



Pain In Primary Care

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Outline

- ✚ Definition of pain
- ✚ Prevalence and significance
- ✚ Causes
- ✚ Assessment and management strategies for Primary Care: “Identify, Prepare, Evaluate, Action”

What is Pain?

- ✦ “an unpleasant sensory and emotional experience” (AGS, 2002)
 - ✦ “it is a complex phenomenon” that is “modified by individual memory, expectations and emotions”
 - ✦ It is associated with actual or potential tissue damage and is not a psychopathology
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Is Pain a Common Problem in the Elderly?

- + Community-living elderly: 25-50%
- + LTC: 45-80%
- + Analgesic use: 24-50%
- + Risk factor for inadequate pain management is **AGE, COGNITION**

Acute vs. Persistent Pain

+ Acute Pain

- Stops without treatment or responds to simple measures such rest +/- analgesic use

+ Persistent (or Chronic) Pain

- “a painful experience that continues for a prolonged period of time that may or may not be associated with a recognizable disease process”. (AGS, 2002)

Consequences of Persistent Pain


✚ Left untreated persistent pain may result in:

- Depression
- Anxiety
- Decreased socialization
- Sleep disturbance
- Impaired ambulation
- Increased healthcare utilization and costs
- Negatively impacting pre-existing conditions

(AGS, 2002)




Why Treating Pain is Important

- ✦ The presence of pain has a negative impact upon perceived health and participation in daily activities
 - ✦ A 25% reduction in pain can result in a 50% increase in function
 - ✦ The more intense pain is the more significant the impact upon performance of daily activities
 - ✦ Up to 40% of depressed elderly have pain
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What are Causes of Pain in the Older Patient?

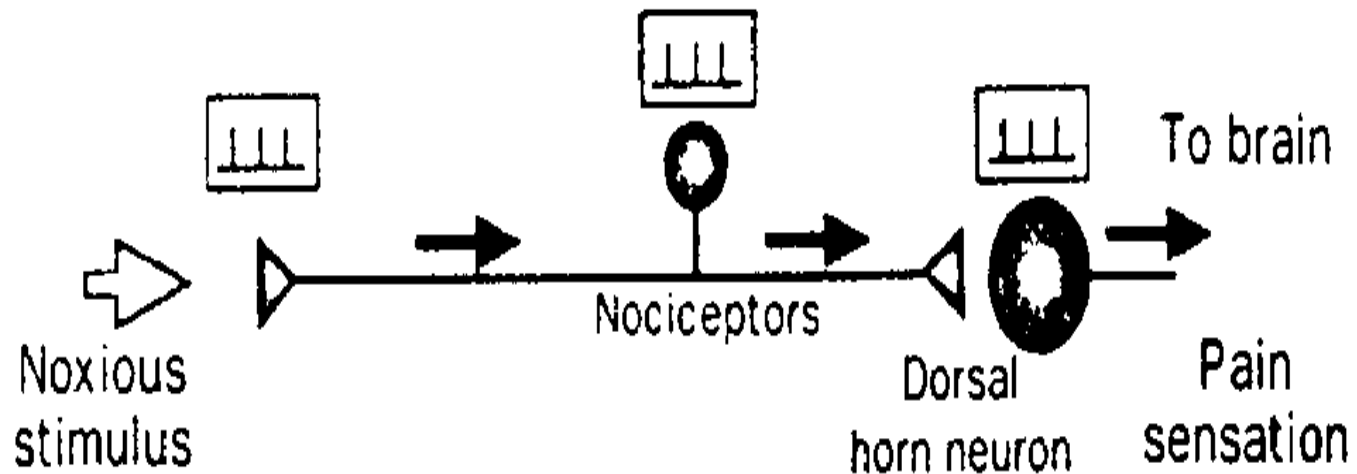
- + OA
- + Post-herpetic neuralgia
- + Diabetic neuropathy
- + Cancer
- + Osteoporosis
- + Spinal stenosis
- + ?Fibromyalgia

Organizing the Types of Pain

- + Nociceptive pain
 - + Visceral pain
 - + Neuropathic pain
 - + Complex regional pain syndromes
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Understanding Nociceptive Pain

Normal sensory function



Quick Examples...

- + Burns
- + Cuts/lacerations
- + Liver metastases
- + Skin ulcers

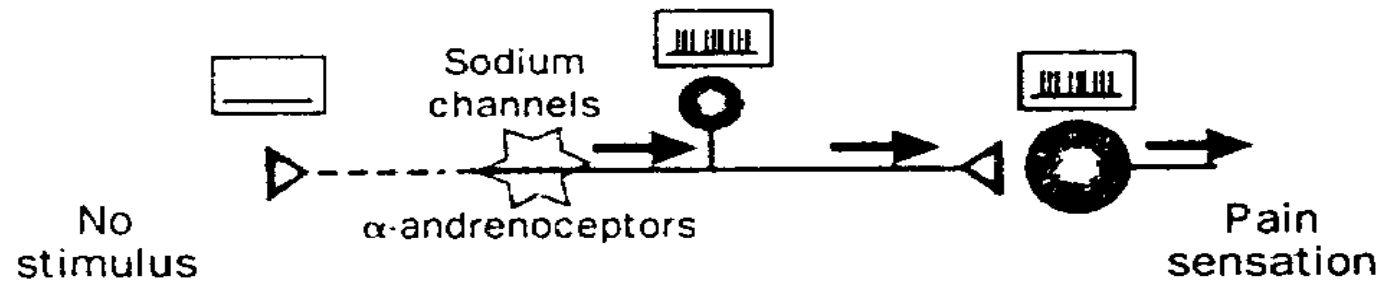
All have the potential to become neuropathic!

