

# Palliative Care for the Older Person in Pain

International Association for the Study of Pain



Worldwide, the population over the age of 60 years will double by 2050 [11]. As people live longer, increasing numbers will live with and die from multi-morbidity, frailty, and chronic health conditions such as renal or cardiac failure. In addition, older people may experience significant psychosocial stressors such as bereavement and loss of independence.

## What is palliative care?

Palliative care aims to maintain or improve quality of life and alleviate suffering, through early identification, detailed assessment, and treatment of symptoms [4]. In older people this:

- Combines geriatric medicine and palliative care focusing on comprehensive assessment to integrate social, spiritual, and environmental factors.
- Requires an understanding of multi-morbidity, safe prescribing, and a multidisciplinary approach.
- Prioritizes good communication, considering autonomy, involvement in decision-making, and the existence of ethical dilemmas.
- Works with older people and their families across settings (home, long-term care, hospices, and hospital) and during transitions [7].

## Pain assessment

How older people experience and report pain is mediated by a range of social and psychological factors, including stoicism, which may lead to under-reporting of pain [2]. The 'gold standard' remains self-report. [3]. Questions about pain include three key dimensions: 1) sensory, 2) affective and 3) impact [8].

## Dementia and cognitive impairment



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Reporting pain can be challenging for older people with cognitive impairment secondary to dementia and other neurodegenerative diseases, strokes, cultural, or language factors. Many people with dementia can report pain reliably [12], but it is essential to obtain collateral history. Direct observation or validated observational pain scales recognize how pain or discomfort may lead to behavioral change [9]. The American Geriatrics Society Guidelines [3] include a range of indicators:

	<b>Domain</b>	<b>Example</b>
1	Facial expressions	Frowning
2	Verbalizations and vocalizations	Moaning, grunting
3	Body movements	Guarding an area of the body, pacing
4	Changes in interpersonal interactions	Becoming withdrawn, aggression
5	Changes in activity patterns or routines	Appetite, activities of daily living, sleep
6	Mental status changes	Delirium, tearfulness, crying

Most observational pain tools contain items from these domains. Commonly used tools include the Abbey Pain Scale [1], Pain Assessment in Advanced Dementia (PAINAD) [10], and the Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC) [5].

### **Principles of management**

Non-pharmacological management, such as exercise, assistive devices or relaxation [2], or topical preparations, including NSAIDs for localized musculoskeletal pain [2], may be effective as a first choice. Pharmacological treatment of pain in older people may be challenging. Polypharmacy is common and changes in how drugs are metabolized and excreted increase the risk of interactions and side effects. Recommendations have been made [2] (AGS 2009) to lessen the risk of adverse events:

- Prescribe using the WHO pain ladder (<http://www.who.int/cancer/palliative/painladder/en/>)
- Start low with one drug and increase the dose slowly to achieve response
- Use the least invasive route of administration

	<b>Indication</b>	<b>Notes</b>
Paracetamol/ acetaminophen	Musculoskeletal pain and osteoarthritis	Effective and safe analgesic
Non-steroidal anti-inflammatory drugs i.e. naproxen, ibuprofen	Musculoskeletal pain and osteoarthritis where paracetamol not effective	Higher risk of adverse events. GI bleeding, cardiovascular side effects (increased risk of arterial hypertension, heart failure) and worsening of chronic kidney disease.
Codeine	Weak opioid for moderate pain	Sedation, hallucinations, delirium, nausea, vomiting, constipation, urinary retention, falls, fractures. Fentanyl or buprenorphine available as patches but cannot be used in opioid naïve patients
Morphine, oxycodone, fentanyl	Strong opioids for severe pain in cancer and non-cancer pain	
Amitriptyline	Neuropathic pain	Postural hypotension, cardiac arrhythmias, urinary retention, glaucoma and worsening cognitive functioning
Pregabalin, gabapentin	Neuropathic pain	Anxiolytic and sedative effect

## Conclusion

A palliative care approach ensures symptoms and goals of treatment are regularly reviewed. Discussing a “ceiling of care” with the person or their family to develop a treatment escalation plan supports good pain management by considering decisions such as discontinuing painful interventions. It may reduce the risks of people undergoing distressing transfers towards the end of life, particularly into hospitals [6]. In palliative care, we consider the concept of ‘total pain’ exploring psychological distress, which may influence the perception of pain and suffering.

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