

Observational Tool May Aid Pain Assessment

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NASHVILLE, TENN. — Pain assessment is moving beyond listening for a patient to say “ouch.”

One possible way to estimate pain in all patients is to apply an observational scale that was first used on patients with advanced dementia.

“Pain behavior is helpful for assessing all patients, not just those who can’t communicate,” Gail H. Reiner said at the annual meeting of the American Academy of Hospice and Palliative Medicine.

A structured, itemized, pain-assessment tool might also work better than an unstructured, subjective impression when caregivers and family members attempt to gauge a patient’s pain, said Dr. Anne C. Mosenthal, chief of surgical critical care at the University of Medicine and Dentistry of New Jersey—University Hospital in Newark.

Ms. Reiner and her associates tested the Pain Assessment in Advanced Dementia (PAINAD) scale on a convenience sample of 98 communicative patients. The scale was first reported in 2003 by researchers from Bedford, Mass. (*J. Am. Med. Dir. Assoc.* 2003;4:9-15). The scale scores five observational elements on a scale of 0-2, with 0 being normal and 2 being the most affected. (See box.) The result is a 0-10 score that’s similar to an Apgar score, said Ms. Reiner, a nurse and director of staff education at San Diego Hospice and Palliative Care. The tool is “very user friendly” and can be applied in about 1 minute, she said.

The tested patients were either at the San Diego Hospice or in the hospice unit of a San Diego nursing home during June and July 2005. Their ages ranged from 32-98, with a mean age of 71 years, and 83% of patients were English speakers. Gender

was evenly divided between women and men. Patients were assessed using the PAINAD tool, and they also underwent two interviews with verbal pain-assessment tools.

A statistical analysis of the results is still in progress. On a qualitative level, the older a patient was, the lower the intensity of described pain. But the patients’ pain behaviors were stable across all ages. “Seemingly, the PAINAD scoring was not altered by age,” Ms. Reiner said.

Gender and English-language ability also appeared to be linked with verbal pain reporting, with women and English speakers more likely to report higher levels of pain. But these effects were not seen in the PAINAD scores.

The limitations of subjective impressions of pain were examined in a separate study by Dr. Mosenthal and her associates. They had critical care nurses, surgical residents, and family members rate the pain and symptom severity of 28 patients in the surgical ICU of University Hospital. Nurses and residents also rated the pain and symptoms of another 36 patients who did not have a family member available.

The observers rated pain using a 10-point scale (10 = severe), and symptoms using a four-point scale (4 = severe). Nine different symptoms were assessed and added for a total symptom score. Patients’ self-ratings of pain and symptom severity were measured by an interview using the Edmonton Symptom Assessment Scale. Of the 64 patients, 37 were being treated for trauma and 27 had recent surgery. All patients were treated with either an opioid or sedative.

The average total symptom score was 22 by patient self-rating, 21 as gauged by family members, 13 when assessed by nurses, and 15 when estimated by physicians. The differences between the nurse

The Pain Assessment in Advanced Dementia Scale

	ASSESSMENT SCORE		
	0	1	2
Breathing	normal	occasionally labored	noisy and labored
Negative vocalization	none	occasional moaning or groaning	repeated, troubled calling out
Facial expression	smiling or inexpressive	sad, frightened, and frowning	grimacing
Body language	relaxed	tense, pacing, and fidgeting	rigid with fists clenched
Consolability	no need to be consoled	distracted or reassured by voice or touch	unable to be consoled

Source: Journal of the American Medical Directors Association

and physician ratings and those of the patients were statistically significant, Dr. Mosenthal reported.

The average pain score among patients with no family members present was 4.7 by patient self-assessment, compared with 2.4 by nurses and 2.6 by physicians; those were statistically significant differences. When family members were present, the average pain score was 4.5 when measured by patients, 6.0 when estimated by family members, 2.2 according to nurse assessments, and 3.8 based on physician ratings.

“I was surprised. I thought nurses would do best,” Dr. Mosenthal said. All patients were receiving treatment for their pain, so their caregivers may have assumed that the pain was controlled.

“I think the PAINAD scale might work better.” They plan to test it and see if it improves results, she said.

