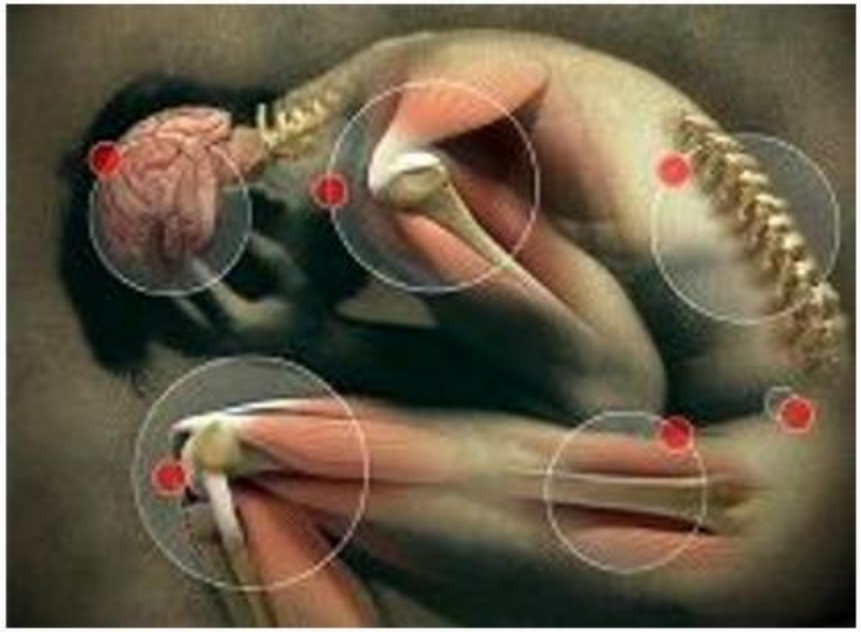
IL DOLORE E LA PERSONA CON DEMENZA

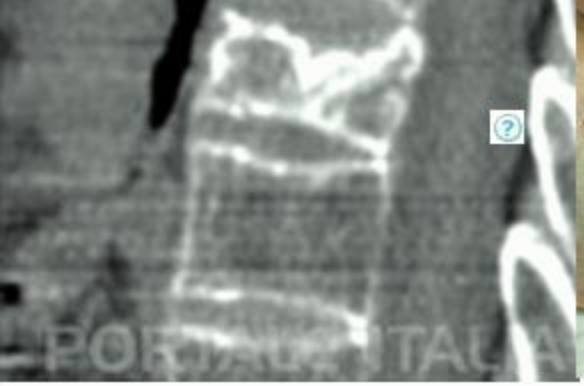
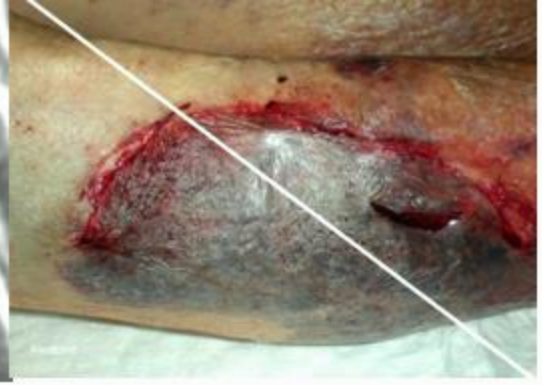
CLAUDIA CANTINI
U.O. GERIATRIA PISTOIA

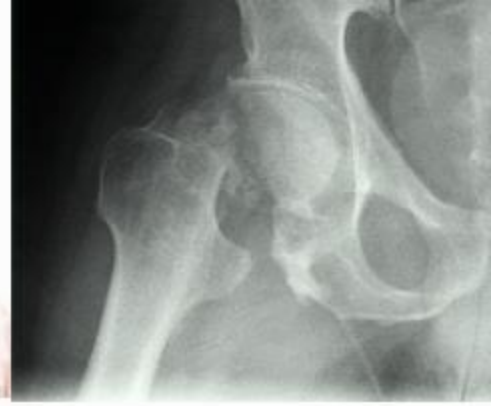
6° CONVEGNO NAZIONALE
SUI CENTRI DIURNI
PISTOIA 15 E 16 MAGGIO 2015



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**

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

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).

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

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

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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.

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

In che modo la demenza influenza queste componenti?

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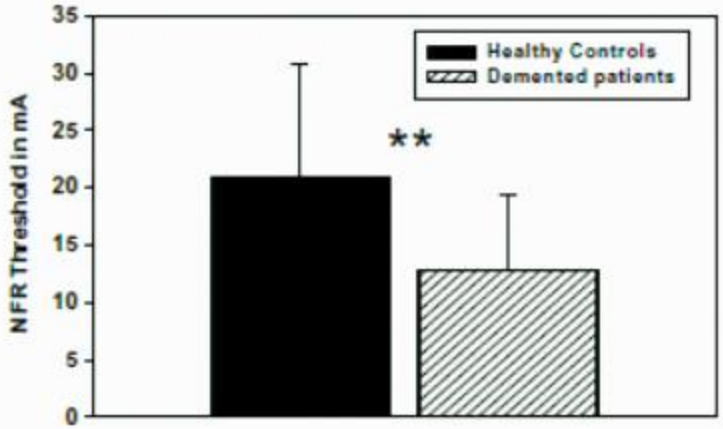
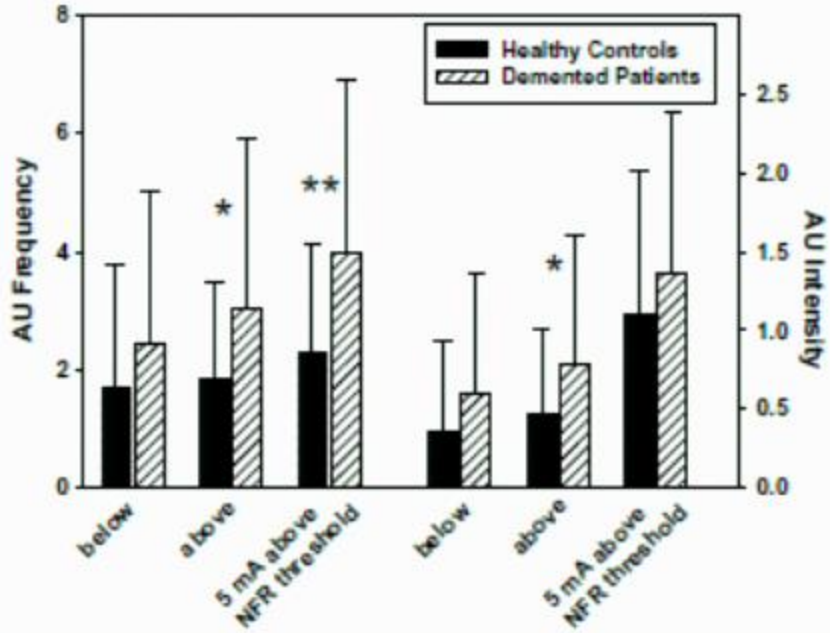
Influence of dementia on multiple components of pain

