# *G - ELNEC Staff Education*

*[End-of-Life Nursing Education Consortium]*

**Eliza Coffee Memorial Hospital**

## *III. <u>Pain Assessment & Management</u>*


Robert J. Webb, MD   Medical Director

Palliative Care Service & OASIS


***Aug. 28/13***

# Objectives …

- Describe the concept of Total Pain
- Understand the pathophysiology of physical pain and sensitization to chronic pain, and how older adults are different
- Know the steps of analgesic management
- Know alternative routes of delivery
- Understand the principles of equianalgesic opioid dosing

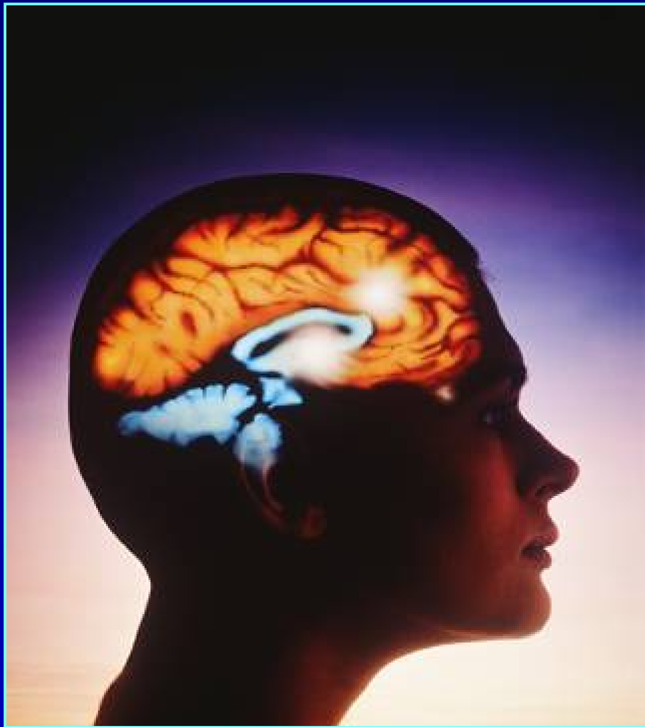
# …Objectives

- Know the use of adjuvant agents
- Understand the adverse effects of analgesics
- List barriers to pain management and understand the concepts of addiction, tolerance, dependence

# Principles of Symptom Mgmt

- Directed H & P
  - Look for treatable causes
  - **Severe Distress is an Emergency !!**
- Work w/ interdisciplinary team
  - symptoms are exacerbated by psychological, social, and spiritual stressors
- Communicate effectively
- Follow up:  what did/did not work

# What is Pain?



"Anything the patient says it is"

*Pasero & McCaffery , 2011*

An unpleasant sensory & emotional experience...

IASP, 1979

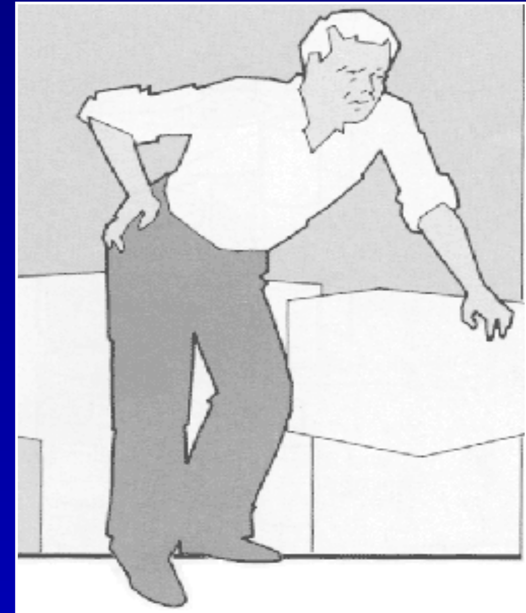
# Common Sources of Chronic (Persistent) Pain in Older Adults

- Musculoskeletal (osteoarthritis, degenerative joint disease e.g., pain in back, hands, feet)
- Osteoporosis/compression fractures
- Peripheral vascular disease
- Neuropathies (e.g., diabetic neuropathy, post-herpetic neuralgia, post chemotherapy)
- Cancer
- Contractures
- Pressure ulcers/wounds

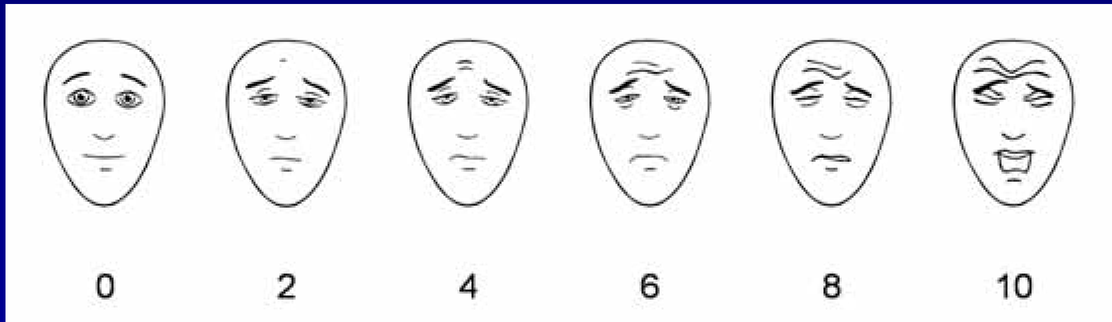
AGS, 2009; Hadjistavropolus et al., 2007; Herr, 2010

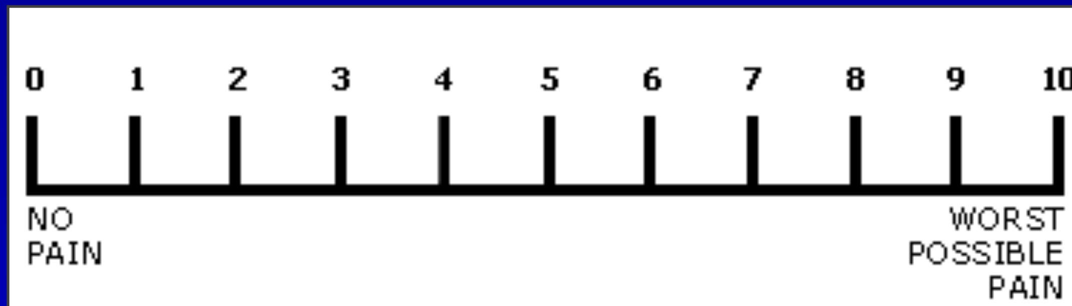
# Challenges: Assessing Pain in Older Adults

