

Pain Assessment in the Older Adult

Denice Economou RN,MN,AOCN
Aptium Oncology
Manager Pain & Symptom
Management

Baltimore Longitudinal Study on Aging

- From 1958 BLSA has followed 1000 people from age 20 – over 90.
- ***“No Single, Chronological Timetable of Human Aging Exists”***

Barriers to Pain Assessment in the Older Adult

- Myths regarding Older Adults ability to cope with pain
- Fear that pain is indicative of death or serious illness
- Inadequate assessment of the pt's pain
- Comorbid conditions
- Lack of Knowledge
- Altered pharmacodynamic and pharmacokinetics
- Impaired ability to communicate

Myths Effecting Older Adults

- Chronic Pain is normal in Older Adults
 - Older Adults are better able to cope with pain
 - Chronic Pain will do no harm to the Older Adult
- King,S. 2000

Elderly Pain

- Common painful diseases with aging include post herpetic neuralgia, degenerative joint disease, and compression fractures.
- **“Pain itself is not part of aging”**
McCarberg,2002

Most Important Factors in Older Adult Management

- Cognition Impairment- challenging and must include assessment of nonverbal cues that may signal discomfort
- Functionality- Complicating in both directions. Unrelieved pain/under treatment or over treatment
- Physiology- decline in renal function, decreased liver mass and hepatic blood flow, decreased pulmonary function and GI changes

Major Symptoms Effecting the Response to Pain in the Elderly

- Depression
- Delirium and Dementia
- Anxiety
- Fatigue

Depression in the Elderly

- Estimates of depression is as high as 50% in some studies.
- The Geriatric Depression Scale has been shown to be between 70% - 85% sensitive and specific for rating geriatric depression
- Distress Thermometer as a one-item screening may be helpful over time.

Other factors related to Depression in the Elderly

- Metabolic abnormalities: electrolyte imbalance, vitamin B12 deficiency or folate deficiency.
- Dysregulation of the hypothalamic-pituitary-adrenal axis, also thyroid dysfunction, decreased growth hormone secretion
- PAIN is the most common cause of depressed mood in cancer patients

Delirium versus Dementia

- Both share impairment in memory, thinking, judgment and disorientation
- Delirium tends to occur in relatively alert individuals, rapid onset(hours to days) and fluctuating symptoms during the course of the day.
- Dementia tends to be a progressive decline. Usually not reversible.
- Assessment tools for Delirium include Delirium Rating Scale and Memorial Delirium Assessment Scale
- The Mini-Mental State Examination (MMSE) is useful for quantitative assessment of severity of cognitive deficits.

Anxiety & Fatigue

- Anxiety lasting beyond the immediate period of a stressor or anxiety that causes impairment in functioning requires further evaluation.
- Not well studied in the geriatric cancer population.
- Symptoms associated with anxiety are often found in panic attacks-tachycardia, SOB, diaphoresis, GI upset, nausea, trembling and dizziness. Winell & Roth, 2005
- Pts with respiratory problems "lung cancer" or pts in respiratory distress can present with anxiety & restlessness.

Anxiety & Fatigue cont.

- Fatigue is common in elderly cancer patients.
- Respini et al. found as many as 84% c/o fatigue that interfered with their general level of activity. Fatigue tended to correlate with anemia and depression.
- Tools for assessment have not been tested specifically in the elderly cancer population.
- Brief Fatigue Inventory, Multidimensional Fatigue Inventory.
- Assess for other potential causes: anemia, electrolyte imbalance, thyroid dysfunction.

Risk Factors of Pain in Elderly

- No evidence that pain perception in the elderly is diminished in anyway; pain tolerance may decrease in older adults.
- Underreport, under treatment, underestimation of sensitivity to pain.

Consequence of Inadequate Pain Control

- Depression
- Anxiety
- Suicidal Ideation
- Insomnia
- Increased Isolation
- Immobility-leads to deconditioning and overall functional decline.
- Greater risk of falls and DVT

Assessment-Self Report

- Determine if the patient can provide a report of pain.
- Keep questions simple
- Older patients may have difficulty “remembering” pain.
- Ask for current pain, or usual pain
- Visual Analog Scale or Faces Scale may be most appropriate

Specific Assessment Hints

- Speak slowly, provide clear simple instructions.
- Allow patient time to respond
- Practice using the tool with the patient and provide examples that may help them understand and put it into words/numbers
- Be sure tool is large enough to be read
- Reassess frequently

Herr, K. 2002

Assessment Tools

- Cognitively intact

Slide Not Available

Cognitively Impaired/ Non Verbal Observations

- Common behaviors
Facial expressions: grimace, frown, frightened expression, rapid eye blinking
- Changes in activity
decreased appetite, unable to do ADL's, withdrawn behavior, difficulty sleeping, fidgeting, agitation, restlessness
- Social changes
withdrawn behavior, disruptive behavior, resisting care, increased irritability, crying, increased confusion

Non Verbal Tools

Cognitively Impaired

- Pain assessment difficult. Non Verbal cues important
- Abbey Pain Scale for people with dementia who cannot verbalize
 - Gives an objective number related to scores given for observed actions. These are then added to relate to a pain score. No test/retest reliability is available. Validity score is unclear.

Slide Not Available

Cognitively Impaired cont.

- Discomfort Scale for the Dementia of Alzheimer's Type-focuses on noisy breathing, negative vocalization, content facial expression, sad facial expression, frightened facial expression, frowning, body language, intense body language. Looks at frequency, intensity and duration with a score total that corresponds to a level of pain.

Slide Not Available

Mr. G.

- 72y/o, newly dx. NSCLC with bony mets
- Hx. of osteoarthritis and COPD has Type 2 Diabetes.
- C/O numbness and burning in his feet.
- Cognitive changes-"minor short term memory deficit", lethargic at this time (new)
- Safely drives and is working on a book
- Adult children local and at a distance
- Appetite "**none**"
- **Shortness of breath with exertion**
- **PAIN IS NOT A PROBLEM**

Mr. G.

Further assessment necessary

- Lab results including chemistry-renal and hepatic function
- Average discomfort experienced daily. Is he using Tylenol and Motrin?
- Any history of Heart disease- CHF clue shortness of breath or only lung cancer
- Diabetic neuropathy untreated and already causing numbness and burning
- What is the treatment plan?
Cisplatin, Taxol, Vincristine, Navelbine, Biologicals-Interferon, IL-2, Levamisole

Mr. G's Assessment cont.

- Medication evaluation- drug to drug interactions. Sedation/antiemetic use
- Evaluate for dehydration- clues-no appetite, new lethargy.
- **Constipation (major concern for diabetic)**
- Type 2 diabetes-hypoglycemia/dehydration
- **Depression-** Have you stopped doing things that once gave you pleasure? Self worth?

Case Study Mr. G.


- How will these affect the treatment strategies planned to relieve his pain?
 - Diabetes
 - Family Stress & Social Support
 - Cost of Medications
 - Poor Appetite/Dehydration

Ask the Questions

- Follow the standard pain assessment
- Ask the patient to describe how they feel.
- Location of pain or pains (What does he call pain)
- Quality of pain
- Aggravating factors
- Alleviating factors
- Associated symptoms

Assessment Continued

- **Past history of gastritis or recent GI bleeding**
- **Spiritual and psychosocial assessment and nutrition**
- **Current Medication List**
- **Over the Counter Medications**
- **Liver & renal dysfunction**



Assessment to Planned Interventions

- Start Low
- Go Slow