THE 5TH VITAL SIGN:
PAIN ASSESSMENT
AND MANAGEMENT

AGS
Considerations for
Older Adults

THE AMERICAN GERIATRICS SOCIETY
Geriatrics Health Professionals.
Leading change. Improving care for older adults.
OBJECTIVES

• Recognize different presentation of acute vs. chronic pain
• Assess pain in older adults
• Be familiar with WHO Pain Ladder
• Be familiar with commonly used analgesics and their side effects
• Initiate opioid therapy, convert from IV to PO, and calculate breakthrough dosing
CASE 1

- Mrs. F. is a 91-year-old nursing home resident with moderate dementia
- She tripped over her walker, fell, and was noted to have a shortened externally rotated right leg
- She is moaning
- How do you know that she is in pain?
SIGNS AND SYMPTOMS OF ACUTE PAIN

• The patient will tell you
• Verbal expressions (crying, moaning, etc.)
• Facial expressions
• Guarding or restlessness, depending on type of pain
• Sympathetic response (BP, HR, RR, pupils)
CASE 2

• Mr. R. is an 84-year-old man who comes to your clinic complaining about lower back pain
• He has had this pain for the last 2 years, but finds now that it is stopping him from climbing the stairs, and he has trouble sleeping
• He has been diagnosed with spinal stenosis
• How do you know that he is in pain?
ASSESSMENT OF CHRONIC PAIN

• The pain is what the patient tells you it is
• Sympathetic drive disappears with chronic pain
• Change in function and/or behavior
• Pain tools may be helpful to track pain
PAIN ASSESSMENT

- Location
- Timing (e.g., onset, constant vs. intermittent)
- Quality
- Severity
- Context
- Associated symptoms (including medication side effects)
- Modifying factors
PAIN ASSESSMENT TOOLS USED IN HOSPITALS

- 0–10 numerical scale
- Visual analog scale
- Wong-Baker Faces Pain Scale
PAIN ASSESSMENT TOOLS FOR OLDER ADULTS

• Verbal scale (none, mild, moderate, severe)

• Functional Pain Scale
  0  No pain
  1  Tolerable (doesn’t interfere with activities)
  2  Tolerable (interferes with some activities)
  3  Intolerable (able to use phone, TV, or read)
  4  Intolerable (unable to use phone, TV, or read)
  5  Intolerable (unable to verbally communicate)
# PAIN ASSESSMENT IN ADVANCED DEMENTIA (PAINAD) SCALE

<table>
<thead>
<tr>
<th>Items</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative vocalization</td>
<td>None</td>
<td>Occasional moan or groan. Low-level speech with a negative or disapproving quality.</td>
<td>Repeated calling out. Loud moaning or groaning. Crying.</td>
<td></td>
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<tr>
<td>Facial expression</td>
<td>Smiling or inexpressive</td>
<td>Sad. Frightened. Frown.</td>
<td>Facial grimacing</td>
<td></td>
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<tr>
<td>Consolability</td>
<td>No need to console</td>
<td>Distracted or can be reassured by voice or touch</td>
<td>Unable to be consoled, distracted, or reassured.</td>
<td></td>
</tr>
<tr>
<td>Total:</td>
<td></td>
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</tbody>
</table>
CASE 3

• Mr. B. is a 66-year-old healthy man who twisted his ankle while playing tennis.
• How do you treat his pain?
TREATMENT OF MILD PAIN

- NSAIDs
- Acetaminophen
- Adjuvants (in this case: ice, elevation, compression)
NSAIDs IN OLDER ADULTS

- GI side effects
- Hypertension
- Congestive heart failure
- Renal failure
- Delirium
- Cardiovascular risk
CASE 3 (continued)

- Mr. B. is on maximum doses of Tylenol and ibuprofen, using ice regularly, but is still in so much pain that he is unable to take care of his usual household chores
- What do you recommend now for his pain?
TREATMENT OF MODERATE PAIN

“Weak” opioid
+/- acetaminophen or NSAID
+ adjuvants

Problems: opioid side effects, ceiling
OPIOID SIDE EFFECTS

- Constipation
- Fatigue/drowsiness/sedation
- Nausea/vomiting
- Pruritus
- Hypotension
- Confusion/delirium
- Urinary retention
- Myoclonus
- Respiratory depression
WHO's Pain Relief Ladder

1. Non-opioid +/− Adjuvant
2. Opioid for mild to moderate pain +/− Non-Opioid +/− Adjuvant
3. Opioid for moderate to severe pain, +/− Non-Opioid +/− Adjuvant

Freedom from Cancer Pain
CASE 4

• Mr. Z. is a 69-year-old man with metastatic lung cancer and no significant past medical history
• He has multiple bony metastases and is in excruciating pain
• He has never taken any opioid medication
You are the treating resident and decide to give him IV morphine
• What instructions do you give the nurse?
OPIOID INITIATION

• In opioid-naïve patient:
  - Maximum effect of IV morphine: 5 min
  - Maximum effect of SC morphine: 30–60 min
  - Maximum effect of PO morphine: 1 hour

• Once you have steady state: half-life is 4–6 hours for short-acting opioids
CASE 4 (continued)

- Mr. Z. ultimately was started on a morphine pump
- He is now very comfortable on IV morphine 6 mg/hour without any side effects
- He wants to go home
- You want to discharge him on MS Contin for maintenance analgesia and MS IR for breakthrough pain
- How do you do that?
OPIOID CONVERSION AND BREAKTHROUGH DOSING

• 6 mg/hour $\times$ 24 hours = 144 mg/day IV (for ease of calculation let’s assume 150 mg/day)
• Conversion IV:PO morphine: 1:3
• 150 mg/day IV = 450 mg/day PO
• MS Contin is a 12-hour formulation (divide daily dose by 2) = 225 mg MS Contin BID
• Breakthrough (1/6 of daily dose): 75 mg q4h PRN for breakthrough pain
PEARLS (1 of 2)

• Treat acute pain with short-acting medication until you achieve pain control, then convert to long-acting

• Keep it simple (use same opioid for scheduled and PRN)

• Demented patients don’t ask for pain drugs: if you think they have pain, schedule the analgesia and avoid PRN only
• Patients with renal insufficiency become toxic easily — better opioid choices for them are oxycodone and hydromorphone

• Do not forget to treat constipation

• Do ask your pharmacist for help if you worry about conversions

• NEVER use propoxyphene or meperidine
SUMMARY

• Use appropriate method to assess pain
• Treat pain adequately, ideally by mouth and scheduled
• Keep it simple
• Monitor and treat side effects
• Educate families
THANK YOU FOR YOUR TIME!

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