Conferenza Episcopale Italiana
Ufficio Nazionale per la
Pastorale della Salute

Società Italiana di Gerontologia
e Geriatria

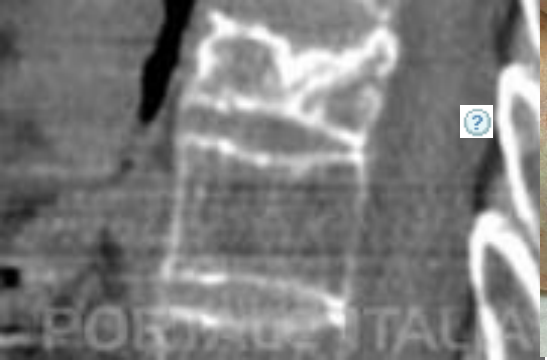
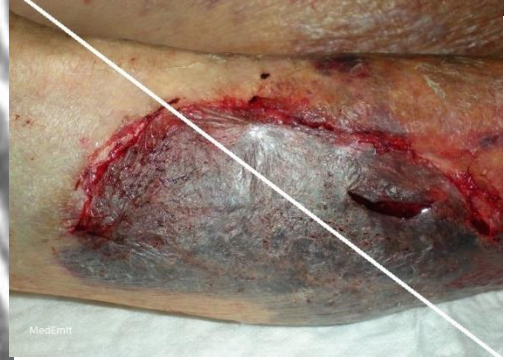
Gruppo di Studio SIGG
"La cura nella fase
terminale della Vita"

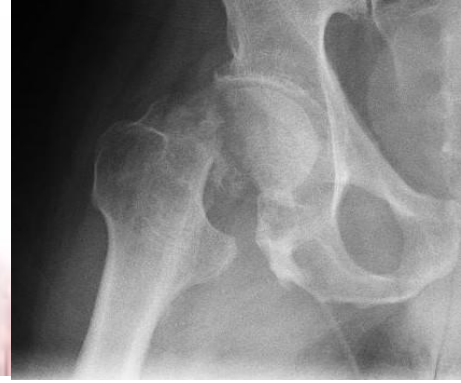
Dolore e sofferenza nell'anziano

Roma, Centro Congressi CEI
23 giugno 2017

Claudia Cantini
U.O. Geriatria Pistoia

IL DOLORE NASCOSTO NELLA PERSONA CON DEMENZA



L'età è il fattore di rischio principale sia per patologie potenzialmente dolorose (osteoporosi, artrite, cancro…) sia per la demenza.

Con l'invecchiamento della popolazione il numero di persone con demenza e dolore tende ad aumentare e i due fenomeni presentano relazioni di reciproca influenza.

Numerosi studi clinici riportano un minor utilizzo di antidolorifici in persone affette da demenza in condizioni potenzialmente dolorose come le fratture di femore (Morrison RS, 2000), le ulcere da decubito (Manfredi PL 2003), il cancro (Bernabei R 1998)

Diagnoses indicating pain and analgesic drug prescription in patients with dementia: a comparison to age- and sex-matched controls

Type of pain	Dementia group (n = 1,848) (in %)	Control group (n = 7,385) (in %)	p-value
Back pain	51.7	53.2	0.23
Pain due to arthritis or osteoarthritis	41.2	41.8	0.64
Neuropathic pain	19.4	16.5	0.0037
Pain due to fractures	4.6	3.0	0.0006
Pain due to multimorbidity and care dependency	9.8	4.0	<0.0001
Pain, not elsewhere classified	9.0	6.0	<0.0001
Headache	6.3	5.0	0.0331
Cancer pain	5.0	5.9	0.14
Total (at least one pain type)	74.4	72.5	0.11

A pazienti con nuova diagnosi di demenza durante il periodo di osservazione di un anno vengono riconosciute patologie potenzialmente dolorose in maniera sovrapponibile ai controlli

On average, patients were 78.7 years old (48% female). **The proportions receiving at least one diagnosis indicating pain were similar between the dementia and control group (74.4% vs. 72.5%; p = 0.11).**

Hoffmann, **BMC Geriatrics 2014**

Diagnoses indicating pain and analgesic drug prescription in patients with dementia: a comparison to age- and sex-matched controls

Dementia group (n = 1,848; 4,441 prescriptions)		Control group (n = 7,385; 14,427 prescriptions)	
Substance	**Proportion (in %)**	**Substance**	**Proportion (in %)**
Metamizole (dipyrone)	27.4	Diclofenac (mono)	26.3
Diclofenac (mono)	18.9	Metamizole (dipyrone)	17.8
Tramadol	13.5	Ibuprofen	13.3
Ibuprofen	12.5	Tramadol	10.2
Fentanyl	6.7	Tilidine/naloxone	7.9
Tilidine/naloxone	6.0	Fentanyl	6.3
Oxycodone	1.8	Oxycodone	2.1
Codeine/paracetamol	1.8	Codeine/paracetamol	2.1
Buprenorphine	1.7	Morphine	2.0
Flupirtine	1.6	Buprenorphine	1.7

The proportion who received analgesics was higher in patients with dementia in the crude analysis (47.5% vs. 44.7%; OR: 1.12; 95% CI: 1.01-1.24), but was significantly lower when adjusted for socio-demographic variables, care dependency, comorbidities and diagnoses indicating pain (OR: 0.78; 95% CI: 0.68-0.88).

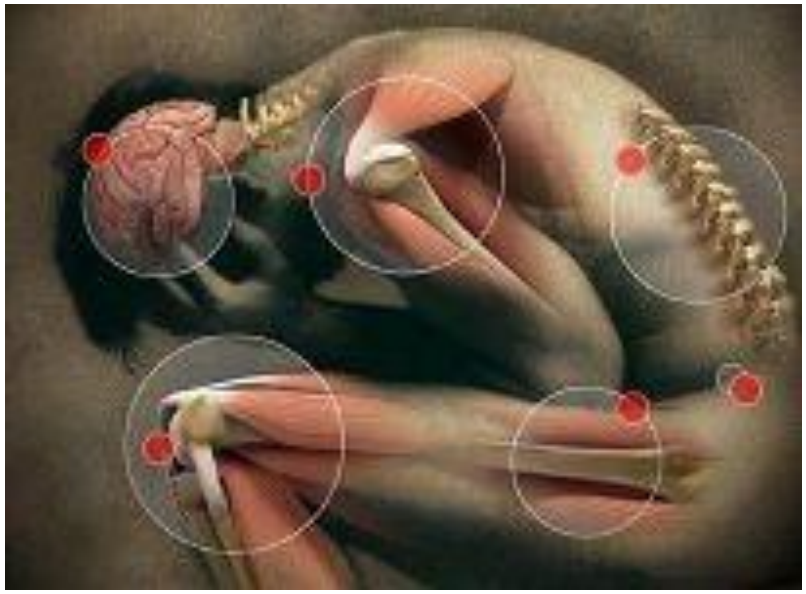
Hoffmann, **BMC Geriatrics 2014**

Disparities in Pain Management Between Cognitively Intact and Cognitively Impaired Nursing Home Residents

Residents' Level of Cognitive Impairment

	None (n=100)	Mild (n=121)	Moderate (n=225)	Severe (n=105)	P Value
With pain	34%	30.6%	23.6%	9.5%	<0.001
With daily pain	19%	14.9%	6.7%	1.9%	< 0.001
With moderate or severe pain	25%	16.5%	13.8%	4.8%	< 0.001
Any Pain Medication	80%	79.3%	63.6%	56.2%	<0.001
"As needed" medication	37%	44.6%	32.4%	33.3%	0.128
Scheduled meds	42%	33.9%	30.7%	23.1%	0.032

Reynolds KS, J Pain Symptom Manage 2008



Il dolore è meno trattato perché non correttamente rilevato o perché la persona con demenza sperimenta meno dolore rispetto all'anziano cognitivamente integro?

Come si modifica la percezione del dolore con l'aggravarsi della malattia o con i diversi tipi di demenza?

Il fenomeno è complesso e ancora non completamente chiarito.

In che modo la demenza influenza queste componenti?

