most reliable vital sign to indicate pain: Respiratory rate and pattern.

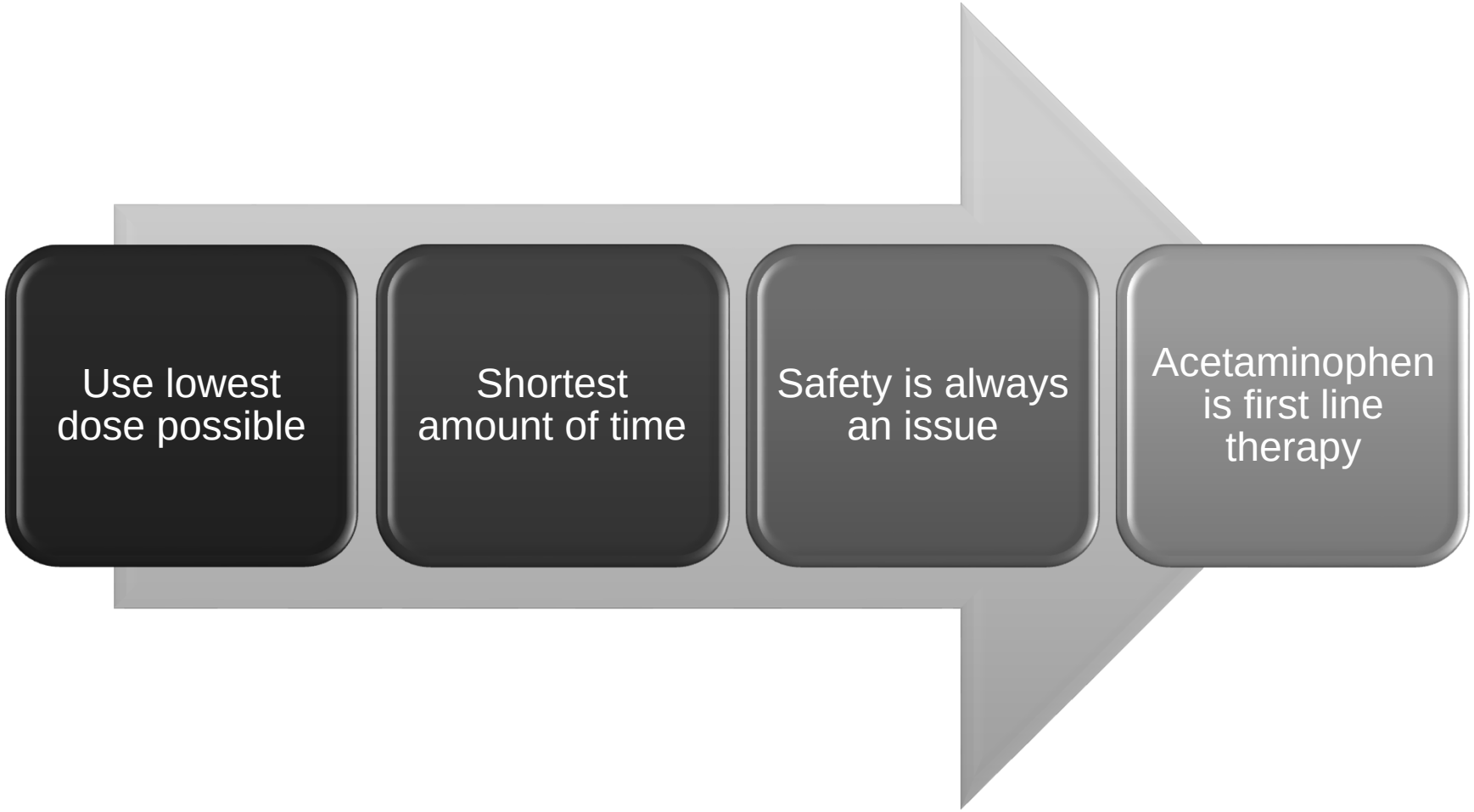
Pain Behaviors: Assessment

- Assess with rest ***and*** movement:
  - Possible behaviors in Cognitively Impaired or Developmentally Challenged patients:
    - Facial expressions
    - Body movements
    - Protective mechanisms
    - Verbalization
    - Vocalization
    - Mental status changes
    - Changes in activity pattern or interpersonal interactions
  - Observe for alterations in usual patterns of behavior

Pain Behaviors

- The pain experience may elicit a broad variety of responses in the Cognitively or Developmentally challenged.
- The routinely active patient may become withdrawn and sedated.
- Persons with historically poor language utilization may become more articulate r/t pain.
- Distractive, repetitious behaviors: rocking, blinking etc. (may be seen in the Developmentally Challenged).

