Pain—the 5th vital sign

“Pain has no element of blank. It knows not when it began or if there were a day when it was not. It has no future but itself. It’s infinite realms contain it’s past. Enlightened to perceive new perils of pain.” - Emily Dickinson

Pain is an unpleasant complex sensation. It arises from sensory stimuli and its perception is modified by memory, emotions, and expectations. Pain is one of the most frequent problems encountered by health care providers. Despite this, many studies have found that pain in older persons is frequently under-recognized and poorly treated.

Data from the NHANES III study show that older persons report more pain of a greater intensity than do younger persons. Older persons tend to complain particularly of joint pain, while headaches, dental, and even muscle pain are more common in young persons. One in five older persons takes over-the-counter analgesics several times a week. Significant pain occurs in 25% to 50% of community-dwelling elders. In nursing homes, pain occurs in up to 83% of residents. Despite this, one national study found that only 37% of nursing home residents were receiving pain medication. In another study in nursing homes, pain was reported to be

(continued on page 6)
ACROSS clues

2. Pain relieving drugs should not be given ___ except to treat occasional acute pain or for breakthrough pain.
5. This is the “body’s own morphine.”
7. Persons with Alzheimer’s disease often present with ___ pain signs.
8. This class of antidepressants is preferred for the treatment of neuropathic pain.
10. Topical cream that relieves pain by altering the substance P system.
13. This drug should be avoided because of its high addiction potential compared to its analgesic activity.
16. Morphine is a schedule ___ drug.
18. A local anesthetic that can give pain relief when ingested orally.
19. This nucleus within the central nervous system can result in neuropathic pain.
21. ___ to the side effects of opiates develops rapidly.
22. Lack of this is the main barrier to pain management.
23. When pain is severe, drugs in this class produce the best relief.

DOWN clues

1. Laxative to use for opiate constipation.
3. When a patient has pain, the physician needs to provide reassurance that he/she will not ___ the patient.
4. Norman Cousins relieved his pain by watching Marx Brothers movies. This is a ___ technique.
6. Pain is now known as this vital sign.
9. Opiates can be given as oral tablets, liquid, injection, patches, or these.
11. When people have chronic pain, they should be given a ___-acting opiate with short-acting opiates for breakthrough pain.
12. The major complication of opiates.
14. The Greek who said, “I must die, but must I die groaning?”
15. Temporal headaches in older persons can often be relieved with neck ___.
17. This agent should never be used to treat pain.
20. Pain is ___ treated in older persons.

Puzzle answer may be found on page 22
Pain Management in our Older Patients – A CQI Approach

When the Veterans Administration (VA) launched its “Pain is the 5th Vital Sign” campaign in 1999, the Geriatrics Research, Education, and Clinical Center (GRECC) of VISN 15 began a pilot Pain Assessment Tool evaluation. In this CQI approach, the assessment form (Figure 1) was presented to each patient upon his/her arrival at the clinic. Question 1 on the form asked patients to self-report any feelings of pain. The provider then reviewed the patient’s responses and used it to guide the development of a treatment plan. Post-visit chart reviews were used to assess whether the Pain Assessment Tool accurately identified patients in need of pain control and whether pain was adequately and appropriately treated by the providers. The goal of the project was to document that 100% of all the complaints of the GRECC patients were treated.

The clinic population was predominately white males over the age of 62 with multiple chronic medical conditions. Providers in the clinic included attending physicians and pharmacists, geriatric-specialty residents and medical students from Saint Louis University, and pharmacy residents and students from the St. Louis College of Pharmacy.

Pain assessment data were collected between May 1999, and April 2001. A total of 987 records (both written and electronic) were reviewed. Two questions were asked during this review: (1) Are the two pain scales (faces and numbers) equally useful in assessing pain in the elderly patient; and (2) Are patients who are in pain given the means to get adequate relief from that pain? Comparisons were made between the responses made to questions 3 and 4, where the patient was asked to self-report overall quality of health and quality of life.

Chart review indicated that 100% of the GRECC patients were asked about pain during the 2-year period. There was a difference in the ability of the two pain scales to predict the level of pain the patient was experiencing (Figures 2-4).

(continued on page 20)
necessarily be a place of pain. Pain is now recognized as the fifth vital sign. We realize that once pain is identified, it should be swiftly treated so as to relieve the patient’s suffering. We are also fortunate that we have sufficiently potent drugs to treat almost any pain. When the body’s own morphine – endorphin – fails us, we have extraordinarily powerful drugs, derived from the poppy, to assuage our pain. The seed of this beautiful Asian flower gives rise to a white, milk-like juice which the ancient Greeks called opium. In the nineteenth century, morphine (named after the god of dreams, Morpheus) was extracted from opium by Sertuerner, a German pharmacist.