DOLORE

esperienza sensoriale ed emozionale spiacevole

associata a danno tissutale, in atto o potenziale, o descritto in termini di danno

International Association for the Study of Pain

Componente sensoriale discriminativa

decodificazione della qualità, della durata, dell'intensità e della localizzazione

Componente affettivo-motivazionale

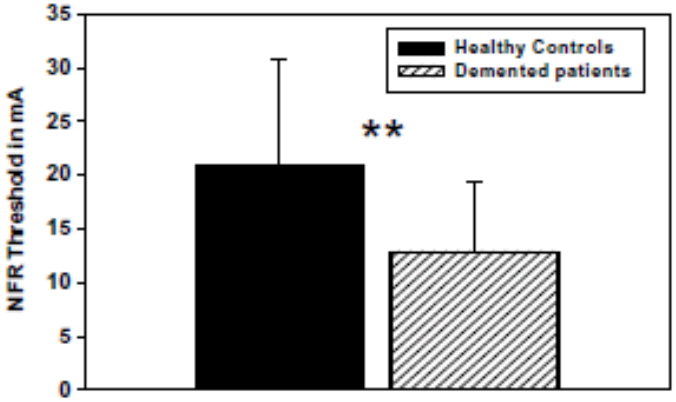
conferisce la sua tonalità spiacevole e pericolosa che determina motivazione alla fuga e le reazioni emozionali

Componente cognitivo-valutativa

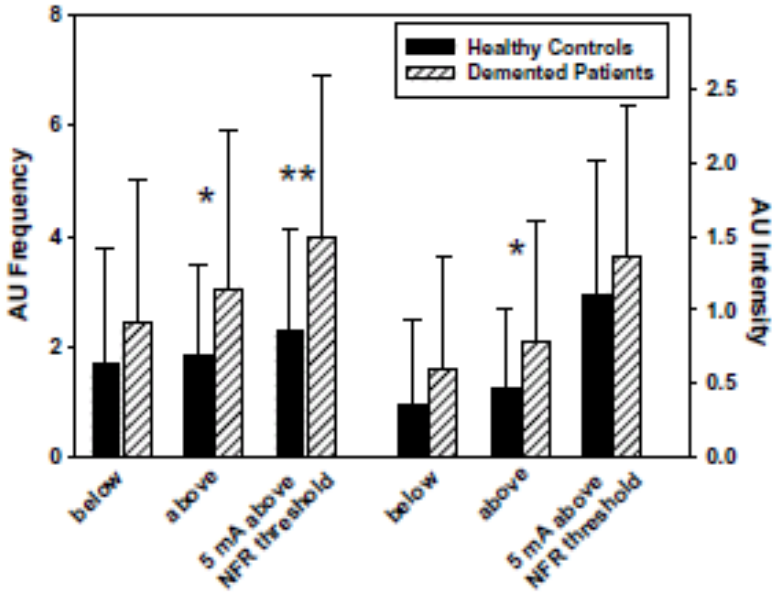
attenzione, interpretazione, anticipazione, raffronti con esperienze dolorose pregresse

Influence of dementia on multiple components of pain

Nociceptive flexion reflex



Facial expression of pain



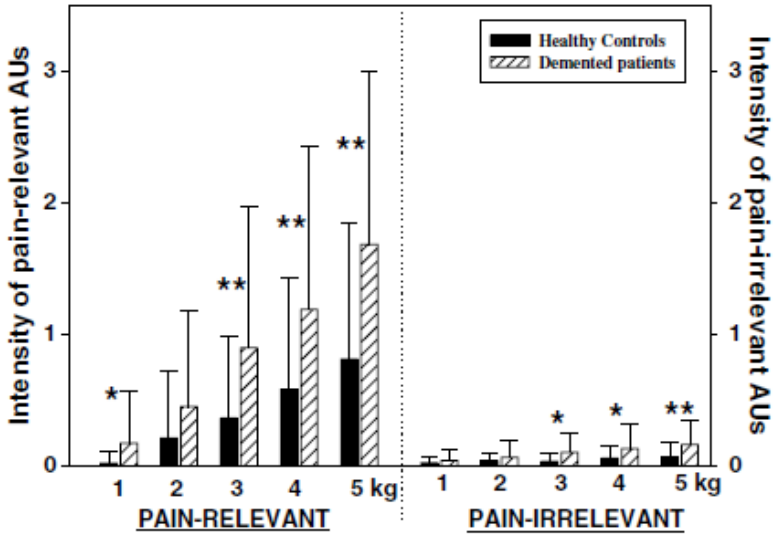
La <u>soglia di rilevazione dello stimolo elettrico è risultata più bassa nelle persone con demenza</u>, infatti i riflessi flessori di allontanamento vengono evocati per stimoli di minore entità rispetto ai controlli.
Le <u>espressioni del volto in risposta al dolore risultano aumentate</u> nei gruppo dei pz con demenza, e aumentano all'aumentare dell'intensità dello stimolo.

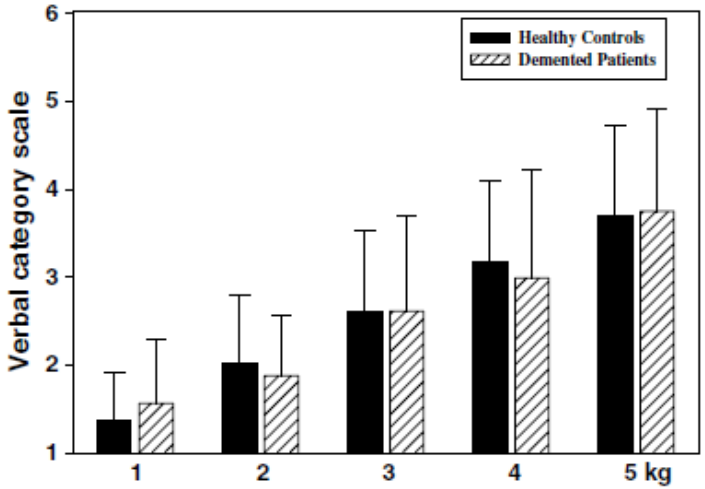
	Pz con demenza = 35 *	Controlli = 46
età	75.7 ± 6.9	73.7 ± 5.6 anni
MMSE	16.4 (±5.3SD)	29.5 (±0.8SD)

* 13 patients AD, 14 patients vascular dementia and 8 patients Mixed Dementia (MD).

(Kunz M, Eur J Pain 2009)

The facial expression of pain in patients with dementia



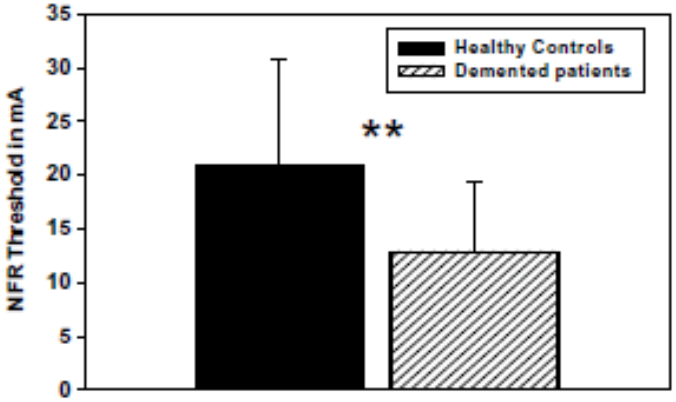


La rilevazione delle espressioni del volto (22 muscoli mimici bilaterali) in risposta a stimoli dolorosi, valutate attraverso un sistema specifico di codifica (Facial Action Coding System, FACS), ha mostrato come esse possano essere un indicatore integrativo utile per la rilevazione del dolore nei pazienti con demenza per la sua origine riflessa.

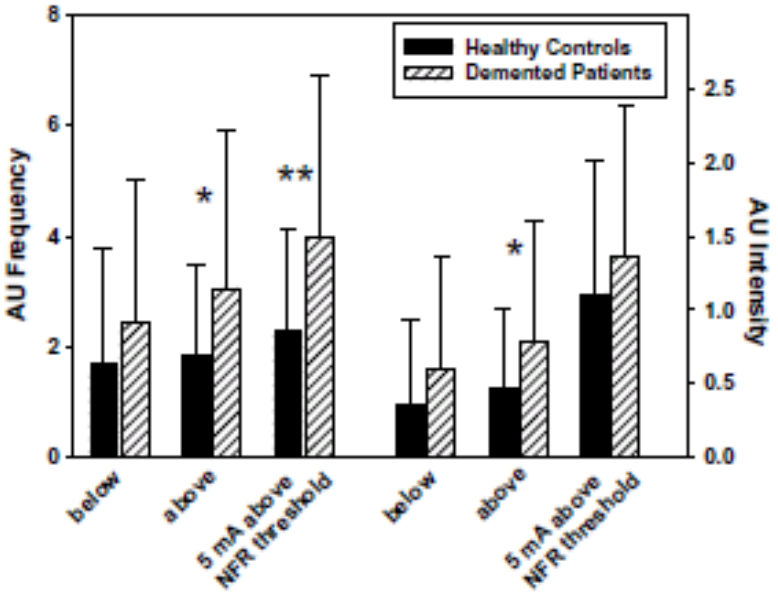
(Kunz M., Pain 2007)

