

Pain Terminology

Acute Pain: Pain that is usually temporary and results from something specific, such as a surgery, an injury, or an infection.

- Knowing if pain is acute rather than persistent guides treatment decisions
- Monitor acute pain for signs of improvement as expected
- Ineffectively treated acute pain can turn into persistent or chronic pain.

Addiction: A primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations.

- Addiction to opioids as a result of pain management is uncommon among people living in nursing homes.
- Tolerance and physical dependence are normal physiologic responses to chronic medication administration, whereas addiction is a disease that is not a normal or common response to opiate use.
- Addiction is more likely to occur in older adults with multiple risk factors for addiction, such as a genetic predisposition, a history of addictive behavior, or a history of abuse and/or neglect.
- It is recommended that pain be adequately controlled before reaching conclusions about concerns related to addictive behaviors.
- An individual's behaviors that may suggest addiction sometimes reflect unrelieved pain or other problems (See Pseudoaddiction, below) unrelated to addiction.
- Good clinical judgment must be used in determining whether the observed pattern of behaviors signals addiction or reflects a different issue such as unrelieved pain or psychological distress.
- Behaviors that are associated with problematic drug use and possible addiction are: use of analgesic medications for other than analgesic effects (e.g., to feel euphoric, less anxious) non-compliance with recommended non-opioid treatments or evaluations; insistence on rapid-onset formulations/routes of administration; reports of no relief whatsoever by any non-opioid treatments. Observation of these behaviors should be documented and investigated further with the older adult and other pain-team members.. ■ Recognition of the disease is made in the presence of one or more of the following behaviors: impaired control over drug use, compulsive use, continued use despite harm, and craving.
- No single event is diagnostic of an addictive disorder. Rather, the diagnosis of substance abuse/addiction is made in response to a pattern of behavior that usually becomes obvious over time.

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Adjuvant analgesic: A drug that has a primary purpose other than pain relief but can also serve as an analgesic for some painful conditions

- Some examples include tricyclic antidepressants or anticonvulsants

Allodynia: A nonpainful stimulus felt as painful in spite of normal-appearing tissues

- Common in many neuropathic pain conditions
- An example of an older adult experiencing allodynia is one who is uncomfortable with the bed sheets resting on their feet or legs.

Breakthrough Pain: Pain that increases above the level of pain addressed by the ongoing analgesics; this would include incident pain and end-of-dose failure.

- Breakthrough pain is reported by 2 out of 3 people with continuous persistent pain.
- The pain may be sudden or gradual, brief or prolonged, spontaneous or predictable.

Duration: How long the pain has been experienced and continues to be present (lasting minutes or hours)

- Information is critical for evaluating the effectiveness of the treatment plan.
- Duration of pain can be gathered as part of a comprehensive history of the pain as well as each time pain is assessed.

Frequency: Number of occurrences in a specified period of time; how often pain is experienced in a given period.

- Knowing the frequency of pain is useful in developing treatment strategies and for individualized scheduling of care activities.

Incident-related pain: Pain triggered by specific movements or activities.

- Incident-related episodic pain is best treated by pre-medicating with a dose of short-acting opioid prior to the pain-inducing event, usually a PRN of a medication that is already prescribed.

Intensity (or Severity): The older adult's descriptive rating of the pain experience.

- Usually helpful to identify intensity for older adult's 'worst pain' over a specified period of time as well as 'the best the pain gets'



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- Assessing the older adult's present pain rating and an identified pain rating acceptable to the older adult is also important.
- Use the most appropriate scale individualized to the older adult's cognitive and sensory abilities.

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Location: Anatomic site(s) of pain

- Older adults often have pain in more than one location.
- Identify and document all sites with corresponding intensity and character.
- Pain maps are very useful in documenting all pain locations, guiding therapy, and as a tool in providing daily care (e.g., CNAs can use the pain map to establish the least painful ways to turn and/or ambulate the person they're working with).

Musculoskeletal pain (or somatic pain): Pain of the muscles, joints, connective tissues and bones

- This pain is relatively well localized, and is typically worse on movement.
- It is often described as a dull, or 'background' aching pain, although the area may be tender to pressure.

Nociceptive: Pain caused by tissue injury in the joints, bones, muscles and various internal organs. In contrast to neuropathic pain, the patient's nervous system is functioning normally, transmitting information about the injury to the brain.

- Nociceptive pain is typically well localized, constant, and often with an aching or throbbing quality.
- Usually time limited: when the tissue damage heals, the pain typically resolves. However, arthritis is a common nociceptive pain in older adults, and is not time limited.)
- Another characteristic of nociceptive pain is that it tends to respond well to treatment with opioids.
- Visceral pain is a subtype of nociceptive pain that involves the internal organs and tends to be episodic and poorly localized.

Neuropathic pain: Pain initiated or caused by a primary lesion or dysfunction in the nervous system

- Some of the words commonly used to describe neuropathic pain symptoms include burning, tingling, numb, squeezing, and itching. There may be electric shooting sensations, often radiating down a nerve path with accompanying sensitivity over the area of skin.
- Pain may persist for months or years beyond the apparent healing of any damaged tissues.
- Neuropathic pain is frequently chronic, and tends to respond less well to treatment with opioids, but may respond well to other drugs such as anti-seizure and antidepressant medications.
- Usually, neuropathic problems are not fully reversible, but partial improvement is often possible.

