

PALLIATIVE CARE TIPS

Issue #32 Assessing Pain in the Palliative Care Patient with Moderate to Severe Dementia

Original contributor: Jamie Tycholiz, RN. Community Team - Regional Palliative Care Program. Editor: Yoko Tarumi, MD. Palliative Care Program, Royal Alexandra Hospital (Issued December 2009)

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.

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 patient is in pain?

- Approach the patient first, as most patients can still report pain even when cognitively impaired.
- Obtain collateral history from caregivers' observations such as painful conditions or behavioural changes such 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. Inflammatory disorders such as pseudogout, gout, rheumatoid arthritis are also common.
- Neuropathic pain conditions such as shingles (herpes zoster), post-herpetic neuralgia, central post-stroke 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 patients who are unable to provide history unless specific signs exist such as skin changes suggestive of herpetic neuralgia.
- 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.

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

- **Rule out delirium superimposed on dementia:** Some factors to consider are medications; metabolic alterations (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; elimination problems such as fecal impaction or urinary retention which can cause agitated behaviour.
- Untreated pain can also cause agitated behaviour misdiagnosed as delirium in patients with dementia.
- **Assessing mental status:** 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 non-cancer 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?

- Trial low dose opioids/ NSAIDS or other adjuvants as appropriate E.G. Morphine short acting po 2.5 mg q4 hours ATC and q1h prn (monitor opioid induced constipation!)
- Reassess every 12-24 hours (increase or decrease the dose and frequency based on improvement of behaviour or worsening cognitive function)
- Consider pre-medication with analgesic prior to significant movement for those with an incident component to their pain (E.G. Morphine short acting 2.5 mg po 30 min prior to transfers/ bathing)
- OT/PT assessment for safe mobilizing, splinting, supports and other non-pharmacological modalities for pain management; pressure reducing equipment
- Treat all causative pathologies in line with the patient and family goals of care
- Regional Palliative Care Program or Geriatric consultation (preferable onsite consultation) as appropriate for specialized treatments such as biphosphonates, radiotherapy options and other adjuvants

References:

Lippincott Williams & Wilkins Inc (2007). An interdisciplinary expert consensus statement on assessment of pain in older persons. *The clinical journal of pain*.

Balducci, L. (2003). Management of cancer pain in geriatric patients; with a summary of guidelines from the American Geriatrics Society. *Journal of supportive oncology*. 1:175-191.

Buffum, M., Hutt, E., Chang, V., Craine, M., Snow, L. (2007). Cognitive impairment and pain management: A review of issues and challenges. *Journal of rehabilitation research and development*. Vol 44 No. 2

REMEMBER: For referrals, questions, or telephone consultations call 496-1300 weekdays and weekends.

Palliative Care Tips are now available of our Website: www.palliative.org