However, not all pain needs opiates and not all pain can be cured by opiates. When I was at UCLA, I had the good fortune to get to know the famous editor and writer, Norman Cousins. Norman had developed ankylosing spondylitis which at times gave him severe back pain. Failing to find relief after consulting many of the world’s finest physicians, he recognized that his pain went away when he watched Marx Brothers movies. He thus made use of laughter therapy and a distraction technique to cure his pain. He waxed eloquently on this mind-body connection in his book *The Anatomy of an Illness*.

When I was a medical student, I worked as a nurse’s aide in the hospital. One of my major duties was to give backrubs to the patients. This was done every two hours and it not only brought comfort to the aching bodies of my patients, but it also forced socialization for them and prevented pressure ulcers. Thus you can imagine my surprise to find on my arrival in the United States that backrubs had disappeared from the therapeutic armamentarium of nurses. Massage therapy remains for me an important part of my therapy and I find neck massage to be especially effective for bitemporal headaches.

It is also important for physicians to recognize that some complementary therapy techniques such as acupuncture and chiropractic can be remarkably effective in alleviating pain for some older persons. Some patients’ pain comes from intrapsychic conflicts, and in these persons appropriate treatment of depression can lead to the disappearance of pain. In some, phantom pain requires yet other approaches.

Humane physicians now recognize that the patient’s description is the most reliable indicator of the existence of pain and its intensity. While, as delineated by the World Health Organization’s pain ladder, pain treatment should start out with mild analgesics, physicians should not be afraid to move rapidly to strong opiates when lesser drugs fail to relieve the pain. Addiction is certainly much less of a fear for us in geriatrics, than for those who deal with younger patients. The misuse of narcotics by some should not create fear among physicians. Use of opiates to relieve pain is an Hippocratic imperative.

In a consensus statement from the American Academy of Pain Medicine and the American Pain Society, it was concluded that: “The undertreatment of pain in today’s society is not justified.” We at Saint Louis University strongly endorse this statement with the hope that our older patients will be relieved of the necessity to needlessly suffer from pain.

We thank Purdue Pharma L. P for an unrestricted educational grant to allow for the production of this issue of Aging Successfully.
Elder abuse and neglect is a societal concern which is gaining appropriate attention as the population of vulnerable, older adults increases. It is not surprising that the demographic imperative has led to a larger number of cases of abuse and neglect and a subsequent increase in awareness. Nevertheless, there is much work to be done.

Although physical abuse of the elderly is commonly reported and easy to understand because of its concrete nature, elder abuse can also be emotional, sexual and quite commonly, financial. Neglect is also a form of abuse. As older adults become frail or lose either physical or cognitive function, the risk for elder abuse grows. When one’s care needs exceed what the caregiver is able to comfortably provide, the risk grows. Elder abuse is a form of domestic violence and is more likely to occur in families where drug and alcohol abuse, mental illness, emotional lability or financial stress is present.

Abusers are most often the primary caregiver and are more likely to be male. An adult child is more commonly an abuser than is a spouse, and the abuser may have a history of aggressive behavior or emotional problems. The victims of abuse are often women over age 70 and have problems with frailty, physical or cognitive impairment.

It is important to realize that those with Alzheimer’s Disease and other dementing illnesses are at special risk for abuse. The memory and language impairments associated with these conditions put dementia patients at special risk. Those who suffer from dementia often have behaviors which challenge their caregivers’ patience, leaving patients at risk for verbal, emotional and physical abuse as well as neglect. The need for early diagnosis of dementia is essential so caregivers can receive education about the challenges of the disease as it progresses. Lack of knowledge can lead the caregiver to think that annoying behaviors such as urinary incontinence, are intentional. In addition, wandering behaviors may lead to the naïve use of restraints. Caregiver support groups and community-based respite services can help assist caregivers of loved ones with Alzheimer’s Disease. Physicians must become comfortable in discussing possible abuse with potential victims and caregivers.

Neglect can also occur as a result of overwhelming care needs. Despite the best of intentions, overburdened caregivers may not be able to meet all of the needs of frail and/or cognitively impaired older adults. For example, pressure ulcers, dehydration, malnutrition, falls and fractures can all occur as a result of overwhelming caregiver burden and the resulting neglect. Such complexities can make caregiver intentions difficult to interpret.
constant in about one-third of the residents, with just over a half of the residents describing their pain as severe, horrible, or excruciating. In other studies, pain has been documented to be present in 80% of hospitalized patients and 55% of home health patients.

Over 50 million Americans are partially or fully disabled by pain. Besides discomfort, pain has many other consequences including depression, limited walking, decreased involvement in recreational activities, impaired posture, insomnia, anxiety, anorexia and weight loss, and interference with the ability to carry out basic activities of daily living.

Pain produces its effects by the sensory nerves carrying the painful message through the spinal cord to the midbrain and thalamus and from there to the cortex. At each of these relay stations within the central nervous system, the painful sensation can be dampened down. In particular, the midbrain can send messages to the spinal cord “gating” the amount of pain allowed to reach the central nervous system. The most important neurotransmitter involved in this process is the “body’s own morphine” – endorphin.