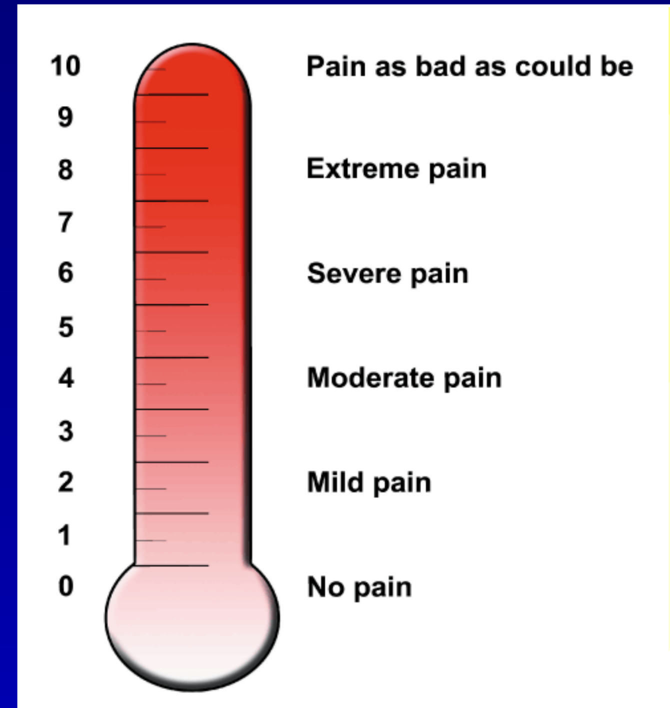
- Stoicism, not wanting to be a "complainer"
- Fears: procedures, side effects, addiction
- Fatalism: Pain is part of aging
- Cultural differences
- Cognitive or sensory impairments
- Depression
- Multiple causes of pain
- Concurrent illnesses
- Use of different words to describe pain, like my hip is "sore".



# Pain Intensity Tools




Fink & Gates, 2010; Herr et al., 2006a

# Pain Assessment in Nonverbal Older Adults

- Advanced dementia
- Progressive neurological disease
- Post CVA
- Imminently dying
- Developmentally disabled
- Delirium

# Differences in the Pain Experience of Older Adults with Dementia

- Dementia may alter response to acute pain
- Tolerance to acute pain possibly increases but pain threshold does not appear to change
- Cognitive impairment may decrease the perceived analgesic effectiveness
- Pain can negatively affect cognitive function

# Can Older Adults with Cognitive Impairment (CI) Give Reliable Pain Reports?

- Various studies
  - CI residents slightly underreport pain, but their reports are valid
  - 83% of residents with mild to moderate CI could reliably complete at least one pain scale
  - 73% of post-op patients with moderate CI were able to complete a 4-point verbal descriptor scale

# ASPMN Position Statement/Guideline

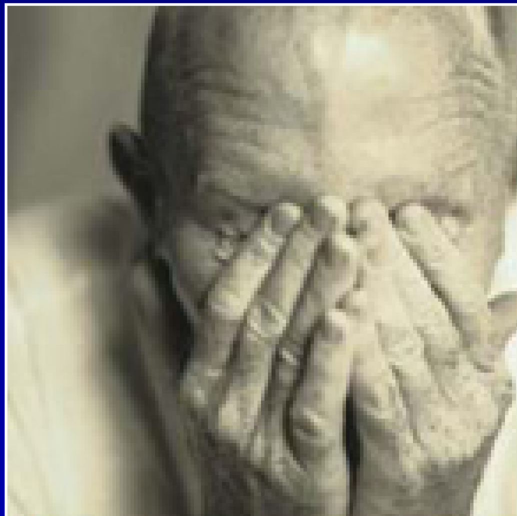
- All persons deserve prompt recognition and treatment of pain even when they cannot express their pain verbally
- Establish a pain assessment procedure
- Use Hierarchy of Pain Assessment Techniques
- **"Assume pain is present"**
- Use empirical trials
- Re-assess and document

*American Society for Pain Management Nursing*.

# Pain Behavior Assessment Tools-for Patients Who Cannot Self Report

- CNPI -Checklist for Nonverbal Pain Indicator
- PACSLAC – Pain Assessment Checklist for Seniors with Severe Dementia
- **PAINAD** – Pain Assessment in Advanced Dementia