PEARLS


Use lowest dose possible
Shortest amount of time
Safety is always an issue
Acetaminophen is first line therapy

Pain Management in the Older Adult

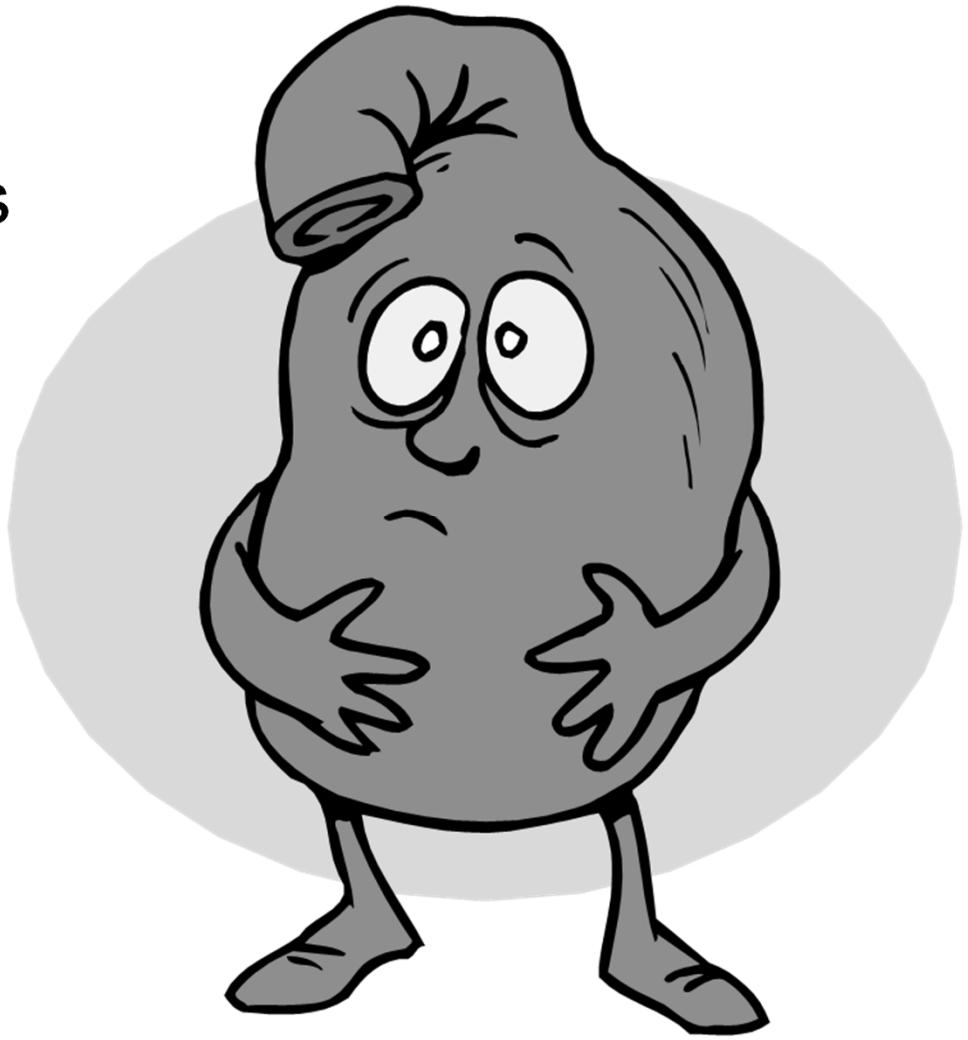
Considerations:

- Reduce opioid dosage with renal failure.
- Consider ability to follow directions for medications.
- Polypharmacy is a concern.
- More prone to side effects.
- Fears of addiction.
- Fears of worsening disease.
- Vision difficulties and fall prevention.
- Supervision and/or help.
- Preserving independence and dignity.

