Meeting the Chronic Pain Care Needs of Older Adults: What is the role of the PCP?

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PAIN  MENTAL ILLNESS

Learning Objectives

1. Identify key psychosocial treatment targets in the older adult with chronic noncancer pain.
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   - Depression, anxiety and other psychosocial factors are often overlooked as significant contributors to PAIN INTERFERENCE...
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1. Identify key psychosocial treatment targets in the older adult with chronic noncancer pain.
   - Depression, anxiety and other psychosocial factors are often overlooked as significant contributors to PAIN INTERFERENCE...
   - ...the key vital sign in patients with chronic pain.
2. List the pathognomonic features of myofascial pain.
Learning Objectives

2. List the pathognomonic features of myofascial pain.
   - Myofascial pain (MP) is arguably the most common chronic pain condition. PCPs trained using allopathic principles have often not been educated about MP.
Learning Objectives

2. List the pathognomonic features of myofascial pain.
   - Myofascial pain (MP) is arguably the most common chronic pain condition. PCPs trained using allopathic principles have often not been educated about MP.
   - As the most effective treatments are non-pharmacological, competence around MP diagnosis and treatment can save costs and morbidity.
Learning Objectives

3. Describe treatment modifications that practitioners may wish to consider for the older adult with pain and dementia.
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   – Dementia may not be clinically obvious.
Learning Objectives

3. Describe treatment modifications that practitioners may wish to consider for the older adult with pain and dementia.
   - Dementia may not be clinically obvious.
   - Recognizing it in the older adult with chronic pain can profoundly impact pain management.
“Can you make this pain go away?”
“Can you make this pain go away?”

Your pain has you.

You have your pain.
Materials on Course Website

- Chronic pain management guide pdf
- Electronic link to guide
- Chronic low back pain series of articles pdf and link
- Myofascial pain PE video
Learning Objectives

1. Identify key psychosocial treatment targets in the older adult with chronic noncancer pain.

2. List the pathognomomic features of myofascial pain.

3. Describe treatment modifications that practitioners may wish to consider for the older adult with pain and dementia.
Case

- 71-year-old white male Veteran with low back pain for over 10 years.

- No leg symptoms, pain in back sitting and standing, better with movement. Right worse than left.
Pain Enjoyment General activity

• **SEVERITY**: During the past week, what number best describes your pain, on average? (0=no pain, 10=pain as bad as you can imagine)

• **INTERFERENCE**: During the past week, what number best describes:
  – How pain has interfered with your enjoyment of life?
  – How pain has interfered with your general activity? (0=does not interfere, 10=completely interferes)

Case

• 71-year-old white male Veteran with low back pain for over 10 years.

• No leg symptoms, pain in back sitting and standing, better with movement. Right worse than left.

• PEG scores (*Krebs E et al 2009; J Gen Intern Med 24: 733*)
  – Average 7-day pain: 5
  – Interference with enjoyment of life: 6
  – Interference with general activity: 7
PHYSICAL EXAMINATION

General: Pleasant, well-groomed, NAD

Neurological: Alert, OX3, strength and reflexes normal throughout, gait stable and coordinated.

Psychiatric: No SI/HI, tearful when talking about pain, PHQ9=17; negative coping statements, fear avoidance beliefs

Musculoskeletal: Mild scoliosis, tautness and tenderness of right parathoracic/paralumbar erector spinae
Treatments recommended

• Duloxetine 20 mg per day for 7 days, then call to check in.
• Acetaminophen 975 mg po tid
• Chiropractic referral
## Case FU – 1 month

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Baseline</th>
<th>1 month</th>
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<tbody>
<tr>
<td>PEG pain</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>PEG enjoyment interference</td>
<td>6</td>
<td>5</td>
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<tr>
<td>PEG gen activity interference</td>
<td>7</td>
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<td>PHQ-9</td>
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**Recommendations:**
1. Increase duloxetine to 60 mg po qd.
2. Continue chiropractic and acetaminophen.
3. Begin walking program
Case FU – 2 months

- Overall, “40-50% better”
- Can get out of bed without difficulty
- Walking ~ 2 blocks per day
- Less irritable – “more mellow”
- Taking pride in chores around the house
Case FU – 2 months