# Behavioral/Observational Cues



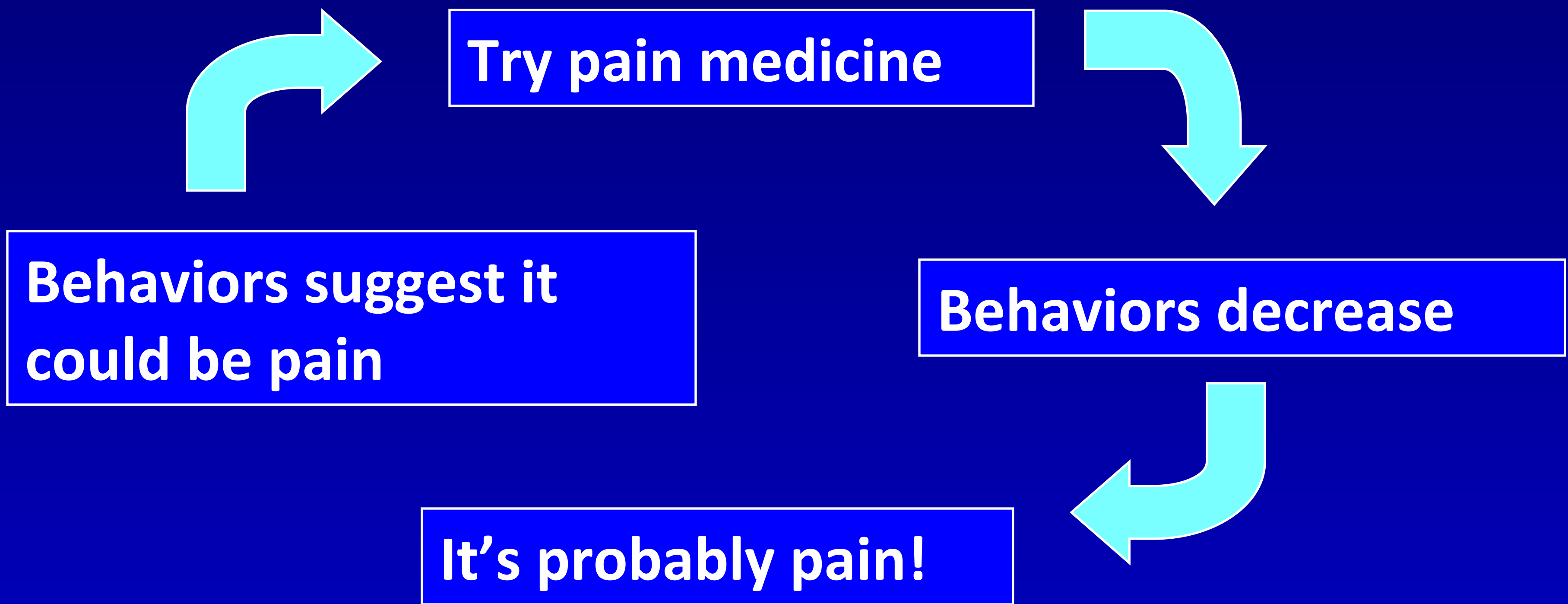
Obvious:

- Grimacing or wincing
- Bracing
- Guarding
- Rubbing

Less Obvious:

- Changes in activity level
- Sleeplessness, restlessness
- Resistance to movement
- Withdrawal/apathy
- Increased agitation, anger, etc.
- Decreased appetite
- Vocalizations

# Analgesic/Empirical Trial in Nonverbal Older Adults for Pain Relief



# PAIN Symptoms

- **Do NOT withhold Rx waiting to identify cause !**
- Mr. Carcinoma (lung) – pain in back/hips
  - He decided to take chemoRx but now 6 mo later he found boney mets causing pain = 7-8 /10 most days

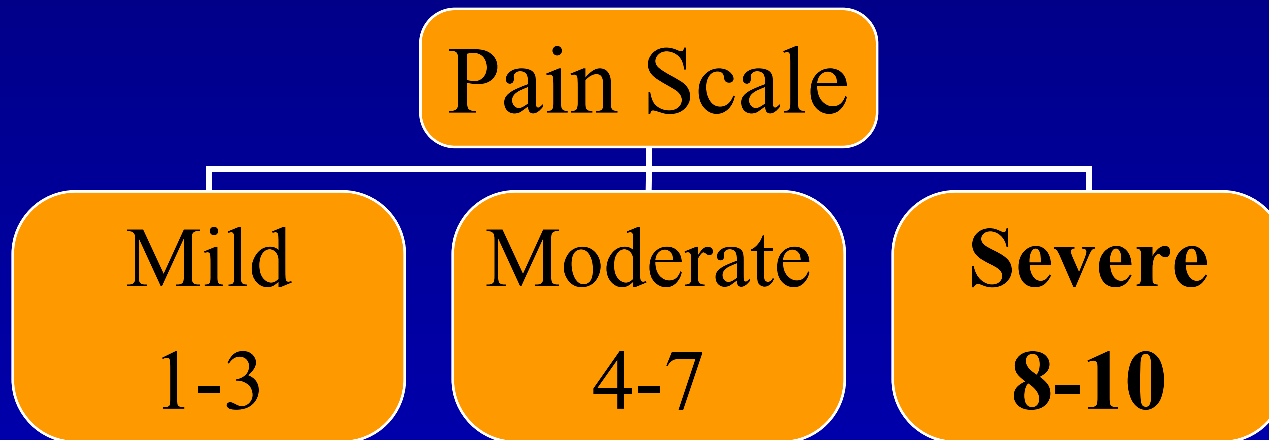
# Consequences of Under Treated Pain

- Untreated pain can cause a patient's emotional and ***spiritual*** death long before the actual end of life – and result in **permanent nerve hypersensitivity**.
- Depression & Agitation/anxiety
- Sleep problems & Anorexia
- Decreased socialization/conditioning

# Pain pathophysiology

- Acute pain
  - identified event, resolves days–weeks
  - usually nociceptive
- Chronic pain
  - cause often not easily identified, multifactorial
  - indeterminate duration
  - Increased sensitization to all stimuli
    - Hyperalgesia – exaggerated response to noxious stim.
    - Hyperesthesia – exaggerated response to touch
    - Allodynia –non-nociceptive stim. perceived as painful
  - nociceptive and / or neuropathic