Nociceptive flexion reflex



Facial expression of pain



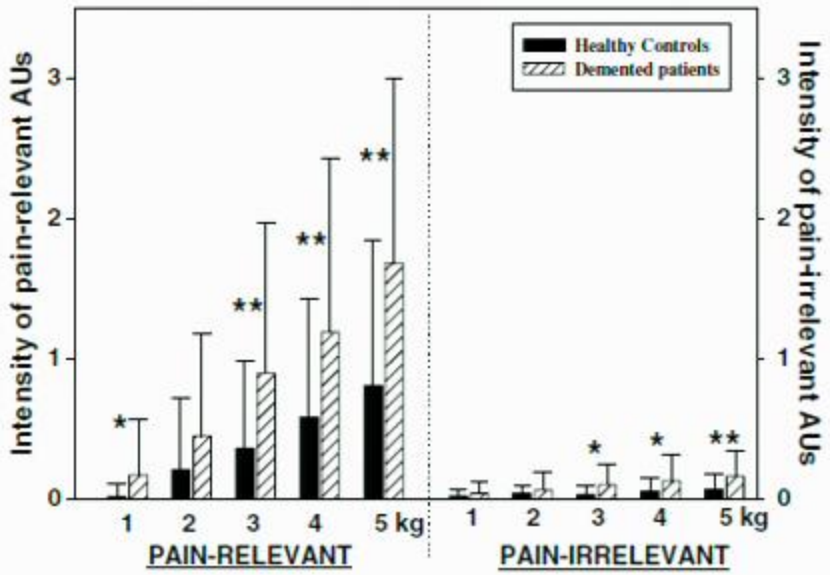
La soglia di rilevazione dello stimolo elettrico è risultata più bassa nelle persone con demenza, infatti i riflessi flessori di allontanamento vengono evocati per stimoli di minore entità rispetto ai controlli.
Le espressioni del volto in risposta al dolore risultano aumentate nei gruppo dei pz con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

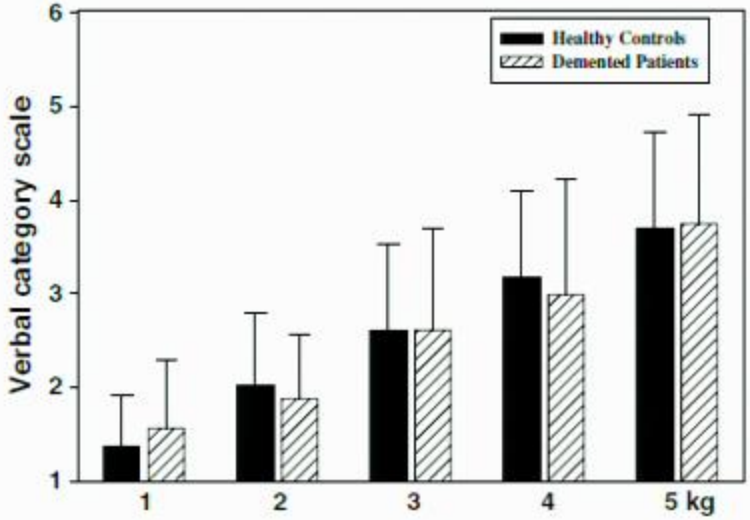
	Pz con demenza = 35 *	Controlli = 46
età	75.7 ± 6.9	73.7 ± 5.6 anni
MMSE	16.4 (±5.3SD)	29.5 (±0.8SD)

* 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



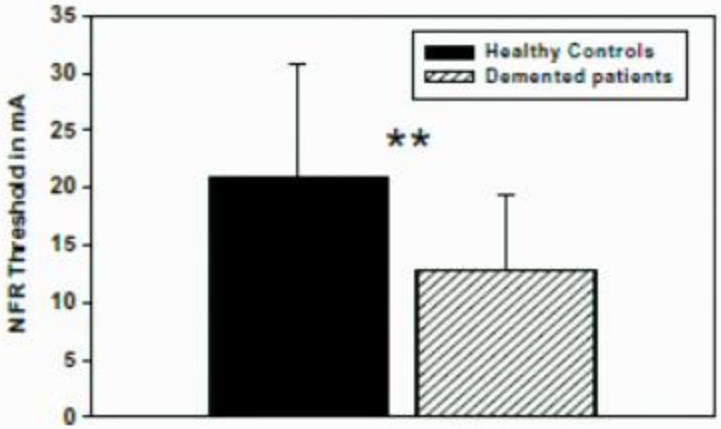


La rilevazione delle espressioni del volto (22 muscoli mimici bilaterali) in risposta a stimoli dolorosi, valutate attraverso un sistema specifico di codifica (Facial Action Coding System, FACS), ha mostrato come esse possano essere un indicatore integrativo utile per la rilevazione del dolore nei pazienti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

(Kunz M., Pain 2007)

Influence of dementia on multiple components of pain

Nociceptive flexion reflex



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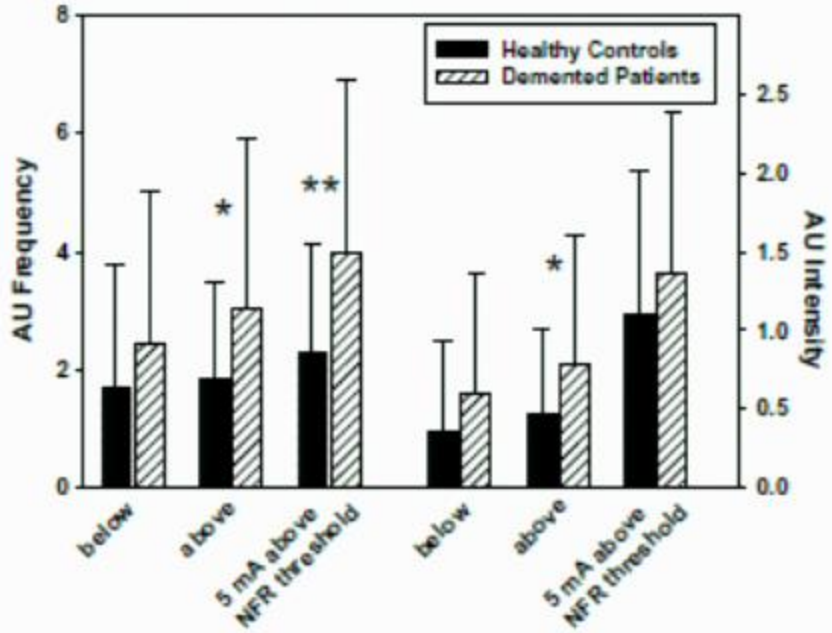
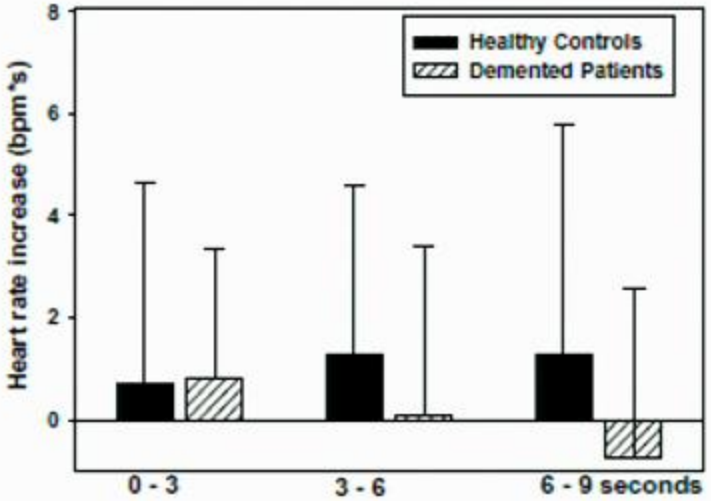


