

Can we improve pain management in nursing homes?

No one, least of all nursing-home staff, likes to see people in pain

MOST OLDER PEOPLE, despite limitations, live happy and active lives. Only a small proportion of them — those with major disabilities and complex medical needs — spend their final days in nursing homes. While these residential facilities may aspire to provide quality care for their residents, there are important gaps. As McClean and Higginbotham point out in this issue of the *Journal* (page 17),¹ one such deficiency is in recognising and managing chronic pain.

Disability in older people is still substantial and the trend for compression of morbidity (ie, a reduction in mortality accompanied by a greater reduction in morbidity, resulting in a longer life with more disability-free years) seen in some countries in the past 10 years has, regrettably, been less marked in Australia.² Chronic pain can be an unfortunate consequence of several degenerative diseases associated with ageing, such as vascular insufficiency, sensory neuropathies, osteoarthritis, osteoporosis, spinal stenosis and vertebral collapse. Such conditions, and the suffering they cause, are major contributors to disability. While older women enjoy greater longevity than men, a disadvantage of their longer lifespan is increased susceptibility to these chronic, disabling, painful diseases. Depression and poor psychological adjustment are also more prevalent in older people who are in pain.³ Moreover, depression appears to heighten the suffering caused by pain.⁴ Predictably, the prevalence of chronic pain is high among nursing home residents.

The *Standards and guidelines for residential aged care services manual* (Standard 2.8)⁵ drew specific attention to the need for nursing homes to develop policies and practices to assess and manage chronic pain in nursing home residents. As McClean and Higginbotham show, pain is still underdiagnosed and undertreated, despite these guidelines. Their survey of nursing homes in New South Wales revealed that for many residents who reported being in pain there was no history of pain recorded in their case notes. Furthermore, dialogue with residents about pain was often suboptimal or non-existent, and a substantial number of patients had inadequate pain relief.

No one, least of all nursing-home staff, likes to see people in pain. We know that pain prevalence is high in this population, so why are we still failing to discern it? One possible reason is a lack of knowledge about geriatric pain. Undergraduate programs often devote little time teaching about geriatric pain management.^{6,7} Another probable reason is simply that medical and nursing staff fail to enquire adequately about pain⁸ or are too busy to spend much time with individual patients. Some staff dismiss pain that does not seem to have an identifiable medical reason and thereby underestimate personal suffering.⁹ Elderly people themselves often minimise their own pain, putting it down to “getting old”,¹⁰ and stoically suffer in silence, not wanting to be “a bother”.

McClean and Higginbotham’s study focused on residents’ self-report in addition to caregivers’ observations, and they

rightly point out that deeper probing may have yielded even higher pain prevalence. The authors specifically looked at patients who could communicate about pain, but excluded the 40% of patients who could not. The prevalence of undetected pain is likely to be even higher among people who cannot communicate their pain than in people who can.

The prevalence of pain ascertained by McClean and Higginbotham was lower than the rate found in some other studies, but this finding is no excuse for complacency. Although the guidelines may have helped to increase awareness of pain among nursing home residents, it is clear that we are still failing to achieve high-quality pain management.

Pain is composed of a sensory component (nociception), a cognitive–affective component that causes the patient to suffer, and a communicative component that expresses the pain to others verbally and/or by pain-related behaviours. Effective pain management needs to assess and manage all these components. Contrary to popular opinion, ageing does not decrease nociception or suffering.¹¹ However, patients with dementia do have less sophisticated ways of communicating pain. While nociception and suffering may be no less in patients with dementia, subjective report is certainly less, and behavioural change may be the main indicator of distress.¹² It is essential that anyone working with older people become expert at observing and interpreting visual cues and behavioural indicators of pain.¹³

Often caregivers put older patients’ behavioural changes down to perverseness, personality, or attention-seeking rather than entertain the possibility of pain.⁵ Frequently, the first-line treatment is antipsychotics or benzodiazepines, drugs that can mask a pain problem or make it worse. As McClean and Higginbotham found, many patients reporting pain had inadequate or irregular analgesia. Had the study included the non-communicating group, it is possible pain treatment in the nursing homes surveyed would have been found even more deficient.