# Assessing Pain



# Pain Assessment by Families for AACA*

**"0"** = no behavior suggesting pain

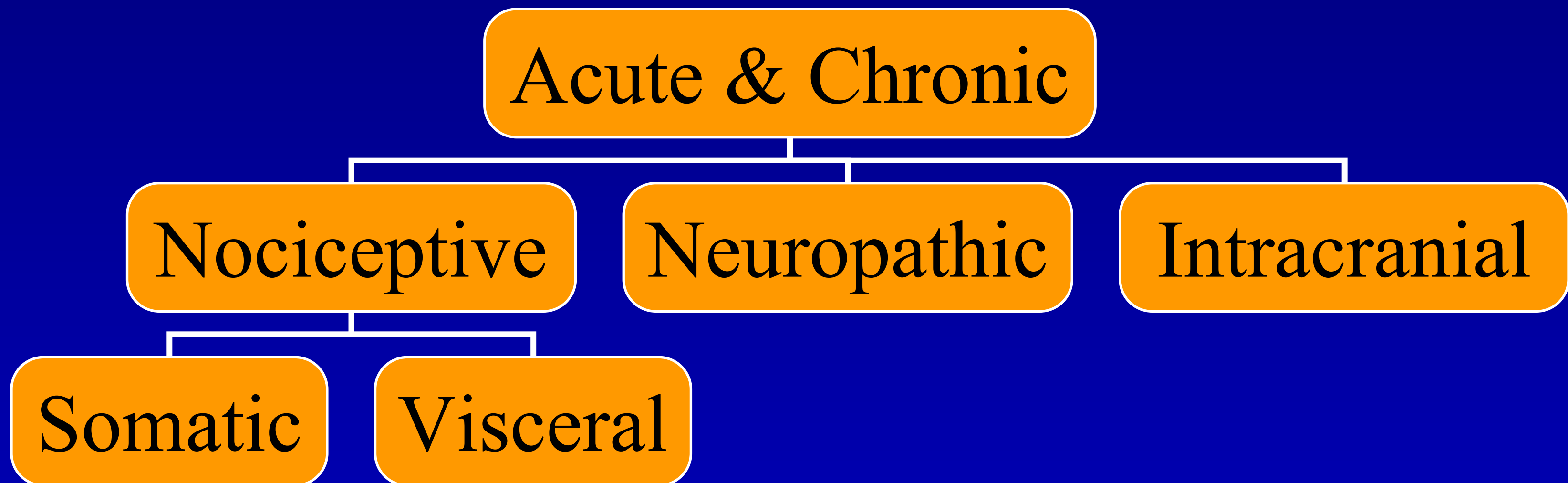
**"1"** = some pain but subsides quickly

**"2"** = pain lasting > 5min; use the AACA clicker

Correlates w/ Pain Scale: mild, mod, severe

* Authorized Agent Controlled Analgesia

# Types of Pain



# Character/Quality of Pain

## Nociceptive

- Sources: organs, bone, joint, muscle, skin, connective tissue
- Examples: arthritis, tumors, gall stones, muscle strain
- Character: dull, aching, pressure, tender
- Responds to traditional pain medicines & therapies

## Neuropathic

- Source: nerve damage, e.g., peripheral nerve or CNS pathology
- Examples: postherpetic neuralgia, diabetic neuropathy, spinal stenosis, chemotherapy
- Character: shooting, burning, electric shock, tingling
- Requires different types of medications than nociceptive pain

# Nociceptive pain . . .vs.

- Direct stimulation of intact nociceptors*
  [*group of cells that acts as a receptor for painful stimuli]
- Transmission along normal nerves
- sharp, aching, throbbing
  - somatic
    - easy to describe, localize
  - visceral
    - difficult to describe, localize

# …Neuropathic pain . . .

- Disordered  or damaged peripheral or central nerves
- Compression, transection, infiltration, ischemia, metabolic injury
- Varied types
  - peripheral, deafferentation, complex regional syndromes

# . . . Neuropathic pain

- Pain may exceed observable injury
  - E.g. diabetic neuropathy
- Described as burning, tingling, shooting, stabbing, electrical
- Management
  - opioids
  - adjuvant / co-analgesics often required

# Pain assessment

- Constant pain has diurnal/circadian pattern
  - Worse during night
- Incidental pain
  - Severe aggravation w/ movement
  - Short duration (seconds – minutes)
- Breakthrough pain

- Tx:  try to avoid sedation threshold

# Principles of **Chronic** Pain Rx

- By mouth
- By the clock – not prn
- By the WHO ladder
- Individualize Rx & Monitor response
- Use Adjuvant drugs
- *For 'constant pain', need to Rx 'constantly'*
  - 10-30% pts have uncontrolled pain due to s/e
- Anticipate nausea & constipation w/ opioids

# WHO Analgesic Ladder Rx

Start @ #1, push to maximum, then #2,etc.

1. Non-opioid + adjuvant
2. Mild opioid + non-opioid + adjuvant
3. Strong opioid + non-opioid + adjuvant

* Purpose of Step 2 is to go to step 3 !
* **Frail elders = start low & go slow !**

# WHO 3-step Ladder

**3 severe**

- Morphine
- Hydromorphone
- Methadone
- Levorphanol
- Fentanyl
- Oxycodone
- ± *Adjuvants*

**2 moderate**

- A/Codeine
- A/Hydrocodone
- A/Oxycodone
- A/Dihydrocodeine
- Tramadol
- ± *Adjuvants*

**1 mild**

- ASA
- Acetaminophen
- NSAIDs
- ± *Adjuvants*

# Chronic PAIN types – Rx Guide*

- Somatic/tissue & bone (nociceptive)
  - Opioids; Bone often needs NSAID or steroid
- Neuropathic
  - opioid + anticonvulsant +/or TCA
- Visceral
  - Opioid + anticholinergic

*Principles of Analgesics Use in the Tx of Acute Pain and Cancer Pain. Am.Pain Soc., 1999.*

*Fine PG. Chronic pain management in older adults. J Pain & Symp.Management. 2009 .*

*Morrison LJ. Pall.care and pain mgmt. Med.Clinics North Am. 2006*

# Analgesics

- Non-opioids
  - Acetaminophen (max. 4gm/day but seniors 3gm/day)
- Adjuvants
  - NSAIDS; Steroids; benzo's; neuroleptics;
  - antidepressants; anti-convulsants
- Opioids [3 classes] [* synthetic]

1) morphine, codeine, Dilaudid*, hydrocodone, oxycodone*, tramadol [Ultram]
2) Fentanyl*, meperidine* [Demerol]
3) Methadone*, propoxyphene* [Darvon]

*Hospice & PC Formulary USA 2nd Ed. 2008*

# NSAIDs . . .

- Step 1 analgesic, co-analgesic
- If one class ineffective, change to dif. class
  - E.g. ibuprofen [Motrin] to diclofenac [Voltaren]
- Inhibit cyclo-oxygenase (COX 1 & 2) [PG's]
  - vary in COX-2 selectivity
- All have analgesic ceiling effects
  - effective for bone, inflammatory pain
  - individual variation, serial trials

# NSAID adverse effects

- Renal insufficiency & edema
  - maintain adequate hydration
  - COX-2 selection inhibitors
- Inhibition of platelet aggregation
  - assess for coagulopathy - GI Bleed
- Confusion/delirium in elders
- Avoid in DM2 and CHF – <u>and in elders</u> !