Visceral Pain

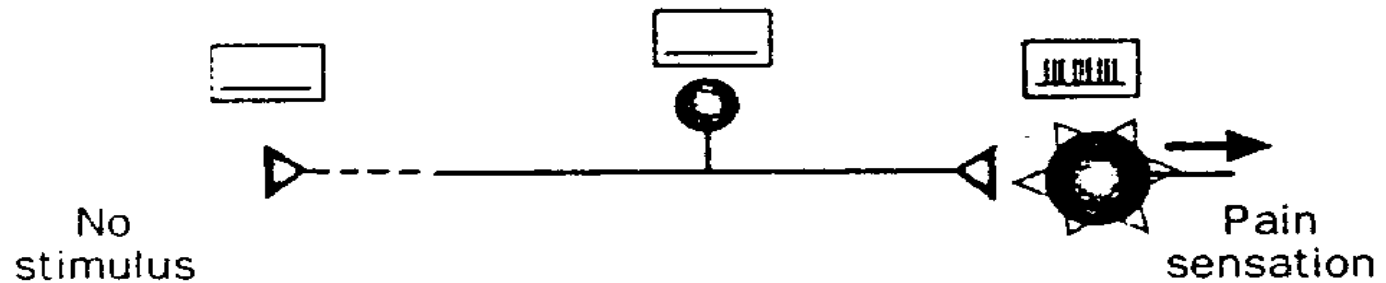
- ✚ Often poorly localized
- ✚ May present “atypically” – delirium, stupor, depression, incontinence

Peripheral & Central F/X


Sensory function after nerve injury with spontaneous firing along axon



Sensory function after nerve injury with spontaneous firing of dorsal horn neurons in spinal cord



What are some Causes of Neuropathic Pain?

- ✚ **Metabolic:** diabetes, B12 deficiency
 - ✚ **Ischemia**
 - ✚ **Medications:** chemotherapy
 - ✚ **Nerve compression:** cancer, sciatica
 - ✚ **Infectious:** post-herpetic neuralgia
 - ✚ **Traumatic:** direct nerve injury
- 

Complex Regional Pain Syndromes

- ✦ continuous, intense pain out of proportion to the severity of the injury
- ✦ gets worse rather than better over time
- ✦ often affects one of the arms, legs, hands, or feet
- ✦ features include dramatic changes in the color and temperature of the skin over the affected limb or body part, accompanied by intense burning pain, skin sensitivity, sweating, and swelling
- ✦ sympathetic nervous system may play an important role in sustaining the pain

How do you know they're in Pain?

- ✚ Ask them!!
- ✚ Ask their families
- ✚ Pain assessment tools
- ✚ Functional assessment
- ✚ Behaviours
- ✚ Depression

How can you assess Pain in the Cognitively Impaired?

