Pain management in older adults

Patricia Schofield

Abstract

We are seeing a significant increase in the older population far outweighing that in younger cohorts, and this is set to dramatically increase by 2050. With increasing age comes an increased risk of co-morbidities and consequently a likelihood of pain. Pain is a common problem for older adults; many reports suggest that the incidence is around 50% in older adults living in the community, increasing to 80% among the nursing home population. Dealing with pain in this population is complex and becomes even more challenging when cognitive impairment exists. This article highlights the challenges, proposes strategies for the assessment and management of pain in the older population and makes recommendations for future research in this area.

Keywords Ageing; assessment; management; pain

Key points

- We are facing a significant increase in the ageing population, which will be accompanied by a significant number of older adults with communication difficulties such as dementia
- Pain is a common problem in the ageing population and increases significantly in those living in nursing homes
- Pain management is generally poor, with poor pain assessment, underprescribing and underadministration
- There is recommended guidance on pain assessment for this group, as well as behavioural scales that can be used when there are communication difficulties
- Numerical rating scales and verbal descriptors are appropriate for older adults, but the approach may need to be varied
- The Abbey, PAINAD and DOLOPLUS scales are recommended where the adult has cognitive impairment
- Most research around management has been conducted with younger adults and simply translated to older adults
- Paracetamol is the drug of choice for pain management. Opioids can be used, but the approach should be to 'start low, go slow'
- Some invasive treatments for chronic pain are effective, but more research is needed.

Introduction

Our population is ageing, with a significant increase in the number of older adults anticipated over the next 25 years, and a decrease in younger counterparts. So we are expecting to see the ratio of older adults increase to that of younger adults. With this will come a higher number of older adults with cognitive impairments. There are already around 850,000 older adults with dementia in the UK. Therefore an ageing population coupled with an increase in co-morbidities and potential communication difficulties is likely to present future challenges to pain assessment and management.

Historically, evidence has suggested that pain is a common problem for older people, with chronic persistent pain affecting at least 50% of community-dwelling older adults, the figure increasing to 80% among those living in care homes. More recent systematic reviews of the literature confirm that this is still the case.[1] As the percentage of our ageing population increases over time (Figure 1), greater demands will be placed on healthcare professionals and informal carers to cope with the problems associated with old age, especially pain assessment and management.

Pain management in older adults is generally poor. The rate of admission to hospital for patients >65 years of age is three times higher than for younger people, and there is evidence that professionals tend to underestimate pain needs, underprescribe and undermedicate. This may in part relate to fears and misconceptions among prescribers regarding pre-existing co-morbidities and the effects of prescribed medicines. Such fears and anxieties are not totally unfounded as older adults tend to have co-morbidities, with concurrent medications prescribed. They are also more likely to have diminished functional status and physiological reserve, as well as age-related pharmacodynamic and pharmacokinetic changes. Cognitive impairment can prevent or complicate adequate pain assessment. In all care settings, healthcare professionals should be aware of pain assessment tools that can be used with older adults – both those who can communicate their pain and those unable to do so as a result of cognitive impairment.

It is frequently assumed that chronic pain is simply a part of getting older and something the individual must learn to live

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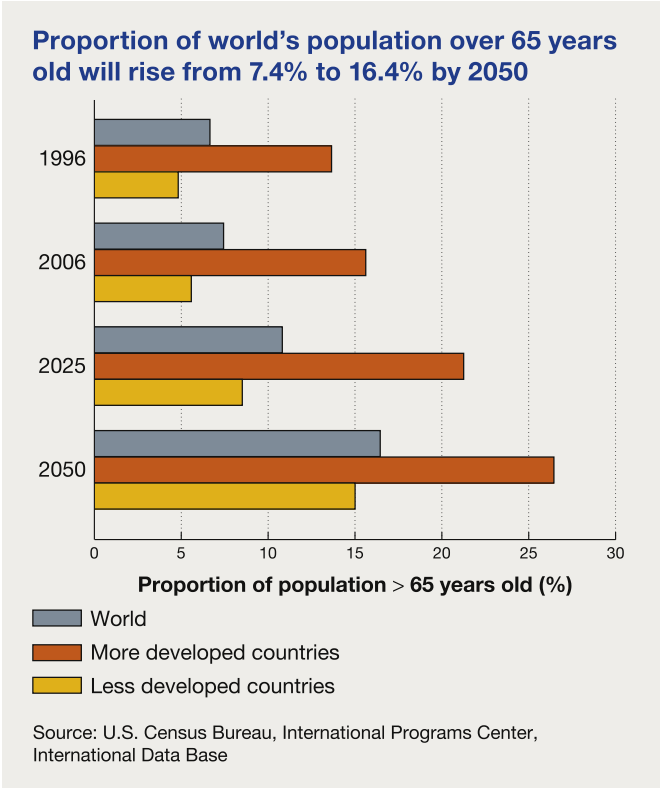