The most common kinds of pain are the nonspecific, such as headaches, and the nociceptive, as produced by trauma, inflammation, pressure, and infection. Neuropathic pain can occur either peripherally in persons with a sensory neuropathy or centrally due either to alterations in the thalamus or with a radiculopathy. Finally, pain can be psychological as occurs with somatization. The biopsychosocial model of pain suggests that while most pain has physical origins, it is the interaction of physical pain with the persons’ psychological state (e.g., coping skills, dependency needs, lack of faith in health care professionals) and the social environment (e.g., job stresses, worker’s compensation, family relationships) that leads to the full expression of pain syndromes.

Pain Assessment Tools

Accurate pain assessment is the key to pain management. Several pain assessment tools have been created and two are shown on this page. For example, pain assessment should include all of the elements in the mnemonic “PAINED.”

Another mnemonic “OLD CART” is useful in describing the specific characteristics of pain.

In addition to these mnemonic assessments, a quantitative scale should be utilized to measure pain and its response to treatment. This scale can use either words or a number to describe the severity of the pain. Alternatively, the use of a visual analog scale, either with numeric ratings on a line or, better, with faces depicting the severity of the pain is most helpful. These scales are the equivalent of a pain thermometer used to measure the severity of pain. Like all other vital signs, their usefulness is not only in being able to record the state of the patient, but also in signaling that action needs to be taken immediately when they indicate a problem.

Among certain populations, the non-verbal expression of pain assumes paramount importance. These populations include patients with dementia or delirium, the developmentally disabled, those with psychiatric impairment, substance abusers, and persons who speak a
Reflections on PBS Series

“On Our Own Terms”

by Douglas K. Miller, MD

In the first episode of the PBS series entitled “Living with Dying,” Bill Moyers asks, “What do we owe the dying?” I will respond to that question, but a full explanation will take some time. I will start with a personal experience, progress to a central theme in the program that we have been developing with grants from Supportive Care of the Dying: A Coalition for Compassionate Care (“SCD Coalition”) and Project on Death in America (PDIA), and finally return to the question.

Just before Thanksgiving in 1996, I came home from a meeting with a sore throat, looked in the mirror, and saw a finger of tissue in the back of my throat that was not supposed to be there. Two days later, I was diagnosed with a very aggressive form of squamous cell throat cancer. I had never smoked cigarettes, drank very little alcohol, and had no family history of this type of cancer. It was a shock. I remember the first three things my wife said when I told her: “You’re kidding, right?” “I don’t believe it.” “Are you sure?” I was determined from the very beginning that whatever happened, I was going to handle it with dignity.

Over the next several weeks, I found myself dealing with my need for emotional support, fears of mutilation and disfigurement from the cancer and its treatment, concerns about being abandoned, priorities (what was most important in my life), what my disease meant to my family, the possibility that I might die, and what legacy I would leave behind.

As I went through my surgery and then the misery of radiation therapy, hugs became as important to me as food, water, and pain relief.

I was lucky to have a superb physician to care for me, someone who interacted with me as a person and was also able to give me the best technical care possible. He didn’t shy away. His eye contact was solid. I could have talked to him about personal things, if it had been important for me to do that. I am eternally grateful for his support and understanding as well as his supervision of the outstanding medical care that I received.

I also thought about spiritual issues. I was very close to the minister at my church, who often described the task of life as the death of one’s ego and immersion in God’s work. The more I thought about his proposition, the more I came to believe that death wasn’t all that different from his suggestion. However, I have three follow-up comments about this concept. First, I found the psychological preparation for death to be hard work. Second, there were four people whom I personally knew who had cancers diagnosed within three months of my diagnosis. Within three years, all four of them had died, while I appear to have been cured of my cancer. I remember being at my daughter’s graduation from high school and feeling an enormous appreciation to have the opportunity to live and love for some time more. And third, I have encountered many people who either don’t understand, have difficulty truly believing, or frankly disagree with my minister’s belief regarding life’s purpose.

After the original staging of the disease (which indicated a reasonably good prognosis), the hardest thing for me was telling my children I had cancer and would need surgery; that I was very hopeful that I would be cured, but that I wouldn’t know for sure for some period of time; and that I would be sick for a while as I fought the disease.

Through all these experiences, as I thought about the legacy that I would like to leave behind, I began to focus on passing on my love. My request to my children (continued on page 9)
IMPORTANT DATE CHANGE
Please take note of the change of date for the next Summer Geriatric Institute. Originally scheduled for June 26, 27, and 28, 2002, the Summer Geriatric Institute has been rescheduled for Monday through Wednesday, June 24th through 26, 2002. Please make sure your calendar reflects these corrected dates so you won’t miss out.