* Hospice & Palliative Care Formulary USA, 2nd edition. 2008

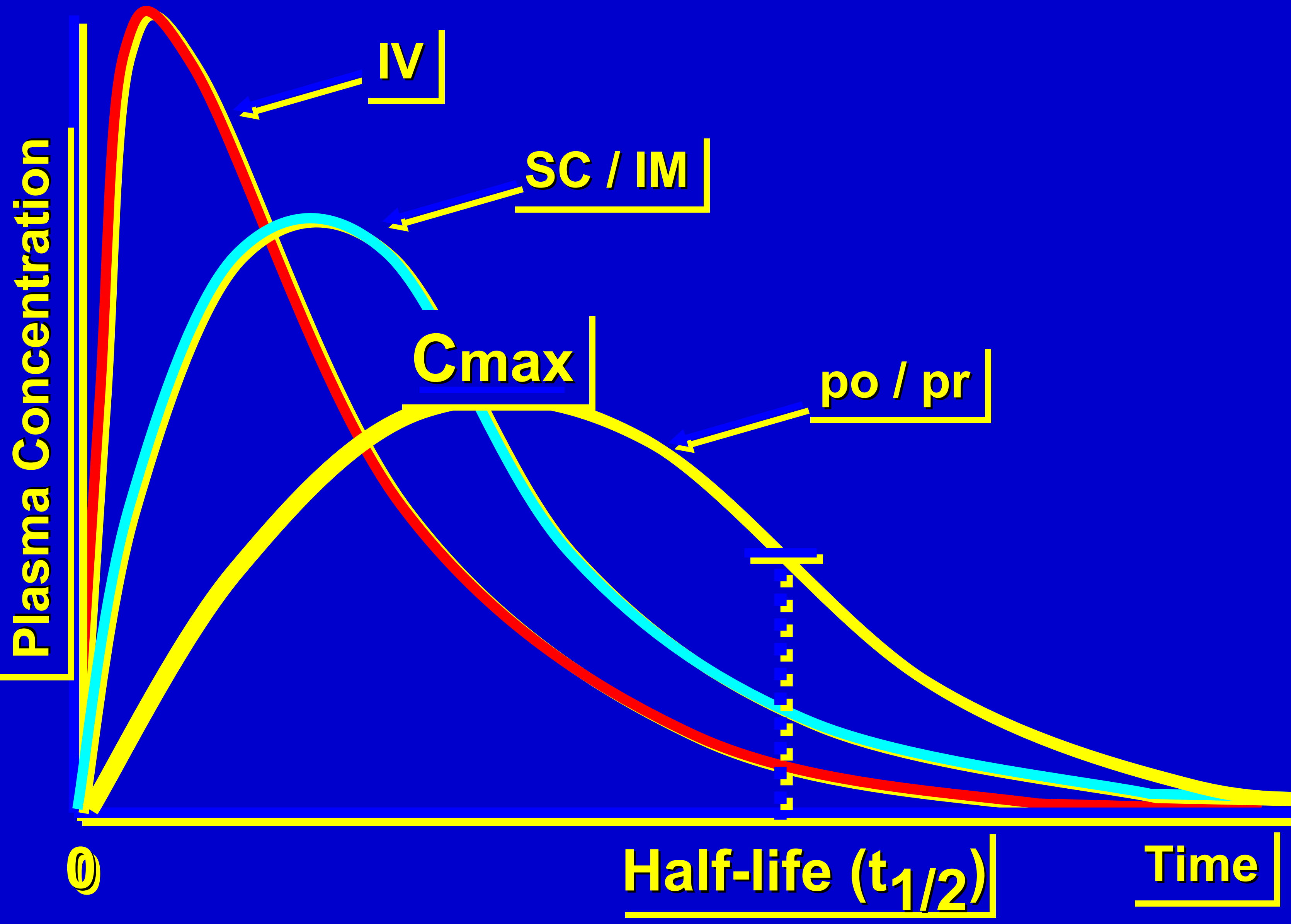
# Opioids

- Preferred – Morphine = gold standard
  - No upper limit dosage e.g. 50mg/hr IV/SC !!
- Discouraged: Demerol
- Equianalgesic doses* (for morphine 10mg)
  - Morphine 10mg po = 3mg IV/SC
  - Oxycodone 6mg
  - Hydrocodone 10mg
  - Dilaudid 2.5mg po = 0.5mg IV/SC

[*Prescriber's Letter, Sept.2004. AAHPM Equianalgesic Table for Adults. 2003]

# Opioid pharmacology

- Steady state after 4–5 half-lives
  - steady state after 1 day (24 hours)
- Duration of effect of "immediate-release" formulations (except methadone)
  - 3–5 hours po / pr
  - shorter with parenteral bolus


IV
SC / IM
Cmax
po / pr
Plasma Concentration
0
Half-life ($t_{1/2}$)
Time

# Routine oral dosing
## immediate-release preparations

- Codeine, hydrocodone, morphine, hydromorphone, oxycodone
  - dose q 4 h
  - adjust dose daily
    - mild / moderate pain ↑ 25%–50%
    - severe / uncontrolled pain ↑ 50%–100%
  - adjust more quickly for severe uncontrolled pain

# <u>Routine</u> oral dosing

## <u>*extended-release*</u> preparations

- Improve compliance, adherence
- No better analgesia or reduced S/E
  + 5 times more expensive in USA !
- Dose q 8, 12, or 24 h (product specific)
  - don't crush or chew tablets
  - may flush time-release granules down FT
- Adjust dose q 2–4 days (once steady state reached)

# Breakthrough dosing

- 90% controlled w/ oral/SC opioids
- If >3 BT doses/day, increase base rate
- Use immediate-release opioids
  - 10% of 24 hr dose q1h
    - If IV/subQ, can give ¼ of 10%, q15min prn
  - offer after $C_{max}$ reached
    - po / pr ≈ q 1 h
    - SC, IM ≈ q 20-30 min
    - IV ≈ q 10–15 min
- Do NOT use extended-release opioids

