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Original Article

Prevalence of Chronic Cancer and No-Cancer Pain in Elderly Hospitalized Patients: Elements for the Early Assessment of Palliative Care Needs

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SUMMARY

Background: We studied prevalence of chronic pain, related or not to cancer, in elderly patients, its correlation with socio-clinical factors, and its effects on daily living, to estimate feasibility of an early assessment of palliative care needs in a non-specialist hospital setting.
Methods: In this prospective study, a questionnaire concerning pain and multidimensional assessment tools were administered to patients consecutively admitted to a Department of Internal Medicine comprising a Stroke Unit.
Results: One hundred patients were recruited, 38 of whom experiencing pain, chronic in 26 patients (68%). A total of 34.3% of patients with pain and 12.5% of patients without pain suffered from depression ($P = 0.013$). Depressed patients showed significantly higher median values in all Brief Pain Inventory (BPI) scores and items. Depressed patients also obtained less pain relief from therapies. Patients with mild dementia showed, significantly or as a trend, a higher median least, average and "pain right now" pain values. Worst pain values in the previous 24 h increased with age. Only 42% of patients reported to be on pain therapy upon admission to hospital, whereas 62% were undergoing treatment at the time of discharge. A correlation was found between the pain value and the level of interference with daily activities. Pain was mentioned in the discharge letter in 36% of cases.
Conclusion: Pain is a critical underestimated problem in elderly patients. A timely systematic evaluation of the pain would call attention to palliative care needs and reduce the negative effects of uncontrolled pain on the quality of life.
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1. Introduction

Pain has been defined as an "unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage".[1] It has been acknowledged as a complex phenomenon derived from sensory stimuli and modified by memory, expectations and emotions.[2] Little is known about the incidence of pain in elderly patients, despite being a serious problem for many people in their later years, due to a lack of systematic epidemiological surveys considering pain as a physiological problem in the elderly. Thus, health care professionals are likely to underestimate the problem, even though pain is not an integral part of physiological aging in the absence of disease.[3]

A large-scale study by Breivik et al using telephone interviewing to explore prevalence, severity, treatment and impact of chronic pain in 15 European countries showed that chronic pain was present in 19% of European adults with seriously compromised quality of life.[4] In a recent review of 64 studies carried out worldwide, mostly in Europe and North America, the prevalence of pain of any type ranged from a minimum of 0% to a maximum of 93%, showing that variations in the population, methods and definitions substantially influence the way pain is perceived and reported.[5]

Although Palliative Care (PC) has been traditionally regarded as "end-of-life PC services", the concept of "early PC" (or "simultaneous PC", as it is provided at the same time as antiblastic treatments) has been recently introduced.[6]

Early PC is divided into two complementary groups: early generalist PC and early specialist PC.

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Early generalist PC is provided by healthcare professionals that have neither specific training in PC nor specialty in palliative medicine, such as GPs, oncologists and geriatricians, that can identify, refer and initially manage a variety of patients with a basic level of PC needs.[7]

Early generalist PC entails:

- Early identification and referral of the patients nearing the end of life;
- Systematic screening of the needs;
- Systematic screening of the quality and intensity of symptoms;
- Participation in the advanced care planning;
- Collaboration with PC specialists;
- Training in PC.

On the other hand, early specialist PC is provided by PC specialists that have had a specific training in PC and dedicate 100% of their professional time to PC services.

The impact of early PC is difficult to assess, as it includes various "models of intervention"[8] at different levels of intensity: sporadic and during consultation, or actual and systematic mono- or multiprofessional healthcare assistance.

Healthcare assistance too can be of a diverse nature. As end-of-life PC is usually dispensed at the hospice, early specialist PC covers both clinic service (more often) and home PC programs, which may be considered as an intermediate stage between early and end-of-life PC.[9]

The efficacy of early PC has been tested and proven for a variety of outcomes relating to three categories: quality of life, quality of care, and costs.[10]

Quality-of-life-related outcomes (i.e., quality of life, overall intensity of symptoms, anxiety and depression, care satisfaction of patients, awareness of disease and prognosis) can often be appreciated as soon as early PC is administered.[11,12] Two recent meta-analyses have confirmed statistically significant improvements of overall intensity of symptoms and disease-related quality of life.[13,14]

Quality-of-care-related outcomes (i.e., reduced treatment aggressiveness) can be observed during end-of-life PC, as a result of the decisions made during early PC.[12,15]

Ultimately, a review of 46 studies comparing different PC services using some kind of comparing system has shown that PC interventions were often statistically significantly less expensive, regardless of the variety of the type and quality of the studies.[16]

The main aim of this study was to assess prevalence of pain among elderly patients hospitalized in an Internal Medicine Unit and to obtain an early evaluation of their PC needs for cancer/non-cancer-related pain. The secondary objectives were to evaluate the correlation between pain and socio-clinical factors, impact on daily living.

