

Pain Relief Connection

The Pain Information Newsletter

Provided by MGH Cares About Pain Relief



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In this issue:

Clinical Focus	Page 1
In the News	Page 1
Education	Page 2
MGH Pain Calendar	Page 2
Pain Topics: Assessment of Pain in Patients with Dementia	Page 3

Clinical Focus: Ten Guidelines for Assessing and Treating Pain

This is the 8th and final installment in a series on principles and guidelines for pain management.

10. Use available resources to update clinical knowledge and to improve utilization of specialty care

The vast majority of patients can have their pain adequately managed by clinicians for whom pain is not a specialty practice. Whether one is a practitioner of another specialty or a generalist, information on the management of most pain is readily available and has been for decades. Some of this information is available on the MGH Cares About Pain Relief [web site](#). JCAHO, some political jurisdictions, and many specialties have mandated that clinicians adequately assess and appropriately treat pain.

Unlearning obsolete practices and assumptions can improve pain management. Examples include:

- Meperidine should be used only for very short term indications because of neurotoxicity with high doses or repeated dosing. The oral (poor GI absorption) and intramuscular (local pain/irritation and scarring) routes for meperidine administration should be avoided.
- Propoxyphene (Darvon, Darvocette), codeine, and mixed opioid antagonist/agonist agents should be avoided for chronic use or for severe pain because of ceiling effects and/or toxicity.
- "Drug-seeking behavior" is more likely to be a symptom of inadequate pain control than of addiction.
- Patients with a history of substance abuse can be treated for pain with opioid analgesics.
- Providing analgesia for patients with acute abdomen does not prevent accurate diagnosis of the underlying condition.
- Neonates and infants experience pain in all situations in which older children and adults experience pain.

It is inevitable that some patients will not respond as expected to standard interventions for pain. When this occurs, the patient's pain should be reassessed, neuropathic pain should be considered, and psychosocial factors should be explored. Consultation with or referral to a multidisciplinary pain team should be considered when:

- the patient's pain persists beyond the expected time for healing
- symptoms of neuropathic pain are present
- there are concerns about addiction (addiction is a disease that should be diagnosed and managed by a specialist in addiction medicine)
- the patient has a current or prior history of substance abuse, including alcohol and prescription drugs
- patient or family psychosocial issues complicate the inherent complexity of patient care

Specialty care or consultation: The Pain Center (x68810)
Palliative Care Service (x49197)
Substance abuse screening (x62712)

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In the News

PainFacts, an innovative resource-in-development, has been launched by MGH Cares About Pain Relief. A beneficiary of a “Making a Difference” grant, *PainFacts* is intended to be a flexible tool that educators and clinicians can use to create in-services, slide shows, and handouts for teaching professionals and patients. Each *PainFact* is a succinct (no more than will fit comfortably on a 3 x 5 card) statement about pain. *PainFacts* can be “mixed and matched” to provide custom educational pieces. A few sample *PainFacts* can be seen on the [PainRelief](#) web site. Many more will be added as the program grows. “Making a Difference” grants are an ideal way to try out a limited-budget idea by an individual or small team who want to improve pain management or another patient care idea. The program funds ideas that will improve, either directly or indirectly, the quality of services we provide our patients. Contact Melanie Cassamas for an application (x61816, mcassamas@partners.org). The application deadline is October 1, 2002.

Remember Pain Pulse, the annual “snap-shot” survey of pain at MGH that was conducted March 19? Hospital-wide and unit-by-unit results are available. The overall reported incidence of moderate to severe pain has not changed significantly since Pain Pulse was instituted in 1999. Importantly, the quality of life question has shown incremental improvement, but the results remain sobering: 30% of total respondents reported (on a scale of 0 – 10) that pain interfered with their ability to enjoy life in a range of 5 – 10; 15% in a range of 8 – 10. The importance and impact of pain goes well beyond, and may not be proportional to, pain severity.

Education

October 3-5 (Thurs – Sat) (Please note that this reflects a schedule change): **New England Conference on Pediatric Hospice**: Sponsored by the [Jason Program](#), dedicated to the care of seriously ill and dying children. An annual multidisciplinary conference. Register online, or print registration form to mail or fax. Phone number for more information: (207) 283-0170 ext 2589.

October 14 (Mon, 9:00pm, [WGBH](#) Ch 44): [And Thou Shalt Honor](#). A “provocative” PBS special on the rapidly increasing need for home-based care by families of aging baby-boomers and the care-giving decisions we will all need to face. If a channel other than WGBH is your PBS station, the broadcast may be as early as Oct 9.

MGH Pain Calendar:

September 19 (Thurs) 8:00am: **Phantom Limb Pain and the Brain**. Sponsored by Dept of Anesthesia and Critical care; Second Annual Beecher Lecture. Location: Clinics 3 Amphitheater.