# Opioids - Why not Demerol??

- Low potency – but addictive!
- Short duration
- Medical myth re pancreatitis & biliary colic
- Toxic metabolite – normeperidine
  - CNS Excitation (Serotonin) Syndrome – tremors, myoclonus, delirium, seizures

# Opioids - Why not Demerol, cont'd

- Am.Pain Soc. Recommends "…meperidine should not be used >48hrs for acute pain in pts w/o renal or CNS disease, or at doses >600mg/24hrs, and should not be RX for chronic pain."
- Not recommended by any national CPG since 1990, for elders, >3days, CPS, CRI
- More hospitals removing from formulary

# Also Not Recommended

- Mixed agonist-antagonists
  - Pentazocine [Talwin], butorphanol [Stadol], nalbuphine [Nubain], dezocine
    - compete with agonists → withdrawal
    - analgesic ceiling effect
    - high risk of psychotomimetic adverse effects with pentazocine, butorphanol
- Propoxyphene [Darvon] – off US formulary 2011

# Addiction + . . .

- Psychological dependence
- Compulsive use:  behavioral !
- Loss of control over drugs w/ continued use of drugs in spite of harm
- Loss of interest in pleasurable activities
- A rare outcome of pain management
  - particularly, if no history of substance abuse

# . . . Addiction

- Consider
  - substance use (true addiction)
  - pseudoaddiction (undertreatment of pain)
  - behavioral / family / psychological disorder
  - drug diversion

# Tolerance

- Reduced effectiveness to a given dose over time
- 9 different mu receptors
  - opioids bind in different proportion often leading to tolerance to one opioid
  - rotating opioids helps treat tolerance
- Usually not clinically significant with chronic dosing
- If dose increasing, suspect disease progression

# Physical dependence

- A physiologic process of neuroadaptation
- Abrupt withdrawal may → abstinence syndrome
- If dose reduction required, reduce by 50% q 2–3 days
  - avoid antagonists

# Substance users

- Can have pain too
- Pain history NB – chronic pain syndrome ?
  - CAGE score 2+ = poor pain control
- Treat with compassion
- Protocols, contracting
- Consultation with pain or addiction specialists

# Pain poorly responsive to opioids

- As dose escalates → adverse effects; so…
  - more sophisticated therapy to counteract adverse effect
  - alternative
    - route of administration
    - **opioid ("opioid rotation" - methadone)**
  - Adjuvants
  - use a non-pharmacologic approach
  - **Look for other causes/factors**

# Pain Assessment: pain increases due to…

**Cancer Related Factors:**

- Tumor growth
- Infection
- Fracture
- ischemia

**Patient Related Factors:**

- Chemical coping
- Delirium
- Opioid tolerance
- Mood change

# Methadone: why it's better

- Mu opioid agonist, NMDA [N-Methyl-d-Aspartate] receptor antagonist; inhibits reuptake serotonin, NE
- No active metabolites
- Better pain control than morphine, but more sedation
- Reduce risk of opioid induced neurotoxicity
- Low cost !!

*[Bruera et al, 2000; Hospice & PC Formulary USA. 2nd Ed. 2008; Cleary JF. Methadone: the ideal long-acting opioid? AAHPM Bulletin, winter 2002. ]*

# …Pain poorly responsive to opioids

- Lidocaine 1% IV option* [cancers]
  - 1-2mg /kg slow push over a few minutes, or, in 25ml saline over 15-30min.
  - May follow w/ continuous infusion 1-2mg/kg/hour
  - Will reduce dose of opioid needed !

*Available only on 6W or ICU/CCU

- Ketamine po/IV [separate handout]

*[Thomas J, etal. IV Lidocaine relieves severe pain. J Pall Med. 2004]*
*[McCleane G. IV Lidocaine: an outdated or underutilized tx for Pain. J Pall Med. 2007.]*

# Ongoing assessment !!!

- Increase analgesics until pain relieved or adverse effects unacceptable
- Be prepared for sudden changes in pain
- Titrate continuous infusions based on assessment and use of AACA !
  - **Follow the EOLC Order Set**

# Alternative routes of administration

- Enteral feeding tubes
- Transmucosal
- Rectal
- Transdermal
- Parenteral – **SubQ** , IM , IV
- Intraspinal

# Transdermal patch

- Fentanyl
  - peak effect after application ≈ 24 hours
  - patch lasts 48–72 hours
  - ensure adherence to skin
  - NOT for opioid naïve !!!
  - Overrated and $$$ [$370/mo 50mcg; $750/mo 100mcg (generics ~1/2)]

# Nebulized and Sublingual Opioids

- Nebulized opioids provide no advantage over IV administration for dyspnea or pain (except: home hospice convenience)
- Sublingual morphine – only 18% absorbed through sublingual mucosa
  - Fentanyl 51%
  - Buprenorphine 55%
  - **Methadone 34%**
  - Oxycodone 16%

Dudgeon , 2010;
Gordon & Weissman, 2005

# Topical Agents: Lidocaine Patch

- Lidocaine 5% patch, ointment
- FDA-approved for post-herpetic neuralgia
- Clinical trials show effectiveness in other neuropathic pain syndromes
- Effective adjuvant for osteoarthritis and back pain
- Local side effects: redness, edema, abnormal sensations at site

# Topical Agents: Capsaicin

- Active ingredient of hot chili peppers
- Clinical trials show effectiveness for diabetic neuropathy, osteoarthritis, and rheumatoid arthritis
- Common adverse effects: burning pain at application site, sneezing and coughing
- Dosed q 6h, usually takes 2—4 weeks to achieve therapeutic effect

# FYI: Relative Opioid Costs

- Morph.liq.20mg/ml 60mg/day = $2.40/day
- Morph.MSIR 15mg ‘’ = $1.50/day
- Methad.liq.10mg/ml 30mg/day= $2.08/d
- Methad.tabs 10mg ‘’ = $ .60/d
- Fent.patch 50mcg q3d = $5.66/d
- Duragesic 50mcg = $10.60/d
- Fentanyl buccal [Fentora 100mcg] = $20 each
- Dilaudid liq 1mg/ml 15mg/day= $4.37/d
- Dilaudid tab 2/4/8mg 16mg/day= $6.00/d
- Lorcet 10/325 qid = $1.21/d
- Morph.pump at home = $30/day pump only
- Morph.10mg/ml PLO [topical] 60mg = $5.40/day

* Avg.Retail Cost – changes !