✚ Behavioural observations

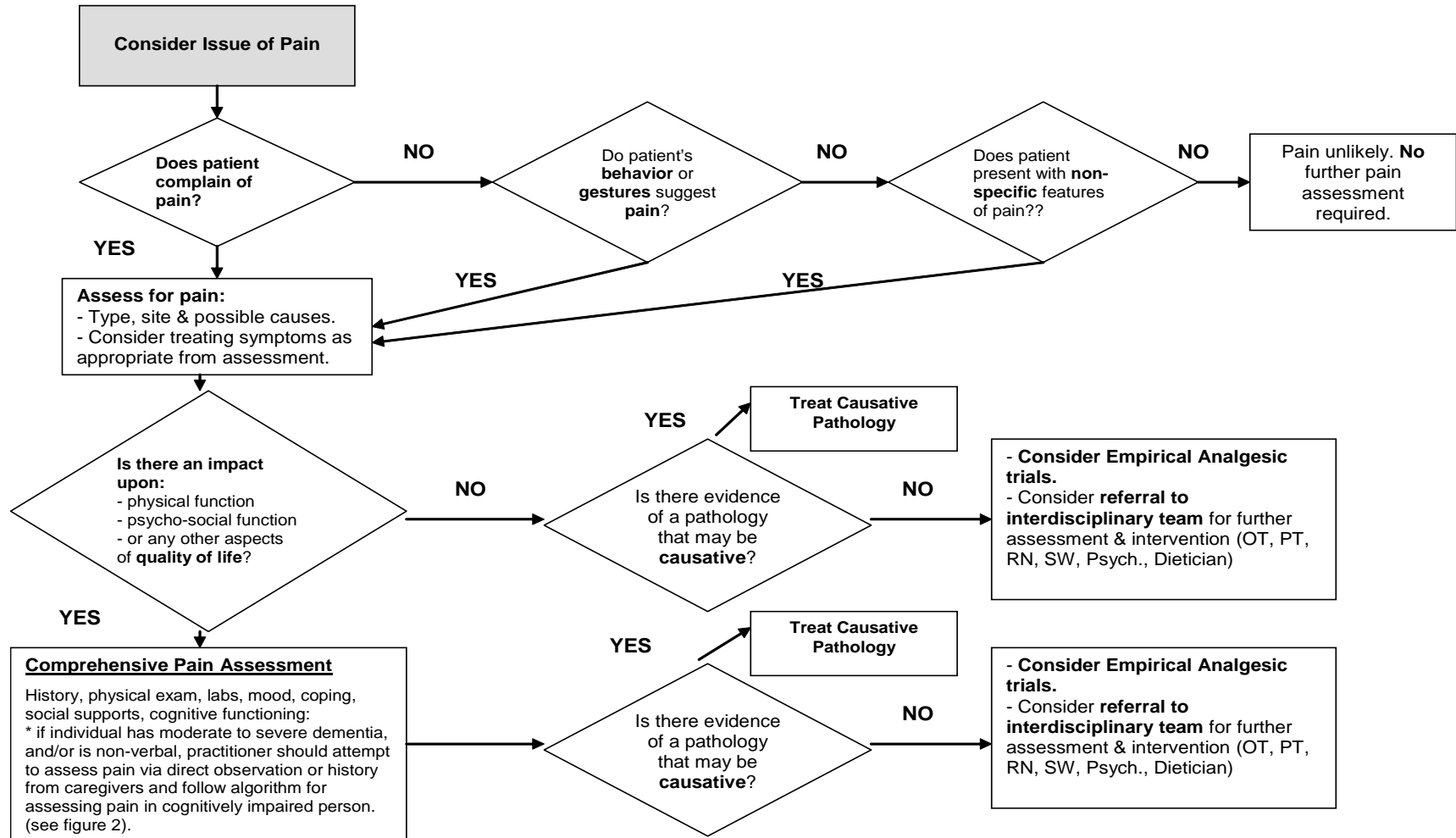
- Facial expressions
 - Frown, sad, fear, grimace, closed eyes, blinking
- Verbalizations
 - Sighing, moaning, noisy breathing, “Help”
- Interpersonal
 - resistive to care, aggressive, withdrawn
- Body movements
 - Restless, pacing, mobility

How can you assess Pain in the Cognitively Impaired?

+ Behavioural observations

- Change in patterns or routines
 - Refusing food, increase in rest periods, wandering
- Mental status changes
 - Crying, irritability

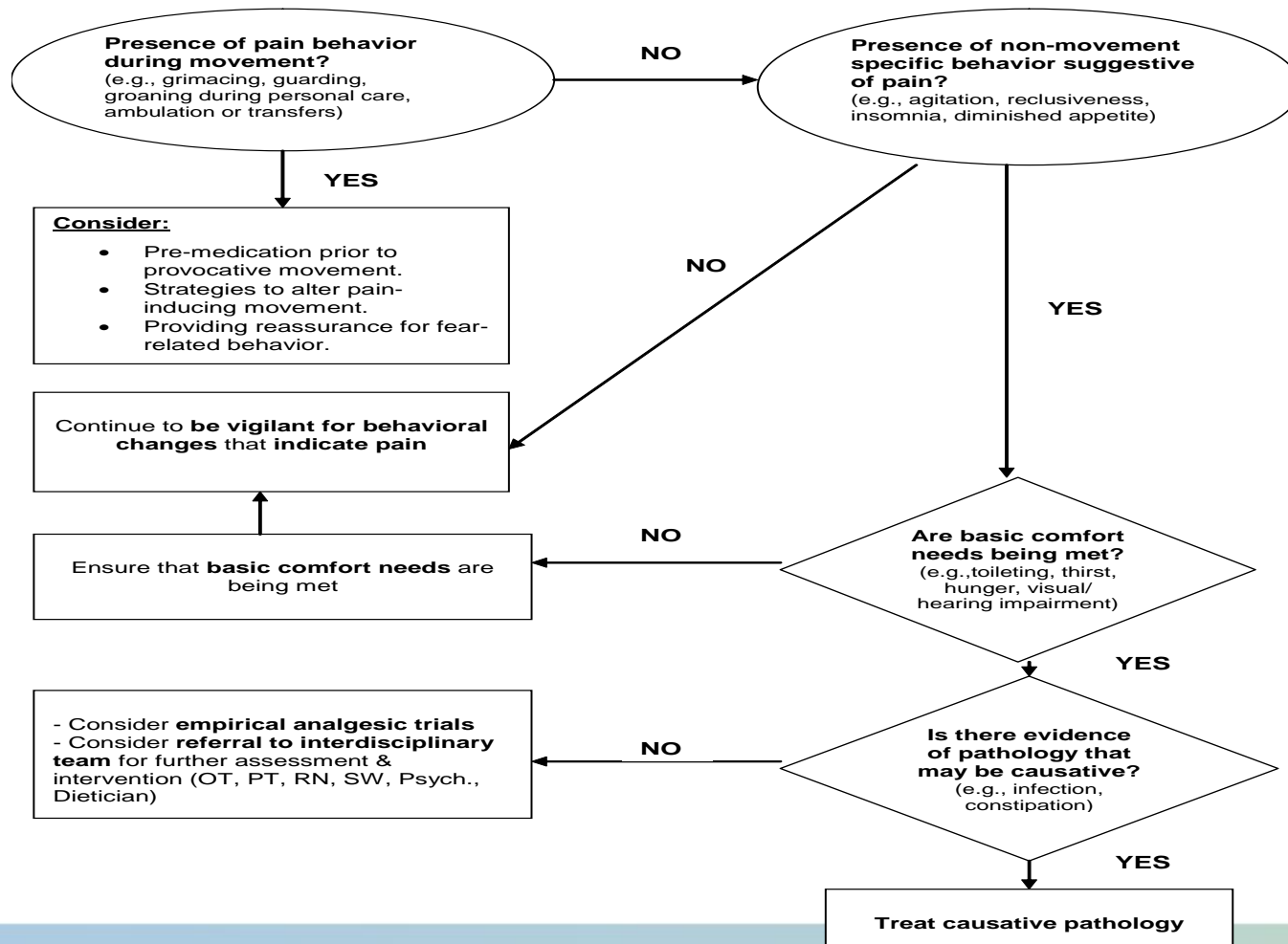
Assessment of Pain in Primary Care Algorithm



