



# Managing pain in the older person in the community

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## Introduction

Effective pain management remains a challenge in modern day clinical practice. Managing persistent pain in the older adult encounters many challenges and the management of chronic pain in the community demands a comprehensive understanding of the physiology of pain and pain processing as well as an understanding of the various assessment tools available and methods to manage pain. It is essential before treating pain that it is assessed using a recognised pain assessment tool that is valid, reliable and comprehensive. In essence, a holistic approach is required with all aspects of the biopsychosocial model considered.<sup>1</sup>

## What is pain?

Pain is defined as an 'unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.'<sup>2</sup> Pain is also 'an individual and subjective experience modulated by physiological, psychological and environmental factors such as previous events, culture, prognosis, coping strategies, fear and anxiety.'<sup>3</sup>

Pain can be classified according to length of duration; whether

acute or chronic, as well as the inferred pathophysiology of pain; nociceptive versus neuropathic or mixed<sup>4</sup> or in a clinical context; postsurgical, malignancy related, non malignant, neuropathic or degenerative. Acute pain passes as injury heals while chronic pain persists for three to six months or longer. Neuropathic pain is defined as pain arising as a direct consequence of a lesion or disease in the somatosensory system.<sup>5</sup> Neuropathic pain is associated with disability and reduced quality of life and is often underdiagnosed and undertreated.<sup>6</sup> Older people can experience many types of neuropathic pain including peripheral neuropathy, central post-stroke pain and postherpetic neuralgia.

## Managing pain in older people

Schofield<sup>7</sup> suggests a definitive prevalence of pain in older people is impossible to establish. Guidelines for the management of pain in older adults identified the prevalence of chronic pain in older people in the community ranged from 25-76 per cent and for those in residential care 83-93 per cent.<sup>8</sup> Older women have a higher prevalence of pain.<sup>8</sup>

The three most common sites of pain in older people are the

back, leg/knee or hip and other joints.<sup>8</sup> Pain may be present in more than one location which can cause further disability for the patient and social isolation.

Older people are at risk of chronic pain due to multiple conditions such as osteoarthritis, diabetic neuropathy, leg ulcers and cancer as well as pain due to surviving cancers. Multi-morbidities, which combined with the possibility of reduced cognition and sensory impairment, can impact significantly on level of function and increase disability.

Managing pain in older people is difficult due to the presence of multi-morbidities, polypharmacy and sensitivity to medications<sup>9</sup> as well as potential drug interactions and drug-disease interactions. Good pain management is essential to support and maintain independent living. Sleep, mobility, appetite and mood can be negatively affected by pain while side effects of medications can include anticholinergic side effects, constipation, nausea and vomiting and the risk of falls.

Dewar<sup>9</sup> suggests older people may be reluctant to report pain and have a stoic approach, accepting incorrectly that pain is part of the normal aging process. Pain is not a normal part of ageing, but its prevalence increases with age and illness, reaching its highest levels among older people in residential care settings.<sup>10</sup> For persistent pain which is resistant to common therapies, medications or alternative methods, the health care professional should consider referral to specialist pain clinics.<sup>10</sup>

In 2005, Schofield et al.<sup>11</sup> suggested the need for chronic pain services in the community; in the current climate, this is more evident than ever. In jurisdictions that are moving forward with a national strategy for pain (such as Australia), this is already happening; specialist pain teams are moving into the heart of the issue in primary care.<sup>12</sup>

### Assessment of pain

A patient's own report is the most reliable indicator of their pain and when possible this should be obtained.<sup>4</sup>

A self-report of pain is also possible in those with mild to moderate cognitive impairment with standard assessment tools or if required with more specialised tools such as the Iowa Pain Thermometer.<sup>13</sup>

Pain assessment offers patients the opportunity to make a largely subjective experience objective.<sup>14</sup> There are multiple assessment tools available to facilitate initial and ongoing assessment of patient pain.<sup>15</sup> However, pain assessment is only of value if it is used to guide selection of comprehensive treatments and interventions and to determine the effectiveness of those interventions. Pain assessment must lead to changes in management and the patient's pain should be re-evaluated following these changes to ensure improvements in the quality of care.<sup>16</sup> The pain assessment tool chosen should be appropriate to the individual patient taking into consideration their developmental, cognitive, emotional, language and cultural factors.<sup>3</sup> Unidimensional pain scales such as the Numerical Rating Scale, Verbal Descriptor Scale, Iowa Pain Thermometer although useful, only measure the intensity of pain. Multi-dimensional scales exist and initial assessment would benefit from the use of a multi-dimensional tool such as the Short Form McGill Pain Questionnaire or the Brief Pain Inventory in the community.<sup>17</sup> Subsequent assessment could then be performed with a unidimensional tool as preferred by the patient.<sup>12</sup>

Nurses should offer assistance with self-report of pain through

the use of adapted scales for those who have difficulties with communication. Consider using alternative words for describing pain which the patient may associate more closely with such as soreness, hurts or discomfort.<sup>18</sup>