Influence of dementia on multiple components of pain

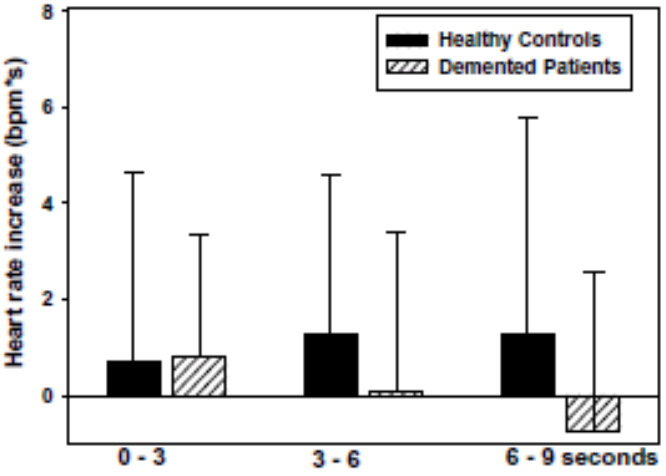
Nociceptive flexion reflex



Facial expression of pain



Heart rate response

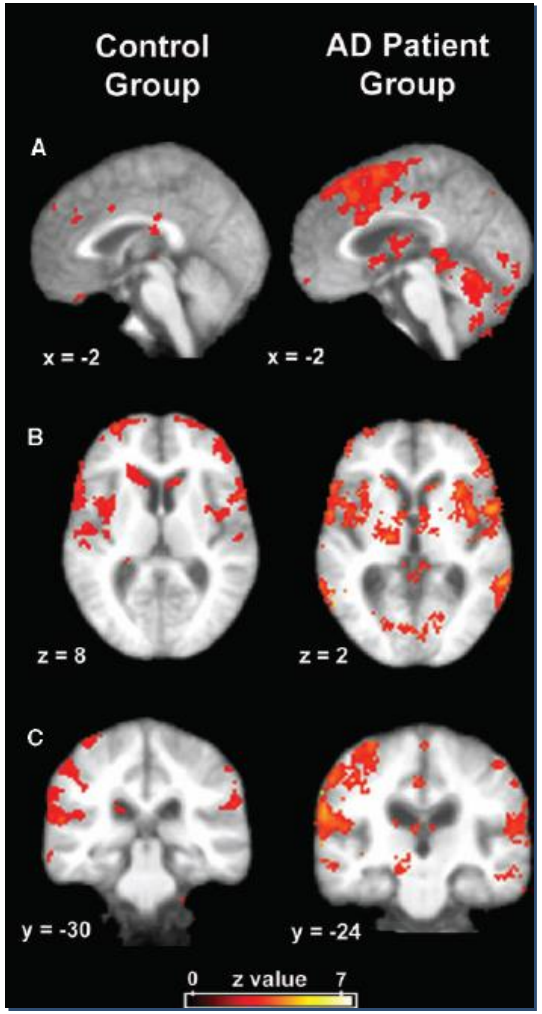


<u>non sono state rilevate differenze significative tra i due gruppi nella risposta della frequenza cardiaca</u> anche se nel gruppo con demenza vi era la tendenza a decrescere nel tempo mentre nel gruppo dei controlli ad aumentare.
Quindi *non tutte le componenti del dolore appaiono alterate allo stesso modo: sensibilità aumentata allo stimolo ma risposta autonomica deficitaria*.

(Kunz M, Eur J Pain 2009)

Pain sensitivity and fMRI pain-related brain activity in Alzheimer's disease

Leonie J. Cole,[1,2,5] Michael J. Farrell,[1,2,5] Eugene P. Duff,[1,3] J. Bruce Barber,[5] Gary F. Egan[1,2] and Stephen J. Gibson[4,5]



Functional MRI (fMRI) brain responses following mechanical pressure stimulation in 14 patients with AD **(MMSE 19.4 ± 5.7)** and 15 age-matched controls

Moderate pain was evoked with similar stimuli in both groups, and was associated with a common network of pain-related activity incorporating cingulate, insula and somatosensory cortices. Between-group analyses showed no evidence of diminished pain-related activity in AD patients compared with controls. In fact, AD showed greater amplitude and duration of pain-related activity in sensory, affective and cognitive processing regions consistent with sustained attention to the noxious stimulus.

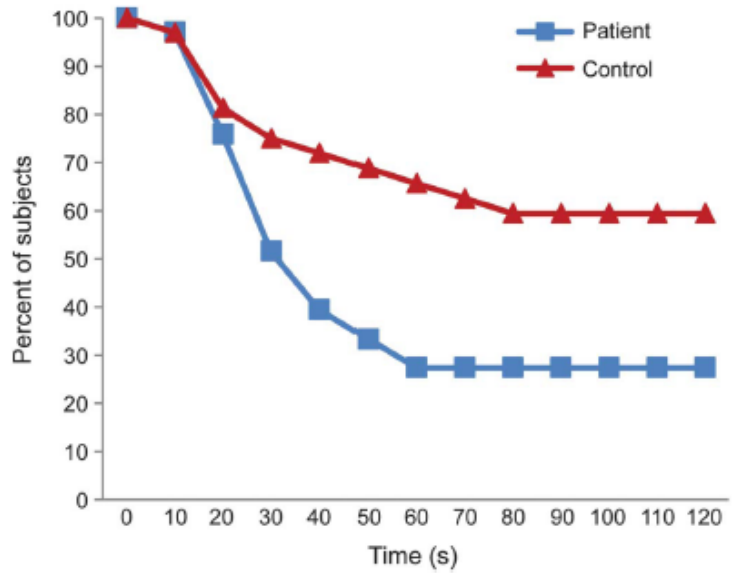
Regional increases in BOLD signal activity during the experience of mechanical pressure stimulation compared with innocuous pressure stimulation.
(A) Mid-sagittal slices showing discrete regions of anterior cingulate cortex activity in the control group, and anterior cingulate cortex activity spreading to supplementary motor area (SMA) and medial frontal cortex in the Alzheimer's disease group. Patients also show increases in the medial thalamus, hypothalamus and cerebellum.
(B) Axial slices showing bilateral insula and secondary somatosensory cortice activity in both groups.
(C) Coronal sections showing increased bilateral activity in primary and secondary somatosensory cortice (S1 and S2) in both groups, as well as increased primary motor cortex activity (on the contralateral side to the stimulus in the control group, and bilaterally in the patient group).

Brain 2006

Discrepancy between stimulus response and tollerance of pain in Alzheimer disease

	AD = 33	Controlli = 32
età	67.8 (65.8 -70.1)	69 (67.1-70.8)
MMSE	23 (20-25)	30 (29-30)

Figure 3 Tolerance to the cold pressor test



The percentage of patients and healthy controls maintaining the hand submersed in the cold water during the cold pressor test. The vertical axis indicates the duration (seconds) of immersion (maximum 120 seconds).

Table 2 Warmth detection and heat pain thresholds and results from the cold pressor test (pain threshold and tolerance and pain rating using the colored analog scale), stratified by patients and controls

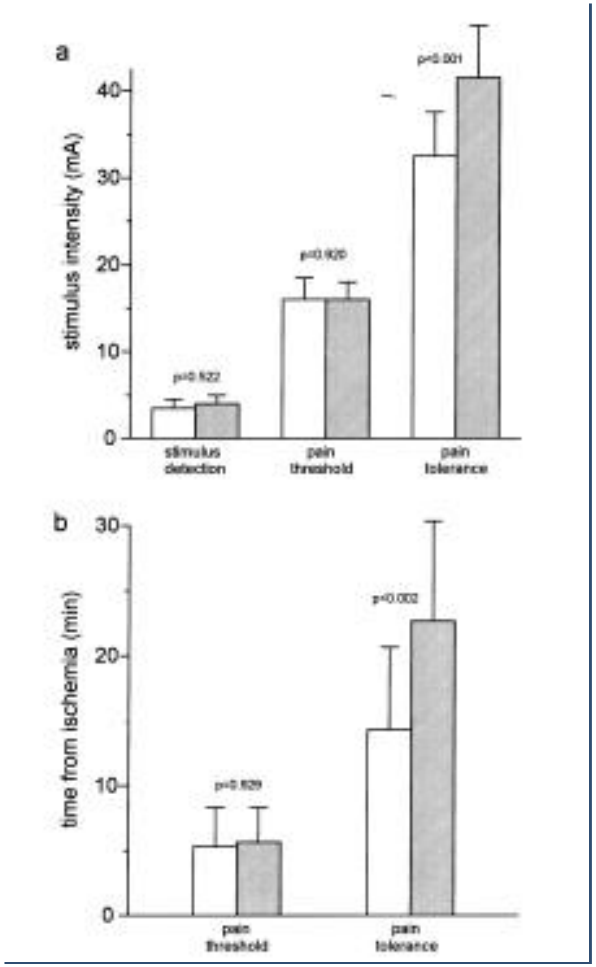
	Patients (n = 33)	Healthy controls (n = 32)	p
Warmth detection threshold, °C	34.4 (34.0-34.9)	34.1 (33.6-34.6)	0.30
Heat pain threshold, °C	40.6 (39.3-41.8)	41.5 (40.1-42.8)	0.33
Cold pressor test			
Pain threshold, s	11.3 (9.3-13.6)	10.7 (7.6-16.1)	0.58
Pain tolerance, s	31.2 (20.7-120)	120 (29.1-120)	0.027
CAS rating	74.0 (50.0-81.0)	81.0 (69.5-92.0)	0.031

Abbreviation: CAS = colored analog scale.
Values are given as mean (95% confidence interval) for normally distributed data (warmth detection threshold and heat pain threshold) and median (25%-75% interquartile range) (cold pressor test) for data with a non-normal distribution.