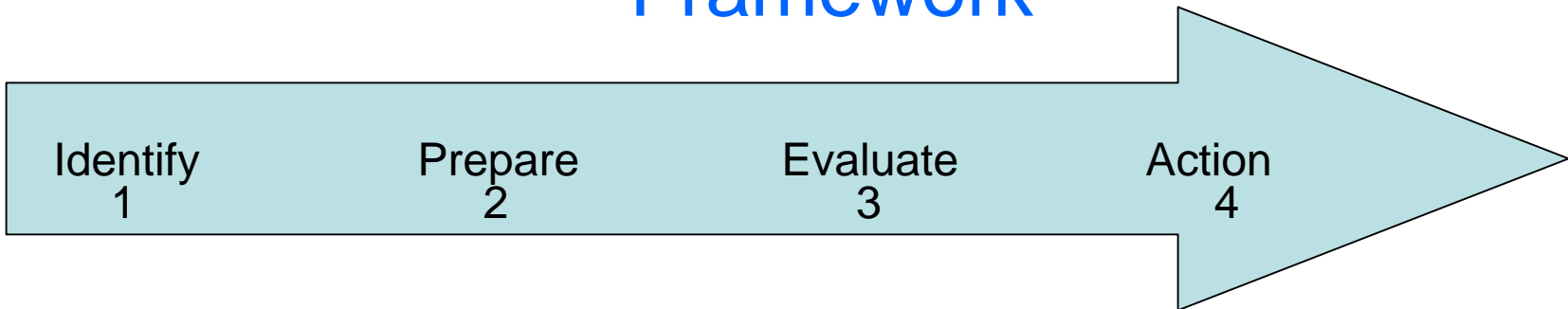
Based upon:
 AGS (2002). The management of persistent pain in older persons: AGS Panel on persistent pain in older persons.
 JAGS, 50, S205 – S224.

Assessment of Pain in Primary Care

Algorithm : Non-verbal Patient

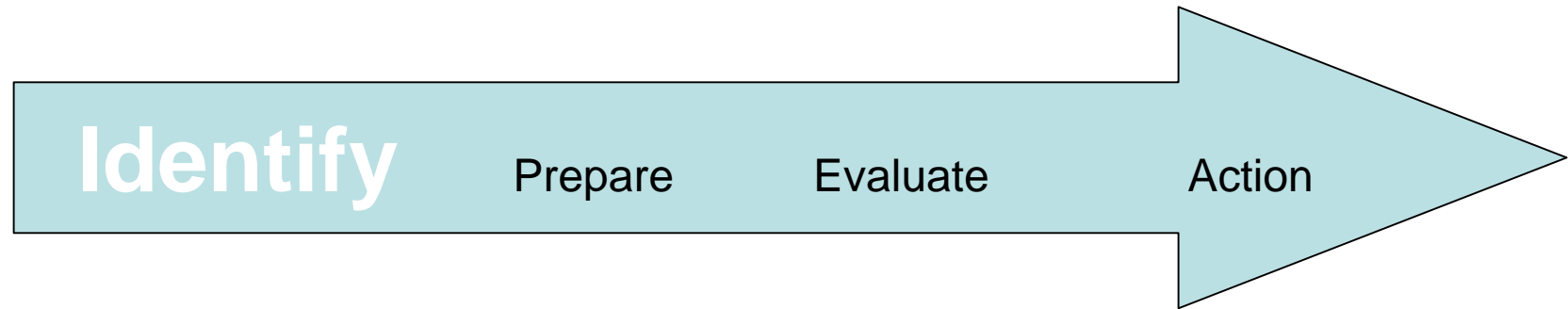


Identify, Prepare, Evaluate and Action Framework



1. Identify = Casefinding / screening for pain in patients/clients in your practice with
2. Prepare = Self-report and directed enquiry to engage individual and elicit info re: impact and possible causes, goals of treatment (history of pain, pain diary)
3. Evaluate = Structured targeted assessment to determine probable cause of pain
4. Action = Initial management in primary care, interprofessional care plan (referral for specialty evaluation and management), follow-up

