



**Smerte hos pasienter med kognitiv svikt:
Hva er det vi behandler –
agitasjon, depresjon eller smerte?**



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GRATULERER MED DAGEN!

- Senior > 50
- Eldre 60-75
- Gammel > 75



Tema

- Smertevurdering og -behandling: Hvorfor er det så vanskelig?
- Forekomsten av demens og smerte
- Smerte og atferdsproblemer
- Hva er det vi behandle?
 - Agitasjon, depresjon, smerte?
- Pågående prosjekter

Smertevurdering og -behandling: Hvorfor er det så vanskelig?

- Pasienter mangler hukommelse, språk, refleksjon og forventning
- Proxy tester
- Akutt vs. kronisk smerte (>90%)
- Pain avoidance effect
- Smerte i muskel- og skjelettsystemet vs. indre organer
- Smertenettverk i hjernen kan rammes av demensutviklingen
- Smerteatferd kan ligne på demensatferd

Smerte hos sykehjemspasienter med demens

Pasienter på sykehjem lider av vedvarende, underdiagnostisert og mangelfullt behandlet smerte (AGS-Panel 1998; Frampton 2003).

83% av sykehjemspasientene opplever regelmessig smerte som fører til inaktivitet, depresjon og redusert livskvalitet (Ferrell 1995).

Pasienter uten kognitiv svikt får 3 ganger mer analgetika enn pasienter med demens (Cohen-Mansfield 2002).

43–57% i Nederlande og Finland (Achterberg 2012), 57-60% (Husebo 2008, Sandvik 2014)

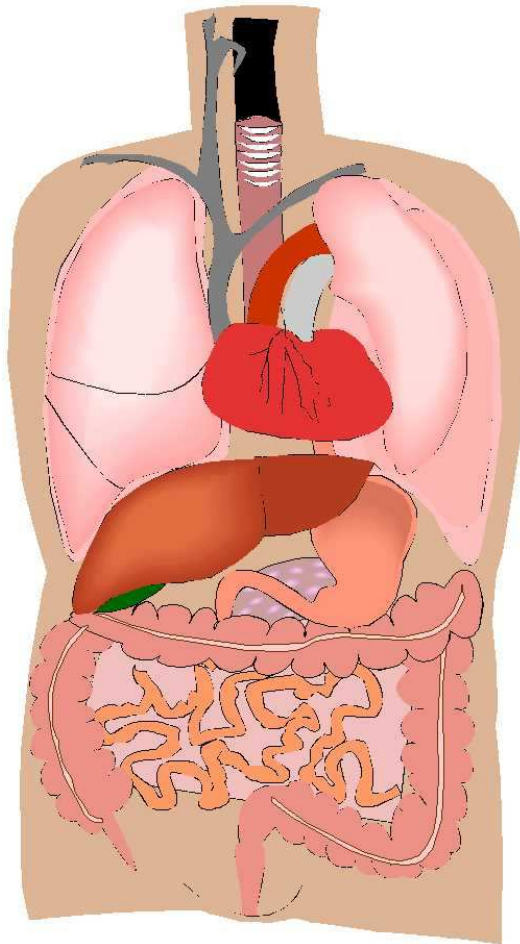
Nociseptiv somatisk smerte



Oppstår i skjelett, hud og bindevev (Moroz a 2008)

- Lett å lokalisere
- Skarpt avgrenset
- Murrende
- Stikkende

Nociseptiv visceral smerte

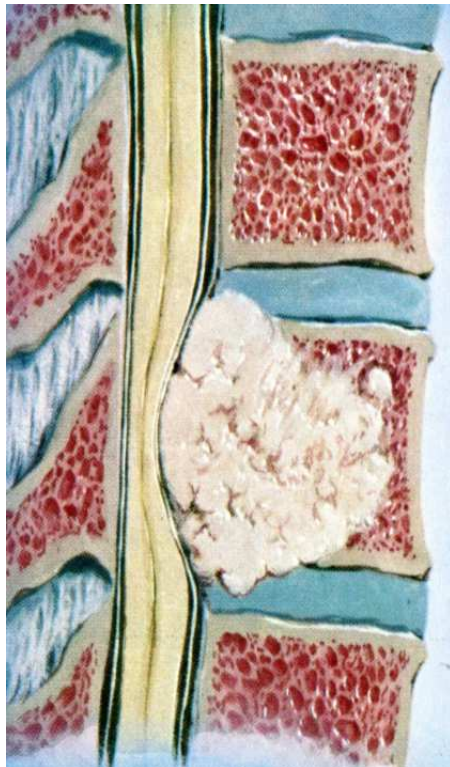


Smerte fra indre organer (Norsk legemiddelhåndbok, 2009)

- Inntrer mer langsomt
- Diffus
- Verkende
- Murrende
- Vanskelig å lokalisere
- Ofte med smerte referert til kroppens overflate

Nevropatisk smerte

Smerte oppstått ved skade eller dysfunksjon av nervevev (Jørum E, 2009)



- Perifer og sentral nevropatisk smerte
- Spontan (uavhengig av stimulus)
- Vedvarende
- Anfallsvis (lynsmerter)
- Verkende, brennende, sviende, skjærende
- Provosert smerte



I. Verbal smerteuttrykk

Verbalt smerteuttrykk og smertelyder må registreres



- Lyder eller ord:
“Au”, “det gjør vondt”, stønning, roping, klaging

Vær oppmerksom på:

- Afasi, fremmed språk

Referanse: For fullstendig referanseliste se oversiktsbilde



II. Ansiktsuttrykk



- Rynker på pannen
- Lukker øynene
- Presser munnen

Vær oppmerksom på:

- Hud, rynker, gebiss, parese, Parkinsons sykdom
- Kronisk – akutt smerte
- Angst

Referanse: For fullstendig referanseliste se oversiktsbilde



III. Avverge reaksjoner

Kroppsspråk



- Stivner, holder pusten
- Avverger
- Beskytter seg
- Uro, agitasjon, aggresjon, apati
- Vandring, søvn, appetitt

Vær oppmerksom på:

- Immobilitet (parese)
- Kontraktur, Parkinsons sykdom
- Manglende evne til å forvente smerte

Referanse: For fullstendig referanseliste se oversiktsbilde



Pleiepersonalet

- Tettest kontakt med pasient under morgenstell - eksperter
- Observasjon er avhengig av opplæring og oppmerksomhet
- Tilvenningseffekt? Selvbeskyttelse?

MOBID-2 smerteskala

Mobilization

Observation

Behaviour

Intensity

Dementia

MOBID-2 Del 1

Mobid-2 smerteskala

Mobilisation – Observation – Behaviour – Intensity – Dementia

Pasientens navn: _____

Dato: _____ Tid: _____ Avdeling: _____

Vær oppmerksom på pasientens smerteatferd relatert til muskulatur, ledd og skjelett under morgenstell. Observer pasienten før du starter mobilisering. Forklar forståelig det du vil gjøre. Led pasienten, og gjennomfør bevegelsene (1-5) med forsiktighet. Stopp bevegelsen om du observerer smerteatferd. Fyll ut skjemaet umiddelbart etter hver bevegelse.

SMERTEATFERD

Sett ett eller flere kryss for hver observasjon som kan være relatert til smerte; smertelyd, ansiktsuttrykk og avvergereaksjon



Smertelyd
«Au!»
Stønner
Yrker seg
Gisper
Skriker



Ansiktsuttrykk
Grimaserer
Rynker pannen
Strammer munnen
Lukker øynene



Avvergereaksjon
Stivner
Beskytter seg
Skyver fra seg
Endringer i pusten
Krymper seg

1. Led til å åpne begge hender	☐	☐	☐
2. Led til å strekke armene mot hodet	☐	☐	☐
3. Led til å bøye og strekke ankler, knær og hofterledd	☐	☐	☐
4. Led til å snu seg i sengen til begge sider	☐	☐	☐
5. Led til å sette seg opp på sengekanten	☐	☐	☐

SMERTEINTENSITET

Tolk styrken av smerteintensiteten basert på observert smerteatferd og sett kryss på linjen 0-10, hvor 0 er ingen smerte og 10 er verst tenkelig smerte

0 er ingen smerte, 10 er verst tenkelig smerte



Referanse: For fullstendig referanseliste se oversiktsbilde



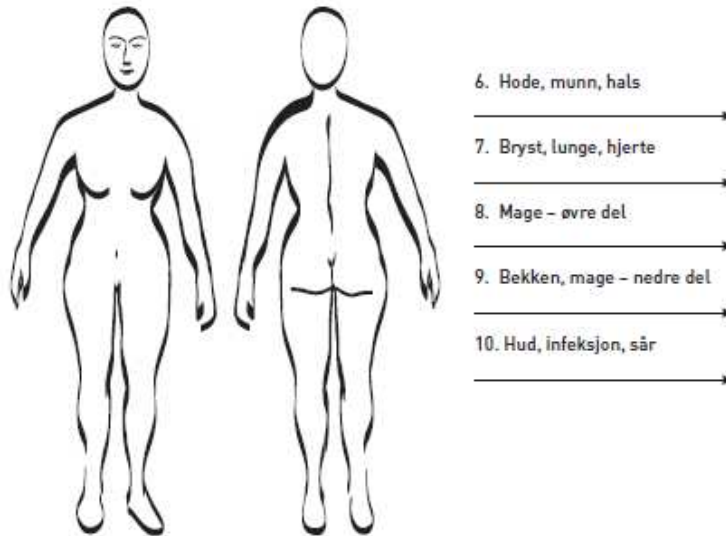
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MOBID-2 Del 2

Vær oppmerksom på pasientens smerteatferd relatert til indre organer, hode og hud. Smerte kan oppstå på grunn av en sykdom, sår, infeksjon eller ulykker. Inkluder alle dine observasjoner fra i dag og de siste dagene (siste uken).

SMERTEATFERD

Bruk front- og baksiden av kroppstegningen aktivt. Sett kryss for dine observasjoner relatert til smerteatferd (smertelyder, ansiktsuttrykk og avvergereaksjon)

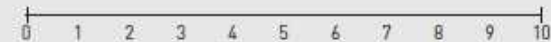


SMERTEINTENSITET

Tolk styrken av smerteintensitet basert på observert smerteatferd og sett kryss på linjen 0-10, hvor 0 er ingen smerte og 10 er verst tenkelig smerte



Gi en helhetlig vurdering av pasientens smerteintensitet basert på alle observasjoner



Battres Helseklubb AS, Institutt for samfunnsmedisinske fag, Universitetet i Bergen

Referanse: For fullstendig referanseliste se oversiktsbilde

Measurement properties

RELIABILITY

- Inter-rater reliability
- Intra-rater reliability
- Test-retest reliability
- Internal consistency

VALIDITY

- Construct
- Concurrent
- Content

RESPONSIVENESS

Husebo et al. Pain Sympt Manage 2007

Husebo et al. JAMDA 2008

Husebo et al. Scand J Caring Sci 2009

Husebo. Int Assoc Stud Pain (IASP) 2009

Husebø. Tidsskr Nor Laegeforen 2009

Husebø & Husebø. Nord Tidsskr Pall Med 2009

Husebo et al. Scand J Caring Sci 2010

Sandvik & Husebø. Sykepleien 2011

Sandvik & Husebø. DemensAlderspsyk 2012

Husebo et al. Eur J Pain 2014



Når bør MOBID-2 brukes?