### Assessing pain in cognitive impairment

Mildly cognitively impaired individuals are almost as able as those without a cognitive impairment to accurately report their pain.<sup>19</sup> Individuals with mild forms of dementia are usually able to communicate their pain experience, but this ability is lost with more advanced dementia.<sup>10</sup> The use of a body chart for the patient to identify the location of their pain is particularly helpful. Pain should be discussed in the present tense using a scale the patient understands, for example, the Numerical Rating Scale,

**Older people may be reluctant to report pain and have a stoic approach, accepting incorrectly that pain is part of the normal aging process.**

Verbal Descriptor Scale or the Iowa Pain Thermometer. The nurse should ensure if assistive devices such as a hearing aid or glasses are usually required that these are in place.<sup>18</sup> (See figure 1: Algorithm for the assessment of pain in the older person<sup>18</sup>). Appropriate time should be given for the assessment and be consistent with the scale used.

Assessing pain in those with cognitive impairment involves a three step approach; self-report, caregiver reports and direct observation.<sup>17</sup> In severe cognitive impairment an observational assessment of pain is necessary. During the assessment process it is essential to obtain insight into behaviour from family members and carers as a change in behaviour is particularly important. Stewart et al.<sup>17</sup> suggest studies show the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC), Abbey Pain Scale and Doloplus-2 as

the most encouraging scales to use in this patient group. If pain is suspected, but efforts to assess pain prove difficult, attempt an analgesic trial in a structured manner using the World Health Organisation (WHO) three step analgesic ladder<sup>20</sup> and observe the patient for effects including side effects.<sup>21</sup>

Updated guidelines on assessing pain in older people are due to be published shortly by the British Pain Society in conjunction with the British Geriatric Society.

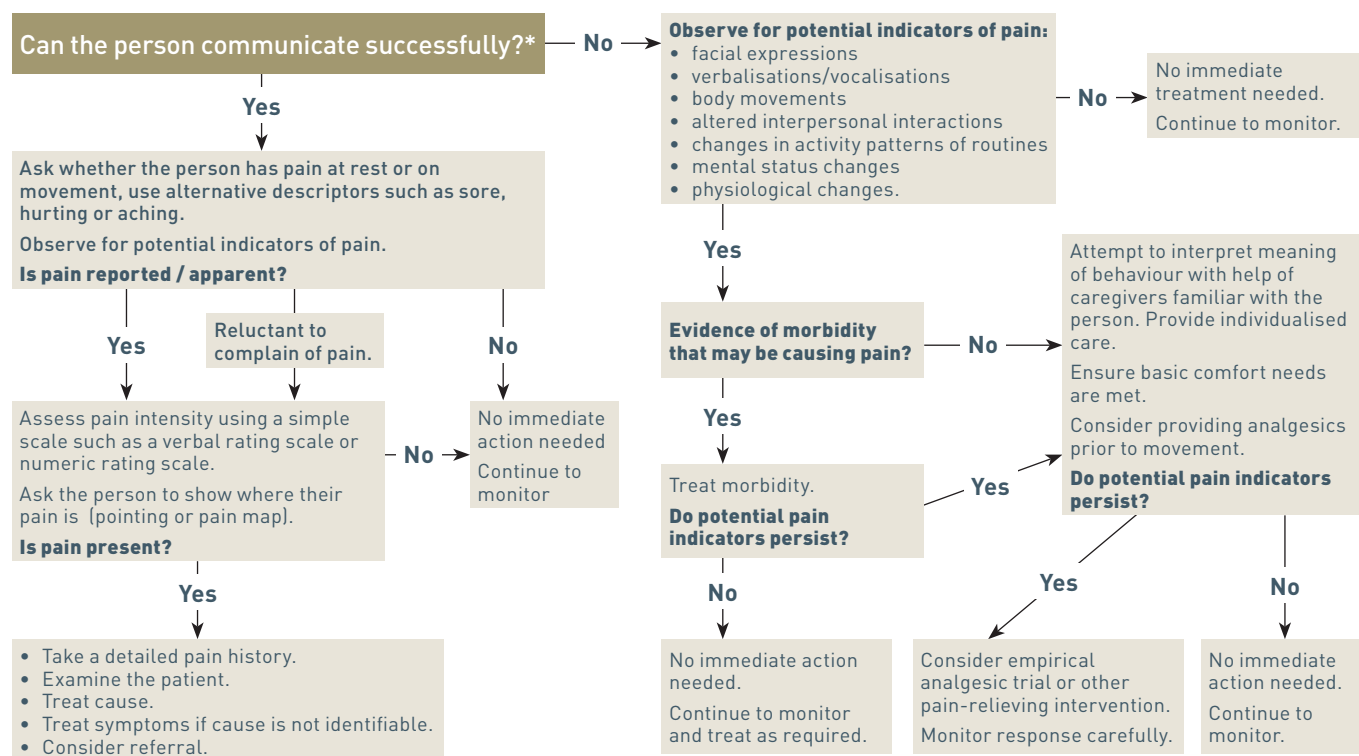
**Pharmacological management of pain**

Pain is best managed using a multimodal approach, which consists of the use of two or more different classes of analgesia targeting different mechanisms of pain.<sup>4-8</sup> Optimising pain management is key, but can be difficult in an older population, as such regimes place the older person at risk due to potential altered pharmacodynamics and pharmacokinetics, increasing the risk of adverse effects,<sup>22</sup> toxicity, drug-drug interactions as well as

drug-disease interactions. Studies also demonstrate a correlation between increasing age and adverse drug reaction.<sup>23</sup>