Pasero & McCaffery, 2011

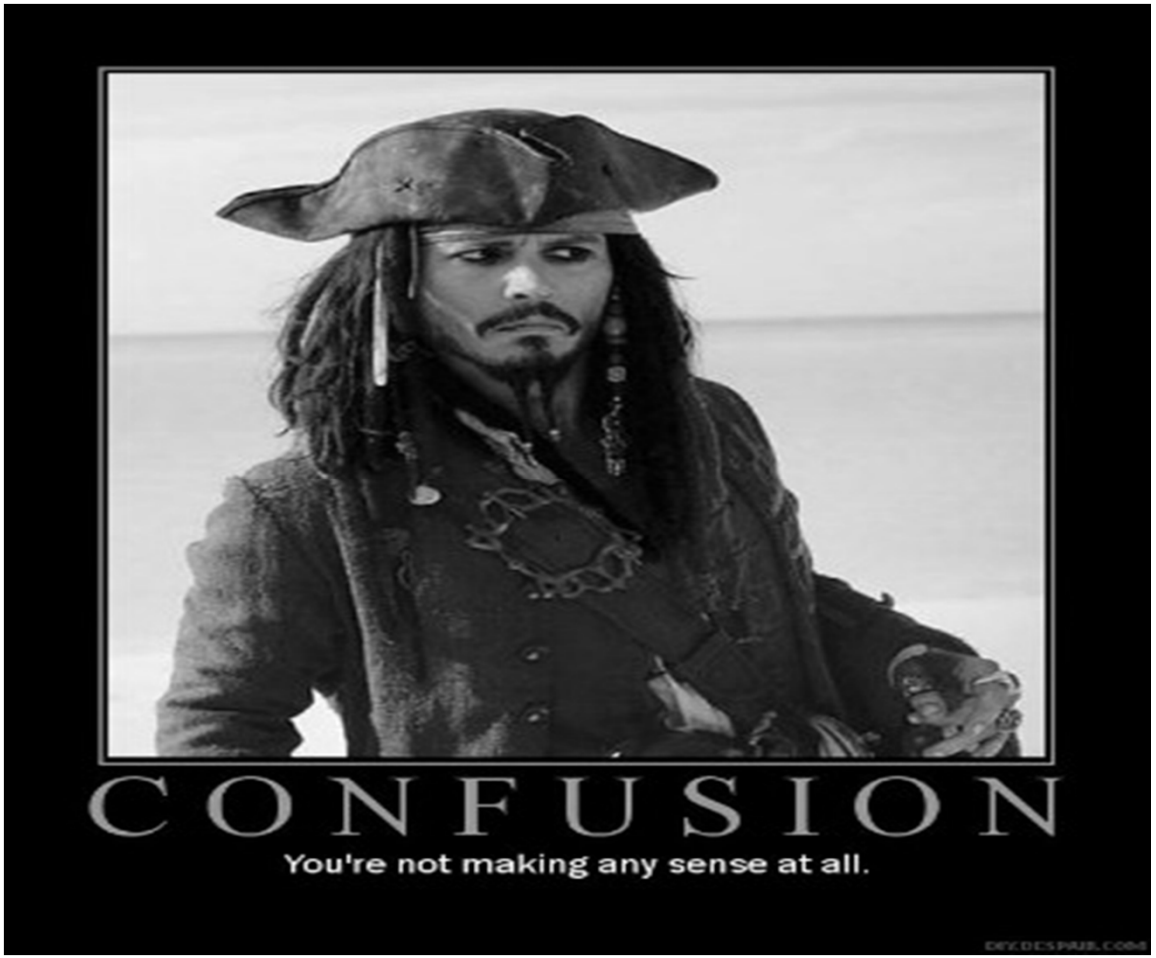
Side Effects

- GI
  - Reduced peristalsis
  - Ileus
  - GI bleeding
  - Nausea/vomiting
  - Loss of appetite



Pasero & McCaffery, 2011

Confusion/ Disorientation



Constipation

Pasero & McCaffery, 2011

Check List for Older Adult Opioid Dosing

- Is the use of a strong opioid the best treatment?
- Will this opioid interact with other medication?
- Can other agents help reduce the dose ?
- Can the risk of opioid tolerance be minimized ?
- What can be done to minimize side effects?
- Which route is most appropriate?
- What dose will be initiated?
- How long is the treatment?
- Will dose escalation be a concern?
- Will limitations on dosage be required?
- How will effectiveness be measured?

McCleane & Smith, 2006

Pain Management Methods for Nonverbal Patients

- PCAs are generally not manageable for Cognitively/Developmentally Challenged patients.
  - If PCA is used, instruct in the patient's own language.
- For this population, learning the patient's "pain history" is invaluable.
  - Previous history/reasons for pain?
  - What medications worked/didn't work in the past?
  - Medication reconciliation a MUST!
  - History of alcohol or illicit substance abuse?

Pain Management Methods for Nonverbal Patients

- Around-the-clock or basal trial for presumptive pain.
- Bolus dosing for breakthrough pain.
- If one agent has suboptimal effects, try another/a combination.
- *Family members cannot ethically refuse pain control or symptom management for patients without clear indications that the patient himself/herself would refuse.*
  - Seek assistance from your Ethicist or Ethics Committee if necessary.

If it Looks Like it Hurts, it Probably Does…

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