- Ved mistanke om akutt eller langvarig smerte - minst 2 ganger i året
- Ved atferdsproblemer: agitasjon, aggresjon, depresjon
- 2-4 dager etter oppstart av smerte behandling
- Ved endring av smertemedikasjon

**HUSK! Unngå at en pasient blir stående unødig lenge på
Medikamenter hun ikke har behov for**
Vurderinger bør gjøres regelmessig, feks. hver 8-12 uke

What do we know?

60 %

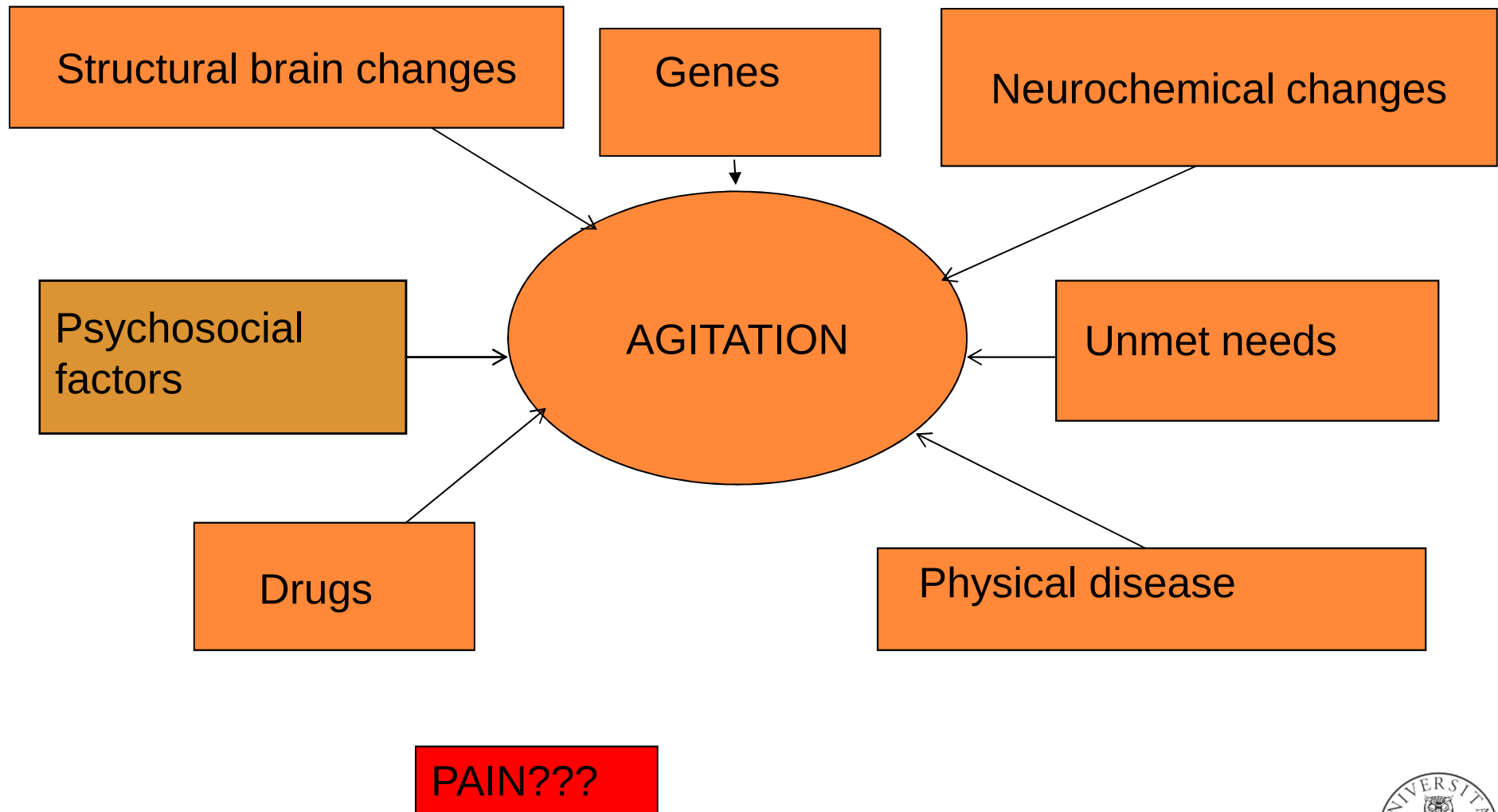
av sykehjemspasienter har smerte (Husebø 2009; Achterberg 2012)

>70 %

av pasienter med demens har atferdsproblemer (Selbæk 2007)

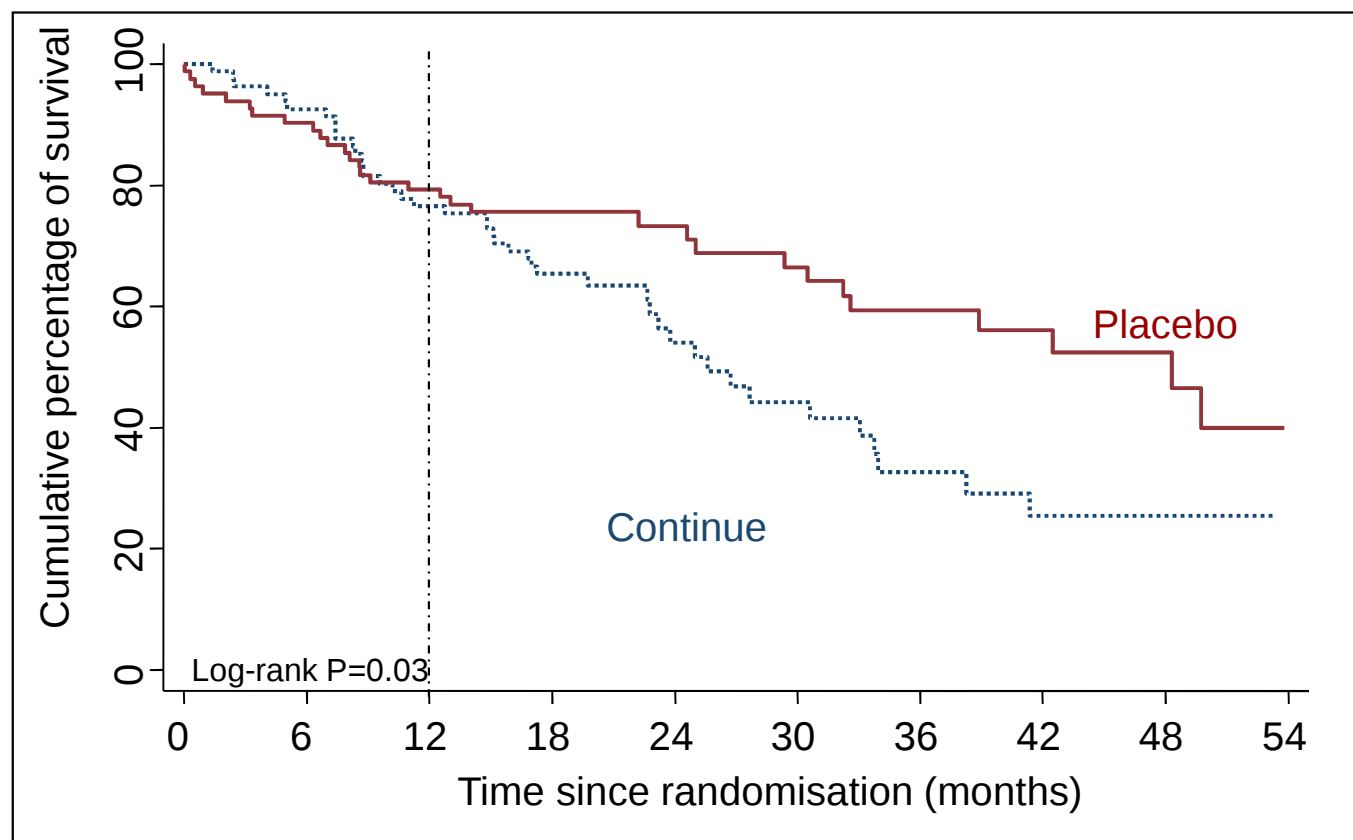
Effekt av smerte på atferd?

Behavioural disturbances: Multi-factorial



Antipsykotika reduserer livsforventning

The CALM-AD study



Log rank p=0.02

At risk (No. of deaths) in subsequent 12 months:

Continue	83 (21)	62 (14)	23 (8)	10 (2)	4 (0)
Placebo	82 (17)	65 (4)	32 (6)	21 (2)	9 (2)

Ballard et al 2009 Lancet Neurology

The dementia antipsychotic withdrawal trial (DART-AD): long-term follow-up of a randomised placebo-controlled trial.
www.thelancet.com/neurology 09 Jan 2009



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Efficacy of treating pain to reduce agitation in residents of nursing homes with dementia: A cluster RCT

- Setting: 18 NHs, 60 NH units (N=352), 5 municipalities in Norway
- Design: Cluster-randomised, 8 week trial + 4-w wash-out period
- Inclusion criteria: 65+ NH resident, dementia, clinically significant agitation for at least one week (ie 39+ on CMAI)
- Exclusion: advanced severe medical illness with expected survival < 6 months, severe psychiatric/neurological disorder, severe aggression, severe renal/liver failure