• Overall, “40-50% better”
• Can get out of bed without difficulty
• Walking ~ 2 blocks per day
• Less irritable – “more mellow”
• Taking pride in chores around the house
• But ran out of acetaminophen one week ago…
Case FU – 2 months

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<td>PHQ-9</td>
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<tr>
<td>Insomnia severity index</td>
<td>11</td>
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<tr>
<td>Fear avoidance beliefs</td>
<td>23</td>
<td></td>
<td>9</td>
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TAKE HOME POINT(S)

• Reduction of pain may not be required to reduce pain interference.
• In this case effective treatment of depression reduced pain interference.
Chronic Pain

PAIN: THE 5\textsuperscript{TH} VITAL SIGN
Chronic Pain

PAIN INTERFERENCE: THE 5TH VITAL SIGN
To what extent does pain interfere with function and quality of life?
Basic Understanding of Pain Channels

- Sensory-discriminative (nociceptive channel)
- Motivational-affective

Descending modulatory influences:
- +/- NE, 5-HT, glut, NMDA, GABA

Key structures:
- Skin
- Muscle
- Joints
- Viscera
- Spinal cord
Basic Understanding of Pain Channels

descending modulatory influences
+/- NE, 5-HT, glut, NMDA, GABA

Depression/Anxiety
Insomnia
Maladaptive Coping (fear avoidance beliefs, catastrophizing)
Low Self-Efficacy
Fibromyalgia
Dementia

sensory-discriminative (nociceptive channel)

skin
muscle
joints
viscera
spinal cord

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PCPR
Pittsburgh Center for Pain Research
Basic Understanding of Pain Channels

Depression/Anxiety
Insomnia
Maladaptive Coping (fear avoidance beliefs, catastrophizing)
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Fibromyalgia
Dementia

Descending modulatory influences
 +/- NE, 5-HT, glut, NMDA, GABA

Skin
Muscle
Joints
Viscera
Spinal cord

Sensory-discriminative (nociceptive channel)
Screening statement for fear avoidance

• Do you agree/disagree:

“It’s not really safe for a person with my pain problem to be physically active.”

Fear-avoidance model

Pain
Catastrophizing
Pain Catastrophizing

- Rumination
- Magnification
- Helplessness
Fear-avoidance model

Pain
Catastrophizing

FEAR
Fear-avoidance model

Pain
Catastrophizing

FEAR

Pain-focused attention

Hypervigilance
Fear-avoidance model

- Pain
  - Catastrophizing
- Activity avoidance
- Hypervigilance
- Pain-focused attention
- FEAR
Fear-avoidance model

Pain
Catastrophizing

FEAR

Pain-focused attention

DISABILITY

Activity avoidance

Hypervigilance

Fear-avoidance model

Fear = Rx Target
Physical Therapy
Pain Psychology
Rx Depression/Anxiety

Pain-Catastrophizing
Activity avoidance
Pain-focused attention
Hypervigilance

DISABILITY
FEAR
Basic Understanding of Pain Channels

- Sensory-discriminative (nociceptive channel)

- Motivational-affective processes
  - Cognitive processes
  - Descending modulatory influences
  - +/- NE, 5-HT, glut, NMDA, GABA

- Depression/Anxiety
- Insomnia
- Maladaptive Coping (fear avoidance beliefs, catastrophizing)
- Low Self-Efficacy
- Fibromyalgia
- Dementia

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Screening for low self-efficacy

How confident are you that you can:

- Do some form of work (e.g., housework, paid/unpaid work) despite the pain?
- Live a normal lifestyle despite the pain?

0 = not confident at all and 6 = completely confident; total score of 8 or higher is desirable. Total score of 5 or less implies that patient needs help with self-efficacy.

Nicholas MD et al 2014, J Pain
DOI: 10.1016/j.jpain.2014.11.002
Low pain self-efficacy predicts poor pain treatment outcomes and is modifiable.

- Kate Lorig’s Self-Help Program for people with arthritis
Learning Objectives

1. Identify key psychosocial treatment targets in the older adult with chronic noncancer pain.

2. List the pathognomonic features of myofascial pain.

3. Describe modifications to treatment that practitioners may wish to consider for the older adult with pain and dementia.
WHAT IS MYOFASCIAL PAIN (MP)?