[Educational Offerings and Events Calendar](#) of The Center for Clinical and Professional Development is now available online.

September 25 (Weds) 8:00am – 4:00pm: [Conversations at the End of Life](#). Topics to be covered include pain and symptom management; ethical issues, struggles, and choices; patient advocacy; and cultural differences. 8.4 contact hours will be awarded. Pre-register by calling the [Center for Clinical and Professional Development](#) at 617-726-3111. Location: Charles River Plaza, 185 Cambridge Street, 2nd floor Room 105.

October 25 (Fri) 8:00am – 6:00pm: **Weaving End-of-Life Care into Nursing Education**. Instruction in the practical application of the [Toolkit for Nurturing Excellence at End-of-Life Transition](#) (TNEEL). Sponsored by the [MGH Institute for Health Professions](#). Location: IHP at Charlestown Navy Yard. Brochure and registration form are on the IHP web site.

November 15 (Fri) 8:00am – 11:00am; repeated 12:00N – 3:00pm: [Care of the Patient at the End of Life: Clinical and Ethical Considerations](#). Pre-register by calling the Center for Clinical and Professional development at 617-726-3111. Location: Charles River Plaza, 185 Cambridge Street, 2nd floor Room 105.

URL notes: **Hold your cursor over the link for a second to see the URL**. If you are reading this in hard copy, this month’s links are:

The Jason Program: <http://www.jasonprogram.org>

Center for Clinical & Professional Development courses:

<http://pcs.mgh.harvard.edu/CCPD/CCPDframe/page%20descriptions/CCPD%20Offerings%20Home%20Page.htm>

WGBH-TV schedule for “And Thou Shalt Honor:” http://www.wgbh.org/schedules/program-info?program_id=746823

“And Thou Shalt Honor” website: <http://www.thoushalthonor.org>

TNEEL: <http://www.son.washington.edu/departments/bnhs/pain>

MGH Institute for Health Professions: <http://www.mghihip.edu>

MGH Cares About Pain Relief web site: <http://www.massgeneral.org/painrelief>

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PAIN TOPICS

Assessment of Pain in Patients with Dementia

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McCaffery has stated that “Pain is whatever the experiencing person says it is, existing whenever he says it does.”¹ This conceptualization of pain emphasizes the subjective and highly individual nature of pain, but seems to exclude the patient with severe dementia because verbalization is a necessary condition for the ability to report pain. Dementia may affect the cognitive, behavioral, and emotional facets of pain.

Multiple studies have documented the under-treatment of pain in elderly patients in the community, nursing home, and acute-care settings.² For example, in elders who were recovering from hip fracture repair, cognitively impaired patients received significantly less pain medication than cognitively intact patients, all of whom reported ongoing moderate to severe levels of pain.³

How then do we assess pain in a patient with dementia? The first principle for evaluating pain in cognitively impaired patients is to believe the complaint if it is verbalized. Parmelee looked at the association between self-reported pain and cognitive impairment among frail elders. Her overall conclusions were:

1. Mildly impaired individuals were almost equally able to accurately report their pain.
2. Patient pain complaints were genuine.
3. Impaired patients with communication skills will not neglect reporting of pain when queried specifically.
4. Markedly impaired patients reported less intense pain and a smaller number of pain complaints than the mildly impaired.⁴

Where is the pain? In patients with a [Mini-Mental State Examination](#)⁵ (MMSE) score of <15, 86% could locate pain on themselves. From this and other studies, it appears that using self to locate pain is the most reliable way to locate pain in those with significant cognitive impairment.⁶

When and what type of pain? With progressive short-term memory deficits, time and aggravating factors are difficult to elicit. Studies confirm that patients with cognitive impairment give confounding reports when asked to give comparison of pain over the last 2 weeks.⁷ Some helpful tips include asking caregivers for information about time of onset, frequency and aggravating factors. Ask about pain when moving or palpating of the area thought to be painful. While at rest, the patient may not remember the pain. This was seen in a study of dementia patients post hip fracture repair: the patients would respond “no” to question of pain until moved. To determine quality, verbalize a list of adjectives such as squeezing, cramping, burning, etc. One or more may ring true with the patient.