RESEARCH

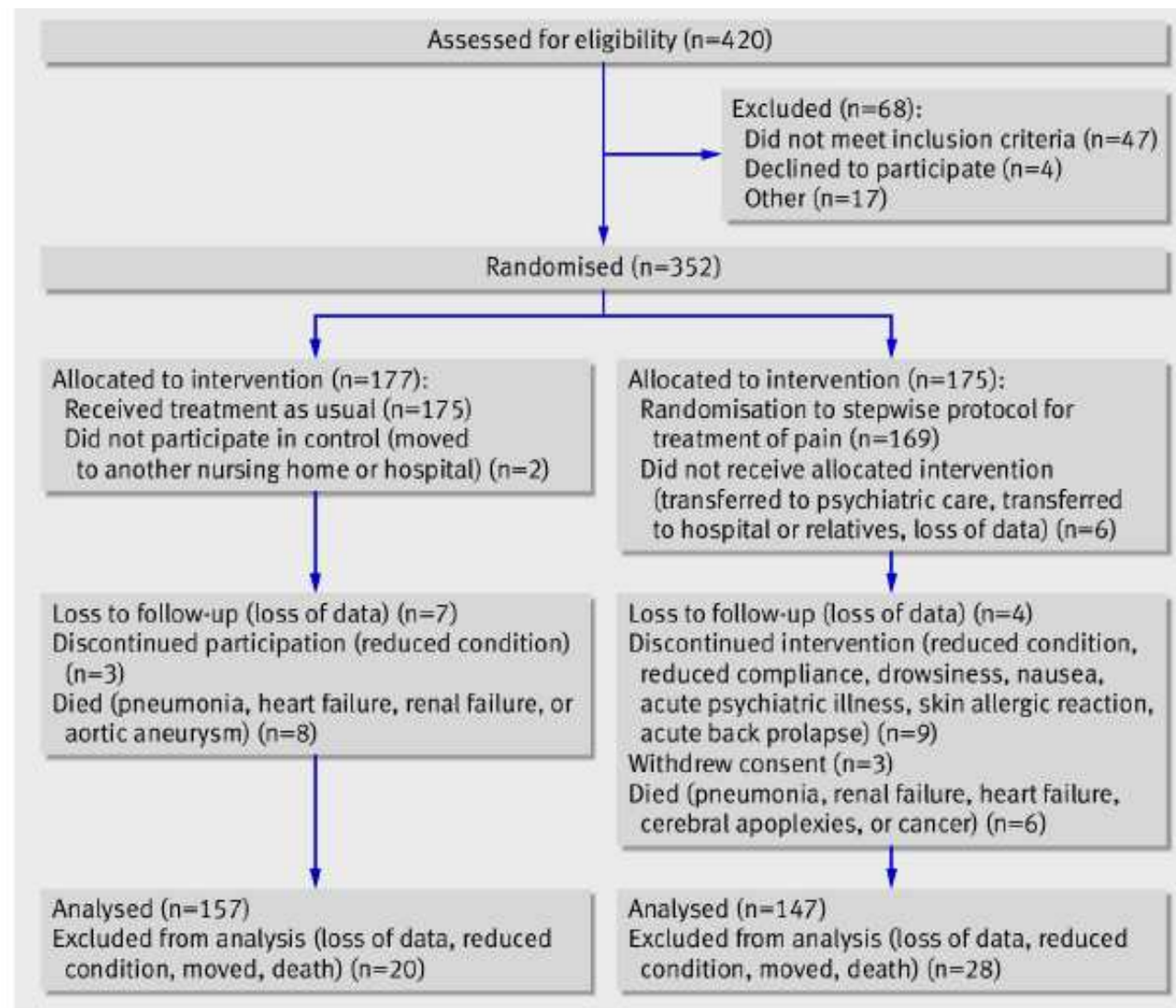


Fig 1 Flow of participants through trial



Smertebehandling

Trinnvis protokoll for smertebehandling		
Patienter med smerte eller atferdsproblemer	Basisbehandling	Smertemedisin og dosering
Med/ uten smerte	Uten smertemedisin	Paracetamol (maks. dose: 3g/d)
Med smerte	Paracetamol og/eller NSAIDs	Morfin (5-10 mgx2/d; forsiktig økning)
Med smerte og svelgeproblemer	Paracetamol og/eller NSAIDs	Buprenorphin plaster (5ug/h, change each 7.day; forsiktig økning)
Neuropathic pain	Paracetamol and/or Morphine	Pregabalin (25 mgx1/d, forsiktig økning)

Assessment of agitation, dementia, pain

Primary outcome measures

Cohen-Mansfield Agitation Inventory – long form (CMAI)

Secondary outcome measures

Mini-Mental State Examination (MMSE)

Functional Assessment Staging (FAST)

Activities of Daily Living (ADL)

Neuropsychiatric Inventory-Nursing Home Version (NPI-NH)

MOBID-2 Pain Scale (MOBID-2)

Reduced agitation during pain-treatment

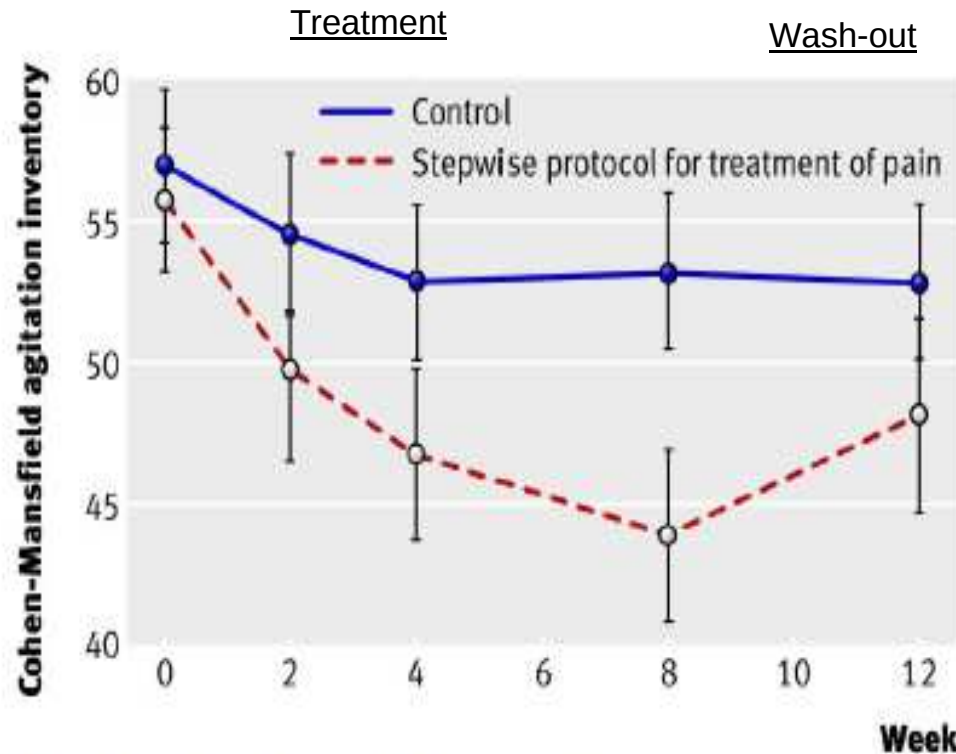


Fig 2 Cohen-Mansfield agitation inventory scores, with 95% confidence intervals, over study period

Repeated measurement ANCOVA (LOCF): $p < 0.001$
Average reduction 17%; Treatment effect 7.0 (95% CI 3.7-10.3)

BMJ

BMJ 2011;343:d4065 doi: 10.1136/bmj.d4065

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RESEARCH

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

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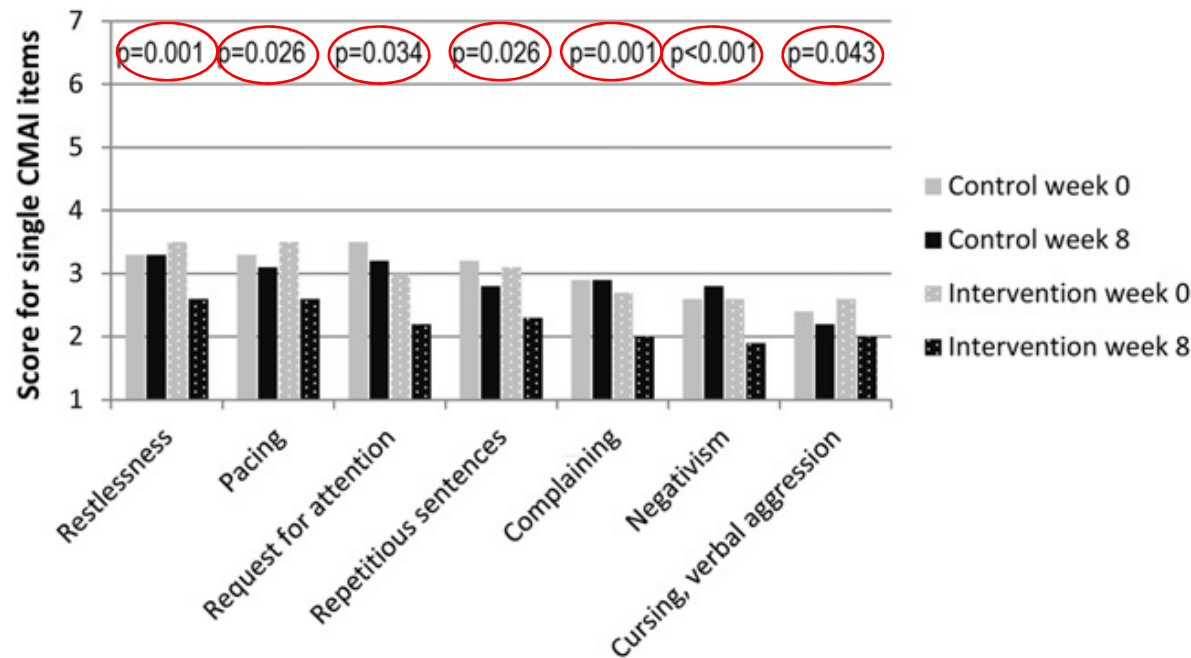
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The Response of Agitated Behavior to Pain Management in Persons with Dementia

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Jiska Cohen-Mansfield, Ph.D., A.B.P.P., Reinhard Seifert, B.Sc.,
Dag Aarsland, M.D., Ph.D.