Screening of Pain in Primary Care



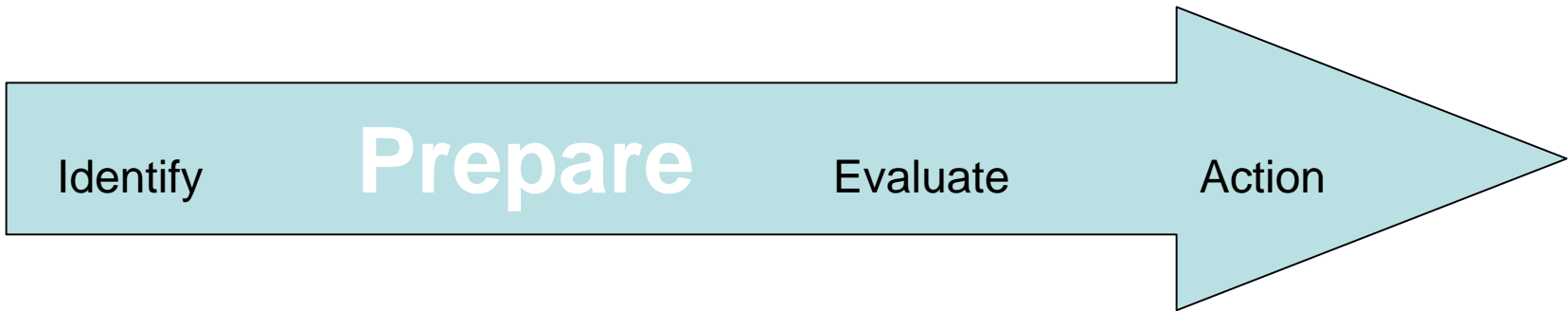
- ✚ Pain may present through:
 - Geriatric Periodic Health Exam - Self report form or clinician assessment
 - Episodic visit or encounter
 - As a problem related to a specific event or health issue (e.g. post-fall, post herpetic neuralgia)

Determining if Pain is Present

Clinicians should use a variety of terms when asking about pain in the older patient (e.g. aching, soreness, heaviness, it hurts, etc.)

- ✦ A change in function or behaviour may be an indicator of pain in seniors, especially if they have dementia
- ✦ Signs of pain in patients with dementia may include:
 - Facial expressions
 - Verbalization/vocalizations
 - Body movements
 - Changes in interpersonal interactions
 - Changes in activity
 - Mental status changes

Patient Self-Report Tools



- + Geriatric Periodic Health Exam – Patient Self-Report
- + Pain History Questionnaire
- + Pain Diary



Evaluation of Pain in Primary Care



✚ Take a good history of the pain

The **PQRST** approach may be useful.

Involve the family/caregivers when appropriate.

✚ Use the **appropriate tools**

- Colour Visual Analogue Scale
- Present Pain Intensity / Verbal Descriptor Scale
- Facial Grimace Scale
- Numeric Rating Scale

PQRST

Provoking- clarify provoking, precipitating and relieving factors

Quality- get the patient's description of the nature of the pain (e.g. burning, stabbing, shooting, etc.)

Radiation- where is the location of each type of pain and does it radiate?

Severity- use the appropriate tool, even with dementia patients

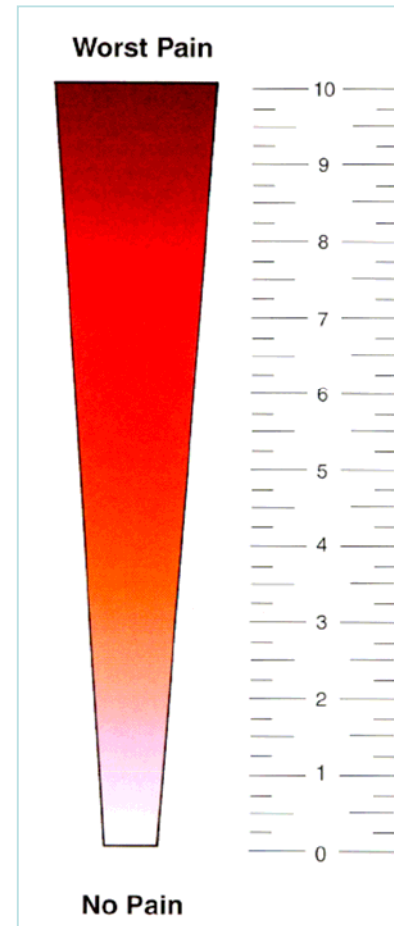
Timing- how long has it gone on for?; how long does it last?; how often does it happen?; has it changed?; include whatever timing questions are appropriate

The Tools (Cont'd)

1. Colour Visual Analogue Scale (VAS)

Description:

- ✦ It is a continuum scale that provides a visual alternative to the Numeric Rating Scale (NRS)
- ✦ It should be explained to patients as follows: the light coloured area at the bottom is no pain at all and the dark red colour at the top is the worst pain imaginable
- ✦ Ask the patient to point to the part of the scale that best describes their pain at rest "R" and with activity "A"
- ✦ Document the score