What is the intensity of the pain? Many pain scales are validated for use in adults; however, high completion failure rates have been noted in those with mild-moderate dementia. Luckily, some studies have been done comparing different pain scales in patients with dementia. In 1995, Ferrell, et al at UCLA did a study of nursing home residents with an average age of 85, and a mean MMSE score of 12. They compared five frequently used pain scales. 83% of patients could complete at least one scale. Only one-third of the residents could complete all of the scales. Overall the authors stressed that most of the cognitively impaired residents could complete at least one bedside assessment tool, but significant patience and time may be required to find the appropriate tool and to await responses.⁸

The numerical rating scale (asking patients to rank pain on a scale of 1-10) and the visual analog scales (a 100 mm line on which the patient is asked to mark the level of pain, from none to severe, with a pencil) are not recommended for use in patients with cognitive impairment. The numerical rating scale was not able to be completed by - ½ of nursing home patients in three separate studies. The VAS (visual analog scale) was the most difficult to use in a study of community dwelling elders and only 44% of cognitively impaired nursing home residents could complete the scale.¹⁰

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The [Wong-Baker FACES Pain Rating Scale](#), a 0-10 scale of 6 faces with range of smiling to crying, has been found to be an effective measure of pain in children and cognitively intact elders.¹¹ However, in patients with moderate to severe dementia, only 55% of patients with an MMSE of <19, and 41% for those with MMSE < 11 could complete the scale.¹² Another author feels that the FACES scale may be a measure of depression rather than of pain for those with dementia. It is very difficult for patients who lack abstraction skills to reliably translate a crying face to severe pain instead of to a depressed or sad face.¹³

What about pain intensity assessment in patients with advanced dementia who cannot effectively communicate? As dementia progresses, the patient is dependent on the medical staff to evaluate and treat discomfort through the observation of pain behaviors or facial expressions. The concept of a pain assessment tool for advanced dementia is that discomfort can be observed, even though the patient cannot verbally express it. Patients with advanced dementia cannot voluntarily control their expressions, so observed behaviors are considered external markers of internal states.¹⁴

There are three published scales to document pain intensity in patients with advanced dementia. The first one developed was the Discomfort Scale in Dementia of Alzheimer Type (DS-DAT) by Volicer, et al in 1992.¹⁵ The second published was the Assessment of Discomfort in Dementia (ADD) Protocol by Kovach, 1999¹⁶. These first two assessment tools are useful for clinical research but are very difficult and time consuming to use; thus, are not recommended for use in day-to-day assessment of pain in those with advanced dementia.¹⁷

The Pain Assessment in Advanced Dementia Scale (PAINAD) by Volicer, et al. 2001 was developed in response to the need for an easy to use, valid and reliable pain assessment tool in advanced dementia. The paper describing the development and psychometric properties has been submitted for publication and was shared with me by the authors – Warden and Volicer at the Bedford Veterans Affairs Hospital. The PAINAD was based on the earlier DS-DAT protocol but was simplified with a score of 0-10 for severity of pain making it more easily comparable to other pain scales used at the hospital.

The PAINAD is an observational scale based on 5 items with a scale of 0-2 for each:

1. BREATHING (independent of vocalizations) – normal (0) vs labored (1) vs noisy labored (2) or long periods of Cheyne-Stokes respirations.
2. NEGATIVE VOCALIZATION – none (0) vs occasional moans or muttering (1) vs. repeated troubled calling out or loud moaning or crying (2).
3. FACIAL EXPRESSION – smiling or inexpressive (0) vs sad, frown (1) vs facial grimacing (2).
4. BODY LANGUAGE – relaxed (0) vs tense and pacing (1) vs rigid with fists clenched, or striking out (2).
5. CONSOLABILITY – no need to console (0) vs distracted or reassured (1) vs unable to distract or console (2).

Although studies on the PAINAD are very limited, it is well liked, easy to learn, and it is the only scale available for patients with advanced dementia that lends itself to routine clinical use. It is currently being used in routine clinical care as part of the Bedford VA's pain management policy. Hopefully, there will be more published data out soon on the PAINAD scale and its use.¹⁸

In summary, pain is highly prevalent among elders and those with cognitive impairment. Patients with mild-moderate dementia may need to try more than one assessment tool to find one that they understand. Studies show the best tools to be verbal descriptive scales and the worst to be numerical rating scales and visual analog scales. In advanced dementia, when patients cannot communicate their needs, there is very limited data. The best scale for clinical use at this time is the PAINAD scale, which is still not yet published and has limited data available.

Some additional tips for improved assessment of pain in patients with dementia include:¹⁹

- Ask “yes/no” questions
- Palpate areas while asking questions
- Use simple descriptors (aching, hurting)
- Assess pain associated with movement
- Don't dismiss pain behaviors as “just part of dementia”
- Also consider UTI, constipation, urinary retention, compression fractures
- Ask family about previous pain complaints
- Assess pain in any patient with poor sleep, appetite, change in function or agitated behavior

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Links

Mini-Mental State examination: <http://www.minimental.com>

Wong-Baker FACES Pain Rating Scale: <http://www.us.elsevierhealth.com/WOW/faces.html>

Feldt article (Reference #10 & 19, below): <http://www.mmhc.com/nhm/articles/NHM0009/feldt.html>

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