NOTICE SOMETHING EXTRA THIS TIME?
DUE TO A PRINTING ERROR, THE CENTERFOLD POSTER, ORIGINALLY PRINTED IN OUR LAST ISSUE, WAS MISSING TEXT. THE POSTER HAS BEEN CORRECTED AND REPRINTED AND ADDED AS A BONUS TO THIS ISSUE. PLEASE REPLACE PAGES 12-13 IN YOUR LAST ISSUE, OR IF YOU WISH, YOU MAY USE THE INSERT AS A POSTER IN YOUR OFFICE. WE APOLOGIZE FOR ANY INCONVENIENCE.

Long before truth-in-advertising became the norm, fanciful advertisements such as this one proclaimed pain remedies fit for humans and animals alike. The idea of a one-size-fits-all medicine is as appealing as it is unlikely. Who would not like to find a magic cure-all in one bottle?
has been, “Please do not grieve for me. Rather, remember how much I loved you, and pass the love that you felt from me on to others. In that way I continue to live on, and in turn so can you. And in a very real sense, I will never really leave you. I know you well and wish only the best for you and you know me very well, at least in many very important ways. After I am gone, any time you want to talk to me, just search your heart and mind for what you think I would say, and, in that conversation, we have come together once again. My spirit will not change that much, and it will live on, especially as you remember it.” This idea was extremely comforting to me as I worked my way through my illness and its treatment. In our later work, this concept distilled into the phrase “To love well is to live forever.”

But what does it mean, “to love well”? Ah, there’s the rub. Obviously, the answer is a personal one and takes some time to work out in most cases. That is why participation in our program for patients with life-threatening illnesses (LTI), described briefly below, takes 6 to 12 months. After additional consideration of this concept in my own life, I finally realized that I had been missing the boat regarding my own mother for many years. She died in 1977 and had a number of traits that really irritated me, but there was never any question that she loved me immensely, with all her heart and without reservation. And there is a lot of my mother in my own personality. I’ve been a little upset that it took me 35 years to realize that I am all the better for her love and that by passing her love on, she – in all her best traits – lives on too. I guess this is what we call reconciliation.

Meanwhile, as medical articles kept appearing demonstrating the inadequate care being given to patients at the end of their lives, I became convinced that the multiple problems would not change until the underlying forces behind our institutions, policies, and procedures were changed. In other words, solutions required embracing a different paradigm. The ingredients for a new paradigm were around, but all the ingredients hadn’t been brought together yet and certainly weren’t embraced by the main medical institutions. The SCD Coalition then published its own focus group work, which demonstrated that patients with LTI have extensive and distressing unmet emotional, relational, and spiritual needs. I was convinced that this work was uncovering some of the most important core issues.

In the fall of 1998, a group of us at Saint Louis University were fortunate enough to receive funding from the SCD Coalition and PDIA to explore our ideas in a randomized controlled trial. Our work focuses on the use of “supportive-expressive” group experiences to respond to LTI patients’ emotional, relational, and spiritual needs. The early part of this work has been published in the Coalition’s journal, Supportive Voice, (vol. 5, no. 3 and vol. 6, no. 2), available through the SCD website (www.careofdying.org).

Let me now return to Bill Moyers’ question of “What do we owe the dying?” I believe that we owe them our very best efforts to provide solace and comfort in the very scary confrontation with their own bodily demise. Not just physically, but emotionally and spiritually as well. To maximize our ability to help, I believe that we clinicians have two main tasks. First, we need to address the issues of death in our own lives – the deaths of our patients,
language different from the health care provider. Non-verbal pain responses are familiar to all of us and include facial expressions (grimacing, frowning, tightly shut or widely open eyes), aggressive behavior (biting or hitting), altered activities of daily living, altered body movements (rocking, moving from side to side, limiting movement in an extremity, altered walking style, rigid posture), irritability, confusion, becoming withdrawn or hyperventilating. In addition, certain non-intelligible verbal behaviors such as calling out, screaming, crying, or moaning also may indicate pain. Using these nonverbal measures, Hurley and colleagues developed a nine-item scale to assess discomfort in persons with Alzheimer’s disease.

Barriers to Appropriate Pain Management

Overwhelmingly, the major barrier to pain management is communication between patients and health professionals. Elevating pain to the status of the 5th vital sign has gone a long way towards alleviating this problem. However, there are still many health professionals who doubt the veracity of the patient’s pain complaint. As we have already pointed out, pain arises intrapsychically and it is the patient’s perception of the pain that counts, not the health care professional’s belief concerning its presence. Most health professionals express five major fears concerning pain management. These are:

1. **The fear of addiction.** Fortunately, in older patients this is a minor problem and should not interfere with treatment.