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Onset: Description of the experience of the beginning of the pain.

- The older adult may describe a sudden or gradual development of the pain, associated with a known injury or illness.
- Asking about onset can also help identify pain triggered by specific movement or activity.
- Asking about onset can also help to distinguish between acute and persistent pain.

Pain: An unpleasant sensory and emotional experience associated with or described in terms of actual or potential tissue damage.

- Pain is always subjective. It is unquestionably a sensation in a part or parts of the body, but it is also always unpleasant and therefore also an emotional experience.
 - Understanding this, it is often helpful to keep in mind that 'pain is whatever the older adult says it is, occurring wherever he/she says it does'.
- Pain is not observable or visible.

Pattern (or Rhythm): The course of the pain over time including variations, often influenced by times of day (e.g., certain hours of the day, night or day, monthly patterns), periods of rest, or specific or general activity/movement.

- Older adults can experience constant and/or episodic pain.
 - Analgesic therapy should be tailored to these patterns.
 - For example, short-acting analgesics are most appropriate for episodic pain, whereas long-acting agents are best for constant pain.
- Routinely dosed, short-acting agents may work well as an alternative to long-acting opioids in older adults.
- Older adults with both constant pain and episodic increases in pain (breakthrough pain) need both short-acting and long-acting medications.

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Persistent pain (chronic or constant pain): A painful experience that continues for a prolonged period of time that may or may not be associated with a recognizable disease process

- It is estimated that up to 80% of people living in nursing homes live with persistent pain.
- More than one clinical diagnosis typically contributes to persistent pain in the nursing home population, e.g., osteoarthritis, postherpetic neuralgia, spinal canal stenosis, cancer, post-stroke pain, diabetic peripheral neuropathy, and others.

Physical Dependence: The body's normal response to the continued use of several classes of medications.

- Physical dependence is a normal physiologic response that occurs with many classes of medications (e.g., beta blockers, alpha-2 adrenergic agents, corticosteroids, opioids and others).
- Withdrawal can be precipitated by: stopping the medication abruptly, rapidly reducing the dose, decreasing blood level of the drug, and/or administration of an antagonist (e.g., naloxone).
- Withdrawal symptoms are typically expected
- Gradual, planned tapering of the medication can usually eliminate any withdrawal symptoms.
- Monitoring of clinical symptoms during the tapering process is recommended.

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Pseudoaddiction: Development of abuse-like behaviors that are driven by desperation surrounding unrelieved pain and are eliminated by effective pain management.

- Behaviors that fall under the term 'pseudoaddiction' include those behaviors in which older adults with unrelieved pain become focused on obtaining medications, start "clock watching", or otherwise seem inappropriately "drug seeking".
- Behaviors considered to be related to pseudoaddiction may place the older adult, prescriber, or others at risk. When these behaviors occur, a careful assessment of the effectiveness of the current pain treatment plan should take place.
- Addiction and pseudoaddiction can both be present at the same time.
- Caution must be taken not to ignore a coexisting addiction even when some behaviors are considered to be pseudoaddiction. When more obvious, overt and potentially harmful drug-related behaviors (e.g., forging prescriptions) are also present, the pain team must assess for a coexisting addiction.

Quality (or Character): Description of the characteristics of the pain, preferably in the words used by the older adult to describe the pain.

- Helpful in determining the type of pain to guide the most appropriate analgesic.
- If the older adult has difficulty describing the pain, it may be helpful to offer examples of descriptions.
- These may include the following: aching, sore, cramping, pounding, sharp, throbbing, dull, nagging, penetrating, shooting, numb, tingling, spasm, burning, gnawing, pressure-like, radiating, stabbing, tingling, tender, knife-like, etc.
- Knowing the quality of pain may assist in distinguishing between types of pain: acute, chronic, nociceptive, and neuropathic.

Refractory pain: Resistant to ordinary treatment

- Older adults with refractory pain may need a referral to an outpatient pain clinic for a comprehensive, interdisciplinary evaluation and development of a treatment plan.

Tolerance: The body's normal response to continued exposure to a medication, resulting in a reduction of one or more of the drug's effects over time.

- Tolerance may occur to both the desired (i.e., analgesia) and undesired (e.g., nausea) drug effects.
- Tolerance tends to develop at different rates for different effects; for example, in the case of opioids, tolerance usually develops more slowly to the pain relieving effects than to respiratory depression, and tolerance to the constipating effects often do not occur at all.
- Tolerance to the pain relieving effects of opioids will likely occur in some, but not all, older adults.
- When tolerance to the pain relieving effects of opioids does occur, an increase in dose is recommended.

Visceral pain: Pain of the body's internal organs, a subtype of nociceptive pain

- This pain is often poorly localized and usually constant
- It is often described as deep & aching and is often referred to other sites.

