

Pain Assessment Among Older Persons with Dementia

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Pain in older adults is often undermanaged. This concern is greater in the case of patients with severe dementia who are less likely (than their cognitively intact counterparts) to be treated with analgesic medications^{e.g.,1-3}, despite a similar prevalence of painful conditions.⁴ Such undertreatment of pain is due, in part, to difficulties in assessing pain in this population.⁵ Specifically, as cognitive functions deteriorate, patients become less likely to self-report pain⁶ although there is no convincing evidence of clinically significant reductions in pain-related suffering.⁷

Over the last decade, there have been significant advances in the area of pain assessment for patients with dementia. In the first instance, it is important to keep in mind that seniors with mild to moderate dementia tend to be capable of providing valid responses to unidimensional self-report measures of pain such as the 21-point box scale⁸ and numeric rating scales.^{9, 10} However, as cognitive functions deteriorate, the self-report of pain becomes less reliable.¹¹ As a rule of thumb, based on the literature,^{12, 13} it can be suggested that patients with Mini Mental Status Examination (MMSE)¹⁴ scores of 18 or higher tend to provide valid responses using certain unidimensional self-report tools (e.g., the 21-point box scale,⁸ the coloured analogue scale¹⁵). Nonetheless, patients with an average MMSE score of 12 are sometimes able to provide valid self-reports of pain as well.¹⁶ When considering self-report measures for older adults it should be noted that some researchers¹⁷ have expressed reservations about use of traditional visual analogue scales with this population because of concern about a high number of unscorable responses.

Given the limitations of self-report in the face of deteriorating cognitive abilities, several observational tools have been specifically developed for seniors with dementia^{e.g.,18-20}. We urge clinicians and researchers to read recent systematic literature reviews^{21, 22} (including a French language review²³) and studies comparing assessment instruments²⁴ in order to select one or more of these assessment tools. Moreover, relevant clinical guidelines are available.^{25, 26} It should be noted, however, that most of the available observational tools be used with caution until additional validation evidence becomes available.

In general, as recommended elsewhere,²⁵ certain steps should be followed by clinicians who are assessing pain among older persons:

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1. Unidimensional self-report measures should always be attempted with seniors with dementia as those with mild to moderate cognitive impairment are often able to provide valid self-reports.^{12, 13} Patients with more severe dementia can sometimes provide valid self-reports as well.¹⁶ Examples of specific tools that could be attempted include (but are not necessarily limited to) the 21-point box scale,⁸ numeric rating scales,^{9, 10} verbal rating scales²⁷ and the Coloured Analogue Scale.¹⁵
2. Use a validated observational tool designed to assess pain among older adults with dementia. Literature reviews such as those of Zwakhalen et al.,²² Hadjistavropoulos²¹ and Hadjistavropoulos et al.²⁵ as well as direct comparisons of tools²⁴ can assist with guiding assessment instrument selection.
3. Patient history, results of physical examinations and caregiver reports should be given careful consideration.
4. An individualized approach to pain assessment is often recommended whereby baseline scores are collected over time (and on a regular basis) and clinicians can observe deviations from such baseline scores. When such an approach is used, it is important that the pain assessments take place under consistent circumstances (e.g., during transfers or as the patient follows a standardized series of movements). It would also be helpful to observe whether interventions designed to alleviate pain lead to reductions in pain behaviours (as assessed by the selected observational tool).
5. Caregivers should consider that pain behaviours are, generally, more likely to be elicited during movement than during rest.
6. It is important to remember that appropriately validated observational pain assessment tools, while clinically useful, cannot be considered to represent definitive indicators of pain. In some cases, pain problems may not be identified through the use of such tools. Similarly, there may be other instances, when high scores are obtained on a pain assessment tool for reasons other than a pain state (e.g., a state of delirium can sometimes produce behaviours that are assessed by several pain assessment tools). As such, clinicians using observational pain assessment tools should exercise great caution.

It is hoped that additional research developments will lead to further progress and better assessment for frail older persons with cognitive impairments.

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