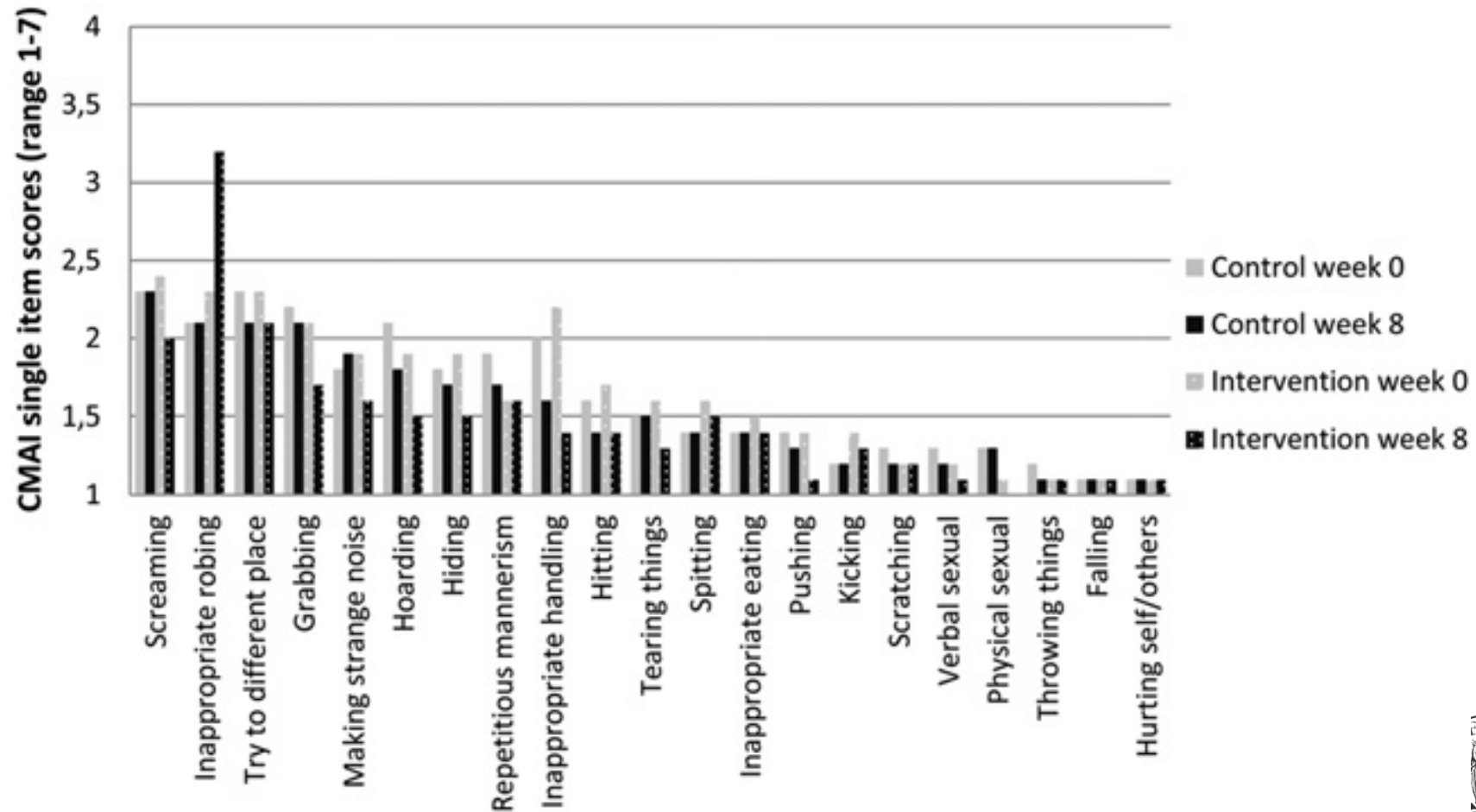


Objectives: Behavioral disturbances and pain are common in nursing home (NH) patients with dementia. An association between pain and increased agitation has been suggested, and recently a significant reduction of agitation has been demonstrated by pain treatment in patients with moderate to severe dementia. We now examined which specific agitated behaviors respond to individualized pain treatment. **Design:** Cluster randomized clinical trial. **Setting:** 60 clusters (i.e., clusters defined as single independent NH units) in 18 NHs within five municipalities of Western Norway. **Participants:** 352 patients with moderate to severe dementia and clinically significant behavioral disturbances. **Intervention:** The control group received usual treatment and care. According to a predefined scheme for 8 weeks, all patients in the intervention group received individual daily pain treatment with acetaminophen, extended release morphine, buprenorphine transdermal patch, and/or pregabalin. **Measurements:** Cohen-Mansfield Agitation Inventory subscales and items. **Results:** Analyses demonstrated that Factor 3 (Verbally agitated behaviors) showed the largest significant difference ($DF = 1294.0, t = -4.308, p < 0.001$), followed by Factor 2 (Physically non-aggressive behaviors) ($DF = 1198.0, t = -2.672, p = 0.008$), and Factor 1 (Aggressive behaviors) ($DF = 1196.0, t = -2.093, p = 0.037$) after 8 weeks, by a linear random intercept mixed model in two-way repeated-measures configuration with adjustment for heteroscedasticity. **Conclusion:** We found that verbal agitation behaviors such as complaining, negativism, repetitious sentences and questions, constant request for attention, and cursing or verbal aggression responded to pain treatment. In addition, restlessness and pacing were sensible to analgesics. Such behaviors should therefore lead to an assessment of pain, and pain treatment. Further studies comparing how pain treatment should be balanced against other strategies including psychotropic drugs are needed. (Am J Geriatr Psychiatry 2013; ■■■■)

Key Words: Dementia, agitation, aggression, behavioral disturbances, pain, pain treatment, cluster randomised trial, nursing home

Received February 22, 2012; revised December 8, 2012; accepted December 12, 2012. From the Department of Public Health and Primary Health Care Center for Elderly- and Nursing Home Medicine, University of Bergen, and Center for Age-Related Medicine, Stavanger University Hospital, Stavanger, Norway (BSH); Kings College, London, UK, and Center for Age-Related Medicine, Stavanger University Hospital, Stavanger (CB); Tel-Aviv University Sackler Faculty of Medicine and Herzog Institute on Aging, Israel, and George Washington University Medical Center, Washington, DC (JC-M); Heart Department, Haukeland University Hospital, Bergen (RS); Karolinska Institute (KI), Department of Neurobiology, Care Sciences and Society, KI-Alzheimer Disease Research Center, Stockholm, and Center for Age-Related Medicine, Stavanger University Hospital, Stavanger (DA). Send correspondence and reprint requests to Bettina S. Husebo, University of Bergen, Department of Public Health and Primary Health Care, Kalfarveien 31, N-5020 Bergen, Norway; e-mail: Bettina.Husebo@isf.uib.no
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<http://dx.doi.org/10.1016/j.jagp.2012.12.006>

Efficacy of pain treatment (intervention group) on single CMAI items that did not differ between groups compared with control group for all patients at baseline and week 8.



Sertraline or mirtazapine for depression in dementia (HTA-SADD): a randomised, multicentre, double-blind, placebo-controlled trial



Sube Banerjee, Jennifer Hellier, Michael Dewey, Renee Romeo, Clive Ballard, Robert Baldwin, Peter Bentham, Chris Fox, Clive Holmes, Cornelius Katona, Martin Knapp, Claire Lawton, James Lindesay, Gill Livingston, Niall McCrae, Esme Moniz-Cook, Joanna Murray, Shirley Nurock, Martin Orrell, John O'Brien, Michaela Poppe, Alan Thomas, Rebecca Walwyn, Kenneth Wilson, Alistair Burns

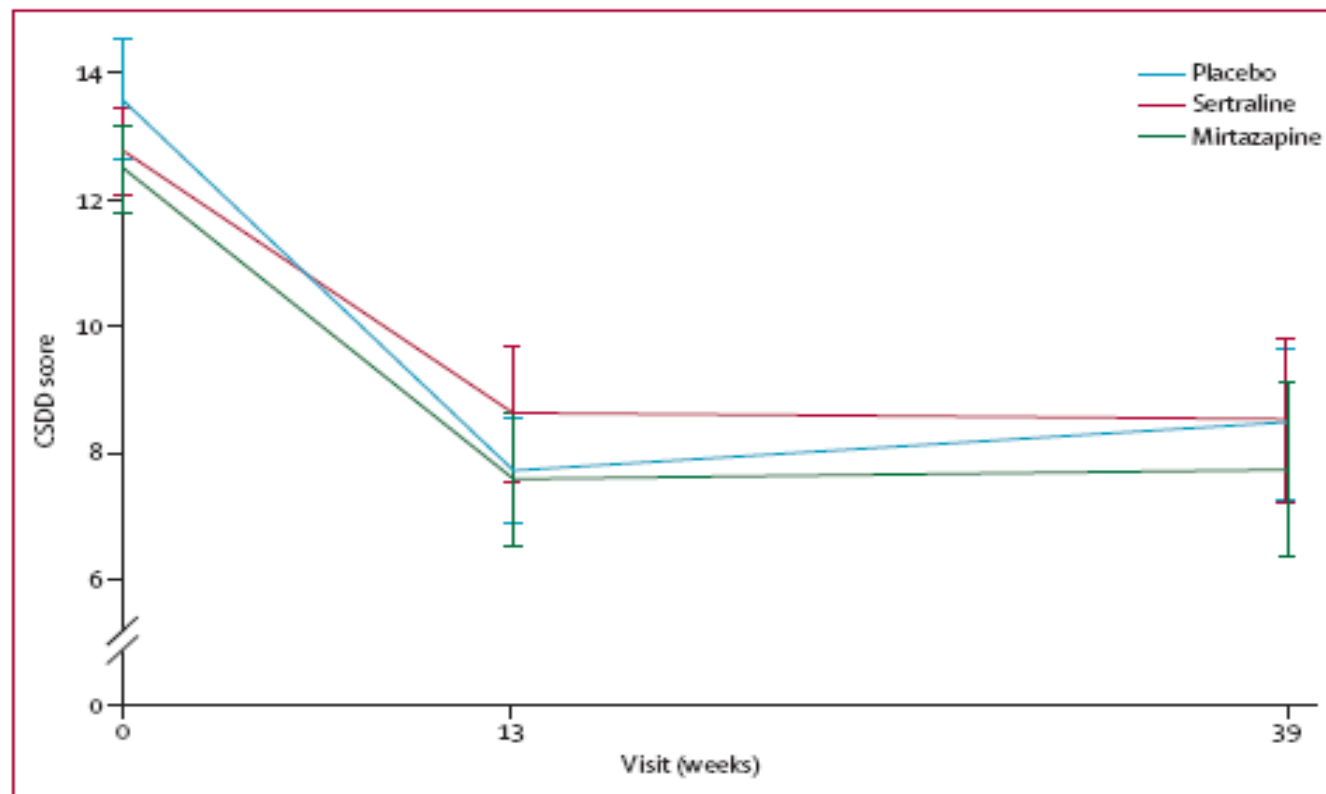
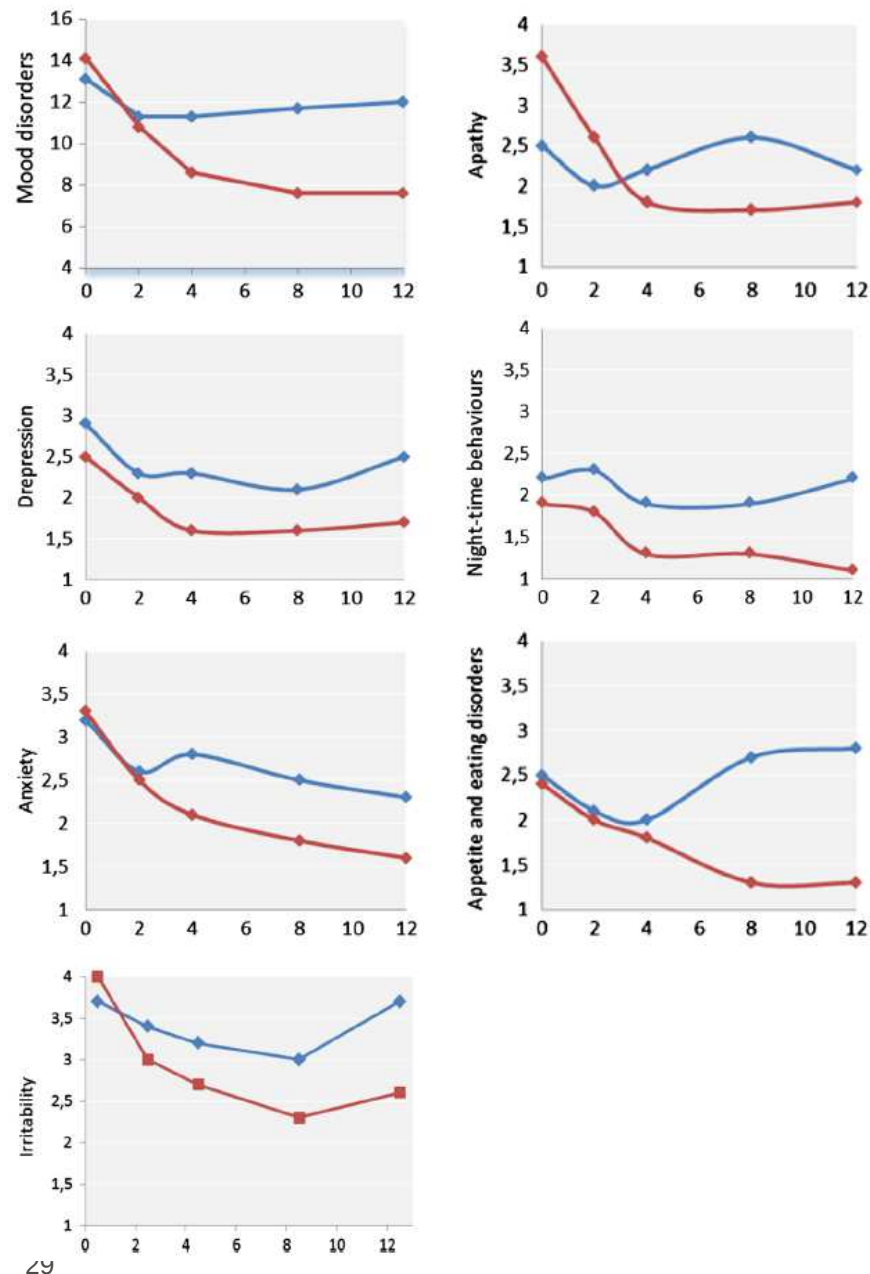


