Did You Ask The Patient?

The Art of Listening!

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Learning Objectives

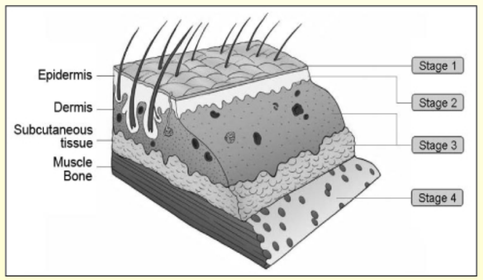
- Recognize the significance of decubitus ulcers and its link to elder abuse.
- Familiarize clinicians with the most common warning signs of abuse among chronic pain patients
- Identify high risk chronic pain patients who stand to benefit from psychological support and screening for abuse early in their disease course.
- Understanding that finding treatment options requires a more nuanced, thoughtful approach that begins with asking the right questions.

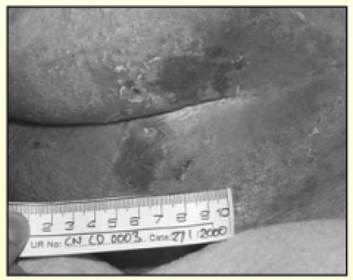
Background

- Pressure ulcers are localized areas of tissue damage or necrosis that develop because of pressure over a bony prominence.
- Pressure ulcers have attracted the attention of the medicolegal community. Some courts regard pressure ulcers as evidence of elder abuse, and some lawsuits have awarded judgments of more than $10 million.[1]
- The last decade has seen a sharp decline in hospital-acquired pressure ulcers (HAPUs) while those that occur outside the hospital setting have increased.[2]
- Specifically, the incidence of pressure ulcers has increased among patients who receive their care at home by home health nurse or a designated caregiver – often a spouse, family member, or close friend.[3]
- Patients with debilitating chronic pain are frequently rendered immobile and/or bed-ridden and therefore are more prone to develop pressure ulcers.[4,5]
- Similarly, patients with refractory pain and and multiple hospitalizations for pain crises can be challenging to manage particularly when traditional therapies have been exhausted.

Case Description

- A 74-year-old woman with stage II multiple myeloma (MM) in remission with chemotherapy-induced peripheral neuropathy, chronic diarrhea, and recurrent pain crises presents to the hospital with right sacral pain radiating to the groin.
- Physical exam demonstrated full motor strength in her upper and lower extremities and a limited range of motion in her lower extremities. She had tenderness to palpation over the lower lumbar paraspinous area (greater on the right), right posterior superior iliac spine and greater trochanter. Skin exam revealed a stage II sacral decubitus ulcer.
- She had multiple pelvic osteolytic lesions status post radiation therapy. Multiple medications and interventions including steroid injections in the hip, sacroiliac joint, and trochanteric bursa were unsuccessful.
- Current medications were: 120 mg of Morphine Extended Release every eight hours, 45mg Morphine Immediate Release every six hours, 30mg Temazepam nightly and 250mg Soma four times a day.
- She developed hyperalgesia at 780mg PO morphine equivalents. She was then rotated to methadone, with pain control complicated by nausea/vomiting two days later leading to hospitalization.
- A psychiatry consultation was requested but she refused.
- A ketamine drip (0.1-0.3mg/kg/hour) was started. Although appearing improved, she continued to report high pain scores. She achieved appropriate pain control after transitioning to intravenous (IV) patient-controlled analgesia (PCA), and so a plan was made to discharge her home with PCA.
- Without any inciting event, she developed a pain crisis the day of anticipated discharge requiring medication escalation to 10mg IV hydromorphone within three hours.
- Further chart review revealed higher pain scores when her husband was around.
- A lengthy discussion with the patient about overall care goals revealed that she was an award-winning ballerina, who married her husband with the promise to travel the world. With debilitation from her MM, her husband now resents and verbally abuses her, which has led to tensions of needing care at home and not wanting to become a burden.
- Full exploration of options with the patient led to discharge on her previous home regimen, with ongoing discussions with her daughter about moving outside the abusive relationship.





Stage II pressure ulcers involve the epidermal layer of skin and may extend into the dermis as well. These usually appear as shallow, open areas or intact serum-filled or serosanguinous blisters. Although the skin is physically intact in a stage I pressure ulcer, a stage II pressure ulcer involves a break in the skin's integrity. This figure depicts a typical example of a stage II pressure ulcer, with excoriation of the involved skin and extension into deeper tissues. When a patient develops a stage II pressure ulcer, it is common to have to contend with issues such as serous drainage that complicate skin care and can cause problems with adjacent areas of the skin that would not otherwise be affected.(Auerbach PS. Wilderness medicine. 5th ed, Kaiser Permanente Multimedia Communications, Los Angeles, CA)

Discussion

- Elder abuse can only be expected to increase in the coming years because of demographic trends and other social changes.[1] Potential financial gains from vulnerable elders are attractive opportunities for unscrupulous people or may serve as venues for continuing long-standing family conflicts.[4]
- Pain physicians, whose practices and clinics may already be under duress because of multiple demands and constraints, must nonetheless recognize their important role in the identification of and protection against elder abuse.
- As in other matters, there are complex ethical and legal issues that must be considered, including confidentiality and the implications for the patient's autonomy.
- Involving psychiatrists and other mental health professionals earlier on in the course have crucial roles in the assessment of the mental functioning that forms the basis for determining capacity and for evaluating the consequences of abuse.

Conclusions

- Patients with pain complicated by untended psychosocial issues present an ongoing challenge. Given the prevalence of psychosocial needs for those with disabling chronic pain, it is imperative that these factors be explored by the pain specialist.
- Care teams are often unaware or may avoid addressing the underlying culprit because they treat the condition instead of the patient.
- Key findings that should alert the clinician to concurrent psychosocial issues are: pain inconsistent with musculoskeletal findings, high healthcare utilization, and evidence of negligent care (e.g. sacral decubitus ulcers).
- The decision to treat the symptoms is often the most comfortable as well as the most familiar decision pain physicians make, however this option may only address the source of the patient's acute needs, rather than address the whole patient
- When reaching the last lines of therapeutic options, getting to the right conclusion often starts with asking the right questions.

References

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