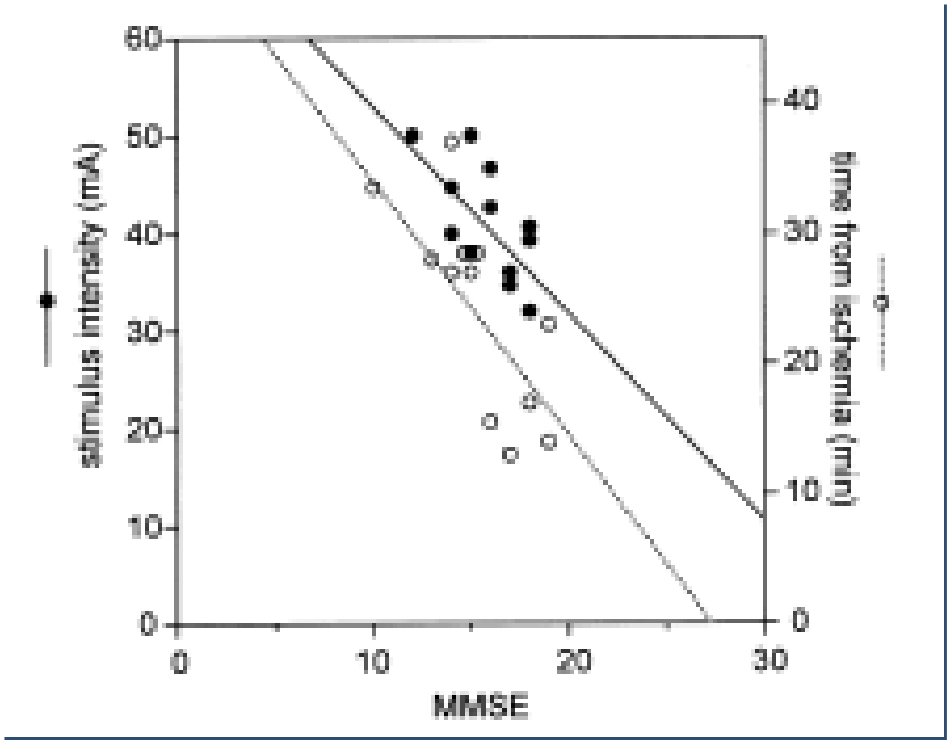
In persone con AD di grado lieve la soglia del dolore con stimolo termico è risultata sovrapponibile a quella dei controlli ma la tolleranza è ridotta (aumentata sensibilità al dolore per ridotta capacità endogena delle vie discendenti di controllare il dolore? ansia aumentata in relazione alla situazione sperimentale?)

Jensen-Dahm C, ***Neurology 2015***

Pain thereshold and tolerance in Alzheimer's disease



Non differenze significative nella rilevazione dello stimolo e nella soglia del dolore ma maggiore tolleranza al dolore negli AD (n=24) vs controlli (n= 24)

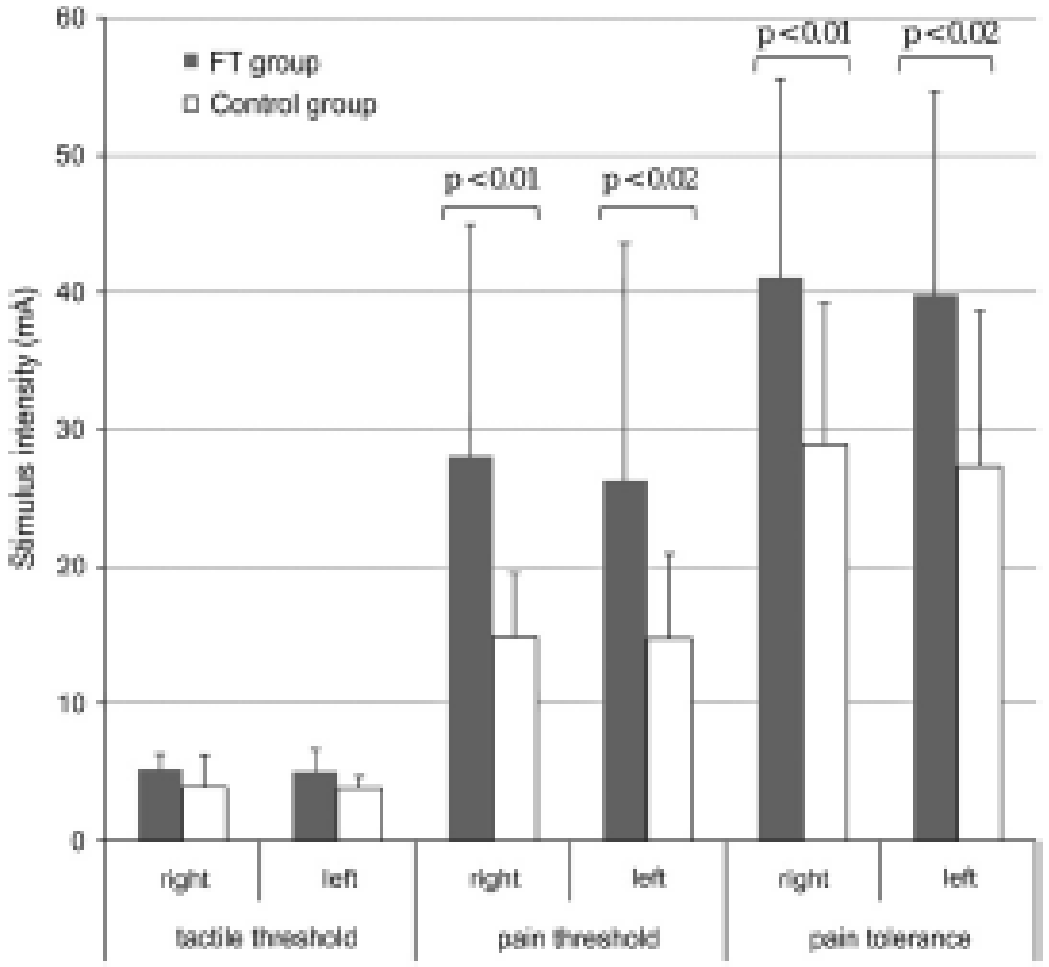


Correlazione tra MMSE e tolleranza al dolore a stimolo elettrico ● e dolore ischemico ○

La tolleranza al dolore (stimolo elettrico e ischemia) aumenta all'aumentare del deficit cognitivo

(Benedetti F., Pain 1999)

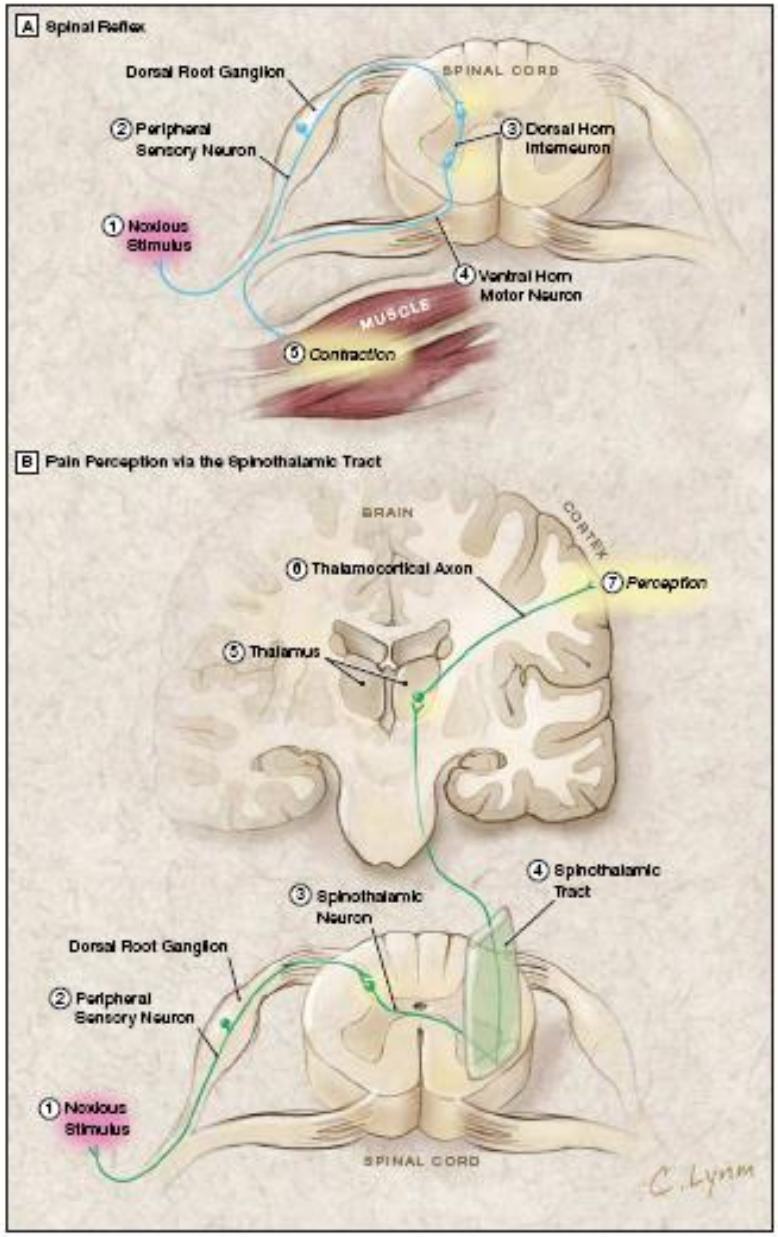
Pain perception and tolerance in patients with frontotemporal dementia



23 soggetti con FTD
(MMSE 21.7±6.1)
18 controlli

Nei soggetti con DFT la soglia del dolore e tolleranza al dolore da stimolo elettrico sono risultati più elevate rispetto ai controlli