A third study reported at the meeting tried to analyze the range of factors that contributed to chronic pain. The study included 50 patients with nonmalignant pain from arthritis, 50 patients with cancer-associated pain and hope for recovery, and

50 patients with terminal cancer pain. The patients were tested using a battery of pain-assessment tools that examined seven aspects of pain: physiologic, sensory, affective, cognitive, behavioral, sociocultural, and spiritual.

This analysis revealed 13 different patterns of pain, said Susan A. Ruzicka, Ph.D., a specialist in chronic nursing care at the University of Texas Health Science Center at San Antonio.

The most common pattern, involving 80 patients, featured a low level of physiologic pain, a high level of spiritual well-being, and a high level of self-perceived function. The second most common pattern, with 28 patients, involved low physiologic pain, high spiritual well-being, and functional dependency. The analysis also revealed 11 other patterns of pain, each of which characterized four or fewer patients.

By assessing patients holistically, using a variety of pain measures, patients can be divided into “distinct pain patterns that can lead to increased options for helping patients alleviate their pain,” Dr. Ruzicka explained. ■

Atypicals for Dementia a Modest Help With Behavior Problems

BY KERRI WACHTER
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SAN JUAN, P.R. — Atypical antipsychotics appear to have a modest effect on behavioral symptoms in elderly patients with dementia, but the effectiveness of nonpharmacologic treatments is less clear, according to a metaanalysis presented at the annual meeting of the American Association for Geriatric Psychiatry.

Dr. Mark B. Snowden of the department of psychiatry and behavioral sciences at the University of Washington in Seattle and his colleagues used metaanalysis techniques to compare the efficacy of nonpharmacologic treatments with that of pharmacologic therapies.

Articles from peer-reviewed, English language publications, including textbooks, from 1970

on were considered for the analysis. Nursing home residents had to make up at least half of the populations being studied. In addition to literature searches in several medical and nursing databases, the researchers submitted articles that they were aware of but that had not previously been identified. Articles were included only if they documented randomized, controlled trials.

The researchers identified five randomized, controlled trials of antipsychotic drugs and three randomized, controlled trials for nonpharmacologic interventions. The drug trials included four atypical drugs and one traditional antipsychotic drug.

The nonpharmacologic trials included 8 hours of nurses’ aide training to communicate more effectively with patients with dementia, 8 hours of education/training with weekly fol-

low-ups and hands-on activities of daily living care, 3 hours per day of psychosocial activities, and combined nonpharmacologic approaches.

The calculated effect size for nonpharmacologic interventions was $-.088$, which was not statistically significant. In comparison, the calculated effect size for pharmacologic interventions was $-.23$, which “would be considered small to modest at best,” Dr. Snowden said. “In this instance, the finding was consistent enough across studies that it is statistically significant.”

Only the pharmacologic studies provided data on the number of patients whose condition did or did not improve. Those studies yielded a statistically significant mean odds ratio of 1.87; thus, patients had an 87% chance of improving with drug treatment.

The researchers also calculated the benefit-to-harm ratio for antipsychotic treatment. “For every 14 people who got a drug and improved, you would expect one excess death,” Dr. Snowden said.

While Dr. Snowden pointed out that one excess death is not a trivial number, “when presented with this data, I have yet to have a nursing home family say that they don’t want an antipsychotic drug given to their relative.”

In 2003, the American Geriatrics Society and the American Association for Geriatric Psychiatry released a consensus statement on the management of behavioral symptoms associated with dementia.

In the statement, the two groups recommended the use of nonpharmacologic interventions as the initial treatment, as long as patients did not display psychot-

ic symptoms and there was no immediate danger to the resident or to others. The statement iterated that antipsychotic drugs should only be considered for first-line treatment in cases with severe behavioral symptoms with psychotic features.

Since that time, the Food and Drug Administration has issued a public health advisory about increased mortality associated with off-label use of atypical antipsychotics among elderly patients.

“Given the modesty of the effect size, I think we probably need to remove the requirement for psychosis or danger. ... Danger is a very high standard,” Dr. Snowden said. “If you say you can only use antipsychotics in someone who is dangerous, there are going to be a lot of people who are distressed that you’re not going to treat.” ■