Heart rate response

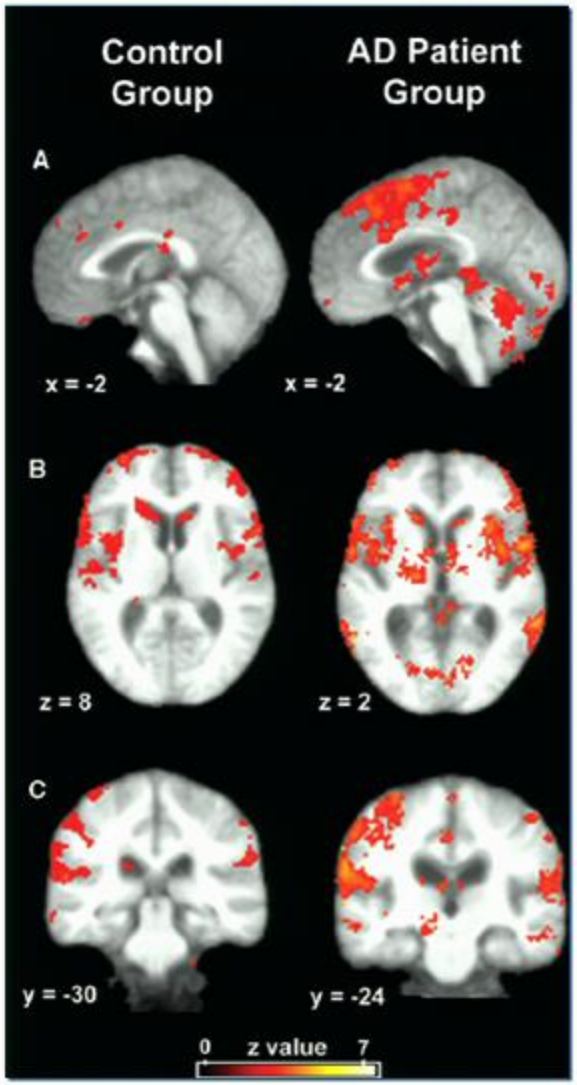


<u>non sono state rilevate differenze significative tra i due gruppi nella risposta della frequenza cardiaca</u> anche se nel gruppo con demenza vi era la tendenza a decrescere nel tempo mentre nel gruppo dei controlli ad aumentare.
Quindi *non tutte le componenti del dolore appaiono alterate allo stesso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

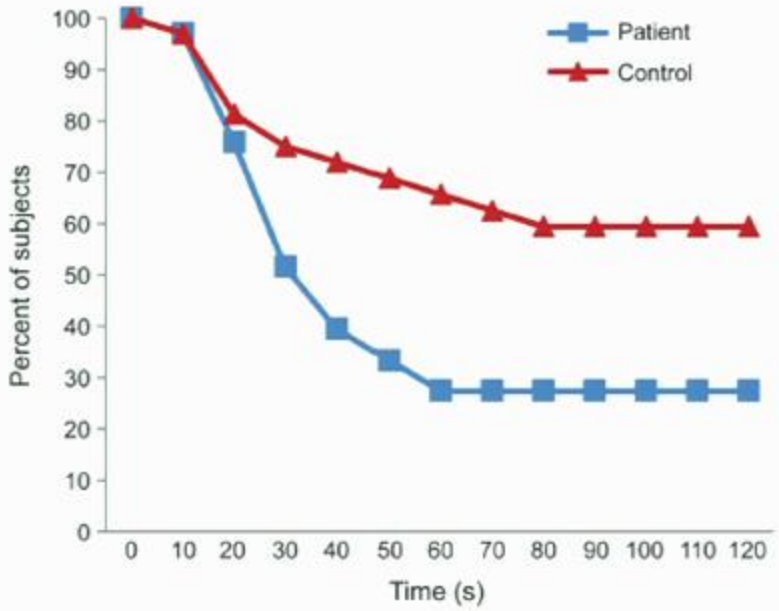
Regional increases in BOLD signal activity during the experience of mechanical pressure stimulation compared with innocuous pressure stimulation.
(A) Mid-sagittal slices showing discrete regions of anterior cingulate cortex activity in the control group, and anterior cingulate cortex activity spreading 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

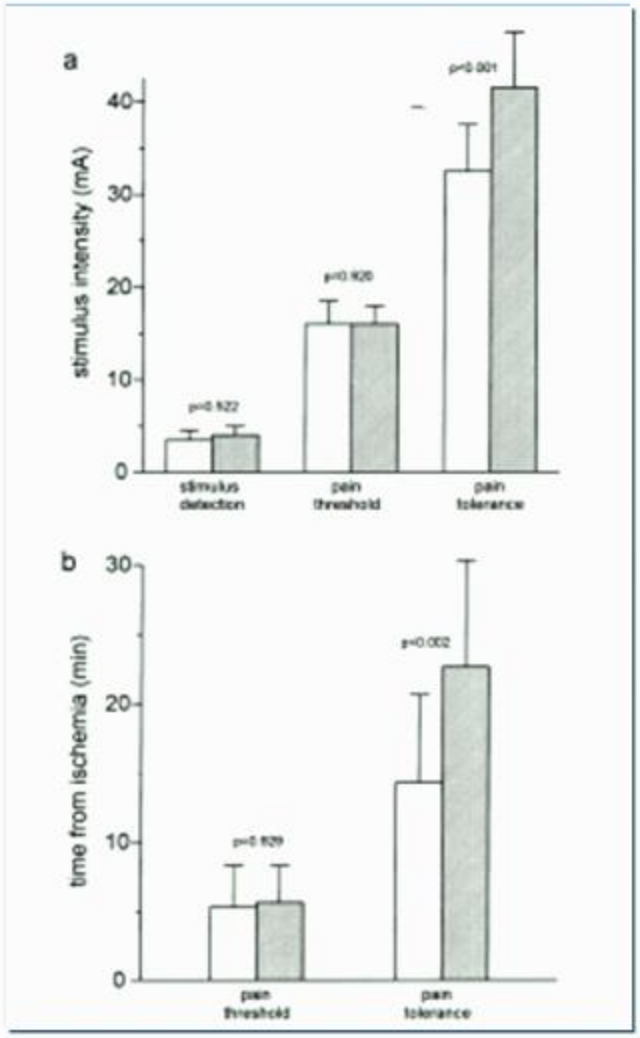
	Patients (n = 33)	Healthy controls (n = 32)	p
Warmth detection threshold, °C	34.4 (34.0-34.9)	34.1 (33.6-34.6)	0.30
Heat pain threshold, °C	40.6 (39.3-41.8)	41.5 (40.1-42.8)	0.33
Cold pressor test			
Pain threshold, s	11.3 (9.3-13.6)	10.7 (7.6-16.1)	0.58
Pain tolerance, s	31.2 (20.7-120)	120 (29.1-120)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