Carlino E, Pain 2010

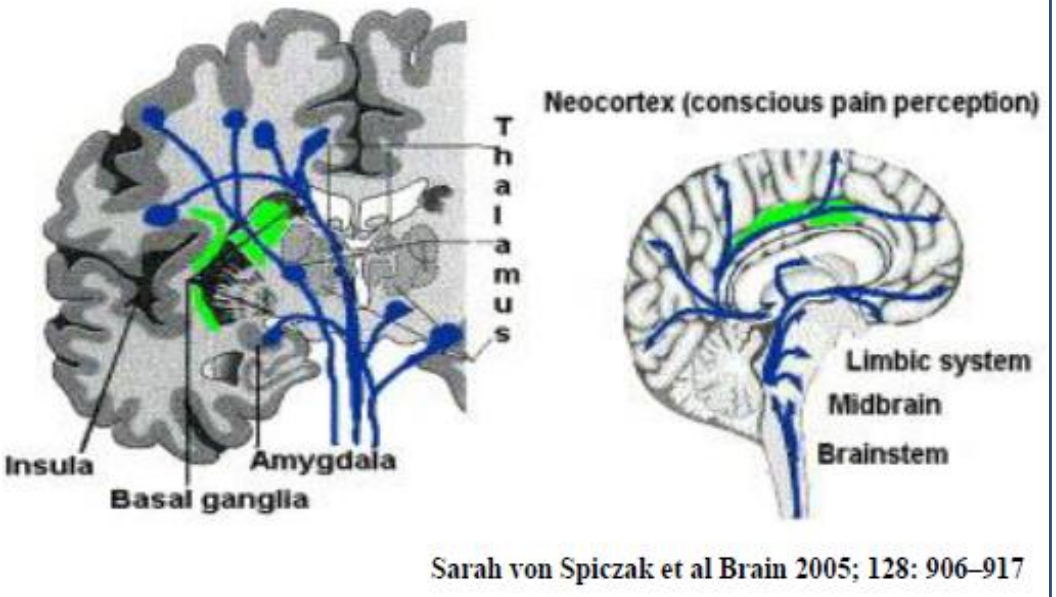


La componente sensoriale discriminativa del dolore appare relativamente preservata nella M. di Alzheimer

Il sistema laterale delle vie del dolore (aree sensitive primarie e i nuclei talamici laterali, opercolo parietale)

è coinvolto relativamente tardi

dal processo neurodegenerativo



Sarah von Spiczak et al Brain 2005; 128: 906–917

La componente motivazionale-affettiva, oltre a quella cognitivo-valutativa e autonomica della percezione del dolore risulta alterata nella demenza.

La tolleranza al dolore sembra aumentare in modo direttamente proporzionale alla gravità della malattia

Il sistema mediale delle vie del dolore (tratto spino-talamico mediale, corteccia prefrontale, sistema limbico) è maggiormente interessato dal processo neurodegenerativo.

La corteccia cingolata anteriore rappresenta la zona cardine dell'integrazione emozionale della percezione nocicettiva cronica

DISSOCIAZIONE SENSITIVO-AFFETTIVA: ASIMBOLIA DEL DOLORE

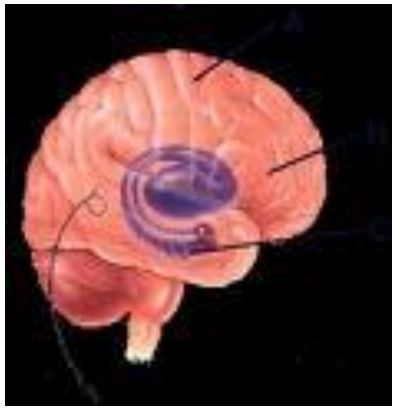
Non c'è proporzionalita' diretta fra intensita'delle informazioni nocicettive *trasmesse* e l'intensita' del dolore *percepito che è modulato da fattori cognitivi, emotivi e biopsicosociali*

Fattori che amplificano la percezione del dolore: *ansia, dolore atteso (ansia anticipatoria), depressione, ridotte strategie di coping*

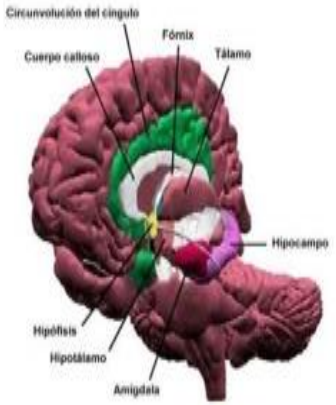
Fattori che riducono la percezione del dolore: *sonno*, analgesia da stress, effetto placebo, *analgesia autoindotta, ipnosi, meditazione*

Nel dolore cronico le *componenti cognitive, affettive e motivazionali prevalgono.*

L'esperienza del dolore dipende dalla sensazione che il soggetto avverte in quel momento ma è influenzata anche dalla memoria di esperienza dolorose passate che viene recuperata in quell'istante e talora precede come ansia anticipatoria di percezione dolorose, ma il cui riconoscimento permette di prevedere l'evoluzione, calcolare e/o evitare il pericolo e controllare le reazioni



Ippocampo
Memoria analitica



Amigadala
Archivio memoria emozionale

la memoria del dolore può determinare un' esperienza dolorosa anche in assenza di stimoli dolorosi: è sufficiente la paura del dolore per mettere in atto una risposta a livello cerebrale.

Nella persona con demenza l'assenza di memoria di una esperienza dolorosa determina una reazione simile a quella che si osserva nei confronti di un "nuovo" dolore, mai sperimentato prima: ogni stimolo doloroso porta con se la stessa angoscia. Il dolore può manifestarsi come una risposta di allarme a una minaccia (esterna o interna) non conosciuta (e quindi non evitata) nè compresa (e quindi non controllata).

Loss of expectation-related mechanisms in Alzheimer's disease makes analgesic therapies less effective

A local anesthetic was applied to the skin of AD patients to reduce burning pain after venipuncture.
The placebo component is represented by the difference between the analgesic effect after open (expected) and after hidden (unexpected) application.

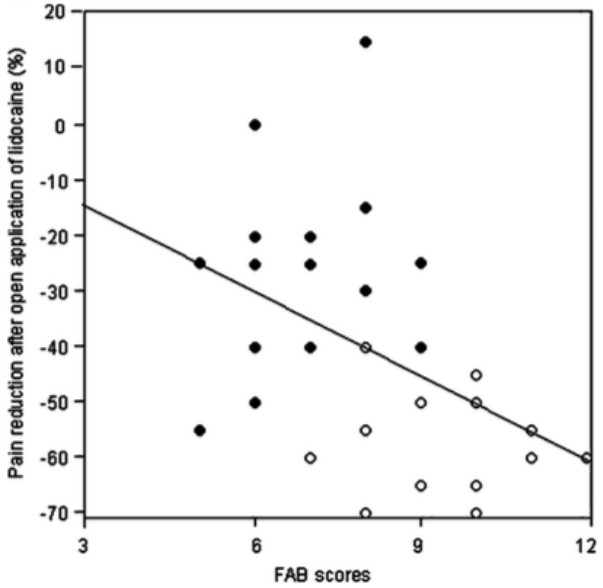


Fig. 1. Correlation between FAB scores and pain reduction following open lidocaine in AD patients. The black circles represent those patients whose prefrontal lobes showed functional uncoupling with the rest of the brain, whereas the white circles represent those patients in whom the functional uncoupling was in the temporal-parietal-occipital regions.

AD patients with reduced Frontal Assessment Battery scores showed reduced placebo component of the analgesic treatment. The disruption of the placebo component occurred when reduced connectivity of the prefrontal lobes with the rest of the brain was present. Remarkably, the loss of these placebo-related mechanisms reduced treatment efficacy, such that a dose increase was necessary to produce adequate analgesia.

Benedetti F, Pain 2006

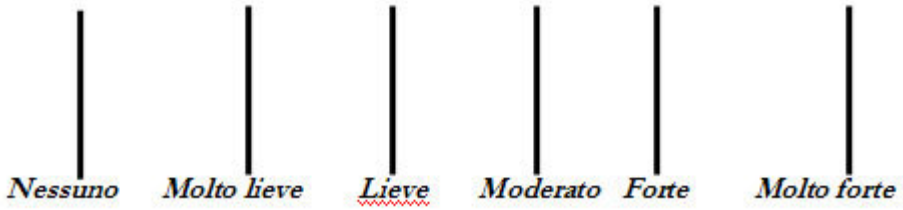
La persona con demenza NON sperimenta il dolore nella stessa maniera ma l'ASSENZA di dolore è un diritto umano fondamentale e necessita di un intervento ATTIVO

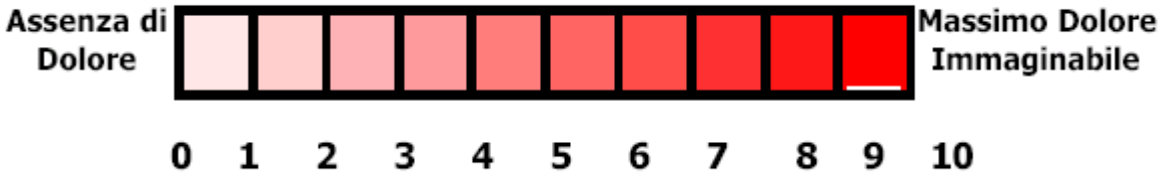
Legge N. 38 del 9 marzo 2010
"Disposizioni per garantire l'accesso alle cure palliative e alla terapia del dolore"