# Parenteral

- SubQ, IV, IM
  - bolus dosing q 3–4 h
  - continuous infusion
    - easier to administer
    - more even pain control

# Hypodermoclysis

- For subQ meds and fluids
- Fluids for rehydration – NS, D5/NS
  - Up to 125ml/hr, +/- KCl; equal absorption
- Meds = anything that can be given IV except antibiotics and a few others
  - Place #23-25 butterfly access – chest best; change only if red/draining
  - Rarely need IV; **No IM injections**

- *AAHPM Bulletin, Winter 2003*

# Bolus effect

- Swings in plasma concentration
  - drowsiness ½ –1 hour after ingestion
  - pain before next dose due
- Must move to
  - extended-release preparation
  - continuous SubQ, IV infusion

# Changing routes of administration

- Equianalgesic table
  - guide to initial dose selection
- Significant first-pass metabolism of po / pr doses – means need more po !
  - codeine, hydromorphone, morphine
  - po / pr to SC, IV, IM
  - 2–3 ≈ 1

# Opioid Equianalgesic doses*

| po / pr (mg) | Analgesic | SC / IV / IM (mg) |
|---|---|---|
| 100 | Codeine | 60 |
| 15 | Hydrocodone | - |
| 4 | Hydromorphone | 1.5 |
| **15** | Morphine | **5** |
| 10 | Oxycodone | - |
| 150 | Meperidine | 40 |
| 25mcg | Fentanyl | = 50mg/day MS |

Methadone – see separate formula scale.

*[*Prescriber's Letter, Sept.2004. AAHPM Equianalgesic Table for Adults. 2003]*

# Case #2 – PAIN Exercise

- Mr. Carcinoma – pain in back/hips
  - Admitted due to severe back & hip pain
    = 7-8 /10 most days
- Controlled after subQ morphine 6mg/hr
- **Convert to po morphine before discharge**

[6mg x4h =24mg x3= 72mg po q4h = 60mg + 15mg q2h prn]

# Adjuvant analgesics

- Medications that supplement primary analgesics
  - may themselves be primary analgesics
  - use at any step of WHO ladder

# Burning, tingling, neuropathic pain

- Tricyclic antidepressants
- Gabapentin (anticonvulsant)
- Methadone
- Ketamine
- SSRIs usually not so useful
  - SNRIs better [venlafexine]

# Tricyclic antidepressants for burning pain . . .

- Nortriptyline > Amitriptyline
- 10–25 mg po q hs, titrate (escalate q 4–7 d)
  - analgesia in days to weeks
  - Fewer anticholinergic adverse effects, cardiac toxicity
  - Sedation helpful at hs
  - Bind plasma protein, displace morphine causing increased analgesia !

# Gabapentin (Neurontin) for burning pain

- Anticonvulsant
  - 100 mg po q d to tid, titrate
  - increase dose q 1–3 d
  - usual effective dose 900–1800 mg / d; max may be > 3600 mg / d
  - minimal adverse effects
    - nausea/drowsiness, tolerance develops within days

# …burning, neuropathic pain

- Anticonvulsant options
  - Gabapentin [Neurontin]
    - 100 mg po tid, titrate
  - Carbamazepine [Tegretal]
    - 100 mg po bid, titrate
  - valproic acid [Depakote]
    - 250 mg po q hs, titrate

# Bone pain . . .

- Constant, worse with movement
- Metastases, compression or pathologic fractures
- Prostaglandins from inflammation, metastases
- Rule out cord compression

Adjuvant

# …Bone pain

- Management
  - **opioids**
  - NSAIDs
  - **corticosteroids**
  - bisphosphonates
  - Calcitonin [nasal]

Adjuvant

# Corticosteroids . . .

- Many uses [bone pain, nausea, appetite]
- Dexamethasone [Decadron]
  - long half-life (>36 h), dose once / day
  - minimal mineralocorticoid effect
  - doses of 2–20 + mg / d [wean down after 2wks]

Adjuvant

# Opioid adverse effects

| Common | Uncommon |
| --- | --- |
| Constipation | Bad dreams / hallucinations |
| Dry mouth | Dysphoria / delirium |
| Nausea / vomiting | Myoclonus / seizures |
| Sedation | Pruritus / urticaria |
| Sweats | Respiratory depression |
| | Urinary retention |

# Opioid allergy

- Nausea / vomiting, constipation, drowsiness, confusion
  = adverse effects, not allergic reactions
- <u>Anaphylactic reactions</u> are the only true allergies
  - bronchospasm
- Urticaria, bronchospasm can be allergies; need careful assessment

# Urticaria, pruritus

- Mast cell destabilization by morphine, hydromorphone
- Treat with routine long-acting, nonsedating antihistamines
  - fexofenadine, 60 mg po bid, or
  - loratadine
- Sedating antihistamines or doxepin if sleep desired

# Constipation . . .

- Common to all opioids
- Opioid effects on CNS, spinal cord, myenteric plexus of gut
- Easier to prevent than treat
- Goal:  have bm QOD – Q3days

# Constipation . . .

- Prokinetic agent - Metoclopramide [Reglan]
- Bulk forming agents **not** recommended – e.g. metamucil
- Stimulant laxative
  - **senna**, bisacodyl, glycerine, casanthranol, etc
- Osmotic laxative
  - MOM, lactulose, sorbitol,
  - **Miralax** 17-68gm/250ml water

# Nausea / vomiting . . .

- Onset with start of opioids
  - tolerance develops within days
- Prevent or treat with dopamine-blocking antiemetic
  - Prochlorperazine [Compazine], 10 mg q 6 h
  - Haloperidol [Haldol], 1 mg q 6 h
  - Metoclopramide [Reglan], 10 mg q 6 h

