PAIN MANAGEMENT IN THE ELDERLY TRAUMA PATIENT
Objectives

• Define the elderly and their most common traumatic injuries
• Review key points when completing a pain assessment in an elderly trauma patient
• Review validated tools for pain assessment
• Identify issues specific to pain management in the elderly
• Identify consequences of untreated pain amongst the elderly
• Identify barriers to adequately identifying and managing pain among elderly trauma patients.
• Discuss strategies for developing care plans to address pain management among elderly trauma patients
Background

- Elderly people account for 12-15% of U.S. population and their numbers are rising
- 10-14% of all trauma victims are >65
- 33% of all trauma monies are spent on elderly patients
- Trauma care cost 3x as much for an elderly person compared to a younger person
U.S. POPULATION OF THOSE 65 AND OLDER  
Source: U.S. Bureau of the Census
Epidemiology
(in order of most to least common)

- Falls
- Motor Vehicle Crashes (MVC)
- Pedestrian struck
- Stab wounds
- Gunshot wounds
Assessing and Managing Pain in Elderly Trauma Patients
Assessing and Managing Pain in Elderly Trauma Patients

- Elderly are more likely:
  - To have prior chronic pain conditions
  - To already be taking opioids and/or nonsteroidal anti-inflammatory drugs to control the chronic pain
  - To have an atypical tolerance for pain and pain medication
  - To be biased against resulting in under treatment or overmedication
Goals of Pain Management

1. Determining the *presence and cause* of pain
2. Identifying *exacerbating* comorbidities
3. Review beliefs, attitudes and *expectations* regarding pain

Overall: the goal is to decrease pain and increase function and quality of life!
Untreated Pain

Consequences of untreated pain:
• Depression
• Suffering
• Sleep disturbance
• Behavioral disturbance
• Anorexia, weight loss
• Deconditioning, increased falls
• Longer length of stay in the hospital
• Increased medical cost
Pain Management Strategies

• Develop pain prevention/management plan.
• Include pharmacologic/non-pharmacologic strategies.
• Implement the plan of care and educate patient, family, and other clinicians.
• Evaluate with frequent reassessment.
Presence and Cause of Pain

Common Chronic Pain Conditions in Elderly

- Degenerative joint disease
- Gastrointestinal disorders
- Fibromyalgia
- Peripheral vascular disease
- Rheumatoid arthritis
- Post-stroke syndromes
- Low back disorders
- Improper positioning
- Dental pathologies
- Renal disorders
- Neuropathies
Presence and Cause of Pain

- **Somatic Pain** - originates in the connective tissue, skin, and bones and usually is located point specific.
- **Visceral Pain** - originates in internal body structures and organs and usually is general or referred.
- **Neuropathic pain** - originates as direct consequence of a lesion or disease affecting the somatosensory system.

Differentiating between somatic, visceral, and neuropathic pain is ESSENTIAL to proper tailoring of pain treatments.
Barriers to Identifying Pain

- Elderly patients may not show the same signs and symptoms as younger patients. Patients may not be able to report feeling pain or respond to questions about pain because of cognitive or sensory impairments or difficulties with language or speech.
- Racial, ethnic, and gender biases may hinder patients from reporting pain and may reduce a caregiver’s sensitivity to the signs and symptoms of pain.
- Use of multiple medications and/or co-existing illnesses may also modify reactions to pain.
- Staff may not be adept at assessing pain or use appropriate assessment instruments. Staff may have biases about pain or be unfamiliar with contemporary approaches to pain management.
- Other factors such as inadequate communication among interdisciplinary team members may inhibit adequate pain management programs.
Elderly Pain Myths

- To acknowledge pain is a sign of personal weakness
- Chronic pain is an inevitable part of aging
- Pain is a punishment for past actions
- Chronic pain means death is near
- Chronic pain always indicates the presence of a serious disease
- Acknowledging pain will mean undergoing intrusive and possible painful tests
- Acknowledging pain will lead to loss of independence
- The elderly – especially cognitively impaired – have a higher pain tolerance
- The elderly and cognitively impaired cannot be accurately assessed for pain
- Elderly patients only complain of pain because they are lonely and want attention
- Elderly patients are more likely to become addicted to pain medications
Assessing and Managing Pain in Elderly Trauma Patients

- Adequate pain management can improve patient outcomes and reduce length of stay.
- Pain is affected multi-dimensionally:
  - physically, psychosocially, and through the communication needs of the patient.
How to Assess For Pain

Basic Tenet

Pain must be assessed regularly, adequately, systematically, consistently, and documented accurately.
Assess For Pain