While analgesia is safe to use in older people, it should be titrated to response<sup>8</sup> and age should not be a reason for withholding treatment.<sup>23</sup> Regular administration of simple analgesics such as paracetamol for continuous pain may be sufficient to reduce pain to a level that allows the person to function more independently. The WHO three step analgesic ladder<sup>20</sup> originally existed for use with patients with pain associated with cancer. It is now widely used to manage pain in a variety of settings including acute and community care. As pain severity increases (or decreases), pharmacological management needs to move up (or down) the ladder utilising stronger (or weaker) analgesics. Adjuvant medications such as neuropathic agents can be added at any stage of the ladder if there is a neuropathic component to pain. It is imperative to initiate one drug only at a time at a low dose.<sup>8</sup> Anti-epileptics, tricyclic

Algorithm for the assessment of pain in older people



\*If there is doubt about ability to communicate, assess and facilitate as indicated in Recommendations 4 and 5 of the Guidelines.

Figure 1: Royal College of Physicians, British Geriatric Society, British Pain Society. The assessment of pain in older people: national guidelines. Concise guidance for practice series no 8: London. RCOP, 2007<sup>18</sup>

Source: Concise Guidance To Good Practice. The assessment of pain in older people. National Guidelines (UK).

## Non-pharmacological methods play an important and significant role in managing pain.

anti-depressants, serotonin-noradrenaline reuptake inhibitors and topical lidocaine are recommended first line for treating neuropathic pain in general.<sup>24</sup>

### Principles of analgesia therapy in older adults

- Perform a full and thorough assessment of the patient's pain and involve family members and caregivers if patient self-report is not feasible.
- Consider other factors in assessing pain including mental status, mood, beliefs and interpersonal interactions and behaviour.
- Listen carefully to the words used by the patient. The older person may deny pain but admit to discomfort, aching or soreness.
- Ask if the patient is taking their medication as advised? Do they know how to take their analgesia? Do they have any worries or concerns about it?
- Under treatment of pain can have detrimental effects to the patient clinically<sup>25</sup> and is just as problematic as overtreatment.
- Consider the most appropriate method of administration of analgesics and be mindful of concurrent medication the patient is taking and the potential for drug-drug interactions.
- Be conscious of age related changes to pharmacokinetics and pharmacodynamics.
- Start low and go slow, but do not stay low.<sup>17</sup> Careful monitoring may be required and titration performed at a slower pace.<sup>25</sup> How much relief have the treatments given in the past 24 hours?
- Monitor for effects, side effects and adverse reactions.

### Non-pharmacological measures

Pharmacological therapy is most effective when combined with non-pharmacological methods.<sup>12,26</sup> Non-pharmacological methods play an important and significant role in managing pain. There is evidence that physical therapies such as exercise,

transcutaneous electrical nerve stimulation (TENS), acupuncture as well as psychosocial interventions such as mindfulness, self-management programmes and cognitive behavioural therapies can be useful methods to manage and control pain in conjunction with pharmacological methods.<sup>27</sup>

### Conclusion

Effective pain management requires a comprehensive assessment of the patient to determine the most appropriate method to manage pain. Careful consideration should be given to the most appropriate assessment tool for the patient. Patients are living longer and surviving more serious illnesses with multi-morbidities, many of which are managed in the community. The complexity of patients is ever evolving and it is essential to keep up with the developments in managing pain.

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### MCQS

**Q1 Pain can be classified according to:**

- a) Length of duration
- b) Pathophysiology
- c) Clinical context
- d) Response to medication

**Q2 The most common sites of pain are:**

- a) Foot
- b) Knee
- c) Hip
- d) Back

**Q3 Pain assessment tools include:**

- a) St George's Questionnaire
- b) Geriatric Depression Scale
- c) Iowa Pain thermometer
- d) McGill Pain Questionnaire

**Q4 In mild cognitive impairment, pain assessment should include:**

- a) Numeric rating scale
- b) Not using a pain assessment tool
- c) Use of a body chart
- d) Observation

**Q5 Pain management includes:**

- a) The use of 2 – 3 classes of analgesia
- b) initiating 2 drugs at the same time
- c) Not titrating the dose of medication
- d) Neuropathic agents can be added at any stage of the pain ladder

**Q6 Non-pharmacological measures for pain management include:**

- a) TENS machine
- b) Acupuncture
- c) Cognitive Behaviour Therapy

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MCQS ANSWERS:  
 Q1: a, b and c; Q2: b, c, and d; Q3: c and d; Q4: a and c;  
 Q5: a and d; Q6: d

**FOR FURTHER INFORMATION ON THIS TOPIC SEE OUR PROFESSIONAL FEATURE ON THE WORK OF THE IPNMS ON PAGES 38-39**