The Tools (Cont'd)

2. Present Pain Intensity (PPI)/Verbal Descriptor Scale (VDS)

Description:

May be used with patients who find the NRS difficult to use

- ✦ It is a six-point fixed interval scale that measures pain intensity
- ✦ The patient should be asked to listen to the anchor words and indicate which word best describes their pain, at rest “R” and with activity “A.”
- ✦ Document the score corresponding to the descriptor

(Melzack, R. & Torgerson, W.S. (1971). On the language of pain)

Anchor Word/ Documentation

No Pain - 0

Mild - 2

Discomforting - 4

Distressing - 6

Horrible - 8

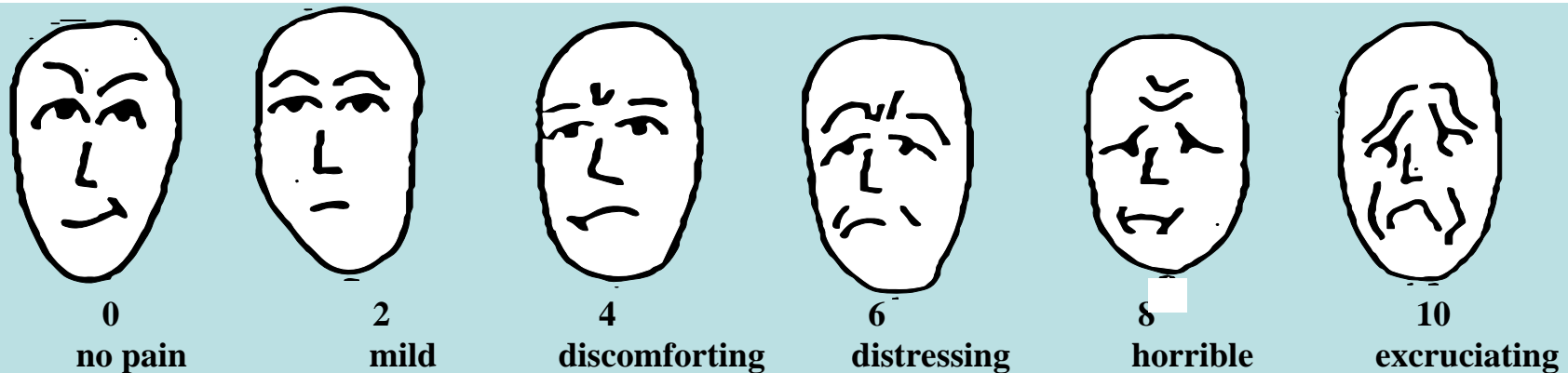
Excruciating - 10

The Tools (Cont'd)

3. Facial Grimace Scale (FGS)

Description:

- ✦ The scale has been developed to assess pain in adults who are cognitively impaired and are unable to communicate using the other tools
- ✦ Caregivers or clinicians can rate pain based on patient's facial expression
- ✦ Clients/patients who can understand this scale can use it also



Adapted with permission from Grey Bruce Palliative Care/Hospice Association Manual
Guidelines for Developing a Pain Management Program. 2000; 2nd edition

The Tools (Cont'd)

4. Numeric Rating Scale (NRS)

Description:


- ✦ The scale should be explained to patients as follows:
 - 0 = NO PAIN AT ALL
 - 10 = WORST PAIN IMAGINABLE
- ✦ “What number is your pain (when you are still) (when you move)?”
- ✦ Ask the patient to assign a number to their pain both at rest “R” and with activity “A”
- ✦ Document the score

Assessing Persistent Pain

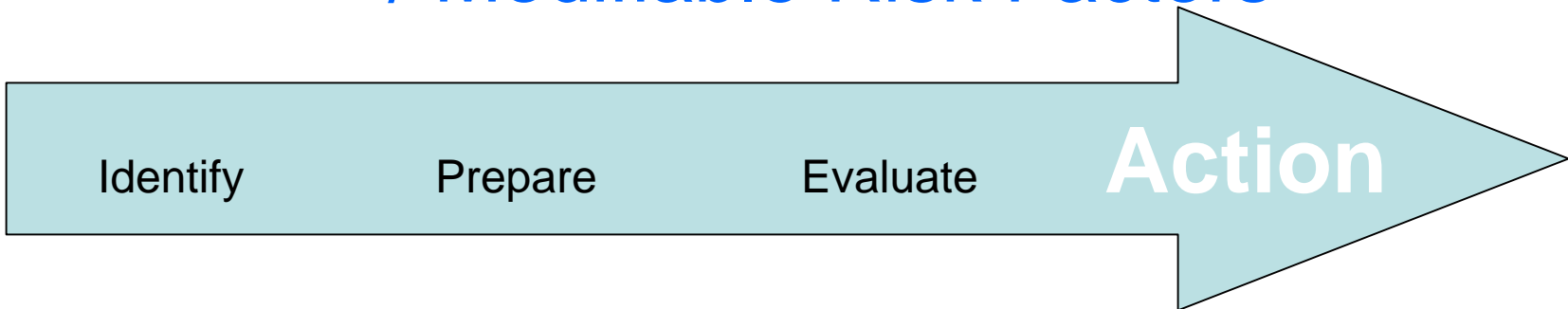
✦ Other Factors to consider:

- Impact on function (e.g. mobility, sleep, social interactions, leisure/recreation, dressing/bathing/meal preparation)
- Clarify what the patient has tried in the past. What has or has not been helpful?
- Consider the psycho-social impact of pain
- Consider the possibility of depression and consider using a screening tool such as the GDS or BASDEC. Pain can cause depression and depression can worsen pain!
- Explore the meaning of the pain for the patient there are socio-cultural influences to pain that should not be ignored
- Assess the emotional impact of pain (e.g. fear, frustration, anxiety, anger, losses, behavioural changes)
- Identify potential barriers to treatment (e.g. previous experiences with pain, beliefs about pain or medications)

Documentation of Pain

- ✦ Possible cause and/or mechanism of pain
 - ✦ Which assessment tool is used and the score
 - ✦ Psychological/spiritual or medical comorbidities
 - ✦ Factors contributing to pain and relevant to treatment
 - ✦ Non-pharmacological and Pharmacological treatment plans
 - ✦ Possible role for rehabilitation and referral to other disciplines and/or practitioners
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Action Framework For Identified Causes / Modifiable Risk Factors



- 1. Initial management – primary care**
2. Secondary management - specialists



Treating Persistent Pain in Primary Care



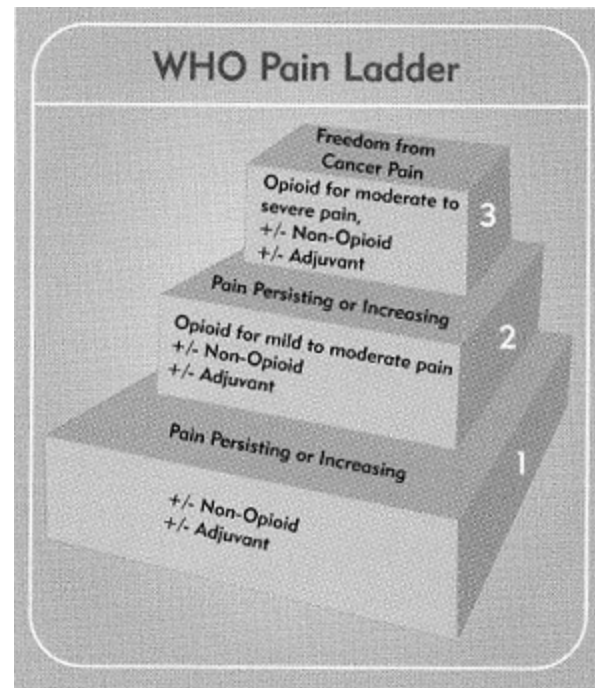
Photo: Health Canada/Santé Canada



WHO Pain Ladder

✚ Basic principles for treating persistent pain:

- **BY THE MOUTH**
- **BY THE CLOCK**
- **BY THE LADDER**

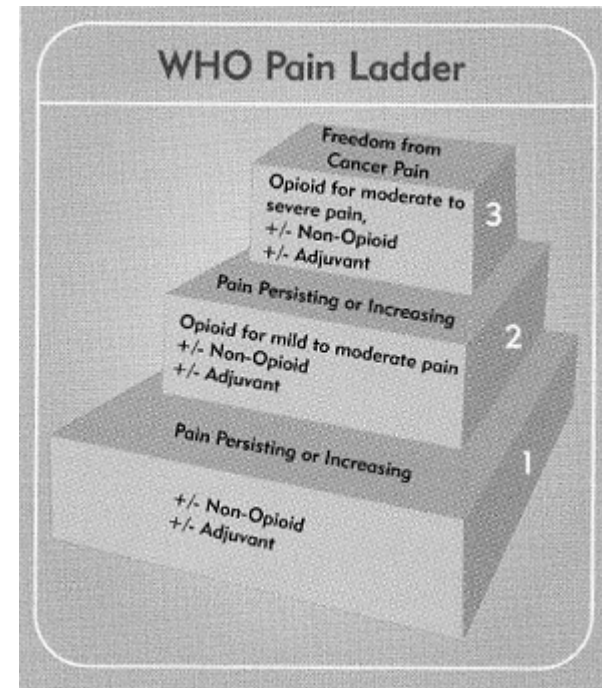


Following some more Principles

- ✚ “Start low & go slow”
- ✚ Take a careful drug history
- ✚ Beware of interactions
- ✚ Know how aging effects the medication
- ✚ Regularly review the treatment
- ✚ Remember: **Drugs may cause illness!**

Managing Nociceptive Pain

- ✚ Use the ladder:
 - Acetaminophen
 - NSAID's
 - ASA
 - Codeine



Is plain Tylenol helpful?

- ✚ Use for non-inflammatory pain
- ✚ Use q4h for chronic pain
- ✚ Caution with:
 - EtOH
 - Liver disease
 - ?Coumadin

Codeine: The #1 drug !!!

