Alberta Health Services

Palliative Care Tip – ISSUE#32:

ASSESSMENT AND MANAGEMENT OF PAIN IN OLDER ADULTS WITH MODERATE TO SEVERE DEMENTIA – 20, April 2018

Older adults have a high risk of under-recognized and under-treated pain, especially when moderate to severe dementia is present. The prevalence estimates of persistent pain in older adults range from 25% to 50%. Unmanaged pain may lead to significant morbidity, such as falls, agitation, mood disorders in older adults.

Consider the following processes while investigating pain in this population for a comprehensive approach to management:

1. How can family and caregivers determine if the person is in pain?

- Approach the person first, as most patients can still report pain even when cognitively impaired.
- Obtain collateral history from caregivers' observations such as painful conditions or behavioral changes such as breathing, vocalization, facial expression, body language and consolability, as well as sleep, appetite, mood, interpersonal interactions, cognitive function, etc.

2. What are common causes of pain in the older adults?

- Nociceptive pain is the most common clinical syndrome involving skin, muscle, bone, joints, or other connective tissue trauma or degenerative disease. Osteoarthritis of the spine and weight bearing joints is common and may be exacerbated by movement but not in the neutral position. Osteoporotic compression fractures are also common. Inflammatory disorders such as pseudogout, gout, rheumatoid arthritis are not uncommon.

- Neuropathic pain conditions such as shingles (herpes zoster), postherpetic neuralgia, central poststroke pain, trigeminal neuralgia, radicular pain due to degenerative disease of the spine, and painful peripheral neuropathy may be considered. However, it is often difficult to establish diagnosis in person who is unable to provide history unless specific signs exist such as skin changes suggestive of herpetic neuralgia with vesicles. Skin or soft tissue changes of suggestive of complex regional pain syndrome might have features of being shiny, thin, hair loss or even swelling.

- Myofascial pain, fibromyalgia syndrome, and chronic low back pain are examples of a mixed pain syndrome.

3. What are some red flag conditions that may cause pain?

- Orthopedic injuries associated with witnessed or unwitnessed fall.
- New onset of severe headache, chest pain, and abdominal pain with guarding may require emergency assessment.
- New onset of bone pain without history of injury may be suggestive of metastatic malignancies.
- Vascular compromise due to occlusion, embolus, thrombosis or aneurysm and affected limbs can be pale and cold if the occlusion arises in the arterial system vs brownish pigmentation and swollen if the venous system is severely affected.

4. What are helpful ideas to ensure a comprehensive approach to pain assessment?

- **Rule out delirium superimposed on dementia**: Factors to consider are medications (esp. opioids, sedatives, D2 receptor antagonists, etc.); metabolic alterations such as hypercalcemia; dehydration; sepsis; hypoxia; brain metastasis/ injury; increased or unmanaged pain; substance abuse or ETOH withdrawal;

environmental triggers such as recent losses, relocation trauma, sleep deprivation or sensory overload;

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elimination problems such as fecal impaction or urinary retention which can cause agitated behaviour.

- **Assessing mental status:** When possible, screen with Mini Mental State Examination**/** Confusion Assessment Method. Collect collateral information from family/ caregivers and collaborate with observational measures for those who are unreliable with self-report.

- **Pain related history and physical examination**: Consider current disease status as well as previous chronic pain etiologies/ other noncancer conditions. Consider age related deficits such as hearing and visual deterioration.

- Consult with family/ caregivers regarding pain related behaviours versus agitation

- Evaluate baseline functional status and behavioural manifestations for comparison in order to determine realistic goals of treatment
- Assess musculoskeletal and neurological systems
- Assess for evidence of infection
- Assess for contractures/ pressure sores or wounds
- Assess for fecal impaction or urinary retention
- Cancer related issues as follows:
    - Bone metastasis/ known sites and potential new sites/ spontaneous fracture
    - Increased pressure from tumour/ lymphedema/ ascites

5. What is the management approach to treating pain in this population?

- Consider the nature of the pain, be it chronic non-cancer pain vs cancer pain. Trial of acetaminophen, or low dose opioids/ NSAIDS or other adjuvants as appropriate E.G. Morphine short acting po 1-2.5 mg q4 hours ATC and q1h prn for severe pain (monitor opioid induced constipation!)
- Reassess every 12-24 hours (increase or decrease the dose and frequency based on improvement of behavior or worsening cognitive function)
- Consider premedication with analgesic prior to significant movement for those with an incident component to their pain (E.G. Morphine short acting 1-2.5 mg po 30 min prior to transfers/ bathing)
- For highly incident pain e.g pathological fractures of the vertebrae, vertebroplasty or kyphoplasty can be considered
- OT/PT assessment for safe mobilizing, splinting, supports and other nonpharmacological modalities for pain management; pressure reducing equipment
- Treat all causative pathologies in line with the patient and family goals of care
- Edmonton Zone Palliative Care Program or Geriatric consultation (preferable onsite consultation) as appropriate for specialized treatments such as biphosphonates, radiotherapy options and other adjuvants

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