Many doctors are reluctant to give analgesics, particularly opioids, to older people. They worry that these powerful drugs may be addictive, produce dangerous side effects, or cause constipation, falls or delirium. Certainly, ageing brain and organ systems are sensitive to opioid analgesics, but withholding them from people in need can have the paradoxical effect of making management even more difficult if patients are behaving in a very uncooperative manner. Most of these drugs are safe if they are sensibly prescribed and the patient is regularly monitored for side effects. Not all patients need strong opioids and many would benefit from milder analgesics. Too many older people have “as required” medication, which is the least effective method to attain adequate blood levels of analgesic. A mild analgesic, such as paracetamol, given regularly in sufficient doses, is safe and effective even in very elderly polymedicated patients.¹⁴

Overall, the literature on pain treatments for the elderly is deficient and the area deserves more research attention.

Why is it important to address this issue? For the simple reason that chronic pain is unnecessary. Work in palliative care has shown that pain can be correctly identified and effectively managed. The Australian guidelines recommend using pain-assessment tools to ascertain pain.⁵ While these may be useful, there is no substitute for greater awareness, direct enquiry, clinical intuition, and commitment to alleviate pain whatever its intensity. Evaluating pain in older people may be challenging, but alleviation of another's pain and suffering can be deeply gratifying. Yes, with more focus on the problem, we can improve pain management in our nursing homes.

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Endometriosis

Improving health outcomes for women with this enigmatic disease

ENDOMETRIOSIS REMAINS AN ENIGMA despite having been extensively studied. Its aetiology remains unclear, although there is a positive correlation with retrograde menstruation, probably with a background genetic predisposition. Traditionally, the symptoms of endometriosis are said to be pelvic pain and infertility, but, while a causal link between these symptoms and the disease is sometimes clear, the link is not always established. Treatment aimed at eliminating endometriotic deposits is effective in controlling symptoms in a proportion of patients, but recurrence is common.

The diagnostic dilemma

Endometriosis is considered difficult to diagnose because the extent of the disease (endometriotic deposits and scar tissue) does not correlate with symptoms. The only accepted diagnostic test is direct visualisation (usually laparoscopically) by an experienced surgeon.¹ Arguably, as endometriosis can be diagnosed in up to 40% of menstruating women at laparoscopy,² it may be detected in all women at some stage of their reproductive lives, only to regress spontaneously in some. In addition, some symptoms associated with endometriosis are common. For instance, dysmenorrhoea occurs in up to 60% of women with regular menses³ and infertility occurs in about 15% of the population (of whom

30% have endometriosis).⁴ Hence, common conditions (mild endometriosis) may be associated with common symptoms (eg, dysmenorrhoea) by chance, not causally. The enormous variation in symptomatic expression and lack of clear correlation with the extent of endometriosis suggest the need for epidemiological studies of each symptom and of women with either mild or severe disease. This would exclude the possibility that mild endometriosis may be a normal finding in women. Epidemiological studies of women with endometriosis associated with dysmenorrhoea may find a causal link only in women with progressive dysmenorrhoea.

In addition, epidemiological studies confined to specific symptoms causally associated with endometriosis (eg, dyspareunia and endometriosis in the uterosacral ligaments, progressive dysmenorrhoea and American Fertility Society stage III and IV endometriosis⁵) may result in consistent findings of the role of genes in disease development.⁶

Management issues

From observations that pregnancy resolves symptoms, particularly of dysmenorrhoea, "mimicking pregnancy" became a treatment option. Medications that resulted in amenorrhoea (such as GnRH analogues, danazol and high-dose progestogens) have been used. These work by antagonising