Pain in the Geriatric Patient with Advanced Chronic Disease

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KEYWORDS

• Pain • Geriatric • Congestive heart failure • End-stage renal disease • Stroke • Opiates

KEY POINTS

- Although pain is prevalent among patients living with advanced chronic illnesses, it is often overlooked and underreported.
- Pain is commonly intertwined with other physical and psychological symptoms that lead to poorer quality of life.
- End-organ dysfunction influences treatment of pain in patients with advanced chronic illnesses.

INTRODUCTION

With advances in medical therapies and improvements in public health, individuals are living longer and more productive lives. As a result, more older adults are living with and dying from chronic diseases. More than 85% of Americans 65 years and older have at least one chronic disease. Many suffer from multiple comorbidities, with an estimated 11 million older adults living with 5 or more chronic conditions.[1] Congestive heart failure (CHF), end-stage renal disease (ESRD), and stroke consistently rank among the leading causes of death in the geriatric population.[2]

Many older adults with CHF, ESRD, or stroke experience pain, which can contribute to disability and diminished quality of life. Pain from these diseases is often less well defined and understood than that originating from musculoskeletal (eg, osteoarthritis,

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spinal stenosis) conditions. Furthermore, concerns about medication side effects related to organ dysfunction often complicate the management of pain in these patients. Therefore, this article provides an overview of the epidemiology, etiology, and challenges of treating chronic pain among older adults with CHF, ESRD, or stroke.

CONGESTIVE HEART FAILURE

Epidemiology and Prevalence

More than 5 million Americans are living with CHF, and approximately 5% have end-stage disease that is refractory to medical therapies.[3,4] Up to 84% of advanced heart failure patients experience pain, and many report pain in multiple sites.[5] Pain is a significant contributor to the overall symptom burden experienced by patients and can be broadly categorized into 2 types: (1) chronic stable angina and (2) noncardiac pain.

Etiology of Pain

Chronic stable angina

Underlying coronary artery disease is the most common cause of CHF and often leads to chronic stable angina, as inadequate coronary artery perfusion leads to demand-induced myocardial ischemia.[6] Chronic stable angina symptoms are reported in up to 29% of patients with heart disease and classically presents as anterior left-sided chest pain that resolves with rest or nitroglycerin.[7] Stable angina is persistent and chronic over a period of months to years. It is more common for older adults and women to experience atypical presentations of chronic stable angina, which may manifest as dyspnea on exertion, sweats, or lethargy.

Noncardiac pain

Although chronic stable angina is a recognized and well-studied entity in cardiology, literature on noncardiac pain in CHF patients is limited. Widely used quality-of-life questionnaires in the CHF population, such as the Minnesota Living with Heart Failure Questionnaire and the Kansas City Cardiomyopathy Questionnaire, do not have questions assessing noncardiac pain.[8,9] However, in one study, 76% of CHF patients report chronic noncardiac pain, which often goes unaddressed by providers.[10] Noncardiac pain in CHF patients is thought to be caused by a combination of complications from refractory disease (ie, skin breakdown from chronic lower extremity edema, peripheral ischemia from poor blood flow), underlying medical comorbidities, and psychosocial stressors.[11,12] Although there are no disease-specific pain assessment tools for patients with heart failure, using the Edmonton Symptom Assessment Scale is a simple standardized way to assess and monitor pain.[13] The Memorial Symptom Assessment Scale can also be used and provides clinicians with a measurement of pain and a multitude of other symptoms.[14]

Symptoms That Co-occur with Pain

CHF patients often report multiple symptoms. Dyspnea, pain, and low mood are most commonly experienced by patients during their last year of life, whereas loss of appetite, sleeplessness, constipation, nausea, and urinary incontinence contribute to the overall burden of disease.[15] Screening for mood disorders is critical in this population, as 1 in 5 patients meet criteria for major depressive disorder. Depression and pain often co-occur and magnify one another, worsening quality of life.[11] The Patient Health Questionnaire-2 is an effective and quick tool clinicians can use to screen for depression in this patient population.[16]