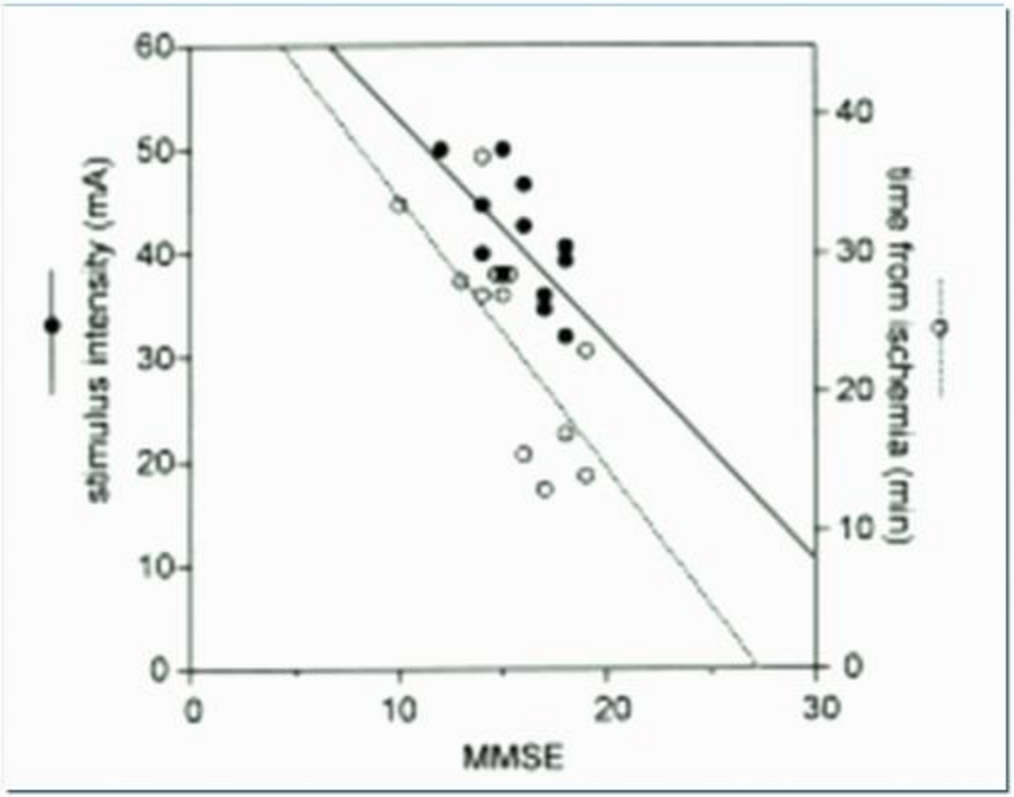
In persone con AD di grado lieve la soglia del dolore con stimolo termico è risultata sovrapponibile a quella dei controlli ma la tolleranza è ridotta (aumentata sensibilità al dolore per ridotta capacità endogena delle vie discendenti di controllare il dolore? ansia aumentata in relazione alla situazione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

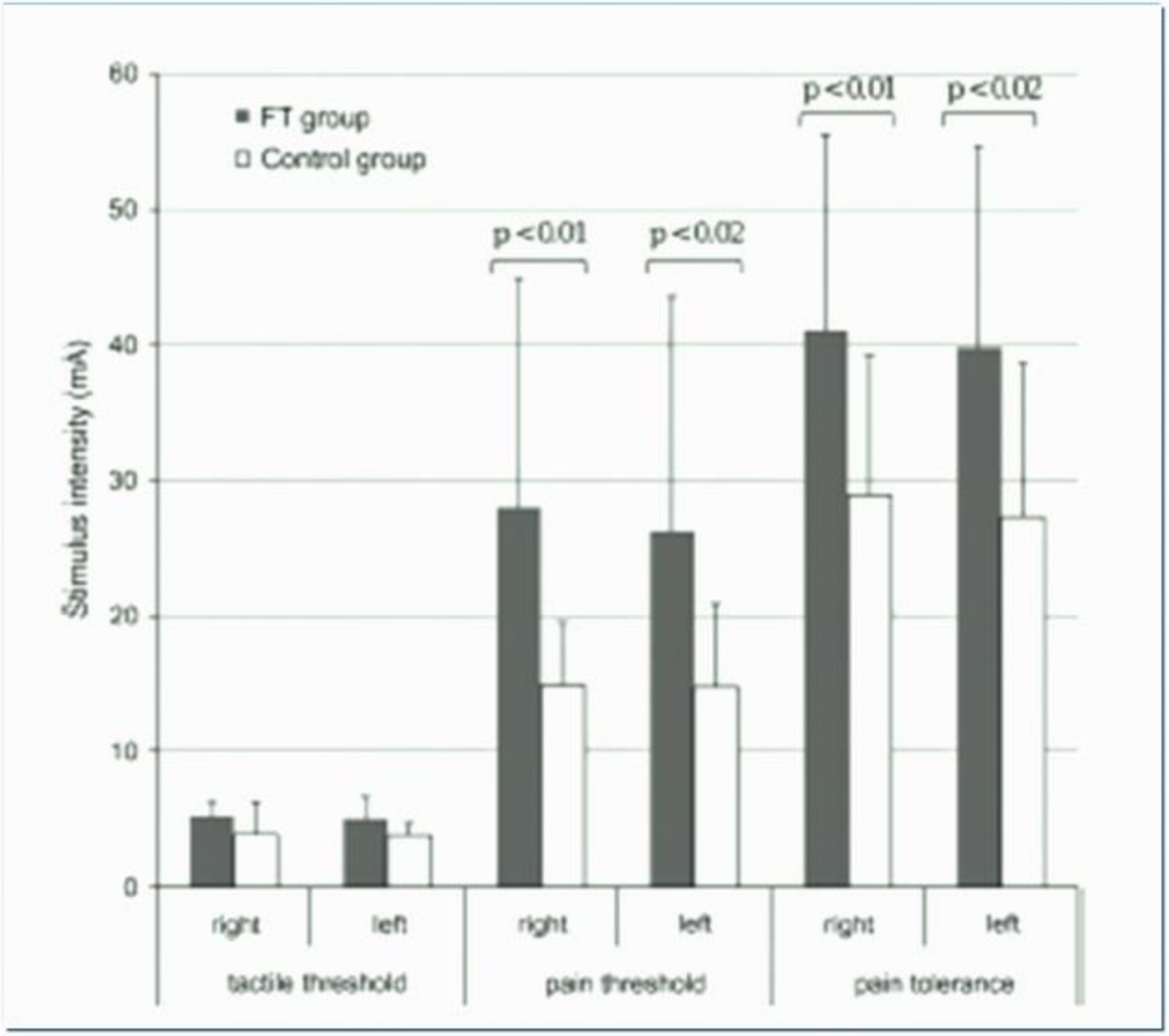


Correlazione tra MMSE e tolleranza al dolore a stimolo elettrico ● e dolore ischemico ○

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

(Benedetti F., Pain 1999)