Figure 2: Unadjusted mean CSDD scores by treatment group
Lowest score is best. Error bars show 95% CIs. CSDD= Cornell scale for depression in dementia.



RESEARCH ARTICLE

International Journal of
Geriatric Psychiatry

Efficacy of pain treatment on mood syndrome in patients with dementia: a randomized clinical trial

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Background: Depression is common in nursing home (NH) patients with dementia, and often clustered with anxiety and other mood symptoms. An association between pain and depressive symptoms has been reported, but the impact of pain management on depression and other mood symptoms has not been investigated.

Objective: Secondary analyses of a cluster randomized clinical trial examine the response of dementia-related mood symptoms to a Stepwise Protocol of Treating Pain.

Method: Three-hundred fifty-two patients with moderate and severe dementia and significant behavioural disturbances, related to 60 clusters (i.e. clusters defined as single independent NH units) in 18 NHs of Western Norway, were included. All patients in the intervention group received individual daily pain treatment with paracetamol, extended release morphine, buprenorphine transdermal patch or pregabalin for 8 weeks, with additional follow-up assessment 4 weeks after completion of the intervention. Clusters randomized to control received usual treatment. A mood cluster consisting of depression, anxiety, sleep disorders, apathy and appetite items from the Neuropsychiatric Inventory-Nursing Home (NPI-NH) was the primary outcome.

Results: Analysed by Mann-Whitney *U*-tests, Stepwise Protocol of Treating Pain conferred significant benefit in treatment of the NPI-NH mood cluster ($F=13.4$, $df=1;299$, $p<0.001$) and depression ($F=2.0$, $df=1;301$, $p=0.025$). Further analyses highlighted improvements in apathy ($F=5.3$, $df=1;300$, $p=0.017$), night-time behaviours ($F=3.1$, $df=1;301$, $p=0.050$), and appetite items ($F=11.6$, $df=1;301$, $p=0.005$), but not irritability ($p=0.092$) and anxiety ($p=0.125$).

Conclusion: Mood symptoms including depression significantly improved with pain treatment, emphasizing the importance of more rigorous treatment of pain in agitated people with dementia. Findings have potentially immediate clinical relevance. © 2013 The Authors. *International Journal of Geriatric Psychiatry* published by John Wiley & Sons Ltd.

Key words: dementia; depression; anxiety; pain; nursing home

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DOI: 10.1002/gps.4063

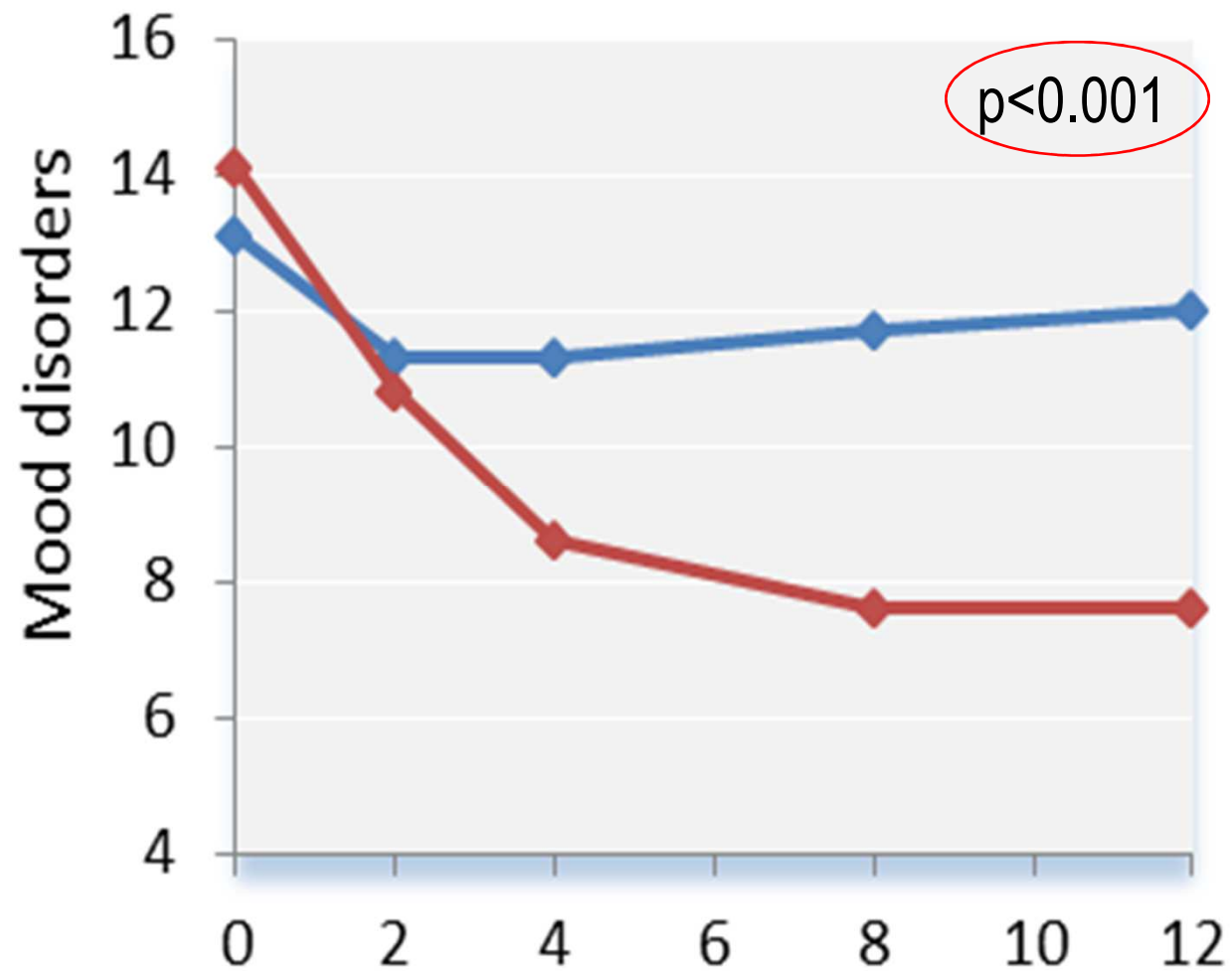
Introduction

In nursing homes (NH), 80% of the patients have dementia, and of them, 90% have one or more neuropsychiatric symptoms (NPSs) (Selbaek *et al.*, 2008). The most frequently occurring of the NPS are