- ✚ 1/12th as potent as morphine
- ✚ Usually in combination with non-opiate
- ✚ Constipating as morphine
- ✚ Other common side effects:
 - N&V
 - Confusion

Are NSAID's safe?

- ✚ Increased risk of:
 - GI bleeding
 - renal failure
 - CHF
 - Drug interactions
- ✚ “Cytoprotection”?

If you need stronger Opiates?

- + Morphine & hydromorphone (Dilaudid)
- + 1:5 ratio of potency
 - 5mg morphine = 1 mg Dilaudid**
- + Similar side effects
- + Dilaudid more \$\$\$

Reviewing the stronger Opiates

+ Myths:

- Addiction
- Only needed at end of life
- Bowel effects cannot be treated
- Starting early will “leave nothing” to try if pain worsens
- Respiratory depression is common


Remember some other Opiate Options

- + Fentanyl patch
- + Long-acting preparations
- + Pumps
- + Su-fentanyl
- + Methadone

Treating Neuropathic Pain

- ✚ History & mechanism may guide Rx
- ✚ In general:
 - shooting pain ⇒ carbamazepine
 - constant/burning/dysesthesia ⇒ TCA

Specific Conditions...

- + Post-herpetic neuralgia ⇒ **TCA**
 - + Trigeminal neuralgia ⇒ **Valproic acid**
 - + Diabetic neuropathy ⇒ **TCA**
- 

What are the Neuropathic Rx Side Effects?

+ Carbamazepine (*Tegretol*)

- Liver function
- Blood disorders
- Rash

+ TCA

+ (Nortriptyline)

- EKG changes
- Anticholinergic side effects

Other Options?

+ **Capsacin cream:**

- Local burning sensation very common
- Needs long treatment time

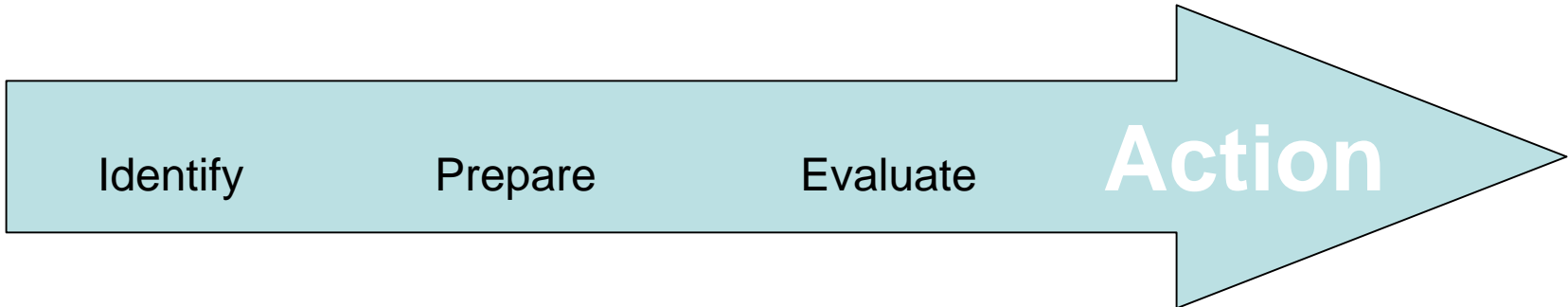
+ **Gabapentin:**

- Mimics inhibitory neurotransmitter in spinal cord
- \$\$\$

+ **Pregablin**

- ??faster onset

Referral to Secondary Care



- Consider referral to Geriatrician if pain combined with multiple medical co-morbidities
- Consider referral to other specialist services as appropriate acute pain service, neurology and/or neurosurgery
- Consider referral to interdisciplinary services (PT, OT, SW, Psychology, Nutrition, RN)
- Consider interdisciplinary pain management program as appropriate

Considering Systemic Barriers

- ✚ Barriers that impact assessment and treatment of persistent pain:
 - limited diagnostic facilities
 - limited staff education and variable responsibilities
 - limited access to other disciplines
 - limited routes of administration
 - limited research on epidemiology and assessment

Summary & Take Home Messages

1. Identify pain in the older patient
2. Identify the nature of pain
3. Identify the cause
4. Proper choice of analgesic
5. Follow principles of Rx for the older patient
6. Monitor for side effects
7. Review the medications regularly

Multidisciplinary Approach to Pain

+ Role of

- Physiotherapy (PT)
- Occupational Therapy
- Social Work
- Nurse/APN/NP
- Pharmacy
- Nutritionist
- Psychology

Toolkit Resources

- ✚ Algorithms
- ✚ Clinician Forms
 - History and Physical Exam
 - Flow Chart for Persistent Pain Management
- ✚ Patient Forms
 - Pain History
 - Daily Pain Diary
 - Persistent Pain Follow-Up Questionnaire
- ✚ Patient Handouts
 - Using Medications
 - Living Well
 - Managing Constipation
 - Treating Pain Without Pain Pills

Where to Go

- + Resources
- + Websites
- + Organizations
- + Assessment and Treatment Programs

References

American Geriatrics Society (2002). The management of persistent pain in older persons. *JAGS*, 50, S205-S224.

Melzack, R. & Torgerson, W.S. (1971). On the language of pain

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