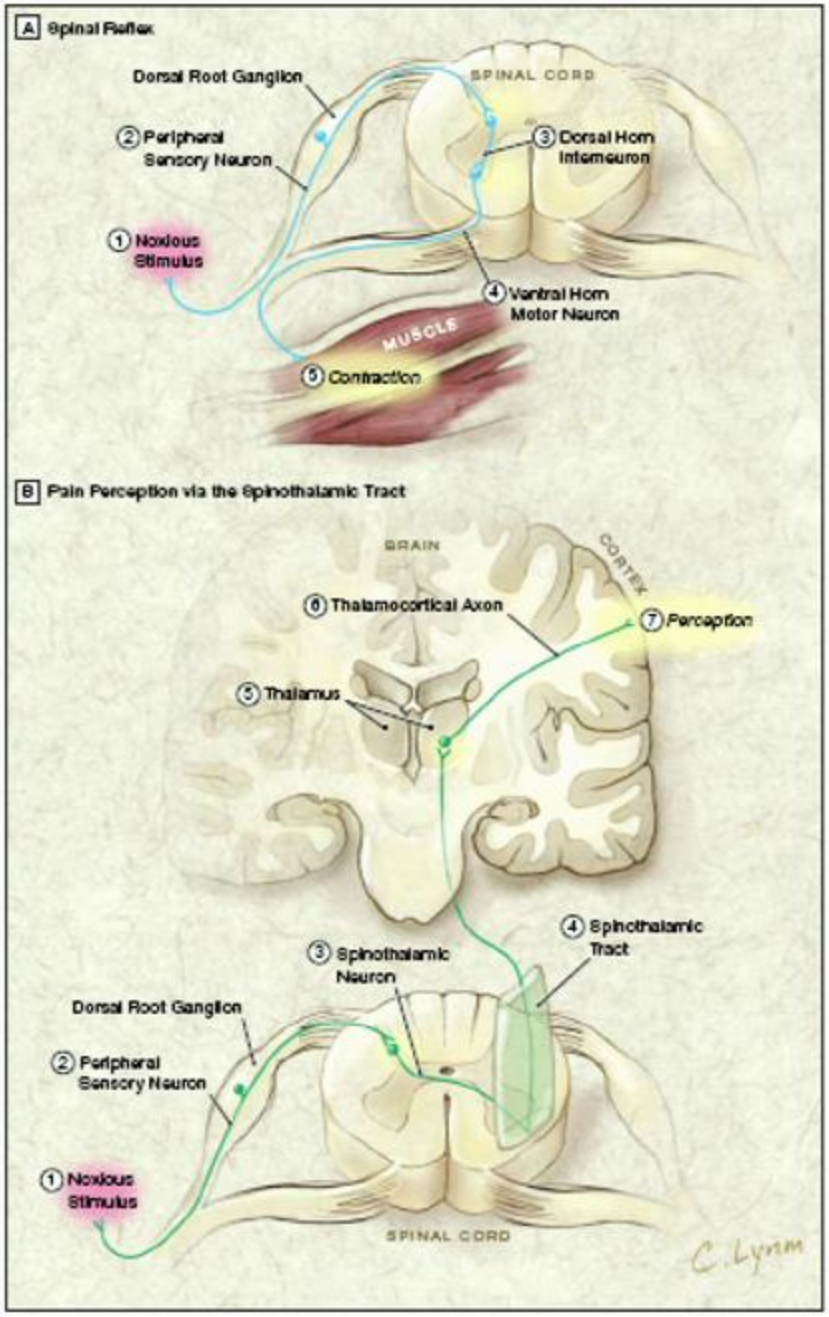
Pain perception and tolerance in patients with frontotemporal dementia



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

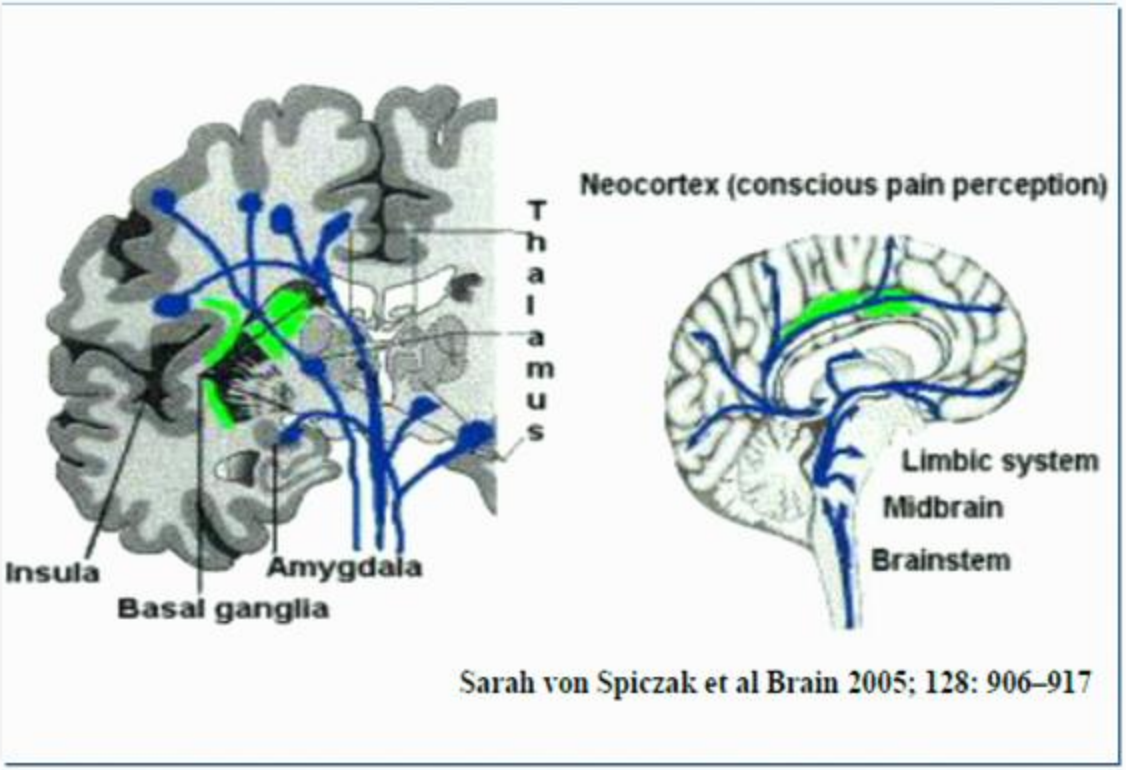
(Carlino E, Pain 2010)



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

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

è coinvolto relativamente tardi dal processo neurodegenerativo



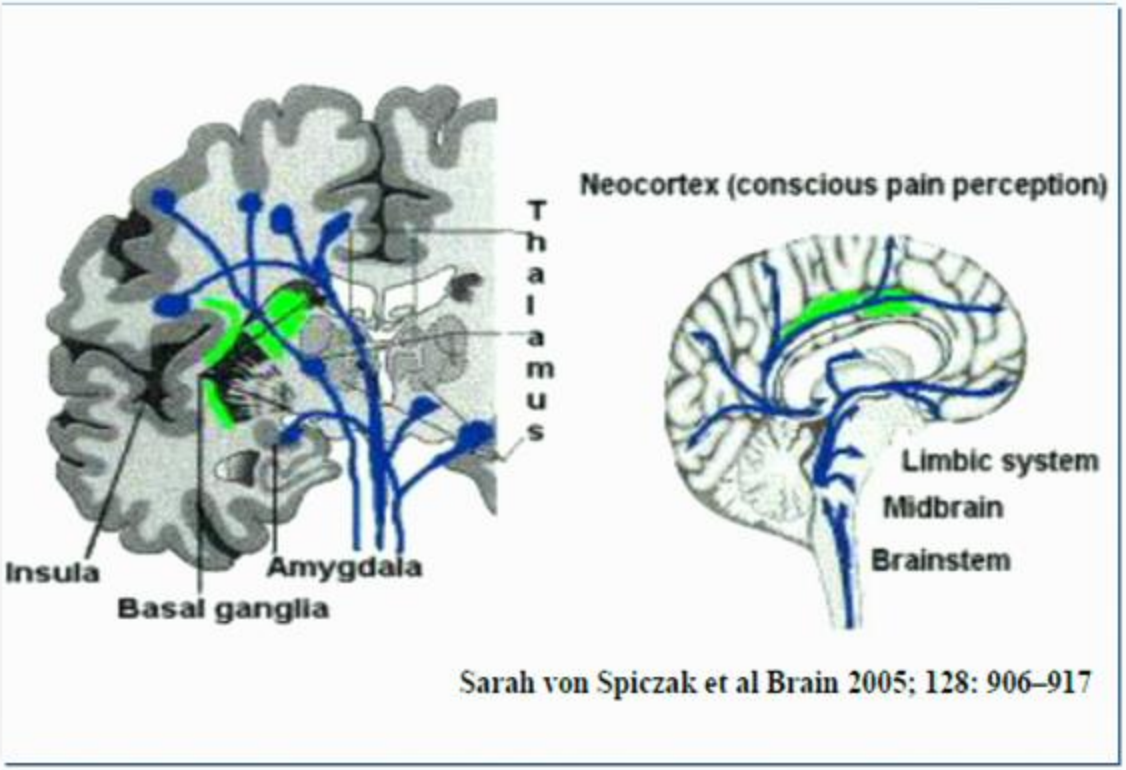
Sarah von Spiczak et al Brain 2005; 128: 906–917