Figure 1

with. However, there is a growing body of research into chronic pain management for older adults, and increasing awareness that self-management of chronic pain is a viable strategy for this population regardless of level of cognitive ability.[1]

Pain assessment

The American Pain Society has stated that pain is the 'fifth vital sign',[2] emphasizing the importance of routine and systematic assessment and monitoring similar to that undertaken for respiration, pulse and blood pressure; it is therefore not an assessment to be avoided because it may be challenging.

Pain assessment is now considered to be the fundamental first step in the complete pain management process, and many healthcare professionals carry out effective pain assessment in most areas of practice as a routine part of care. The process of assessing pain in older adults can be complicated by the presence of not only cognitive impairment, but also visual or hearing problems and other communication difficulties, for example dysphasia caused by the common co-morbidity of cerebrovascular disease.

Pain intensity scales can be used for older adults with mild or moderate levels of cognitive impairment. If possible, the patient's own descriptions should be used, and if the person denies the presence of pain when asked directly, it can be useful to follow up with questions around 'aching' or 'soreness'. It has been demonstrated that many older adults do not like to complain about pain, perhaps because of increased levels of stoicism; this can be worse among the residents of care homes, who may not wish to be perceived as a 'problem' to carers or staff.

Many pain intensity scales are used in practice with the adult population in general, but not all are appropriate for the older population. In 2007, a UK national pain assessment guideline for specific use in older people was published.[3] This guidance was updated in 2015.

The best evidence to date recommends numerical rating scales (0–10) and verbal rating scales (none, mild, moderate, severe) (Figure 2, Table 1). Both types of scale can be used in the presence of mild to moderate cognitive impairment, but consideration must be given to the visual presentation to ensure that the scales are in large enough print to be seen. It is also important to be flexible: if one scale does not work, carers should change their approach and adopt an alternative. Similarly, the choice of words should be flexible and modified accordingly. For example, 'pain' may need to be replaced with 'soreness' or 'hurting', and the question may need to be repeated. The least effective scale for use with the older population is the visual analogue scale.

The presence and intensity of pain are not the only factors that should be assessed. Pain is a multidimensional experience, and assessment should also consider the onset, time-course, radiation, aggravating/relieving factors, information on current and previous management, including medications and complementary therapies, impact of the symptom on physical function or quality of life, and the patient's beliefs, understanding and expectations related to the pain.

For older adults, a number of other issues may be as important as, if not more important than, the pain itself. These include, quality of life, depression, mobility, social isolation and independence. The patient is the main source of information in the assessment process, but it is also important that carers or family members are involved, particularly if the patient is unable to communicate.

Behavioural pain assessment

Observation is a vital tool when assessing the existence or intensity of pain, particularly in patients who have communication problems, such as cognitive impairments or visual and hearing problems. Commonly cited indicators include facial expressions and body movement (guarding to protect against pain) and physical indicators such as pallor, tachycardia and hypertension.

Over the last two decades, a number of pain scales have been designed to measure behaviours associated with pain. At least seven currently exist[4] and are consistent in listing the following observable or recordable phenomena associated with pain:

- physiological observations (e.g. changes in respiration or pulse)
- facial expressions (e.g. grimacing)
- body movements (e.g. uncharacteristic restlessness)
- verbalizations (not clearly indicating the presence of pain)
- changes in interpersonal interactions (e.g. uncharacteristic aggression towards carers)
- changes in activity or routines (e.g. wishing to stay longer in bed)
- changes in mental status (e.g. depression, confusion).

The tools have so far been evaluated only in single clinical settings, and it is difficult to recommend one particular tool as being more reliable and valid.

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