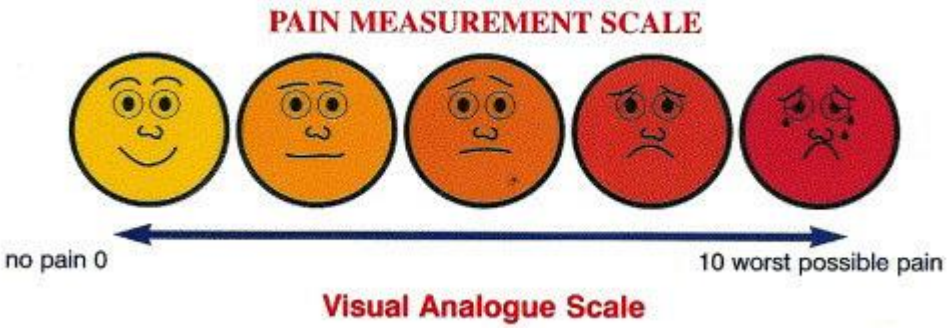
Art. 7. All'interno della cartella clinica, nelle sezioni medica ed infermieristica, in uso presso tutte le strutture sanitarie, devono essere riportati le caratteristiche del *dolore rilevato e della sua evoluzione nel corso del ricovero, nonché la terapia antalgica farmacologica e non, il dosaggio dei farmaci ed il risultato antalgico conseguito.*
Devono essere identificati strumenti per il monitoraggio del dolore più idonei per le specifiche realtà (oncolologia, pediatria, **geriatria** etc)

Essendo un'esperienza soggettiva, il self-report è da considerarsi il primo step per la valutazione del dolore anche in persone con deficit cognitivo (su richiesta > spontaneo)

(Basler, 2001; Herr, 2004; Taylor 2005; Andrade 2011)







Biomarker del dolore

Pain Med. 2015 Feb

Can biomarkers differentiate pain and no pain subgroups of nonverbal children with cerebral palsy? A preliminary investigation based on noninvasive saliva sampling.

Symons FJ, ElGhazi I, Reilly BG, Barney CC, Hanson L,

Neurosci Lett. 2015 Apr

Tumor necrosis factor-alpha is a potential diagnostic biomarker for chronic neuropathic pain after spinal cord injury.

Xu J, Liu H, Li F, Cao Y, Tian J, Yan J

Anaesthesia. 2015 Mar

Assessing pain objectively: the use of physiological markers.

Cowen R , Stasiowska MK, Laycock H, Bantel C.

INDICATORI DI DOLORE NELLA PERSONA AFFETTA DA DEMENZA GRAVE (American Geriatric Society)

- **ESPRESSIONI DEL VOLTO che esprimono disagio, sofferenza, paura**
- **POSTURE a protezione di parti del corpo, assunzione di posizioni antalgiche, irrigidimento, dondolio, riduzione del movimento etc.**
- **MODIFICAZIONI DEL COMPORTAMENTO: agitazione, oppositività alle manovre assistenziali, aggressività.**
- **VOCALIZZAZIONI negative, lamento, pianto, urla, grugniti, cantilene, richieste di aiuto**
- **MODIFICAZIONI DELLO STATO MENTALE**
- **MODIFICAZIONI ABITUALI ATTIVITA': rifiuto del cibo, ritmo giorno/notte..**

PAINAD Pain Assessment in Advanced Dementia
(Warden 2003, Costardi 2007)

DOLOPLUS 2
(Lefevre 2001)

NOPPAIN Non Comunicative Patient's Pain Assessment I
(Snow 2004, Ferrari 2009)

Pain assessment for people with dementia: a systematic review of systematic reviews of pain assessment tools

Valentina Lichtner[1*], Dawn Dowding[2,3], Philip Esterhuizen[1], S José Closs[1], Andrew F Long[1], Anne Corbett[4] and Michelle Briggs[5]

Abstract

Background: There is evidence of under-detection and poor management of pain in patients with dementia, in both long-term and acute care. Accurate assessment of pain in people with dementia is challenging and pain

NESSUNO DEGLI INDICATORI E' NECESSARIAMENTE CONSEGUENZA DEL DOLORE E VANNO UTILIZZATI COME PARTE DI UN PROTOCOLLO ASSISTENZIALE GLOBALE

«On the basis of this review no one tool can be recommended given the existing evidence.
Tools may be more useful in detecting relative changes in individual patients than differences between patients»

assessment. The 20 tools appear to have been studied in a variety of settings and with varied types of patients. The reviews identified several methodological limitations across the original studies. The lack of a 'gold standard' significantly hinders the evaluation of tools' validity. Most importantly, the samples were small providing limited evidence for use of any of the tools across settings or populations.

Conclusions: There are a considerable number of pain assessment tools available for use with the elderly cognitive impaired population. However there is limited evidence about their reliability, validity and clinical utility. On the basis of this review no one tool can be recommended given the existing evidence.

BMC Geriatrics 2014, 14; 138

PAIN AND AGITATION IN DEMENTIA

Pain is not the only cause of distress in dementia

Claud Regnard *consultant in palliative care medicine*

St Oswald's Hospice and Newcastle Hospitals NHS Trust, Newcastle upon Tyne, UK

BMJ 2011; 343

The meanings of screams in older people living with dementia in a nursing home

Anne Bourbonnais[1] and Francine Ducharme[1,2]

[1]*Faculty of Nursing, Université de Montréal, Québec, Canada*
[2]*Desjardins Research Chair in Nursing Care for Seniors and their Families, Centre de recherche, Institut universitaire de gériatrie de Montréal, Québec, Canada*

A qualitative research design: critical ethnography.

Screaming is related to vulnerability, suffering, fear and loss of meaning experienced by older persons

Each person's scream constitute a unique language that can be learned

Intervening appropriately with older people who scream is not easy, interventions should be selected based on the meanings of screams

(International Psychogeriatrics 2010)

Pain, agitation, and behavioural problems in people with dementia admitted to general hospital wards: a longitudinal cohort study

Associations between pain and behavioural and psychiatric symptoms of dementia, using generalised estimating equations in 230 older people with dementia and unplanned acute medical admission.

	PAINAD (pain during movement)									PAINAD (pain at rest)		
	Unadjusted (930 observations on 230 participants)			Adjusted* (928 observations on 229 participants)			Excluding those with delirium at baseline* (800 observations on 200 participants)			Adjusted* (932 observations on 229 participants)		
	Coef.	95% CI	P	Coef.	95% CI	P	Coef.	95% CI	P	Coef.	95% CI	P
CMAI	0.01	−0.00 to 0.03	0.160	0.01	−0.00 to 0.03	0.157	0.01	−0.01 to 0.02	0.524	0.01	−0.01 to 0.04	0.322
Total BEHAVE-AD score	0.21	0.08 to 0.35	**0.002**	0.20	0.07 to 0.32	**0.002**	0.17	0.03 to 0.31	**0.008**	0.41	0.14 to 0.69	**0.003**
Paranoia/delusions	0.00	−0.02 to 0.02	0.970	0.00	−0.01 to 0.02	0.997	0.00	−0.02 to 0.01	0.605	0.05	−0.02 to 0.11	0.181
Hallucination	−0.01	−0.03 to 0.01	0.209	−0.02	−0.03 to 0.00	0.115	−0.01	−0.03 to 0.01	0.082	−0.01	−0.06 to 0.04	0.747
Activity disturbance	−0.02	−0.05 to 0.01	0.243	−0.02	−0.05 to 0.01	0.292	−0.02	−0.05 to 0.02	0.185	−0.01	−0.08 to 0.06	0.815
Aggressive	0.17	0.09 to 0.24	**<0.001**	0.16	0.09 to 0.23	**<0.001**	0.13	0.05 to 0.20	**<0.001**	0.16	0.02 to 0.30	**0.023**
Sleep disturbance	0.01	−0.01 to 0.04	0.312	0.01	−0.02 to 0.03	0.462	0.01	−0.02 to 0.04	0.611	0.02	−0.04 to 0.09	0.475
Affect	0.01	−0.02 to 0.03	0.716	0.00	−0.02 to 0.03	0.799	0.01	−0.03 to 0.04	0.794	0.08	0.00 to 0.15	**0.047**
Phobia/anxiety	0.03	0.00 to 0.07	**0.036**	0.04	0.01 to 0.07	**0.021**	0.04	0.01 to 0.08	**0.024**	0.11	0.04 to 0.17	**0.001**
BEHAVE-AD scale removing PAINAD-related items	0.08	0.00 to 0.16	**0.043**	0.07	−0.01 to 0.14	0.069	0.06	−0.03 to 0.14	0.177	0.26	0.08 to 0.44	**0.005**

Results from generalised estimating equations, the coefficients (coef.) represent estimates of the mean difference in CMAI and BPSD score for each 1-point increase on the PAINAD score.
* Adjusted for age, gender, hospital, Functional Assessment Staging category, Charlson score, and the reason for admission.
Bold text indicates significance at <0.05 level.
BEHAVE-AD, Behavioural Pathology in Alzheimer Disease Scale; CI, confidence interval; CMAI, Cohen–Mansfield Agitating Inventory; PAINAD, Pain Assessment in Advanced Dementia scale.