2. **Drug side-effects** and (3) **The possibility of overmedication remain acceptable fears.** Older patients often are more prone to side effects from medicines, (Beers, MH. The medication list: A part of the patient’s health. J Gerontol Med Sci 2000: 55A, M549) but it should be realized that the side effects of major painkillers often are less than those of minor painkillers. Also, it has now been well demonstrated that treatment of pain improves, rather than worsens functional status in older persons.

3. **The fear that the medication may result in death.** While this is a rare possibility, one should recall the words of Epictetus who said in AD 135, “I must die. But must I die groaning?”

4. **The final fear most prescribers of opiates face is the fear of legal action against them.** Fortunately, the law enforcement agencies are now somewhat better educated and harassment of legitimate prescribers of pain medication has decreased. Unfortunately, there are still some areas where this is not the case and when these drugs fall into the hands of illegitimate users, the nation’s drug war often brings the fear of prescribing to the forefront. Ethically, the fear of legal action should never be a reason not to treat patients. There remains a need to continue to educate politicians, law enforcement officers, family members, and unfortunately, some physicians that treatment of pain is an appropriate behavior. To overcome these barriers to pain management, it is essential that we increase knowledge among all of these concerned groups regarding the appropriate approaches to pain management.

**Non-pharmacological Management of Pain**

While the approach to pain management usually involves and often requires analgesics, a variety of non-pharmacologic management strategies can result in pain relief in some persons. Exercise often improves musculoskeletal pain over time. Temporal headaches experienced by older persons with excess neck muscle spasms respond particularly well to massage. Teaching patients to use distraction techniques can be useful. Physical therapy and the use of ultrasound or the use of heat or cold at home improves some pain. Acupuncture and transcutaneous electrical nerve stimulation (TENS) work for some patients. Cognitive behavior therapy, which tries to alter belief systems about pain and suffering and includes relaxation techniques, biofeedback, and hypnosis, has been very helpful for treating some patients. Chiropractic has been shown to be particularly helpful in the
Saint Louis University Hospital is One of The Best
Listed Among the Top Ten Hospitals in Geriatrics in the U.S.

On July 23, 2001, US News and World Report issued its twelfth annual rankings of America’s Best Hospitals. This ranking shows where to find the best care in 17 specialties including cardiology, cancer, and geriatrics. Saint Louis University Hospital remains at 7th place in the national ranking of geriatric care. The purpose of the US News and World Report’s assessment of hospital ranking is to assist patients with complex medical conditions that threaten quality of life or life itself by identifying medical centers with unmistakable expertise in various medical specialties. To that end, several criteria are reviewed: membership in the Council of Teaching Hospitals, affiliation with a medical school and the presence of at least 9 out of 17 prescribed technological services. From these criteria, 1,701 hospitals were identified as eligible for further scoring. For geriatrics, these hospitals were then given an institutional ranking, the US News Index, made up of three equal parts relating to quality of care: reputation, mortality, and a group of factors such as technology and nursing care.

Saint Louis University Hospital has a highly successful geriatrics program, not only in clinical care, but also in research and educational programs. In addition, it has several other supportive care programs including an acute care unit (Acute Care for the Elderly or ACE Unit), a sub-acute care unit (Life Care Center of St. Louis), a nursing home, home care, and outpatient and assisted living programs. Educational programs offered each year to healthcare professionals, as well as to the lay public, by the Division of Geriatric Medicine include conferences, newsletters, newspaper columns, television and radio interviews, workshops, and interactive Internet web sites. All of these programs help make Saint Louis University Hospital an excellent place to receive geriatric care.

### Products
- GEROPADY
- Senior Safety Solitaire
- ACE Unit Video
- Crossword Puzzle Book
- Choices & Challenges
- Aging Successfully Newsletter
- Books

Call 314-577-8462 for more information.

### Services

Services of the Division of Geriatric Medicine, Saint Louis University Health Sciences Center include clinics in the following areas:

- Aging and Developmental Disabilities
- Bone Metabolism
- Falls: Assessment and Prevention
- General Geriatric Assessment
- Geriatric Diabetes
- Medication Reduction
- Menopause
- Nutrition
- Podiatry
- Rheumatology
- Sexual Dysfunction
- Urinary Incontinence

Call 314-577-6055 to make an appointment.
Pain – the Fi

PAIN PATHWAYS

Illustration adapted from: Know your Body: The Atlas of Anatomy - Ulysses Press - (800)-377-2542

Nonpharmacological Pain Management Strategies

Distraction therapy
- Movies
- Laughter
- Art therapy
- Music therapy

Behavioral modification
- Imagery/meditation
- Relaxation techniques
- Hypnosis
- Biofeedback

Physical therapy
- Massage
- Ultrasound
- Hot/cold therapies
- Exercise

Neurostimulation
- Transcutaneous nerve stimulation (TENS)
- Acupuncture

PAIN IS TREATABLE –
ASSESSING PAIN

- ROVOCATIVE FACTORS (What brings pain on?)
- AGGRAVATING FACTORS (What makes pain worse?)
- NAME WHERE THE PAIN IS AND WHERE IT GOES TO.
- SEVERITY (Rate on a scale of 1 to 10)

The Analgesic Pyramid

Which face best describes your pain?