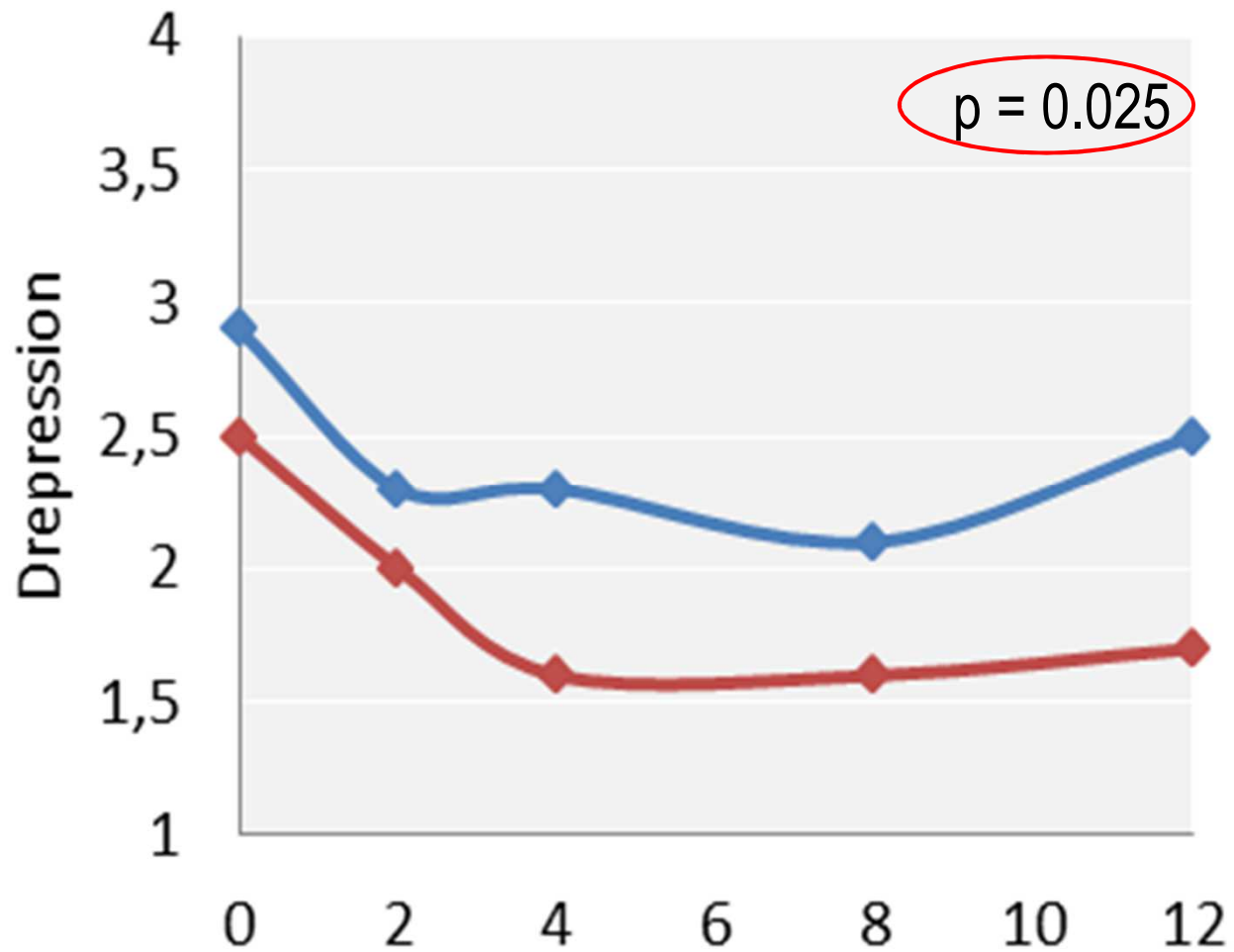
depression, apathy and anxiety (Robert *et al.*, 2005). The prevalence of these symptoms differs in accordance to the diagnoses and severity of dementia. In patients with Alzheimer's disease, about 50% will have depressive symptoms at some stage of the disease (Lyketos and Olin, 2002). In vascular dementia,

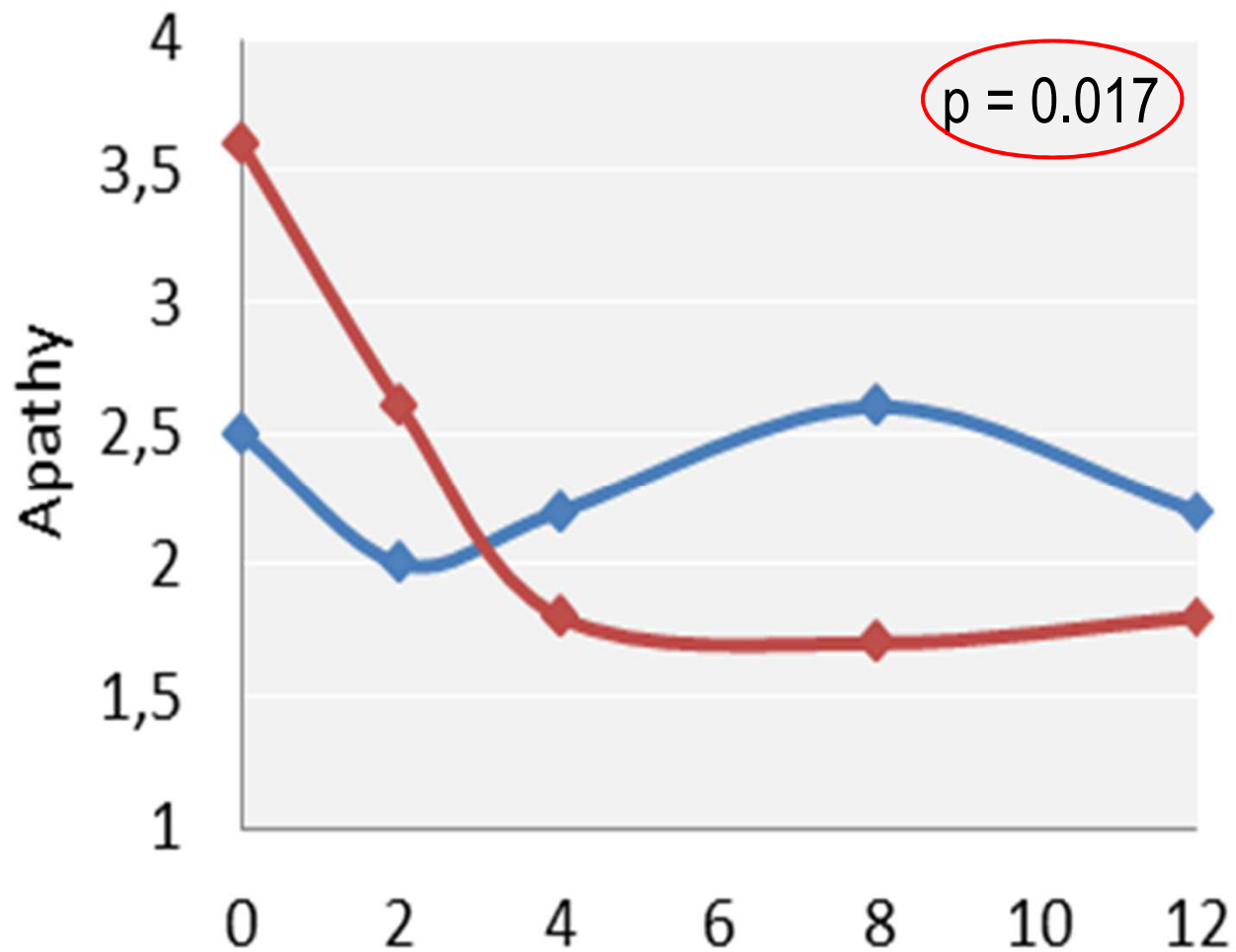
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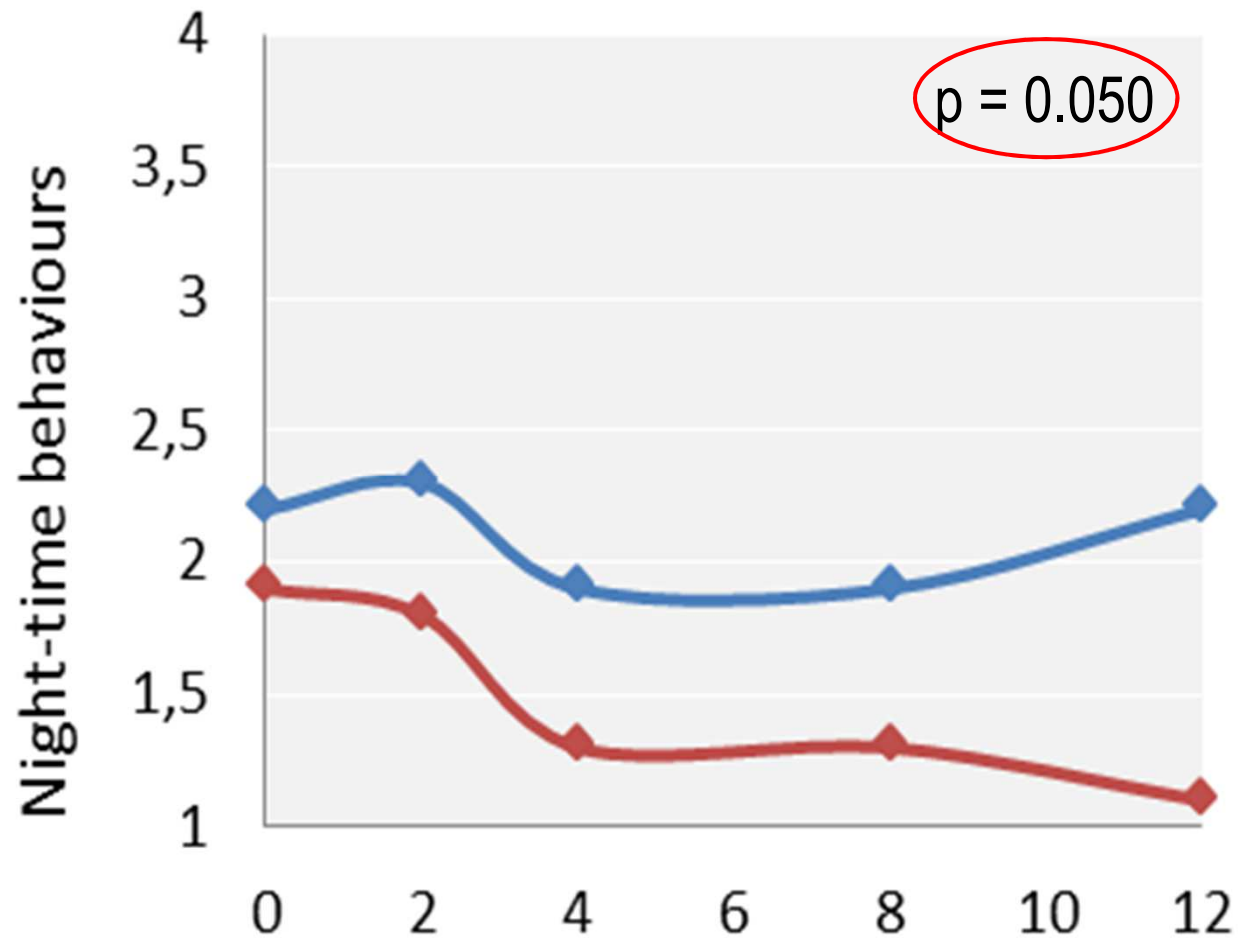


