PAIN AND DEMENTIA: Recognition, Assessment and Management of Pain in Patients with Late-Life Dementia

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Presenter Disclosure

- **Faculty/Presenter:** Tolulola Taiwo

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OBJECTIVES

- Provide an overview of the importance (prevalence, relevance) of pain in patients with late-stage dementia.
- Identify pain assessment methods and strategies in dementia
- Identify limitations of pain assessment (tools).
- Strategies for pain treatment/management for dementia.

PREVALENCE OF PAIN

- 60% of community dwelling older adults (> 65 years old)
- In institutionalized care, may be up to80%
- Under-estimated, under-reported and under-diagnosed

Pain Experiences in Dementia

- Increased prevalence of pain in advancing age
- Acute and chronic (persistent) pain are common in older adults
- Under-reported, Under-diagnosed and Under-treated.

PAIN

Unpleasant sensory and/or emotional response arising from potential or actual tissue injury or damage.

- Neuropathic pain (central and peripheral)
- Nociceptive pain (visceral and somatic)
- Mixed pain (nociceptive and neuropathic)

Causes of Pain in Dementia patients

NEUROPATHIC PAIN

- Peripheral neuropathies
- Phantom pain
- Post herpetic neuralgia (PHN)
- Post-stroke central neuropathic pain
- Multiple sclerosis
- Spinal stenosis

NOCICEPTIVE PAIN

- Osteoarthritis
- Orofacial pain (dental caries, abscesses etc.)
- Pressure ulcers
- Constipation
- Fibromyalgia
- Polymyalgia rheumatica

Impact of Pain on Dementia patients

Physical

- Pacing/wandering
- Activities of daily living
- Pressure ulcers
- Gait impairment
- Falls
- Sleep disturbances
- Decreased appetite
- Polypharmacy /medication side effects

Psychosocial

- Social isolation/introversion
- Depression/emotional distress
- Agitation
- Verbal aggression
- Resistance to care

Caregivers

- Caregiver burden/burnout
- Dependence
- Risk of injuries

Impact of Dementia on Pain

- ? Effect on neurophysiology of pain
- Impact on pain perception (Somatosensory cortex is unaffected)
- Impact on pain processing
- Effects on pain expression

Comprehensive Pain Assessment: Goals

- Identify pain severity
- Impact of pain on quality of life and functional abilities (activities of daily living)
- Identify physiological and psychological factors causing pain
- Development of an intervention/plan

Pain Assessment Tools

- Self-report scales
- Caregiver/informant tools
- Observational rating scales
- Interactive Rating Scales

  Assessment of Discomfort in Dementia protocol

Corbett A, Husebo B et al. Assessment and treatment of pain in people with dementia. www.nature.org May 2012. Vol.8

Pain Assessment Tools

Numeric Pain Intensity Scale (0 – 10)

1- 3 – Mild 4-6 Moderate ≥ 7 Severe

Visual Analog Scale

No pain

Pain as bad as it could possibly be

Pain Assessment Tools

FACES Pain Rating Scale

Simple Descriptive Pain Intensity Scale

Pain Assessment Tools (2)

- Pain Assessment in Advanced Dementia (PAINAD)
- ABBEY Pain Assessment Scale
- Pain Assessment for the Dementing Elderly (PADE) and global staff rating

Pain Assessment in Advanced Dementia (PAINAD)

Indicator	Score = 0	Score = 1	Score = 2	Total Score
Breathing:	Normal breathing	Occasional labored breathing Short period of hyperventilation	Noisy labored breathing. Long period of hyperventilation. Cheyne-Stokes respiration	
Negative vocalizations	None	Occasional moan/groan. Low level, speech with a negative or disapproving quality	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial Expression	Smiling or inexpressive	Sad, frightened, frowning	Facial grimace	
Body Language	Relaxed	Tense, distressed, pacing, fidgeting.	Rigid, fists clenched. Knees pulled up.	
Consolability:	No need to console	Distracted by voice or touch.	Unable to console, distract or reassure.	

ABBEY PAIN ASSESSMENT SCALE (FOLLOW ON

	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME	DATE AND TIME
VOCALIZATION									
e.g. whimpering, groaning, crying Absent 0 Mild 1 Moderate 2 Severe 3									
FACIAL EXPRESSION									
e.g. looking tense, frowning grimacing, looking frightened Absent 0 Mild 1 Moderate 2 Severe 3									
CHANGE IN BODY LANGUAGE									
e.g. fidgeting, rocking, guarding part of body, withdrawn Absent 0 Mild 1 Moderate 2 Severe 3									
BEHAVIOURAL CHANGE									
e.g. increased confusion, refusing to eat, alteration in usual patterns Absent 0 Mild 1 Moderate 2 Severe 3									
PHYSIOLOGICAL CHANGES									
e.g. skin tears, pressure areas, arthritis, contractures, previous injuries Absent 0 Mild 1 Moderate 2 Severe 3									

Total score =
Signature of person completing score

0-2 NO PAIN **3-7 MILD PAIN**
8-13 MODERATE PAIN **14 + SEVERE**

ABBEY PAIN ASSESSMENT SCALE

- Need for ongoing monitoring
- Scores: 0 -1 = no pain; 3- 7 = mild pain; 8- 13 = moderate pain; >14 = severe pain.

