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## **Chiropractic Strategies for Pain Management in Older Persons**

By Nancy Molina, DC

RP is an 81-year-old male with a recent three-month history of centralized low back pain. He resides with his wife of 60 years, a recent left-sided hemiparalytic patient (status: postcerebral vascular accident) confined to a wheelchair. The couple has survived both their children. RP's low back pain was treated with pain analgesics and then referred by the medical generalist for physical therapy modalities, both of which failed back complaint, which only depressed his respiratory volume and aggravated his difficult breathing.

On physical examination RP clothed in a bathrobe and pajamas, is stooped, ill-nourished, and ambulates with a walker. He is alert, afebrile and in apparent respiratory distress with any simple movement or exertion. He's in obvious pain. He is observed during the "tripod sign" test on seated position with pursed lips (to facilitate respiratory uptake). General appearance reveals slight nasal flaring, monosyllabic speech patterns and trachea "tugging." No airway stridor, drooling or cough is observed. Skin vitals are warm, dry and pink. Capillary refill is greater than one minute without cyanosis at nailbeds, and skin turgor reveals "tenting" of the forearms.

Chiropractic assessment yields joint fixation of the lower lumbar vertebrae. Asymmetry in the position of the lumbosacral muscles with slight soft tissue swelling is noted. Palpable pain is elicited at the right sacroiliac joint. Neurological and orthopedic examination is essentially negative with the exception of slight rubor quality to the lower extremities at the ankles, nonpitting edema, and reduced sensation of the bilateral L3-L5 dermatomes that are attributed to analgesic medication and geriatric pain perceptions. Radiographic imaging studies are not performed to evaluate his spine.

The consequences of chronic pain among older people are numerous. Depression, sleep disturbance, impaired ambulation, social withdrawal and increased medication use have all been associated with the presence of pain in the geriatric population. Pain is recognized as a complex phenomenon derived from sensory stimuli and modified by each individual's reactions, and emotions. Nociceptive pain may arise from

tissue inflammation, mechanical deformation, ongoing injury, or destruction. Examples include inflammatory or traumatic arthritis, myofascial pain syndromes, and ischemic disorders. Nociceptive mechanisms usually respond well to nondrug strategies such as chiropractic management. The following outlines some clinical guideline suggestions for use by the chiropractor in evaluation of the older pain-presenting patient.

A thorough initial assessment is crucial to understanding the causes of chronic pain in the older adult. Older patients themselves may present substantial barriers to accurate pain assessment. They may be reluctant to report pain despite substantial physical or psychological impairment. Not only do older people expect pain with aging, but they also often describe discomfort, hurting, or aching rather than use the specific word "pain." They may be reluctant to talk about pain, because they may fear the need for diagnostic tests or medications that have side effects. For some older patients, pain is a metaphor for serious disease or **death**.

Pain assessment should include a history, a physical examination, a review of the results of the pertinent laboratory, and other diagnostic tests. Initial evaluation of the pain complaint should include characteristics such as: intensity; character; frequency (or pattern, or both); location; duration; and precipitating and relieving factors. The mnemonic PPQRST may be helpful to follow: palliative, provocative, quality, region (or radiation), severity and temporal pattern of pain.

Initial evaluation should include a thorough medication history, including current and previously used prescription medications, over-the-counter medications, and "natural" remedies. Initial evaluation should include a comprehensive physical examination with particular focus on the neuromuscular system (e.g., search for neurologic impairments, weakness, numbness, and paresthesias) and the musculoskeletal system.

Evaluation of physical function should include a focus on pain-related disabilities, including activities of daily living (e.g., Katz ADLs). Evaluation of physical function should include performance measures of function (e.g., range of motion, gait assessment). A quantitative assessment of pain should be recorded by the use of a standard pain scale (e.g., visual analog scale, word descriptor scale, numerical scale).

Patients with chronic pain should be reassessed regularly for improvement or deterioration. The frequency of follow-up should be a function of the severity of the pain syndrome. Reassessment should include evaluation of significant issues identified in the initial evaluation. The same quantitative assessment scales should be used for follow-up assessments. Reassessment should include an evaluation of the positive and negative effects of chiropractic conservative care.

In older patients, the chronic use of NSAIDs is associated with a high frequency of adverse effects, and these should be used with caution. High-dose, long-term NSAID use should be avoided. When used chronically, these should be used as needed, rather than daily or around-the-clock. They also should be avoided for in-patients with abnormal renal functions, or those with a history of peptic ulcer disease or on blood thinners. The use of more than one NSAID at a time should also be avoided.

Patients taking any prescribed analgesic medications should be monitored closely. The chiropractor should watch for signs of narcotic use for inappropriate indications (e.g., anxiety, depression).

Chiropractic management should be an integral part of care plans for most chronic pain patients. Chiropractic pain management strategies encompass a range of treatments and physical modalities: spinal and joint health education programs; exercise programs; transcutaneous nerve stimulation; heat; cold; massage; distraction techniques; chiropractic adjustments; and nutritional and dietary management. Each has been helpful for these patients. Moreover, these strategies carry fewer adverse effects compared to drug therapy and hospitalization.

For those of us who encounter participation in provider networks that require use of the network's standardized history and examination forms, we often recognize that these required forms fall far short of these recommendations with respect to physical function analysis. It is therefore suggested that the chiropractic provider incorporate these recommendations as a part of their integral clinical record keeping.

After the initial complimentary visit (I cannot in all good conscience charge for this due to patient RP's current level of disability and his spouse's recent disability), he reports that the low back pain has resolved for nearly 72 hours. He is educated on NSAID use, and adequate hydration to avoid any painful muscle conditions; the low back condition is explained, and I offered housecalls so future subluxations of the spine are not left untreated. Initial chiropractic care includes an extra precaution in going extremely slow in moving this patient to avoid any aggravation of his COPD, because the slightest provocation would lead to tachypnea. Prone positions are avoided as much as possible. Lumbar articular process pushes with soft hypothenar and anterior inferior sacral using side position with anterior sacrum side up was used.

Presently, my 81-year-old patient has returned as a walk-in and reports no analgesic use since initial visit, and that his sleep disturbance has resolved. He wants to become a private pay patient of his own accord, since he realises how chiropractic has helped him. Follow-up care of the patient is performed. This 81 year-old successfully becomes a chiropractic patient, and his low back pain has not returned.

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