MP IS COMMON IN OLDER ADULTS

96% of those with CLBP

MYOFASCIAL PAIN: PATHOGNOMONIC FEATURES

• **Taut Band**: The group of tense muscle fibers extending from a trigger point to the muscle attachments.

• **Trigger Point**: Hypersensitive palpable nodules in skeletal muscle residing within taut bands.

MP vs. Fibromyalgia

Myofascial Pain
- Regional disorder
- Taut bands and trigger points on exam
- May coexist with many other pain conditions, including fibromyalgia

Fibromyalgia
- Systemic disorder
- Hyperalgesia without palpable abnormalities – tender points
- Often associated non-restorative sleep, fatigue, AM stiffness
ELEMENTS OF MP HISTORY

Pain worsens with:

- Cold
- Incorrect intensity or type of activity
- Psychological stress
- Illness
- Excessive pressure or stretching
Elements of MP History

Pain improves with:

– Heat
– Gentle activity
– Gentle pressure/stretching
– Relaxation
SYMPTOMS ASSOCIATED WITH MP

• Pain (aching, stabbing, burning) that radiates
SYMPTOMS ASSOCIATED WITH MP

- Pain (aching, stabbing, burning) that radiates
- Paresthesias, numbness
- Weakness
- Autonomic phenomena – piloerection, sweating
Symptoms Associated with MP

- Pain (aching, stabbing, burning) that radiates
- Paresthesias, numbness
- Weakness
- Autonomic phenomena – piloerection, sweating

MP can mimic neuropathy and/or radiculopathy.
ASSESSING MYOFASCIAL PAIN

The Physical Examination
HONING YOUR PHYSICAL EXAM SKILLS

Tip 1: Palpate WITH INTENTION

– Direction perpendicular to fiber direction
– Firmly enough to elicit pain (if there is severe spontaneous pain, start more gently)
HONING YOUR PHYSICAL EXAM SKILLS

Tip 1: Palpate WITH INTENTION
- Direction perpendicular to fiber direction
- Firmly enough to elicit pain (if there is severe spontaneous pain, start more gently)

Tip 2: Practice on friends and family
- Trapezi in many, if not most people, in those with and without pain
- Muscle groups in regions of pain
AN EXCELLENT RESOURCE

TRIGGER POINT THERAPY for Myofascial Pain

The Practice of Informed Touch

DONNA FINANDO, L.Ac., L.M.T. AND STEVEN FINANDO, Ph.D., L.Ac.

www.innertraditions.com
MYOFASCIAL DYSFUNCTION: A CONCEPTUAL MODEL

Muscle Resilience

Perpetuating Factors

Pain-free

PAIN
MYOFASCIAL DYSFUNCTION: A CONCEPTUAL MODEL

Muscle Resilience

Perpetuating Factors

LATENT TRIGGER POINTS

Pain-free

PAIN
MYOFASCIAL DYSFUNCTION: A CONCEPTUAL MODEL

Muscle Resilience

Perpetuating/Precipitating Factors

LATENT TRIGGER POINTS

Pain-free

ACTIVE TRIGGER POINTS
MP PERPETUATING FACTORS: PHYSICAL

- Muscle stiffness (aging associated, Parkinson’s, statins)
- Sarcopenia
- Axial spondylosis
- Spinal malalignment
- Gait disturbance
  - LE arthritis, foot pain, etc., etc., etc.
  - Iatrogenic LLD (post arthroplasty)

AXIAL SPONDYLOSIS: ONE MP PERPETUATING FACTOR

- Ubiquitous in older adults
- "Neuropathic myofascial pain"
This image was published in The Gunn approach to the treatment of chronic pain, Gunn CC, Shortened paraspinal muscles, p. 31, Copyright Churchill Livingstone [an imprint of Elsevier] (1996).
MP PERPETUATING FACTORS: PSYCHOSOCIAL

- Fear avoidance beliefs
  - Fear of falling
  - Fear of pain
- Depression, anxiety
- Social isolation
- Dementia
In patients with CLBP, the most common sites of MP are...