0: No pain
1: Very mild pain
2: Mild pain
3: Moderate pain
4: Severe pain
5: Worst pain

The Analgesic Pyramid:
- 0: NO TREATMENT
- 1: NON-OPIOID (Mild)
- 2: MILD OPIOID + NON-OPIOID
- 3: STRONGER OPIOID
- 4: STRONGER OPIOID + NON-OPIOID
- 5: SURGICAL

TALK TO YOUR DOCTOR

Questions? FAX: (314) 771-8575 • email: agingsuccess@slu.edu
Preventing Elder Abuse

The physical exam will not help clarify these situations.

Most states have clear laws regarding the reporting of elder abuse and neglect. Healthcare professionals and employees of hospitals, nursing homes, and home health agencies are mandated to report abuse. Despite the law, concerns about being wrong and poor understanding of the variety of types of abuse and neglect lead to serious delays in reporting.

Reporting has a variety of benefits. Overwhelmingly, victims of abuse are willing to participate with authorities. Elder abuse investigations may result in much needed services being made available to the client and caregiver such as homemaker services, respite, daycare, etc. Investigation may also help clients gain access to healthcare and geriatric assessment. This case management for the frail elder with complex care needs can be helpful to both patients and caregivers.

The growing numbers of older adults in this country with complex needs for care will lead to greater numbers of elder abuse cases. Awareness of the issue along with the concurrent development of community programs for prevention and interventions for abuse and neglect will lead to increasingly safe environments for frail, older adults.

For more information on elder abuse prevention and reporting, please see the website shown here.
The address for the National Center of Elder Abuse (NCEA) is www.elderabusecenter.org.

www.elderabusecenter.org
Twelfth Annual Saint Louis University Summer Geriatric Institute Declared a Success

Held June 13-15, 2001 at the Saint Louis University’s Margaret McCormick Doisy Learning Resources Center, the twelfth annual Saint Louis University Summer Geriatric Institute drew over 300 participants from seventeen states and six foreign countries.

Day 1 of the conference focused on the importance of calcium in maintaining health throughout life. The first day of the conference was cosponsored with St. Louis’s Logan College of Chiropractic. Day 2 consisted of multiple workshops. Opportunities for networking and knowledge exchange abounded. Day 3 talks concentrated on aging research, clinical care, and educational programs offered throughout Missouri and Illinois, the two states served by the Gateway Geriatric Education Center.

Pictured here are guest lecturers John Morris, MD of Washington University School of Medicine, St. Louis, and Susan B. Roberts, Ph.D., of Tufts University in Boston. Dr. Morris gave the Jim Flood Memorial Lecture entitled, “Early Diagnosis and Treatment of Alzheimer’s Disease.” James Flood, Jr., affiliated with the St. Louis VA GRECC, was a pioneer in research on the neurotransmitter regulation of memory. James Flood, Jr. died in 1999. Dr. Roberts gave the Max K. Horwitt Memorial Lecture, “Changes in Regulation of Food Intake and Energy Expenditure with Aging.” Max Kenneth Horwitt, long affiliated with Saint Louis University, was one of the world’s key experts in nutrition, metabolism, vitamins, and anti-oxidants, participating in the important work of defining Minimum Daily Requirements. He died in 2000 at the age of 92.

Mark your calendar for next year’s conference: June 24-26, 2002.

Challenges and Choices

The Gateway Geriatric Education Center is pleased to introduce a new game to its readership. “Challenges and Choices” was created by Dr. William Gingold at the GEC Consortium partner, The University of Illinois - Urbana-Champaign. This game presents care providers with an easy-to-use tool for identifying problems, concerns, and conflicts arising in caregiving. The magnetic game board and game pieces allow easy use and repeat evaluations of constantly changing caregiving situations. The game is available at a cost of $30.00. Direct inquiries to Ronna Rhodes at 314-268-5644.
Geriatric Medicine Adds Faculty

Syed Tariq, MBBS, recently joined Saint Louis University as an Assistant Professor of Medicine in the Division of Geriatric Medicine. Dr. Tariq completed his medical degree at King Edward Medical School in Lahore, Pakistan in 1991. He completed his subspecialty residency in geriatrics in May 2001. Dr. Tariq also has joined the staff at the St. Louis VA Medical Center.

The MOGGEC Injury Prevention Project presents this Second Edition of the multi-cultural game, Senior Safety Solitaire, that promotes both home and personal safety. This game comes complete with pictures of safety problems and solution cards and is designed to provide safety information for older adults, volunteers, para-professionals, and professionals, and can be played by a single player or by a group. Price: $65.