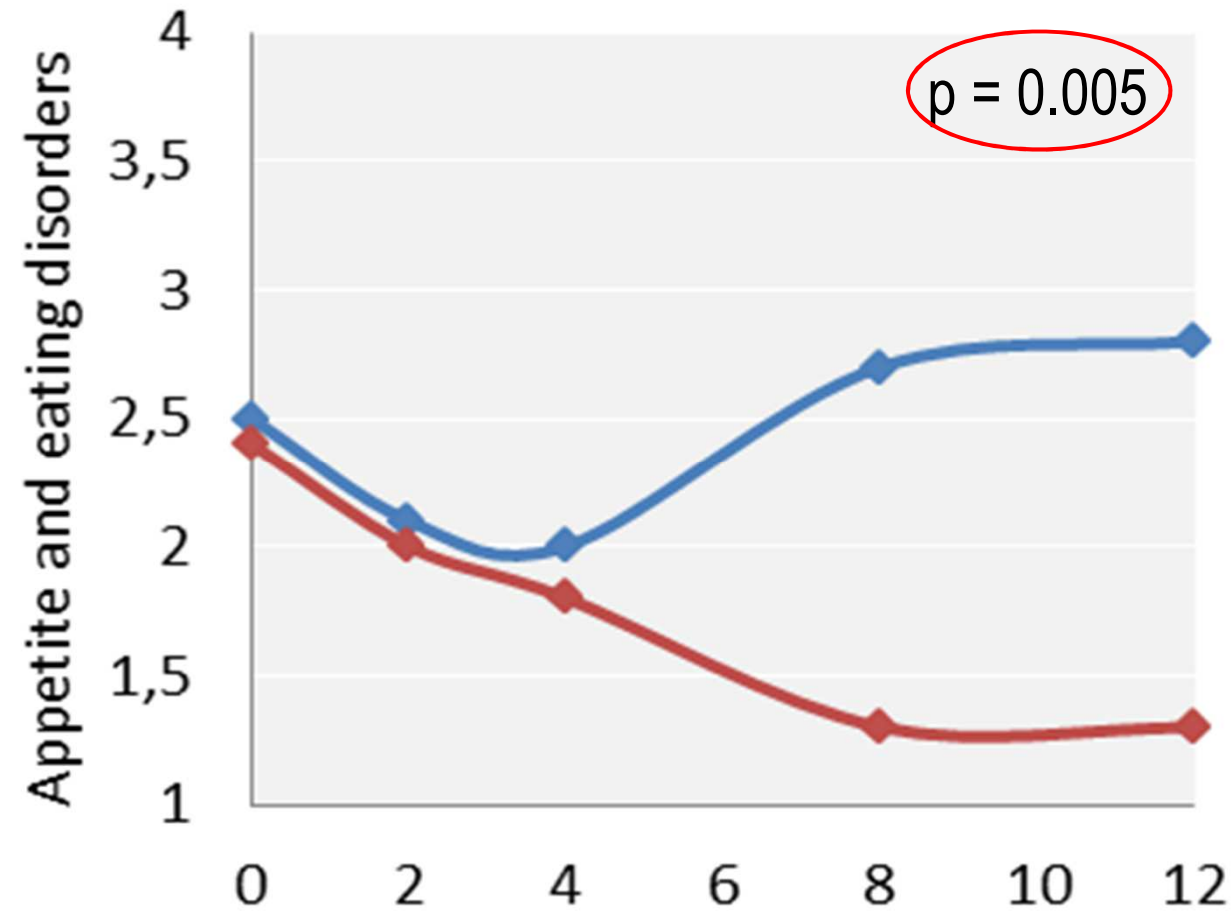


Husebo et al. Int J Geriatr Psychiatry 2014









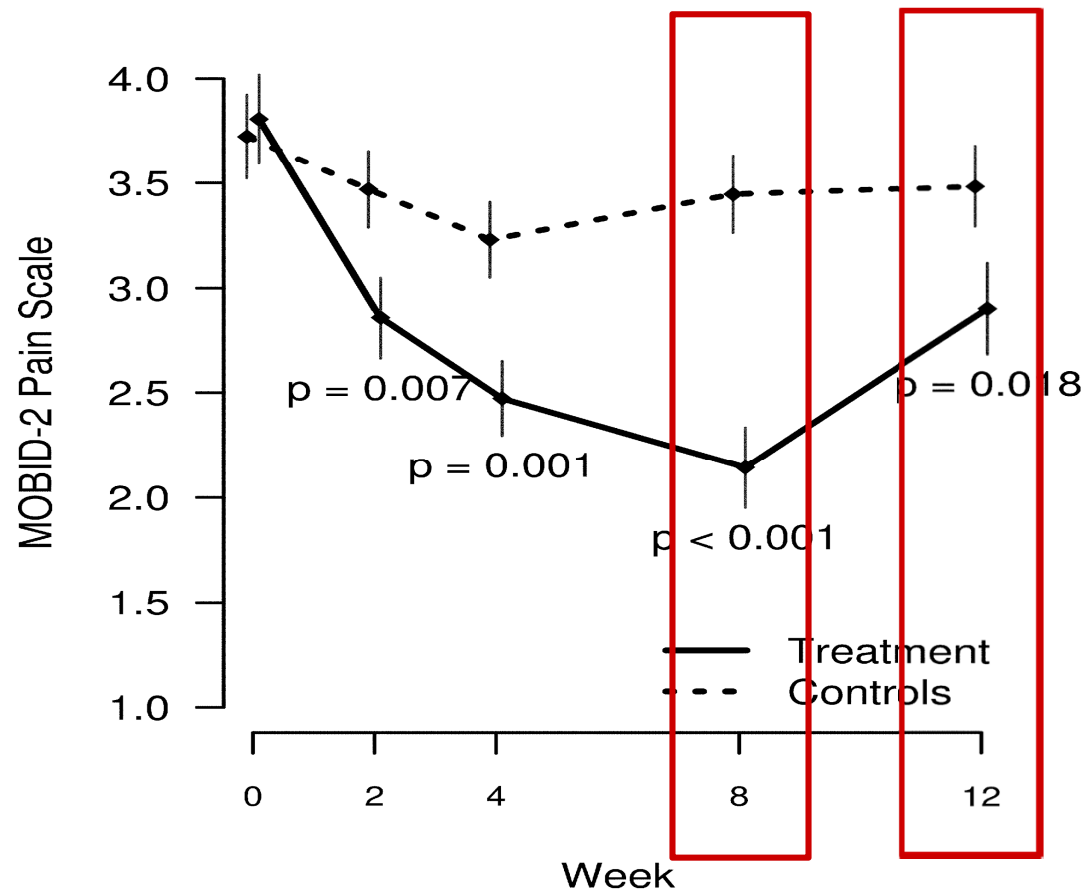


Fig: Pain intensity between treatment and control group during eight weeks of treatment and four week wash-out



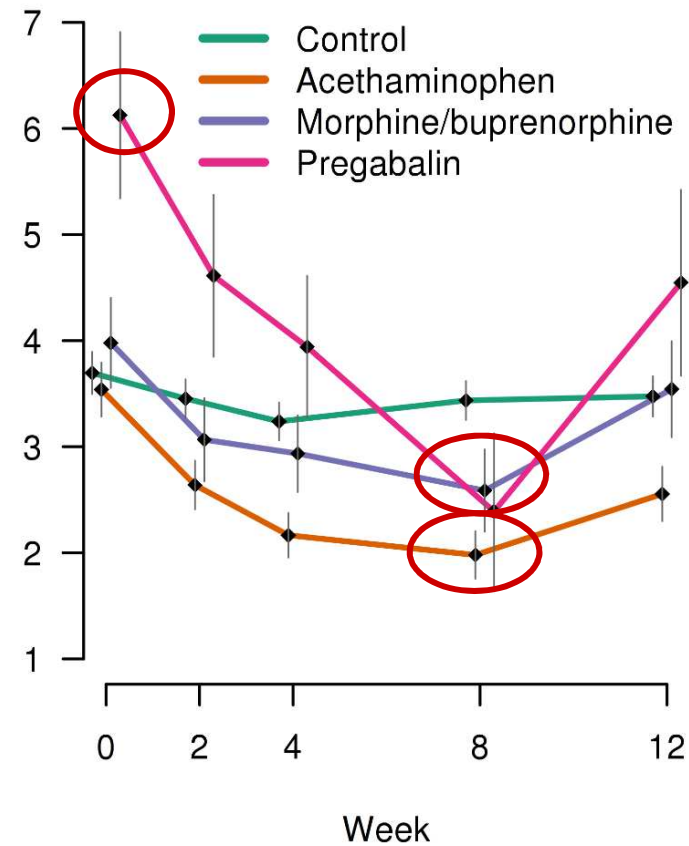


Fig: Pain intensity in all groups during eight weeks of treatment and four week wash-out

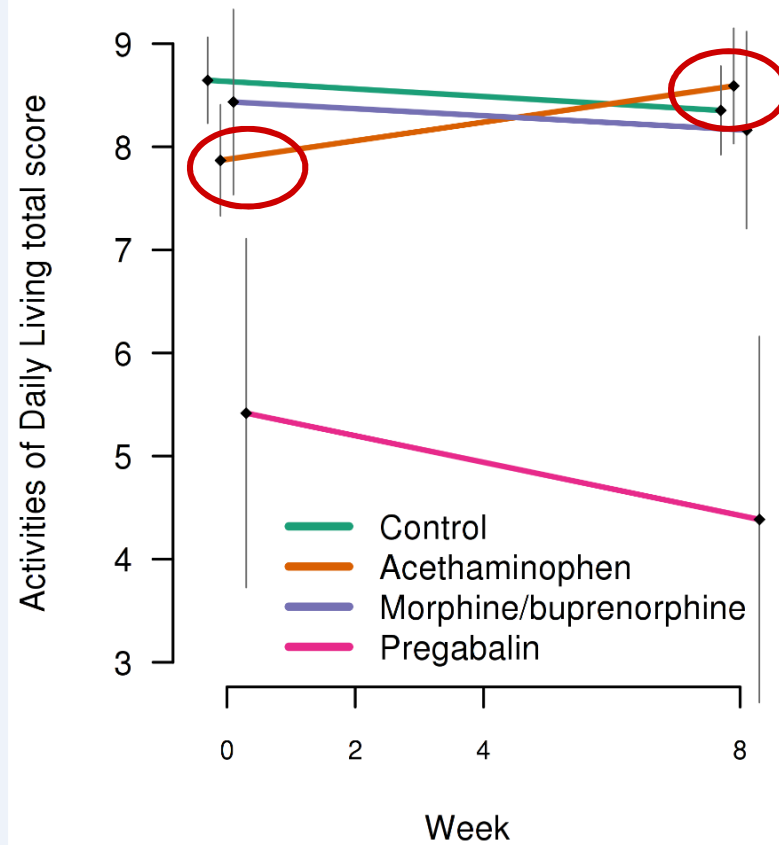


Fig: Activities of daily living in all groups during eight weeks of treatment

Sandvik et al. Eur J Pain 2014.

