Older Adult Emergency Department Pain Management Strategies

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KEYWORDS

• Pain • Pain assessment • Analgesics • Geriatrics • Quality • Management • Emergency medicine

KEY POINTS

- Older adults frequently present to the emergency department (ED) with pain.
- They have a reasonable expectation of pain relief that is often not met.
- Older adult acute ED pain is underrecognized and undertreated.
- There is high variability of pain management and prescribing practices by ED providers.
- Social supports and follow-up must be considered in discharge treatment recommendations.

INTRODUCTION

Pain is the most-frequent symptom reported by emergency department (ED) patients.[1] Older adults experience moderate to severe pain in approximately 40% to 50% of all ED visits.[2,3] However, pain in the ED elder population is often inadequately managed.[4] One reason for this inadequacy is the significant variability in the assessment, reassessment, and treatment of older adult pain in the ED.[2,3,5] First, older adults present with unique barriers to pain assessment, including atypical presentation of disease, stoicism, and communication difficulties such as cognitive impairment, multimorbidity, and polypharmacy. Second, pain assessment scales are often poorly communicated, understood, and variably administered to older adults by ED staff. Additionally, pain score documentation is poor.[6] Reassessment of pain is highly variable, limiting potential augmentation of pain relief modalities or improvement of

Disclosure: The authors have nothing to disclose.

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Clin Geriatr Med ■ (2018) ■–■
https://doi.org/10.1016/j.cger.2018.04.009
geriatric.theclinics.com

communication around pain. Finally, given the vast array of treatment options and concern for side effects, there are significant variations in the prescribing practices of emergency physicians for older adults with pain.[3,7,8]

Poor pain treatment has many detrimental consequences. Pain is associated with worse health status and older adults in pain experience greater functional impairment, falls, depression, decreased appetite, impaired sleep, and social isolation compared with those not in pain.[9,10] Unresolved pain can cause a downward spiral of sadness, illness, and even untimely death. Recurring pain also causes increased health care utilization and costs.[10] Thus, it is important that ED providers work to break this cycle and more effectively manage pain in older adults.

GENERAL APPROACH TO PAIN IN OLDER ADULTS

Effective pain management in older adults is based on a comprehensive and thorough pain assessment, and on frequent reassessment. This assessment enables high-quality, individualized care.[11] An appropriate pain assessment requires an appreciation that pain may present atypically and that communication of pain is problematic, particularly in the cognitively impaired. Reassessment first requires an understanding that pain changes with time and activity, and that multiple attempts are likely to achieve adequate pain relief.

Three essential components of pain assessment are appropriate self-reporting through the use of scripted pain scales,[12] understanding and setting reasonable goals of care, and shared decision-making in treatments that are understood by the patient and family. Self-reporting is essential because no reliable biological pain markers exist.[10] However, in older adults, self-reporting may be confounded by cultural factors, age-dependent stoicism, multimorbidity, polypharmacy, and cognitive impairment. Elders underreport pain despite suffering pain-related functional impairment and psychological distress.[11,13] Goals of care should be understood by both patient and provider, and may include discussion that some baseline pain will exist. Treatments should generally incorporate multimodal pain relief. Multimodal treatment strategies include directions on simple modalities such as position, ice, heat, and appropriate ambulation or mobility issues. The selection of analgesic is only 1 step in the multimodal treatment and should be based on patient-specific risks and preferences that enhance safe pain reduction. The maxim of analgesic dosing in older patients is to start low and go slow. The optimal analgesic management requires frequent assessment and reassessment with titration of medications. The fast pace of the ED culture enhances a 1-time consideration of pain and this must be overcome with common sense understanding that one cannot know if pain has been relieved without a reassessment.

Pharmacologic pain management in older adults is challenging owing to physiologic changes in renal function, drug absorption, sensory issues, and polypharmacy. Socially, older adult pain treatment is complicated by cognitive impairment, beliefs about pain, and concerns for adverse effects. Despite these challenges, pain can usually be effectively managed in this population.

ASSESSMENT OF PAIN

The most commonly used ED pain scales for cognitively intact older adults are the Verbal Descriptor Scale and the Numeric Rating Scale (NRS).[14] Using the NRS, patients rate the severity of their pain from 0 to 10, with 0 being no pain and 10 being the worst possible pain. The World Health Organization has developed the pain ladder to help categorize numeric pain scores into meaningful groups by linking groups with graded