Pain was common in people with dementia admitted to the acute hospital and associated with BPSD. Improved pain management may reduce distressing behaviour and improve the quality of hospital care for people with dementia

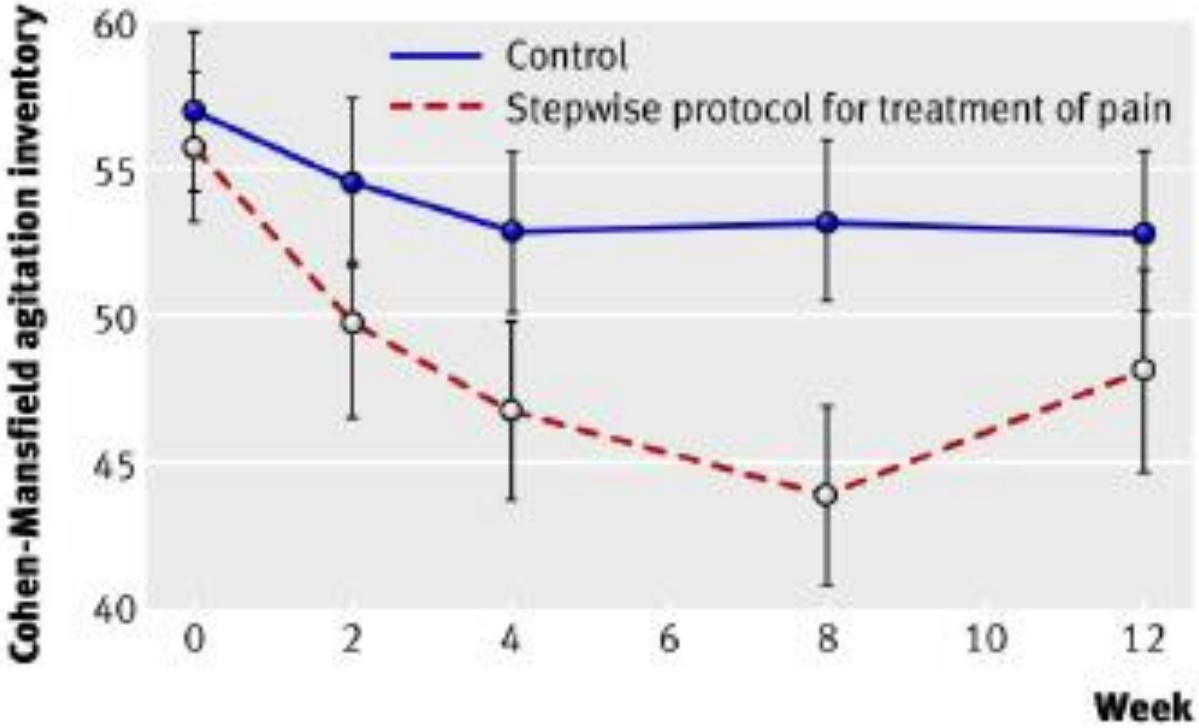
(Sampson E.L, Pain 2015)

BMJ

2011

Efficacy of treating pain to reduce behavioural disturbances in residents of nursing homes with dementia: cluster randomised clinical trial

BS Husebo, C. Ballard, R Sandvik, OB Nilsen, D Aarsland



352 pazienti con demenza moderata-grave
e sintomi comportamentali (CMAI>39)
Ospiti di 60 RSA

n=175

n= 177

Approccio sistematico di terapia del dolore per 8 settimane

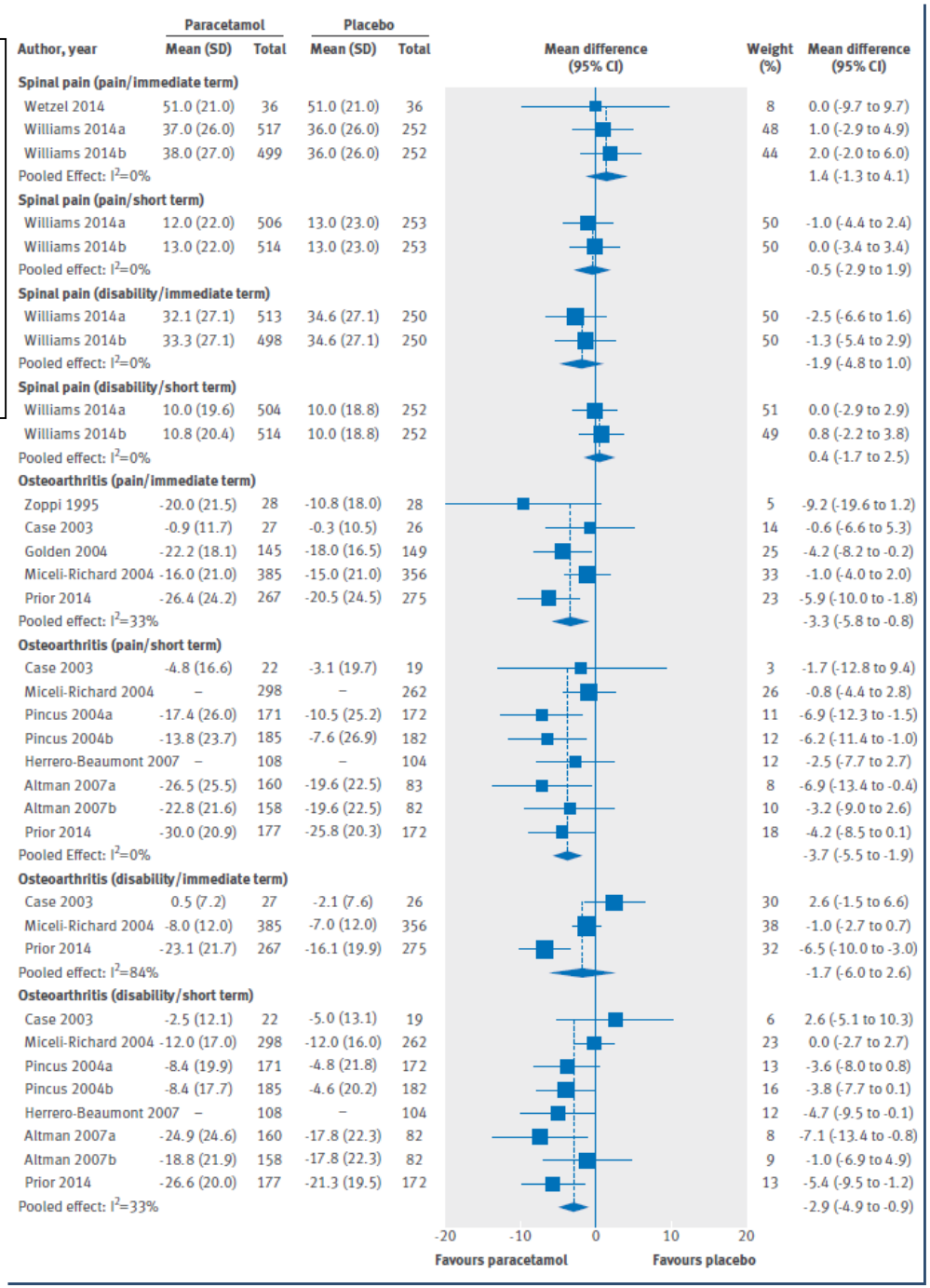
Step	Pain treatment at baseline	Study treatment	Dosage	No (%) of residents (n=175)
1	No analgesics, or low dose of paracetamol	Paracetamol (acetaminophen)	Maximum dose 3 g/day	120 (69)*
2	Full dose of paracetamol or low dose morphine	Morphine	5 mg twice daily; maximum dose 10 mg twice daily	4 (2)
3	Low dose buprenorphine or inability to swallow	Buprenorphine transdermal patch	5 µg/h, maximum dose 10 µg/h	39 (22)†
4	Neuropathic pain	Pregabaline	25 mg once daily; maximum dose 300 mg/day	12 (7)

Efficacy and safety of paracetamol for spinal pain and ostearthritis; systematic review and meta-analysis of randomised placebo controlled trials

13 randomised trials were included.

Paracetamol is ineffective in the treatment of low back pain and provides minimal short term benefit for people with osteoarthritis. The number of patients reporting any adverse event was similar in the paracetamol and placebo groups.

Machado GC BMJ 2015;350:1225



Uso dei farmaci analgesici (WHO "ladder")

RIFLESSIONE APPROFONDITA E PERSONALIZZATA SUL TRATTAMENTO DI UN PAZIENTE COMPLESSO

- **VALUTARE CONTROINDICAZIONI E PLURITERAPIA**

- **PREVEDERE E RICERCARE POSSIBILI EFFETTI COLLATERALI**
(che il paziente con demenza non riferirà spontaneamente)

- **SCEGLIERE LA VIA DI SOMMINISTRAZIONE MENO INVASIVA**

- **SOMMINISTRARE AD INTERVALLI REGOLARI**
(non «al bisogno»)

- **SEQUENZIALE**
TITOLAZIONE FINO AL CONTROLLO DEL DOLORE
"start low and go slow"

- **RIVALUTARE EFFICACIA**

Pain trajectories of Nursing Home residents nearing death

Description of 4 main pain trajectories in less severe cognitively impaired resident (Cognitive Performance Scale score of >3 at death) **n= 408**

Main pain trajectories	Subcategories		N (%)
Always no or mild pain	Group 1	From no to no pain	114
	Group 2	From no to mild pain	31
	Group 5	From mild to no pain	13
	Group 6	From mild to mild pain	65
	subtotal		***223 (54.4%)***
Substantial decreasing pain levels	Group 9	From moderate to no pain	13
	Group 10	From moderate to mild pain	14
	Group 13 e 14	From severe to mild or no pain	2
	subtotal		***29 (7.1%)***

Thompson GN 2017

Pain trajectories of Nursing Home residents nearing death

Description of 4 main pain trajectories in less severe cognitively impaired resident (CPS score of >3 at death) **n= 408**