To order:
Please send check or money order to:
SLU-HSC
Senior Safety Solitaire
Division of Geriatric Medicine
1402 S. Grand, Room M238
St. Louis, MO 63104
For more information, please call 314-577-8462.

Join Thousands Playing Longevity Online

This interactive game is being played by thousands online.
This is a game that will take you through the ER to the ICU, on to Step-Down Units, and into the Nursing Home if you are very skillful. Try your hand at this and compare your score to others. This is a great learning tool too. If you miss the question, clues are provided to help you find the right answer.

Score: 23400
Level: 8
Question: 10/10

Topic: Mental Health/Treatment

An 82 year old presents with a 50 pound weight loss, atrial fibrillation and proximal muscle weakness. His eyes are hooded. He is depressed. He has a history of smoking two packs per day and has COPD. A cortisol level is 27 mg/dl. Which of the following tests would be most helpful in making the diagnosis?

A Birmingham Apnea Score
B Epworth Sleepiness Score
C Polysomnography
D London Sleep Score
E Presence of obesity

Current High Scores
Tracy 10,000
Smith 9,775
David 7,850
management of back pain and even magnetotherapy (originally introduced as mesmerism by the French physician, Messmer) has some scientific credibility. However, none of these therapies should be used as a ploy to avoid analgesics. Analgesics remain the cornerstone of pain therapy and in most cases, produce the most rapid pain relief. Finally, it needs to be recognized that pain management works much better when the patient receives appropriate education about pain. All patients with chronic pain should receive education on the nature of pain, coping strategies and other non-drug approaches to pain, the use of pain diaries and assessment instruments, and the use of medications and their side effects. Reassurance that the physician will not abandon the patient is a key component of education.

Pharmacological Management of Pain

Pain relief is better obtained when drugs are given on a consistent schedule, i.e., around the clock rather than on an as-needed basis. Initial pharmacological management of pain should begin with low potency non-opioid medications such as the non-steroidal anti-inflammatory drugs (NSAIDs) or acetaminophen unless the pain is very severe. In most cases, acetaminophen should be the first choice. Because acetaminophen appears somewhat safer than NSAIDs. Studies examining the NSAIDs in older persons have shown that both the nonspecific inhibitors of cyclooxygenase (COX) inhibitors and the specific COX-2 inhibitors produce equal pain relief and improvement in function. While COX-2 inhibitors are less likely to cause gastrointestinal bleeds, they are more likely to produce renal impairment. Thus, the final choice of which drug to use depends on careful assessments of individual patients and their risks of bleeding compared to their risks of renal failure.

When these drugs are no longer effective at producing pain relief, the physician should utilize low potency opioids either alone or in combination with acetaminophen or NSAIDs. Propoxyphene should be avoided because of its high addiction potential compared to its analgesic activity. If these fail to alleviate pain, the physician should have no fear in prescribing more potent opioids. These should not be limited to use for pain at end-of-life. They also are appropriate for a variety of other pain syndromes such as arthritis. Opioid use is safe in the majority of older persons. The major complication of these drugs is constipation. The prescription of an osmotic drug such as sorbitol, should usually accompany the prescription of an opioid. Stimulant laxatives should be avoided. Other side effects include cognitive disturbances, sedation, nausea, and respiratory depression. In most cases, tolerance develops rapidly to these side effects. This leads to a rapid escalation of the dose needed for pain relief. Driving should be avoided when opiates are first used until the patient adapts to their use.

With opiates, as with other analgesics, the basic approach should be to give around the clock coverage against pain using long acting drugs when possible. Continuous pain requires a continuous medication regimen. However, short-acting analgesic medication should be given on an as-needed basis for breakthrough pain.

Placebos (inert medications given orally or by injection) have no place in the management of pain. Their use is unethical!

Other Treatments

When pain is accompanied by depression, aggressive treatment of that depression is a sine qua non of pain management. Tricyclic antidepressants are preferred because they activate the descending inhibitory pain pathways. There is no evidence that selective serotonin receptor inhibitors activate the descending inhibitory pain fibers from the midbrain to the spinal cord. In older persons the less anticholinergic tricyclics, desipramine or nortryptiline, should be used. They are also appropriate for treatment of neuropathic pain. Gabapentin and carbamazepine are excellent drugs...
for neuropathic pain and trigeminal neuralgia. Clonidine has been successfully used for complex regional pain syndromes. The majority of patients receiving these drugs receive only partial relief. Thus, patients should not be given these drugs without access to other opiates. The active ingredient of marijuana, Marinol (dronabinol), provides some pain relief while reducing nausea and particularly increasing appetite. It is useful in the treatment of pain in end-of-life patients.

Topical treatments include capsaicin cream and lidocaine. They often work well for localized nerve irritant pain. Mexilitine is a local anesthetic that appears to give pain relief when given orally.