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

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



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DISSOCIAZIONE SENSITIVO-AFFETTIVA: ASIMBOLIA DEL DOLORE

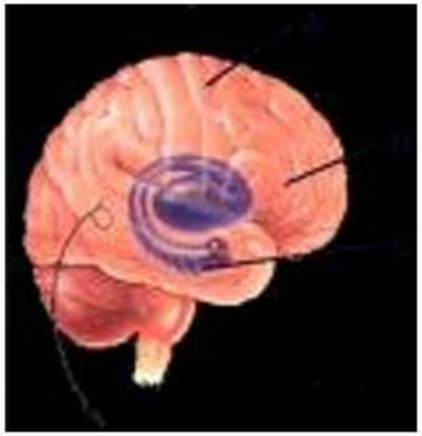
Non c'è proporzionalita' diretta fra intensita'delle informazioni nocicettive *trasmesse* e l'intensita' del dolore *percepito che è modulato da fattori cognitivi, emotivi e biopsicosociali*

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

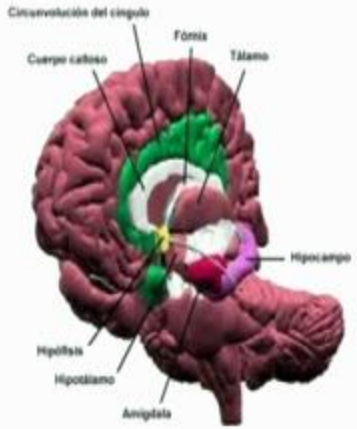
Fattori che riducono la percezione del dolore: *sonno*, analgesia da stress, effetto placebo, *analgesia autoindotta, ipnosi, meditazione*

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



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.

Amigadala
Archivio memoria emozionale

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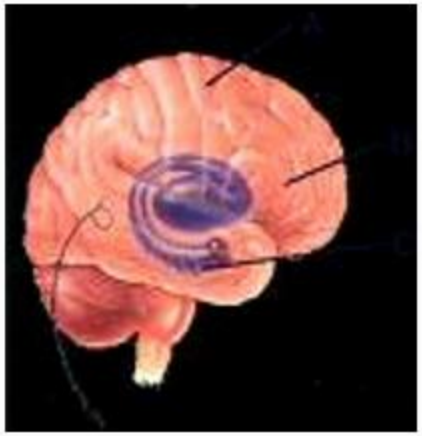
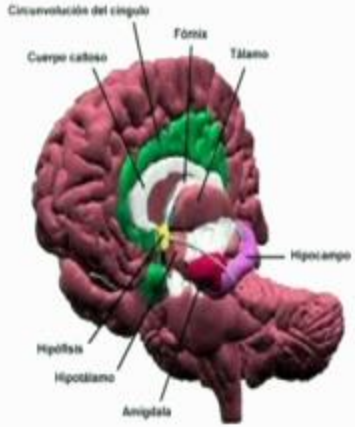


Ippocampo
Memoria analitica



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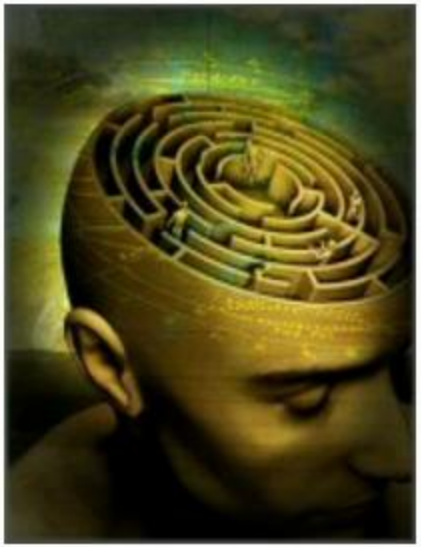
Amigadala
Archivio memoria emozionale

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, either overtly or covertly, 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.
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

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"

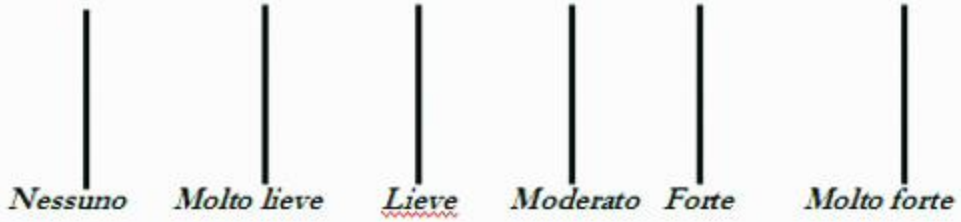
Ministero della salute

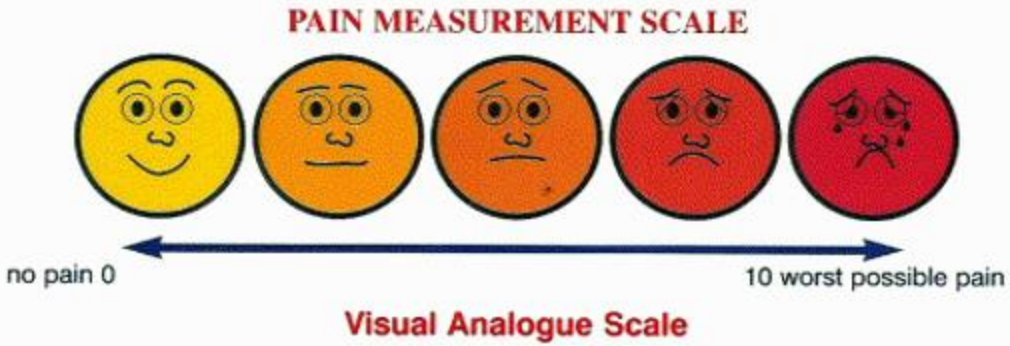
Art. 7. All'interno della cartella clinica, nelle sezioni medica ed infermieristica, in uso presso tutte le strutture sanitarie, devono essere riportati le caratteristiche del *dolore rilevato e della sua evoluzione nel corso del ricovero, nonché la terapia antalgica farmacologica e non, il dosaggio 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..**

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

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

DOLOPLUS 2
(Lefevre 2001)

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 assessment tools have received considerable attention over the years, with an increasing number of tools made available. Systematic reviews on the evidence of their validity and utility mostly compare different sets of tools. This review of systematic reviews analyses and summarises evidence concerning the psychometric properties and clinical utility of pain assessment tools in adults with dementia or cognitive impairment.

Methods: We searched for systematic reviews of pain assessment tools providing evidence of reliability, validity and clinical utility. Two reviewers independently assessed each review and extracted data from them, with a third reviewer mediating when consensus was not reached. Analysis of the data was carried out collaboratively. The reviews were synthesised using a narrative synthesis approach.