Main pain trajectories	Subcategories		N (%)
Substantial increasing pain levels	Group 3	From no to moderate pain	25
	Group 16	From severe to severe pain	9
	subtotal		*93 (22.8%)*

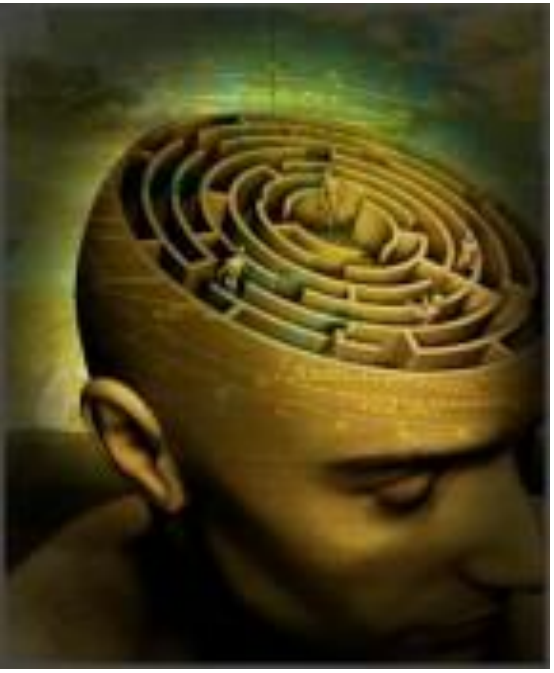
"Although a majority of NH residents experienced consistently low or improved pain levels in their last 6 months of life, a substantial number experienced consistently high or substantially worsening pain levels during this same time period.
These results highlight the *need to better manage pain levels* for some NH residents during this important period of time"

Thompson GN 2017

Learning Their Language

The Importance of Detecting and Managing Pain in Dementia

Lauren B. Gerlach, D.O., Helen C. Kales, M.D.



DESCRIBE facial expressions, vocalizations, body language, changes in interpersonal interactions changes in activity patterns, and mental status changes.

INVESTIGATE Signs on physical examination (pressure sores, skin tears, joint deformities or stiffness, sweating, pallor, noisy or labored breathing, changes in mobility or gait, and distended abdomen). Common causes of pain in people with dementia include constipation, urinary tract infection, pressure sores, tooth decay or abscesses, and undiagnosed fractures.

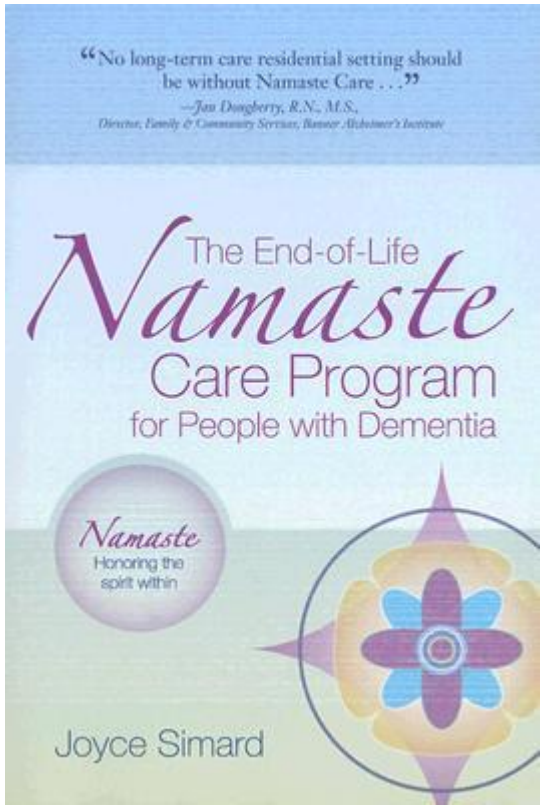
CREATE a combination of nonpharmacologic and pharmacologic treatment including reassurance of the person with dementia, treating the underlying causes found in the Investigate, comfort, painkillers

EVALUATE the response

Il dolore “nascosto”del caregiver

a volte urlato,… negato,…trascurato,…incompreso…
ma che va accolto e supportato….

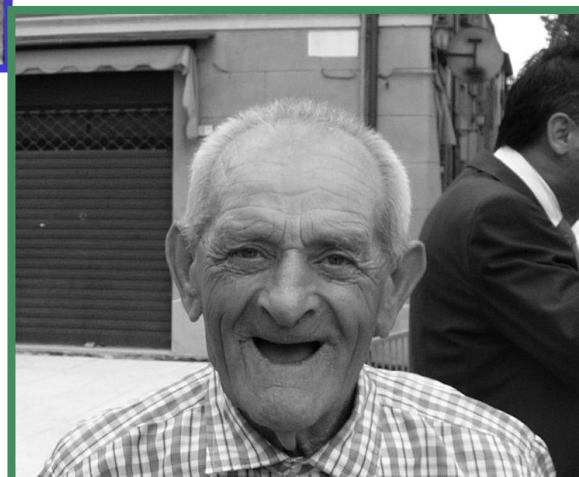
sentimenti di perdita, stanchezza, senso di colpa o di inadeguatezza, frustrazione, rabbia, paura, percezione di "inutilità”..



The *Namaste Care Program* can enrich quality of life for people with advanced dementia and those who care for them without additional resources

BMJ Support Palliat Care, 2015

...perché sei un essere speciale



ed io avrò cura di te..

La Cura

Franco Battiato

La scala PAINAD (PAIN ASSESSMENT IN ADVANCED DEMENTIA) rileva la presenza di dolore valutando 5 aree comportamentali ad esso collegate, ovvero:

- ✓ **Respirazione**
- ✓ **Vocalizzazione**
- ✓ **Espressioni del volto**
- ✓ **Linguaggio del corpo**
- ✓ **Consolazione**

A ciascuno di questi comportamenti è attribuito un punteggio basato sull'osservazione del paziente, utilizzando una scala che va da 0 a 2.

Il punteggio totale così ottenuto può essere interpretato secondo la stessa modalità della scala numerica: un valore 1-3 è considerato indice di dolore lieve, 4–7 dolore moderato, 8-10 dolore grave.

Breve tempo di somministrazione: 5 minuti di osservazione

Prevede 3 delle 6 categorie di comportamenti non verbali di dolore descritti dalle linee guida dell'AGS. Sono presenti alcuni indicatori non molto specifici come respirazione e consolabilità ma utili per pazienti che non possono usare il linguaggio corporeo.

(Warden V , J Am Med Dir Assoc 2003)

PAINAD

	0	1	2
Respiro (indipendente dalla vocalizzazione	Normale	Respiro a tratti alterato. Brevi periodi di iperventilazione	Respiro alterato. Iperventilazione. Cheyne-stokes
Vocalizzazione	Normale	Occasionali lamenti. Saltuaria coprolalia.	Ripetuti richiami. Lamenti. Pianto.
Espressione facciale	Sorridente o inespressiva	Triste, ansiosa, contratta.	Smorfie.
Linguaggio del corpo	Rilassato	Teso. Movimenti nervosi. Irrequietezza.	Rigidità. Agitazione. Ginocchia piegate. Movimento afinalistico, a scatti.
Consolabilità	Non necessita di consolazione	Distratto o rassicurato da voce o tocco.	Inconsolabile; non si distrae né si rassicura

Warden et al., J Am Med Dir Assoc 2003

Discomfort Scale – Dementia of the Alzheimer Type (DS – DAT)

Behavioral Indicators	Frequency (# of episodes in 5 min)	**Intensity low/high	Duration short <1 min, long >1 min.
Noisy Breathing: negative sounding noise on inspiration or expiration, breathing looks strenuous, labored, or wearing; respirations sound loud, harsh, or gasping; difficulty breathing or trying hard at attempting to achieve a good gas exchange; episodic bursts of rapid breaths or hyperventilation.			
Negative Vocalization: noise or speech with a negative or disapproving quality; hushed low sounds such as constant muttering with a guttural tone; monotone, subdued, or varying pitched sound with a definite unpleasant sound; faster rate than a conversation or drawn out as in a moan or groan; repeating the same words with a mournful tone; expressing hurt or pain.			
Lack of Content Facial Expression: pleasant calm looking face; tranquil, at ease or serene; relaxed facial expression with a slack unclenched jaw; overall look is one of peace.			
Sad Facial Expression: troubled looking face, looking hurt, worried, lost or lonesome; distressed appearance; sunken, "hound dog" look with lackluster eyes; tears; crying.			
Frightened Facial Expression: scared, concerned looking face; looking bothered fearful or troubled; alarmed appearance with open eyes and pleading face.			
Frown: face looks strained; stern or scowling look, displeased expression with wrinkled brow and creases in the forehead; corners of the mouth turned down.			
Lack of Relaxed Body Language: easy openhanded position; looking of being in a restful position and may be cuddled up or stretched out; muscles look normal firmness and joints are without stress; look of idle, lazy or "laid back" appearance of "just killing the day"; casual.			
Tense Body Language: extremities show tension; wringing hands, clenched fist, or knees pulled tightly; look of being in strained or inflexible position.			
Fidgeting: restless impatient movements; acts squirmy or jittery; appearance of trying to get away from hurt area; forceful touching, tugging, or rubbing of body parts.			
Score			

(Hurley 1992, Dello Russo 2008)