• Review medical/surgical history, physical exam, and diagnostic tests to understand sequence of events contributing to pain.
• Review medications, include current and previously used prescription and OTC drugs, and home remedies.
• Determine which pain control methods have previously been effective.
• Assess patient’s attitudes and beliefs about use of analgesics, and other therapies.
Ongoing Assessment For Pain

• Watch for changes in behavior from the patient’s usual patterns.
• Gather information from family members about the patient’s pain experiences, verbal and nonverbal behavioral expressions of pain, particularly in patients with dementia or cognitive dysfunction.
• If symptoms persist, assume pain is unrelieved and treat accordingly.
• Anticipate and aggressively treat pain before, during, and after painful diagnostic or therapeutic treatments.
Quantify Physical Pain with Validated Pain Scales

• Numeric Rating Scale
  – May be used for patients age 7 years and older.

• PAINAD (Pain Assessment in Advanced Dementia)
  – Used to assess pain in patients who are cognitively impaired due to dementia, non-communicative, or suffering from dementia and unable to use self-report methods to describe pain.

• Behavioral Indicators
  – Used to assess pain in patients unable to self-report and for whom the PAINAD is not appropriate.

• Assume Pain Present (APP)
  – Use to assess pain in patients who cannot self-report and who cannot demonstrate behaviors. (example – ICU patient on paralytics)
Pain Assessment

Reminder: Perform and Document a Pain Assessment:

• At Minimum Once Per Shift
• When Monitoring indicates an unacceptable level of pain
• At Minimum- Every 4 hours when patients are using PCA, opioid infusions, indwelling pain catheter, intrathecal (IT), morphine (Duramorph), or other IT medication.
Pain Reassessment

Reassessment Of Pain And Patient’s Response

• **Must occur after any PRN analgesic and/or intervention to reduce unacceptable pain:**
  • **Reassess within 30 minutes of an IV opioid**
  • Reassess within 60 minutes of any other PRN analgesic intervention (subcutaneous, Oral, ice/heat, repositioning, etc)
  • If patient is not satisfied with pain relief after the PRN intervention, continue to intervene and reassess **hourly (30 minutes after IV)** until patient reports satisfaction with pain level.
  • If unable to self-report: continue to intervene and reassess **hourly (30 minutes after IV)** until there are no behavioral pain indicators.
Psychosocial Aspects of Pain

• Research supports that elderly report pain more adequately managed when:
  – Caring behavior is exhibited by staff
  – There are flexible visiting hours for family and friends
  – They felt that they had an increase in control with open communication with their medical team
Communication Needs

• It is not uncommon for elderly trauma patients to experience cognitive or iatrogenically induced difficulties with communication.

• Even if it is apparent that the patient has difficulties with communication, staff should attempt to speak to them.
Communication Needs

• Communicating directly with the patient facilitates comprehension and diminishes sense of uncertainty and fear
• Providing information related to their disease, prognosis, and plan of care enhances their understanding and increases their sense of control
Pain Management

Pharmacologic approaches:

WHO 3-step Ladder

1. Mild
   - ASA
   - Acetaminophen
   - NSAIDs
   - ± Adjuvant

2. Moderate
   - A/Codeine
   - A/Hydrocodone
   - A/Oxycodone
   - A/Dihydrocodeine
   - Tramadol
   - ± Adjuvant

3. Severe
   - Morphine
   - Hydromorphone
   - Methadone
   - Levorphanol
   - Fentanyl
   - Oxycodone
   - ± Adjuvant

Freedom from cancer pain
- Opioid for moderate to severe pain
- ± Non-opioid
- ± Adjuvant

Pain persisting or increasing
- Opioid for mild to moderate pain
- ± Non-opioid
- ± Adjuvant

Non-opioid ± Adjuvant

Pain persisting or increasing
Pain Management

Pharmacologic approaches:

- Consider action, duration of action, side effect potential, and patient preference
- Opioids may produce higher plasma concentrations in older persons
- Smaller starting doses may be required
- Reevaluate and adjust medications as needed
Pain Management

Non-Pharmacologic approaches:

- Behavioral therapy
- Spiritual counseling
- Physical therapy
- Psychotherapy
- Splinting
- Surgical correction
- Cold packs
- Meditation

- Support groups
- Radiation therapy
- Acupuncture
- Hypnosis
- Cultural healing rituals
- Heat packs
- Prayer
- Community resources
Conclusion

• Assessment and management of pain in elderly trauma patients is extremely difficult
• Nurses are the key to assessing and identifying pain
• The entire medical team must be involved to effectively treat and manage the elderly patient’s pain
References


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