Patients with cancer may experience acute, chronic, and uncontrolled pain. About 75% of patients with advanced cancer experience some form of pain. The most common types of cancer pain are somatic, visceral, and neuropathic. Somatic pain occurs as the result of injury to tissue or bone, visceral pain occurs in body organs, and neuropathic pain involves the neurologic pathways and is described as a tingling or burning sensation (McDonald, 1999). Healthcare professionals must assess pain accurately so that they may take appropriate steps to provide a pain-free state for patients.

Oncology nurses report pain control to be one of the more challenging aspects of caring for patients with cancer. Three decades ago, Margo McCaffery proposed a realistic definition of pain that guides nursing practice today. “Pain is whatever the experiencing person says it is, existing whenever the experiencing person says it does” (McCaffery, 1968, p. 95). Assessing pain becomes more difficult when patients with cancer are cognitively impaired. Prior to such assessment, healthcare providers must distinguish between impairment related to opioid use and impairment secondary to dementia, delirium, Alzheimer’s disease, or a cerebral vascular accident. Opioid-related cognitive dysfunction tends to be subtle in the earlier stages of cancer, and delirium is likely to be present in patients with advanced cancer (Lawlor, 2002). In patients with advanced disease, careful clinical assessment is essential, and either dose reduction or use of a different opioid might be necessary.

The ability to assess pain is hindered in cognitively impaired older adults by the subjective nature of pain and the inappropriate use of assessment tools (McDonald, 1999). Traditional pain scales may not be appropriate for use with cognitively impaired older adults. This article describes methods and tools used by healthcare providers to accurately assess pain in cognitively impaired older adults with cancer, specific behavioral indicators that healthcare providers should recognize to assess pain accurately among this population, and the most appropriate pain scales to use when assessing pain in this population.

Key Words: cognition disorders, pain measurement, aged impaired older adults with cancer. Compounding this problem is the fact that cognitive impairments can occur in varying degrees. Not all patients with cognitive impairments are alike; therefore, care must be individualized.

Simons and Malabar (1995) studied pain behaviors in older adults with a variety of medical conditions. Nurses observed pain behaviors in cognitively impaired older adults using the Scale of Discomfort designed by Hurley and colleagues (Simons & Malabar). The behaviors used to assess discomfort were breathing noisily, having an absent look of contentment, looking sad, looking frightened, frowning, having an absence of relaxed body posture, looking tense, and fidgeting. Simons and Malabar found that pain interventions, such as analgesia administration, eliminated the behaviors in a vast majority of the patients studied. When pain behaviors persisted, changing the analgesics effected the desired change (Simons & Malabar).

A more recent study (Kovach, Griffie, Muchka, Noonan, & Weissman, 2000) examined nurses’ perceptions regarding assessment and treatment of pain in people with late stage dementia. Thirty nurses were interviewed, and all agreed that cognitively impaired older adults provided behavioral cues to indicate pain. Facial grimacing and restless body movements were the most

Assessing Pain in Cognitively Impaired Older Adults With Cancer

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Background

Much research has focused on the assessment of pain in patients with cancer and the elderly, but very little has targeted the assessment of pain specifically in cognitively impaired older adults with cancer. Compounding this problem is the fact that cognitive impairments can occur in varying degrees. Not all patients with cognitive impairments are alike; therefore, care must be individualized.

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