# Sedation . . .

- Onset with start of opioids
  - distinguish from exhaustion due to pain
  - tolerance develops within days
- If persistent:
  - alternative opioid or route of administration
  - Psycho-stimulants may be useful
    - Methylphenidate [Ritalin], 5 mg q am and q noon, titrate

# Delirium . . .

- Presentation – hyper/hypo/mixed
  - confusion, bad dreams, hallucinations
  - Inattentiveness – fluctuating !!
  - restlessness, agitation
  - myoclonic jerks, seizures
  - depressed level of consciousness

(*will discuss next session)

# Respiratory depression . . .

- Opioid effects vary with patients sensitivity
  - pain is a potent stimulus to breathe
  - loss of consciousness precedes respiratory depression
  - pharmacologic tolerance rapid
- Management – identify contributing cause
  - if unstable vital signs
    - naloxone [Narcan], 0.1-0.2 mg IV/subQ q 1-2 min

# Nonpharmacologic pain management…

- Palliative Radiotherapy – localized cancers bone
  - Only for those >2mo prognosis;
  - Single dose as effective as multiple usually
  - 40% have 50% pain decrease
- Neurostimulation
  - TENS, acupuncture
- Anesthesiologic
  - nerve block
- Surgical
  - cordotomy
- Physical therapy
  - exercise, heat, cold

# …Non-Drug Techniques

Physical

- **Distraction**
- Massage
- Cold
- Heat
- Vibration
- Positioning
- Exercise

Psychological

- **Distraction**
- Relaxation
- Music
- Comfort Foods
- Imagery
- Controlled Breathing

# Non-Drug Symptom Relief: Specifics

- Massage
- Applications of cold and heat
- Positioning
- **Distraction**
- Relaxation
- Music
- Comfort foods

# Distraction: Visual & Physical

1) Visual - pictures used to focus attention on something other than pain. By decreasing concentration on pain, it becomes more bearable.

- Have patient describe picture by:
  - Talking about the picture
  - Pretending they are in the picture
  - Telling a story about the picture
- Choose a new picture as soon as their interest decreases in the current one

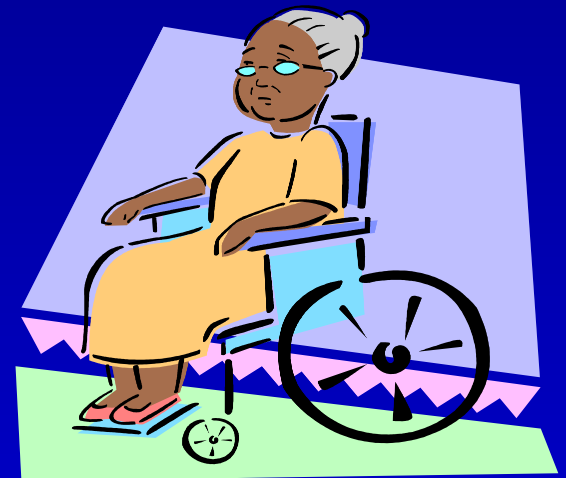
2) Physical - Use topical mentholated rubs

# Common Myths

| Myth | Reality |
| --- | --- |
| If people can be distracted from their pain, the pain isn't "real" or it's not as bad as they are saying. | People can be distracted from pain because distraction is an effective nondrug therapy |
| | |

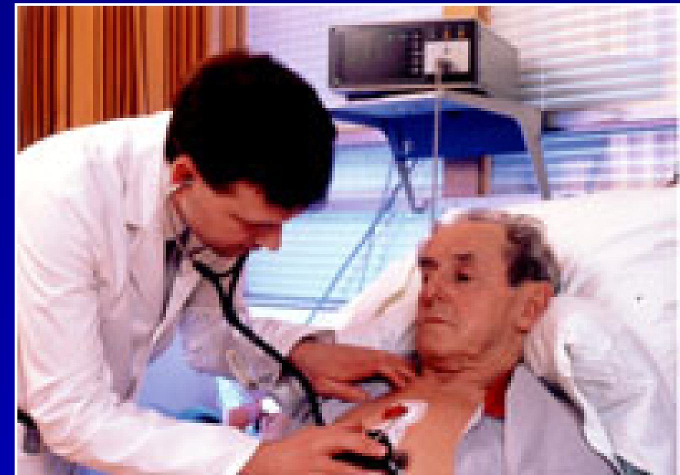
# More Myths About Pain in Older Adults

- Pain is a natural part of growing old.
- Older people are less sensitive to pain.
- If an older person doesn’t report pain, that person doesn’t have pain.
- If a person can sleep or be distracted from pain, that person doesn’t really have pain.



# …Myths About Pain in the Older Adult

- Strong pain medicine, like morphine, can’t be used safely for the older adult because they are too sensitive to dangerous side effects.
- People who use morphine-like drugs become addicted to them.



# More Myths About Pain in Older Adults

- People with dementia and other brain conditions don’t feel pain.
- People with dementia and other brain conditions can’t reliably report their pain.

# Barriers . . .

- "Not important"
- Poor assessment
- Lack of knowledge
- Fear of [by pt/family/MD/RN !]
  - addiction
  - tolerance
  - adverse effects

# . . . Barriers

- Regulatory oversight
- Patients unwilling to report pain
- Patients unwilling to take medicine

# Pain Management Associated Problems – Mr. Charles

- NB to document doses and responses !!!
- Started on morphine 15mg q4h po (8/10)
- Reglan 10mg po q8h [anticipatory]
  - Can reduce or wean off after a week
- Added Motrin 800mg q8h
- Pain still 5/10, not sleeping; (goal=3/10)
  - **Add nortriptyline 25mg hs = slept and 3/10**

# Summary & Pearls

- Severe pain is an EMERGENCY !
- Don’t delay Rx while investigating !
- “Total Pain” concept of tx
- No Demerol for Chronic Pain
- Scheduled Tx – Morphine = Gold Std.
- Methadone good option
- Anticipate S/E of constipation, nausea
- Use SubQ route & NO IM’s

**“Growin’ old ain’t for sissies”**

- Bette Davis

***THANK YOU !***