Assessment of Discomfort in Dementia (ADD) protocol

Nurse administered intervention tool

Pain identification/recognition

- If potential pain behaviors are identified, the protocol consists of the
- following steps:
- Step 1: Assessment of physical signs and symptoms
- Sept 2: Review patient's history (Current / past history of pain)
- Step 3 : If steps 1 and 2 are negative, assess environmental causes of pacing or increased activity/stimulation, meaningful human interaction and intervene with nonpharmacological Rx's.
- Step 4: If unsuccessful, medicate with non-opioid analgesic per written
- order.
- Step 5: If symptoms persist, consult with physician/other health professional
- or medicate with prn psychotropic per written order.

Diagnostic and Treatment Challenges

- Communication
- Culture
- Cognition
- Caregiver and patient awareness
- Physician/health care provider barriers
- Medication side effects

Analgesic agents

Medication	Examples	Benefits	Risks
Acetaminophen			Ceiling (maximum dose
NSAIDS	Diclofenac, ibuprofen		GI hemorrhage, renal toxicity, cardiovascular
Opioids	Codeine, morphine, oxycodone	Transdermal, parenteral routes	Constipation, opioid toxicity, respiratory depression
SSRIs/SNRIs	Duloxetine	Mood	Hyponatremia, Serotonin syndrome

CONCLUSION

- Pain is subjective
- Common among community dwelling and institutionalized older adults
- Disruptive behaviors are usually an expression of an unmet needs
- Proper/detailed pain assessment is central in effective (pain) management.

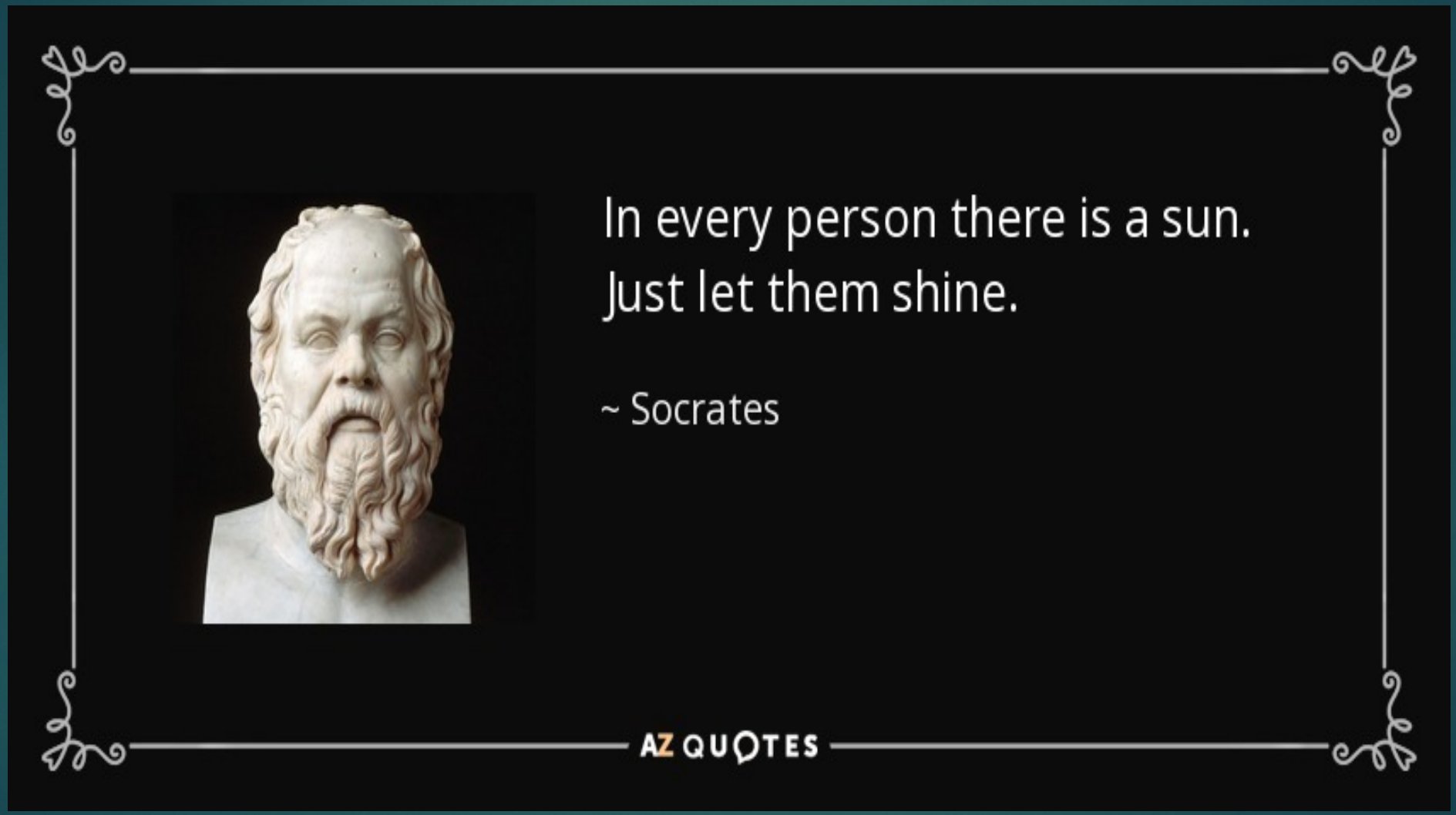
Useful Resources

www.geriatricpain.org

www.geriu.org

British Geriatric Society

American Geriatric Society


In every person there is a sun.
Just let them shine.
~ Socrates
AZ QUOTES

QUESTIONS?

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