But time is changing...

- Kungsholmen Study: 46% of the patients (N=2610) > 64 years with dementia used at least one analgesic drug compared with 25% of those without dementia. (Haasum Y et al 2011)
- Sweden, Finland use of analgesics (N=546) >85 years, with and without dementia, at home. In dementia, significantly higher proportion used paracetamol, no differences for opioids. (Lovheim H 2008)
- Finland: Use of strong opioids, especially due to transdermal fentanyl, was higher in patients with dementia (Hamunen K 2006)
- Increasing warnings against morbidity and death associated with the initiation of fentanyl in previously opioid-naïve patients (Dosa DM 2009)
- Denmark: 41% of NH patients receive opioids (Jenssen 2014)

REVIEWS

Corbett A, Husebo BS, Malcangio M et al. Nature Review Neurology 2012; 8: 264-74.

Assessment and treatment of pain in people with dementia

Anne Corbett, Bettina Husebo, Dag Aarsland and Peter Verhaeghen

John-Mansfield,

Abstract

People with dementia often do not take analgesic medication. Pain is also common in people with severe disease. As no robust clinical guidelines are available in the context of dementia, the risk of inadequate treatment in individuals with dementia is high. Moreover, our understanding of the aetiology of pain and the potential for central sensitization and neuropathology in pain is limited. These issues are important in the clinical management of individuals with dementia, as untreated pain is a major contributor to reduced quality of life, increased behavioural and psychological symptoms. Assessment scales to identify pain in people with dementia have been highlighted in recent studies, but there is little evidence for consistency between these tools. Numerous studies have evaluated various approaches for the treatment of pain, including stepped-care protocols and/or administration of paracetamol and opioid medications. In this Review, we summarize the best-available evidence regarding the aetiology, assessment and treatment of pain in people with dementia. Further validation of assessment tools and large-scale trials of treatment approaches in people with dementia are needed to improve clinical guidance for the treatment of pain in these individuals.

Corbett, A. et al. Nat. Rev. Neurol. 8, 264–274 (2012); published online 10 April 2012; doi:10.1038/nrneurol.2012.53

Konklusjon

- Ja, takk –begge deler...
- Systematisk smertevurdering ved bruk av MOBID-2 smerteskala
- Kontakte legen ved MOBID-2 skår ≥ 3
- Kompetent behandling av underliggende fysiske sykdommer for eksempel UVI, tannpine eller magesår
- Trinnvis protokoll for smerte-behandling med medikamenter
- Andre hensiktsmessige tiltak: kommunikasjon, massasje, musikkterapi og tilrettelegging av hjelpemidler
- Også for smertemedikamenter bør vi ha en plan for seponering!

Effekten av smertebehandling på depresjon hos personer med demens.

DEP·PAIN·DEM studie (2013-2015)

Finansiering: Norsk forskningsråd

Start: September 2013

Personellressurser

1 PhD kandidat (100%)

Postdok forsker (50%)

Statistikker (20%)

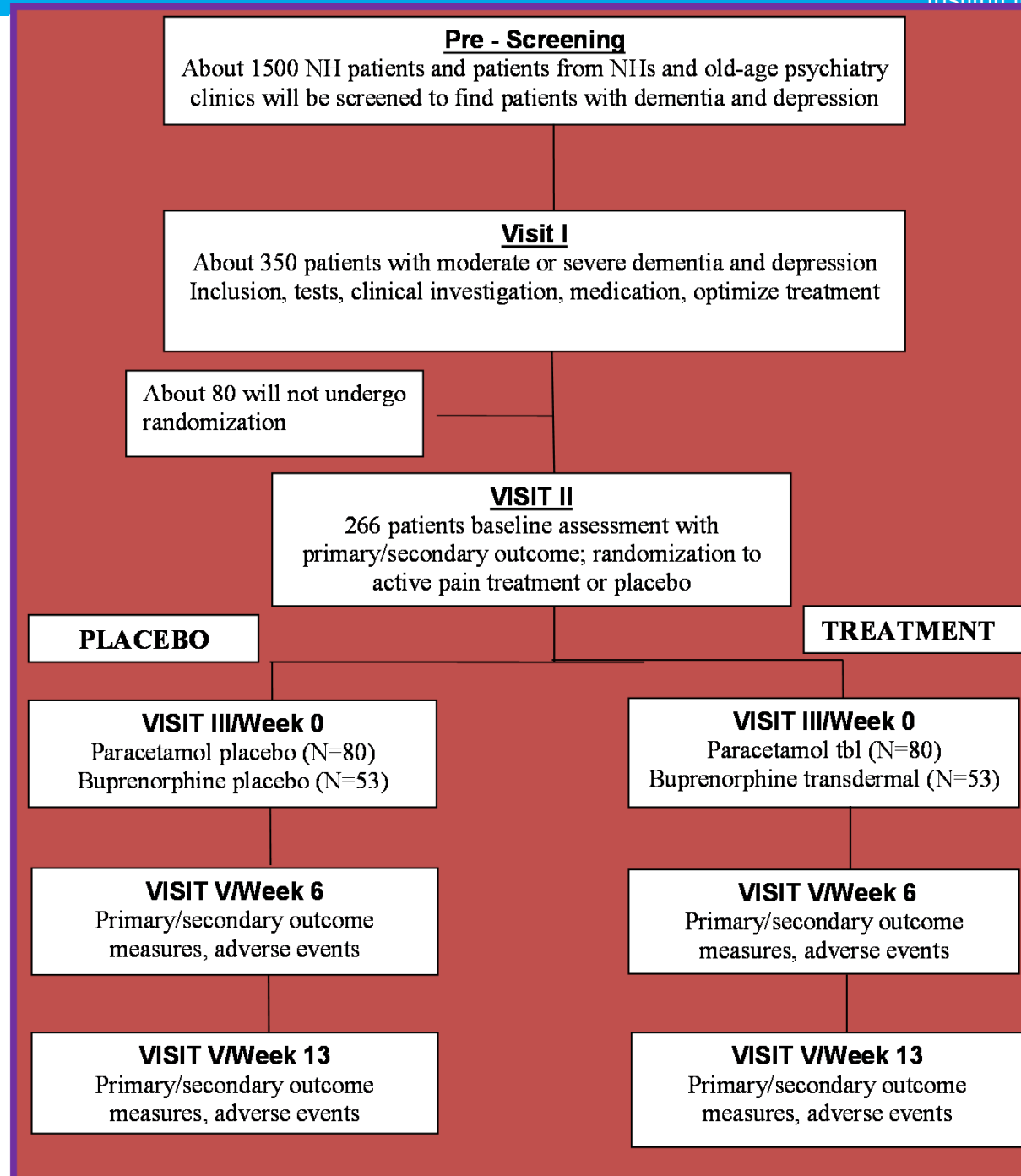


**Karolinska
Institutet**



Studiens formål

- Å undersøke om individuell smertebehandling reduserer depresjon hos pasienter med demens



Postdok eller PhD stipendiat til prosjekt om eldre kvinners helse - KKL kompetanse senter

Oslo Universitetssykehus HF

I samarbeid med Senter for alders- og sykehelsemedisin, vinnstutt for global helse og samfunnsmedisin, Universitetet i Bergen utlyser Nasjonal kompetansetjeneste for kvinnehelse en stilling som PhD eller postdoktor stipendiat tilknyttet prosjektet «Home time – Home death». Organisasjonen av den hjemmebaserte omsorg i kommunen er en av de store helsepolitiske utfordringer Norge står over i dag og de kommende år. I Norge lever det 220 000 eldre mennesker over 80 år, og 82 % av dem bor hjemme og får hjelp fra pårørende, hjemmesykepleie og hestlege. På tross av at de aller fleste innbyggere ønsker å avslutte sine siste dager hjemme i kjente omgivelser, der bare 5-15 % hjemme, hvilket er det laveste antall i verden.

«Home time – Home death» er et multidisiplinært samarbeidsprosjekt for å optimalisere tilbudet til pasienter som ønsker å bli i egen bolig så lenge som mulig.

Arbeidsoppgaver

- Stillingen innebærer både forskning og klinisk arbeid rettet mot primærhelsetjenesten. Prosjektet er tiltenkt postdoktor nivå eller en Ph.d kandidat med en tidsramme på 3 år i 100% stilling, uten andre pålagte arbeidsoppgaver ved institutt for global helse og samfunnsmedisin, UiB.
- Geografisk er stillingen plassert ved Universitetet i Bergen.

Kvalifikasjoner

- Vi ser etter høyt motiverte og kompetente kandidater med relevant erfaring, kompetanse og interesse innenfor primærhelsetjenesten. Vi oppfordrer personer med medisinsk embetskarakteren til å søke.
- [Søknadsskjema og søknadsmal](#) [UiB søknadsskjema](#) [Søknadsskjema](#) [Søknadsskjema](#)

Søknadstidst:

01.02.2019

Nøkkelinformasjon:

Annonse:
Oslo Universitetssykehus
HF

Ref. nr.: 2456294132
Stillingsgrad: 100%
Engasjement:
Antall stillinger: 1

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no

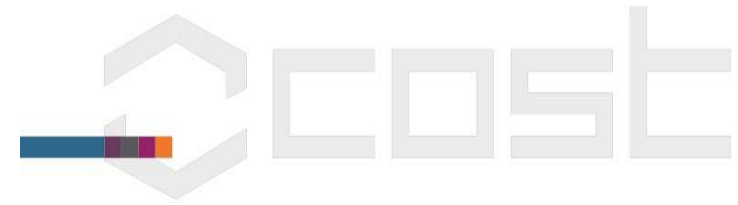
Søkekrav:

Bransje
Helse / Sosial
Fagfelt
Medisin
Rolle
Medarbeider

Post-doc/Ph.D utlysning: Home time – Home death



University of Bergen
Dep. Global Public Health Primary Care
Center Elderly and Nursing Home Medicine



EU - COST Congress, Bergen 2015, Norway

24./25.04.2015

7. International Congress of Pain in Dementia



Future Directions

Call for Abstracts: 15 Nov 2014 – 15.02.2015
Program: <http://tiny.cc/wlzwqx>