2. Materials and methods

2.1. Data collection and measurements

We screened patients consecutively admitted to the Department of Internal Medicine and Stroke Unit of the Sant'Orsola-Malpighi University Hospital (Bologna, Italy) from 14th January to 9th March 2016. Patients were required to be $\geq$75 years old and able to give informed consent to take part in the study. Study was approved by ethical committee of the Institutional board.

Within 48 h of admission, this information was collected through a standardized interview: personal details, level of education, living status and cognitive impairment and/or depression.

In this study patients were considered depressed if they had been admitted with an anamnestic history of depression and/or if they had been taking antidepressant drugs. The medical conditions considered were: hypertension, cardiovascular disease, cerebrovascular disease, peripheral vascular disease, diabetes, chronic lung disease, primary or metastatic cancer, hematological malignancy, dementia, chronic renal failure, and severe liver failure. Any clinical information was retrieved from the remote and recent history of the personal medical records. A specific questionnaire (Charlson Comorbidity Index) was used to evaluate comorbidities.[17]

The reason for hospital admission were: surgical diagnosis, cardiovascular disease, infectious disease, non-infectious respiratory disease, neurological/vascular disease, solid tumor, hematological malignancy, diseases of the genitourinary or gastrointestinal tract, and other.

Pain-related diseases were classed into the following groups: bedsores, chronic peripheral arterial disease, generalized arthritis, osteoarthritis, cardiogenic pain, infection, low-back pain, psychosomatic conditions, and fibromyalgia.

Pain was assessed by directly asking the patient with validated rating scales and whether the pain had been present for longer than 12 weeks because it was considered chronic.

The Italian version of the Brief Pain Inventory (BPI) was administered to the patients capable of answering simple questions (cognitively intact or mild-to-moderate cognitively impaired patients).[18] The BPI is a tool that uses an 11-point numerical rating scale (0–10) to measure intensity and interference of pain with patient's life. For the patients unable to answer the questions, pain presence was assessed with the Italian version of the PAINAD (Pain Assessment in Advanced Dementia) scale.[19]

Finally, the number and type of pain medications reported upon admission and in the discharge letter (classified as acetaminophen, non steroidal anti-inflammatory drugs [NSAIDs], opioids, and adjuvants) were evaluated and recorded in writing. . As the study had a descriptive-epidemiological primary aim, we did not impose any specific pain treatment policy on the clinical healthcare providers.

2.2. Statistical analysis

The variables are presented as mean ± standard deviation (SD) and/or median (range) (continuous variables) or number and percentage (categorical variables). The T-test and χ-square test were used for comparisons between groups. The nonparametric Mann-Whitney test was used to evaluate comparative hypotheses on the median. All statistical analyses were performed with SYSTAT10 (SPSS Inc, Chicago, Il, USA). All tests were performed two-tailed, and $P < 0.05$ was considered as significant.

3. Results

We screened 112 patients consecutively admitted to the Department of Internal Medicine and Stroke Unit of the Sant'Orsola-Malpighi University Hospital (Bologna, Italy) from 14th January to 9th March 2016. Our study included 100 patients; the remaining 12 patients had either been discharged or transferred to another hospital, or had died before the assessment could be made. Patient characteristics are reported in Table 1. The mean age was 83.6 years (±5.5). The population included 63 (63%) females and 37 (37%) males. Average schooling was 8.9 years (range 3–22). Twenty-two patients lived alone, while 12 lived in nursing homes or sheltered housing. Thirty-four patients had clinically confirmed cognitive impairment and 19 suffered from depression. Pain assessment was not possible in 8 patients because they either went into a coma or had a life expectancy of a few hours. A total of 92 patients were thus evaluable for pain. Of the 35 (38%) who reported to have pain, 24 (68%) suffered from chronic pain and 11 (32%) from acute pain.

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