Results: We retrieved 441 potentially eligible reviews, 23 met the criteria for inclusion and 8 provided data for extraction. Each review evaluated between 8 and 13 tools, in aggregate providing evidence on a total of 28 tools. The quality of the reviews varied and the reporting often lacked sufficient methodological detail for quality assessment. The 28 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

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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

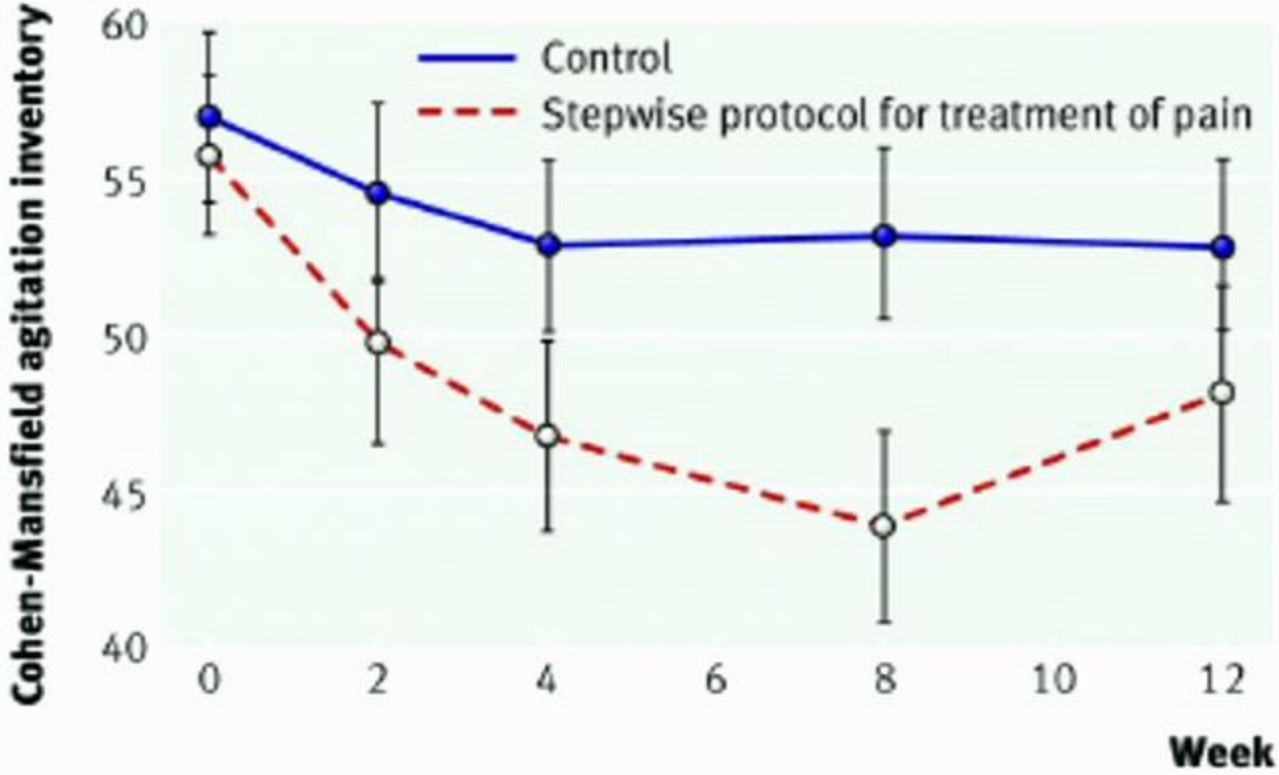
(Sampson E.L, Pain 2015)

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

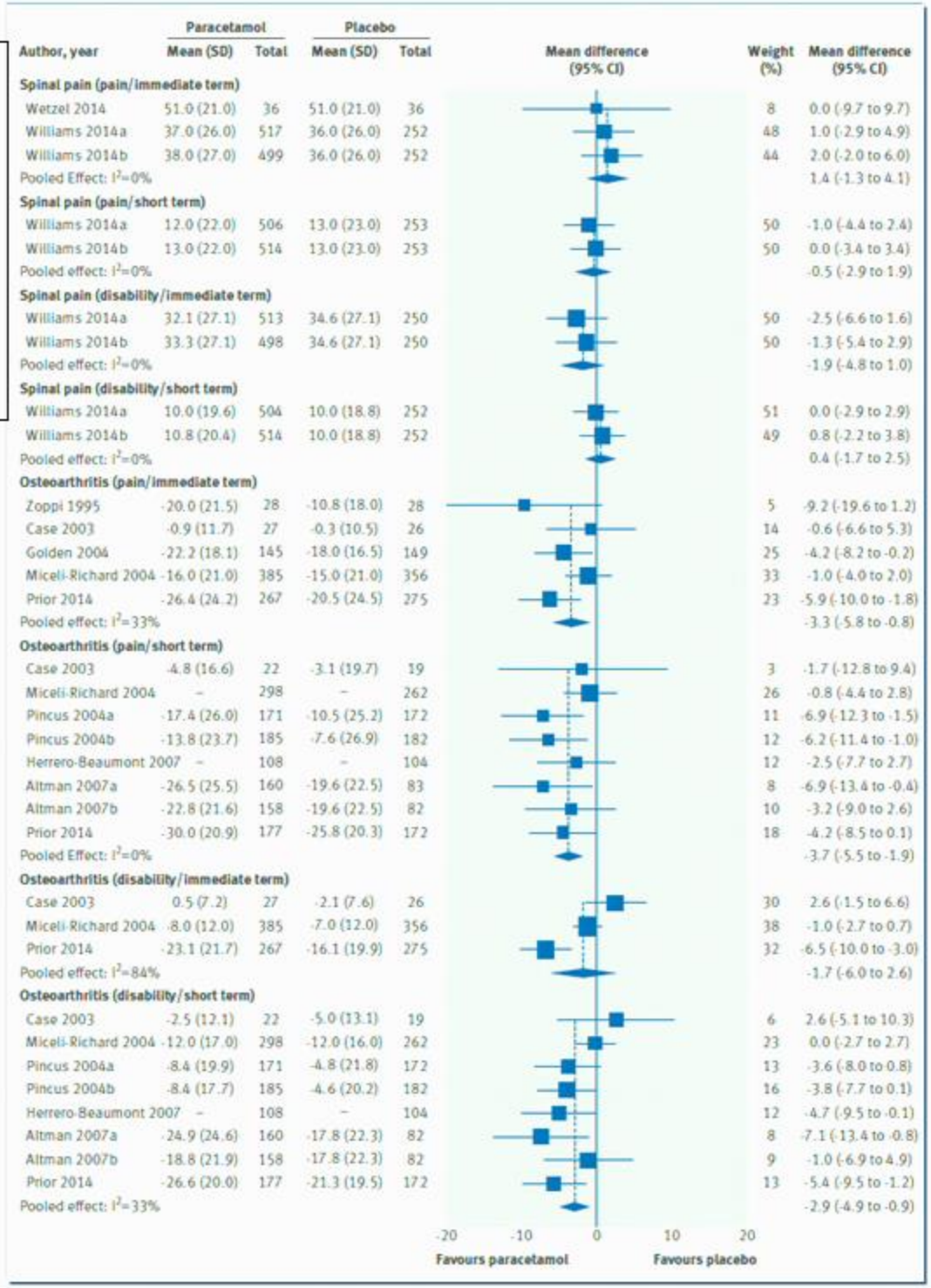
Step	Pain treatment at baseline	Study treatment	Dosage	No (%) of residents (n=175)
1	No analgesics, or low dose of paracetamol	Paracetamol (acetaminophen)	Maximum dose 3 g/day	120 (69)*
2	Full dose of paracetamol or low dose morphine	Morphine	5 mg twice daily; maximum dose 10 mg twice daily	4 (2)
3	Low 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 osteoarthritis; 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

- **CONTROINDICAZIONI ED EFFETTI COLLATERALI**
- **VIA DI SOMMINISTRAZIONE MENO INVASIVA**
- **AD INTERVALLI REGOLARI**
  (non «al bisogno»)
- **SEQUENZIALE**
  TITOLAZIONE FINO AL CONTROLLO DEL DOLORE
  "start low and go slow"

  SCRUPOLOSITA' APPLICATIVA

Efficacy and tolerability of low-dose oral prolonged-release oxycodone/naloxone for chronic nononcological pain in older patients

Purpose: to evaluate efficacy and safety of low-dose oral prolonged-release oxycodone–naloxone (OXN-PR) in patients aged ≥70 years.