- Erector spinae
- Quadratus lumborum
- Gluteus medius

ERECTOR SPINAE (ILIOCOSTALIS LUMBORUM)

**QUADRATUS LUMBOrium**

GLUTEUS MEDIUS

GLUTEUS MINIMUS MP CAN MIMIC LUMBAR RADICULOPATHY

TREATING MP: A 3-PRONGED APPROACH

1. Address perpetuating factors

Myofascial Dysfunction: A Conceptual Model

- Pain-free
- Active trigger points
- Perpetuating factors

Diagram showing the relationship between muscle resilience and perpetuating factors.
MYOFASCIAL DYSFUNCTION: A CONCEPTUAL MODEL

Perpetuating Factors

LATENT TRIGGER POINTS

Muscle Resilience

Pain-free

PAIN
TREATING PHYSICAL PERPETUATING FACTORS – SOME EXAMPLES

• Kyphoscoliosis, balance impairment: Walker to unload spine and/or stabilize gait
• Unilateral leg pain: Cane to unload leg, treat OA
• Leg length inequality (> ½ inch): PT referral, +/- orthotic if no PT response
• Obesity: Weight loss
• Cervical spondylosis: Low dose gabapentin (100-300 mg qhs – bid)?
• Shoulder restriction: OT referral
TREATING PSYCHOSOCIAL PERPETUATING FACTORS – SOME EXAMPLES

Examples:

• Depression/anxiety: Non-pharmacological & pharmacological treatment
• Fear avoidance beliefs: PT referral, CBT
• Social isolation: Facilitate support
• Dementia: Caregiver education and support to diminish fear
TREATING MP: A 3-PRONGED APPROACH

1. Address perpetuating factors
2. Deactivate trigger points
   - Manual
   - Injection (wet needling)
   - Dry needling
   - IM electrical stimulation (with acupuncture needles)

SEVERAL PROFESSIONALS MAY HAVE TRIGGER POINT TRAINING AND EXPERTISE.

- Physical therapist
- Massage therapist
- Chiropractor
- Acupuncturist
- Pain medicine provider
TREATING MP: A 3-PRONGED APPROACH

1. Address perpetuating factors

2. Deactivate trigger points
   - Manual
   - Injection (wet needling)
   - Dry needling
   - IM electrical stimulation (with acupuncture needles)

3. Self-management to build and sustain resilience

MYOFASCIAL DYSFUNCTION: A CONCEPTUAL MODEL

Muscle Resilience

Perpetuating Factors

Pain-free

PAIN

Graph illustrates a conceptual model of myofascial dysfunction, showing the relationship between muscle resilience and perpetuating factors, leading towards pain-free and painful states.
MUSCLE RELAXANTS
MUSCLE RELAXANTS
CASE PRESENTATION

The Importance of Addressing Perpetuating Factors
ID/CC & HPI

• 82 y.o. white female with low back pain for many years
• Steadily worsening functional limitation
• Average 7-8/10 pain, worse with walking/standing
• Poor sleep
**Prior Treatments**

- Numerous prior treatments: acupuncture, chiropractic, traction, physical therapy, aqua therapy, numerous injections, inpatient pain rehabilitation
- Back surgery was recommended and scheduled but patient cancelled
- Pain medications: naproxen prn
PHYSICAL EXAMINATION

• Musculoskeletal: mild kyphoscoliosis, bilateral SI tenderness, bilateral piriformis and gluteus medius taut bands and trigger points

• Neurological: Reflexes symmetrical, strength 5/5 throughout, gait with short step length

• Psychiatric: Anxious affect
INITIAL RECOMMENDATIONS

• SI joint injections – for SIJ syndrome
• Physical Therapy
  ➢ Treatment of myofascial pain
  ➢ Strengthening
• Cognitive behavioral therapy – for anxiety

RESPONSE: None
ADDITIONAL HISTORY

Over the past ~ 1 year:
- Voice has gotten softer
- Handwriting has gotten smaller
- Posture has worsened
Findings:
- Little facial expression (new)
- Mild cogwheeling of right arm
Neurology Consultation

Parkinsonian symptoms:

- Masked facies
- Diminished blink
- Myerson’s sign
- Minimal asymmetrical cogwheeling
- Tendency to retropulse
- NO tremor or shuffling gait
TREATMENT

- Carbidopa/levodopa 25 mg/100 mg po bid
- Continue PT
FOLLOW-UP

~ 1 month later:

- Average pain 4/10
- Able to walk 2 blocks without having to stop
- Lumbar flexion increased from 3.5 cm to 4.6 cm
- Posture and balance markedly improved
Parkinson's Disease

Muscle tone → Myofascial Dysfunction

Posture → SIJ Syndrome

Spondylosis

LBP
Learning Objectives

1. Identify key psychosocial treatment targets in the older adult with chronic noncancer pain.

2. List the pathognomonic features of myofascial pain.

3. Describe modifications to treatment that practitioners may wish to consider for the older adult with pain and dementia.
Dementia may impact...