Methods: This open-label prospective study assessed older patients naïve to strong opioids presenting with moderate-to-severe chronic pain. Patients were prescribed OXN-PR at an initial dose of 10/5 mg/day for 28 days. In case of insufficient analgesia, the initial daily dose could be increased gradually.

Results: Of 53 patients enrolled (mean 81.7±6.2 years [range 70–92 years]), 52 (98.1%) completed the 28-day observation. At T28, the primary end point (30% reduction in mean pain from baseline in the absence of bowel function deterioration) was achieved in 38 patients (71.7%). OXN-PR significantly relieved pain (NRS score –3.26; $P<0.0001$), as well as daily need for rescue paracetamol (from 86.8% at baseline to 40.4% at T28; $P<0.001$), and reduced impact of pain on daily activities (Brief Pain Inventory Short Form from 6.2±1.5 to 3.4±2.1; $P<0.0001$). OXN-PR was also associated with significant improvement in daily functioning (Barthel Index from 53.3±14.1 to 61.3±14.3; $P<0.01$). No changes were observed in cognitive status and bowel function. OXN-PR was well tolerated.

Conclusion: Findings from this open-label prospective study suggest that low-dose OXN-PR may be effective and well tolerated for treatment of moderate-to-severe chronic pain in older patients.

Guerriero F, Clinical Interventions in Aging 2015

Post hoc analyses of data from a 90-day clinical trial evaluating the tolerability and efficacy of tapentadol immediate release and oxycodone immediate release for the relief of moderate to severe pain in elderly and nonelderly patients

OBJECTIVE: To evaluate the tolerability and efficacy of tapentadol immediate release (IR) and oxycodone IR for relief of moderate to severe pain in elderly and nonelderly patients.
METHODS: Post hoc data analyses were conducted on a 90-day randomized, phase 3, double-blind, flexible-dose study of adults with moderate to severe lower back pain or osteoarthritis pain who received tapentadol IR 50 mg or 100 mg, or oxycodone IR 10 mg or 15 mg every 4 h to 6 h as needed for pain relief. Treatment-emergent adverse events and study discontinuations were recorded.
RESULTS: Data from 849 patients randomly assigned (4:1 ratio) to treatment with a study drug (tapentadol IR [n=679] or oxycodone IR [n=170]) were analyzed according to age (younger than 65 years of age [nonelderly], or 65 years of age or older [elderly]) and treatment group. Among elderly patients, incidences of constipation (19.0% versus 35.6%) and nausea or vomiting (30.4% versus 51.1%) were significantly lower with tapentadol IR versus oxycodone IR (all $P<0.05$). For tapentadol IR- and oxycodone IR-treated elderly patients, respectively, incidences of study discontinuation due to gastrointestinal treatment-emergent adverse events were 15.8% and 24.4% ($P=0.190$). Tapentadol IR and oxycodone IR provided similar pain relief, with no overall age-dependent efficacy differences (mean pain scores [11-point numerical rating scale] decreased from 7.0 and 7.2 at baseline, to 4.9 and 5.2 at end point, respectively).

CONCLUSIONS: Tapentadol IR was safe and effective for the relief of lower back pain and osteoarthritis pain in elderly patients, and was associated with a better gastrointestinal tolerability profile than oxycodone IR.

Vorsanger G, Pain Res Manag. 2011

Progressiva rigidità / Retrazioni muscolo-tendinee / Anchilosi

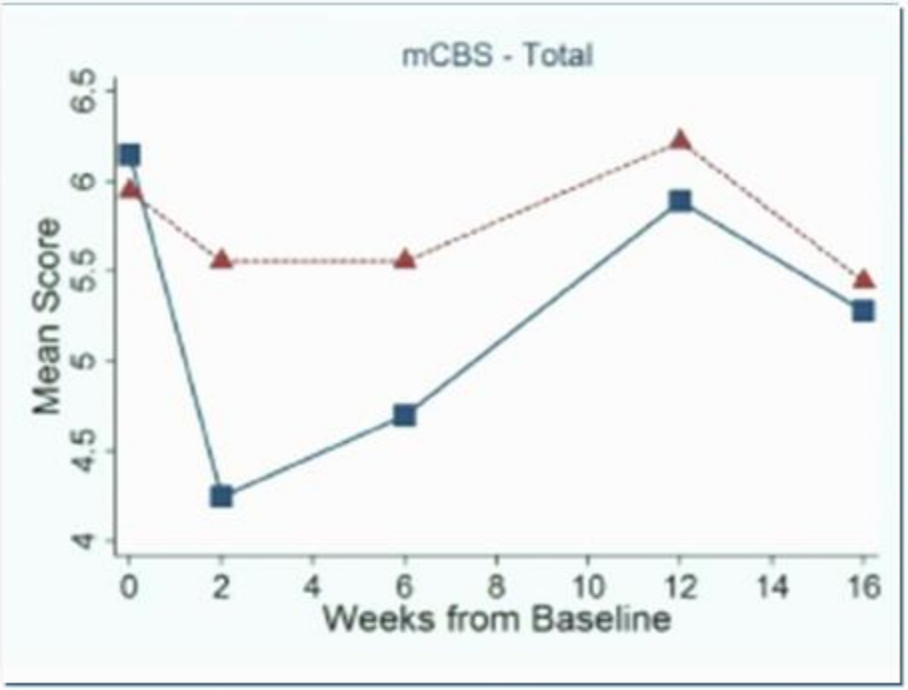
DETERMINANO DISAGIO FISICO E DIFFICOLTA' ALL'ASSISTENZA
anche per la semplice igiene o l'alimentazione

Mobilizzazione passiva: non efficace
Passive range of motion exercise was not beneficial in the treatment of paratonia (Hobbelen JH, Int Psychogeriatr 24: 834–844, 2012)

Baclofen: scarsa efficacia, effetti collaterali

Tossina Botulinica: off label nel paziente con demenza

A randomized, placebo controlled pilot trial of Botulinum Toxin for paratonic rigidity in people with advanced cognitive impairment



mCarer Burden Scale (mCBS) in subject treated with Incobotulinumtoxin A (■) and Placebo (▲)

OUTCOME	N	TREATMENT EFFECT (95% CI)	P value
PAINAID	10	–0.09 (–0.70 to 0.51)	0.8
Visual Analogue Scale (VAS)	10	5.30 (–4.64 to 15.23)	0.3

No significant treatment effects were found for the VAS of caregiver perceived burden of care, or the PAINAD

Administration of Incobotulinumtoxin A in elderly people with advanced dementia and paratonia may be an efficacious and safe treatment to increase range of motion and reduce functional burden

(Galit Kleiner-Fisman, 2014)

I muri non sono lì per tenerci lontano ma per darci la possibilità di dimostrare quanto profondamente teniamo a qualcosa.

Perché i muri fermano le persone che non hanno abbastanza voglia di superarli

da L'ultima lezione di Randy Pausch