- Pain reporting
  - Reliable for current pain intensity, ? validity
  - Historical inaccuracy
- Treatment compliance
- Pain coping
  - Fear avoidance
- Treatment expectancy
- Treatment response?
Dementia may impact...

- Pain reporting
  - Reliable for current pain intensity, ? validity
  - Historical inaccuracy
- Treatment compliance
- Pain coping
  - Fear avoidance
- Treatment expectancy
- Treatment response?
Is patient able to verbally report pain?
Is patient able to verbally report pain?

No → Behavioral Assessment
Is patient able to verbally report pain?

No → PAINAD
PAINAD
(Pain Assessment in Advanced Dementia)

0-10 scale
Summary score based on 5 items, 0-2 each

1. Breathing independent of vocalization
2. Negative vocalization
3. Facial expression
4. Body language
5. Consolability

Warden V et al 2003; J Am Med Dir Assoc 4:9
Pain self-report and facial pain indicators: AD vs. cognitively intact

Porter et al 1996; Pain 68, 413. Kunz et al, Pain 2007; 133: 221-228
Pain self-report and facial pain indicators: AD vs. cognitively intact

Acute Painful Stimulus

More in AD

Porter et al 1996; Pain 68, 413. Kunz et al, Pain 2007; 133: 221-228

Self-reported pain intensity equivalent in AD and cognitively intact.

Kunz et al, Pain 2007; 133: 221-228
IMPLICATIONS: Pain & Dementia

• Pain behaviors may be a more accurate indicator of suffering than pain reporting.
Is patient able to verbally report pain?

Yes

No → PAINAD
Is patient able to verbally **report** pain?

- **Yes**
  - Are signs of suffering **observed** (e.g., PAINAD, other behavioral indicators?)

- **No** → **PAINAD**
Is patient able to verbally report pain?

Yes

Are signs of suffering observed (e.g., PAINAD, other behavioral indicators?)

No

1. Distraction
2. Stop asking about pain (i.e., prevent perseveration)

No

PAINAD
Is patient able to verbally report pain?

- Yes
  - Are signs of suffering observed (e.g., PAINAD, other behavioral indicators?)
    - No: 1. Distraction, 2. Stop asking about pain (i.e., prevent perseveration)
    - Yes: Explore cause(s) of suffering:
      1. Is there fear?
      2. Is there another unmet need?
      3. Is pain causing suffering?

- No: PAINAD
Dementia may impact...

- Pain reporting
  - Reliable for current pain intensity
  - Historical inaccuracy, ? validity

- Treatment compliance

- Pain coping
  - Fear avoidance

- Treatment expectancy

- Treatment response?
Dementia may impact...

- **Pain reporting**
  - Reliable for current pain intensity
  - Historical inaccuracy, ? validity
- **Treatment compliance**
- **Pain coping**
  - Fear avoidance
- **Treatment expectancy**
- **Treatment response?**
Case Presentation

**ID/CC:** 80 yr., LBP/R leg pain X 2 yrs., lumbar spinal stenosis on MRI

**HPI:** Forced to retire 2 years ago. Pain is worse with standing, walking, OK at night, better with heat, no constitutional symptoms. Increasing trouble with heavy housework, afraid to go on bus by self. Reports passive suicidal ideations. Frequent near falls at home. Failed PT trials.

**PE:** Poor balance, impaired clock-drawing test, kyphoscoliosis, SI/paraspinal/TFL pain, leg strength impaired from pain.
Medications:

gabapentin
oxycodone CR
celecoxib
tramadoli/Acetaminophen
olanzapine
escitalopram
lorazepam

Weiner, Pain in Older Persons; IASP Newsletter 12-07
WEIGHING THE RISK OF DISABILITY

0

++

Affluent

Socially isolated
Physically ill
Psychologically unwell
Demented
Impaired mobility
Chronic pain
Affluent

Socially isolated
Physically ill
Psychologically unwell
Demented
Impaired mobility
Chronic pain
**Rx:** Short nursing home stay for detox. and balance/gait retraining. D/C’d on tramadol + acetaminophen. Did very well while in NH.

**Recommendation:** Assisted Living

**Family’s Decision:** Patient to return home.
Course: Immediate deterioration at home with frequent calls, escalation of need for analgesics.

Her condition continued to deteriorate (eventual morphine pump trial), until she was admitted to an assisted living facility, where she did well.
Affluence
Social Support

Socially isolated
Physically ill
Psychologically unwell
Demented
Impaired mobility
Chronic pain
Socially isolated
Physically ill
Psychologically unwell
Demented
Impaired mobility
Chronic pain

Affluence
Fear & Pain Perseveration

Dementia & Social Isolation

Fear = Rx Target

Undermine dementia

Falsely escalate pain severity & impact
Basic Understanding of Pain Channels

- Sensory-discriminative (nociceptive channel)
- Motivational-affective processes
- Cognitive processes
- Descending modulatory influences: +/- NE, 5-HT, glut, NMDA, GABA

Applications:
- Depression/Anxiety
- Insomnia
- Maladaptive Coping (fear avoidance, catastrophizing)
- Low Self-Efficacy
- Fibromyalgia
- Dementia

Locomotor systems:
- Skin
- Muscle
- Joints
- Viscera

Spinal cord

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Dementia may impact...

- Pain reporting
  - Reliable for current pain intensity
  - Historical inaccuracy, ? validity
- Treatment compliance
- Pain coping
  - Fear avoidance
- **Treatment expectancy**
- Treatment response?
What is the effect of treatment expectancy?

Analgesic $\rightarrow$ Pain
What is the effect of treatment expectancy?

Analgesic → Pharmacodynamic effect
What is the effect of treatment expectancy?

Analgesic → Pharmacodynamic effect

Treatment Expectancy → Hope → Pain
What is the effect of treatment expectancy?

Analgesic $\rightarrow$ Pharmacodynamic effect

Treatment Expectancy $\rightarrow$ Hope $\rightarrow$ Placebo effect
What is the effect of treatment expectancy?

Analgesic $\rightarrow$ Pharmacodynamic effect

Treatment Expectancy $\rightarrow$ Hope - Placebo effect

Pharmacodynamic effect + Placebo effect
What is the effect of treatment expectancy?

Analgesic → Pharmacodynamic effect

Treatment Expectancy → Hope (Placebo effect)

Pharmacodynamic effect → PAIN
Loss of expectation-related mechanisms in Alzheimer’s disease makes analgesic therapies less effective

Benedetti F, et al.
Pain 121 (2006) 133–144
Impact of Dementia on Rx Response?

- Because of reduced treatment expectancy, patients with advanced dementia may respond less robustly to treatment interventions.
Modification of Rx Approach

• Involve caregiver in treatment sessions
• Teach more slowly
• Alter your expectations of rate of progress
• Reinforce, reinforce, reinforce
• Start low, go slow…and keep going
Modification of Rx Approach

• Involve caregiver in treatment sessions
• **Teach more slowly**
• Alter your expectations of rate of progress
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Modification of Rx Approach

• Involve caregiver in treatment sessions
• Teach more slowly
• Alter your expectations of rate of progress
• Reinforce, reinforce, reinforce
• Start low, go slow…and keep going
1. Treating psychosocial dysfunction (e.g., depression, anxiety, fear-avoidance beliefs, low self-efficacy) holds an important key to minimizing PAIN INTERFERENCE, the key treatment outcome in those with chronic pain.
2. Myofascial pain (characterized by taut bands and trigger points), a mimicker of neuropathic pain, is most effectively treated with a 3-pronged approach:

- Treat perpetuating/precipitating factors
- Treat trigger points
- Engage patient in self-management
TAKE HOME POINT

3. Patients with dementia may express pain and respond to pain treatments differently than those who are cognitively intact. Cornerstones of effective management include:

• Observing behaviors
• Addressing fear
• Involving caregivers