In persons with severe pain, percutaneous continuous analgesia, given either intravenously, subcutaneously, intrathecally, or epidurally, can give dramatic relief with fewer side effects. These techniques have been successfully used in frail older patients. Finally, it should be remembered that in some cases, pain relief might require surgical intervention.

Conclusions
Several points bear repeating. • Pain needs to be taken seriously by health care professionals and treated in a timely manner. • When depression coexists with pain, it also needs to be treated. • A combination of non-pharmacological and pharmacological modalities should be used to treat pain. • Patients with pain should receive appropriate education regarding its causes and management. • Placebos are inappropriate for pain management. • Pain medication works better when given continuously. • The use of opiates for uncontrolled pain is appropriate and should not be avoided. As so clearly stated by Bruce Ferrell, a geriatrician at UCLA, “Clinicians have an obligation to provide comfort, pain relief, and dignity for patients, even if such interventions may shorten life by a few hours or days.” For the majority of patients, appropriate treatment of pain improves functional status and their quality of life without altering lifespan. No patient should be doomed to live in the “shadowlands of pain.” We have the technology. It is up to us to use it to alleviate suffering.

We have the technology. It is up to us to use it to alleviate suffering.

Have you just been caught reading someone else’s mail?
If you are reading someone else’s copy of this newsletter, don’t panic. We won’t call the police, notify the post office, or haul you off to jail. Since there’s no penalty, if you wish to receive your own copy of Aging Successfully, please fax or mail your name and address to: Ronna Rhodes, Division of Geriatric Medicine, 1402 S. Grand Blvd., Rm. M238, St. Louis, MO 63104 (FAX: 314-771-8575)

He Did it Again!
M. Louay Omran wins Osler Award

Dr. M. Louay Omran of the Division of Geriatric Medicine at Saint Louis University has been awarded the Osler Award for the second year in a row. This award is presented annually to the physician voted as the best teacher of the year by his students, the residents and interns. Named after perhaps the most important figure in medical education in the United States, Sir William Osler, the award is given to one who knows and teaches that “medicine is learned by the bedside and not in the classroom.” Osler was a common-sense teacher; he loved books and emphasized that a patient, a library, and a notebook were the tools of medical education. Dr. Omran exemplifies this philosophy, and, like Osler, is very tenderhearted toward his patients and patient with his students. Congratulations, Dr. Omran!
**Upcoming CME Programs**

**University of the Third Age Conference**  
**A BOUNTIFUL HARVEST: REAPING OUR EXPERIENCES**  
October 27, 2001

**The 21st Annual GRECC Symposium**  
**NUTRITION AND THE ELDERLY**  
December 7, 2001

**The 13th Annual Nursing Home Directors Meeting**  
**NURSING HOME ISSUES**  
December 8, 2001

**UPDATE IN PSYCHIATRICS**  
February 8-10, 2002  
San Juan, Puerto Rico

**CERTIFICATE PROGRAM IN DEMENTIA**  
February 2, 22, March 8, 22,  
May 5 and 19 in Peoria, Illinois.

All the above conferences will be held at Saint Louis University except as noted.  
For more information, please call 314-268-5644  
or 314-894-6560.

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**Drug Dosing Chart**

### Analgesic Drugs

#### Opiates

<table>
<thead>
<tr>
<th>Drug</th>
<th>Starting Dose</th>
<th>Dosage Interval</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine Immediate Release Tablets, Liquid, Suppository</td>
<td>10-15 mg</td>
<td>q 3-6 h</td>
<td>Older persons more sensitive to side effects. Give sorbitol to prevent constipation</td>
</tr>
<tr>
<td>Morphine Sustained Release Tablets, Liquid, Suppository</td>
<td>15-20 mg</td>
<td>q 12 or 24 h</td>
<td>Tablets cannot be crushed or chewed</td>
</tr>
<tr>
<td>Hydromorphone Tablets, Liquid, Suppository</td>
<td>1.5 mg</td>
<td>q 3-4 h</td>
<td>Half-life shorter than morphine</td>
</tr>
<tr>
<td>Oxycodone Immediate Release Tablets</td>
<td>5-10 mg</td>
<td>q 3-4 h</td>
<td>Combination with acetaminophen (Percocet/Roxicet)</td>
</tr>
<tr>
<td>Oxycodone Sustained Release Tablets</td>
<td>5-10 mg</td>
<td>q 3-4 h</td>
<td>Combination with acetaminophen (Vicodin/Lorset/Lortab/Norco) and Ibuprofen (Vicoprofen)</td>
</tr>
<tr>
<td>Oxycodone Liquid</td>
<td>q 3-4 h</td>
<td>Combination with acetaminophen (Vicodin/Lorset/Lortab/Norco) and Ibuprofen (Vicoprofen)</td>
<td></td>
</tr>
<tr>
<td>Fentanyl Transdermal</td>
<td>25-50 µg</td>
<td>q 72 h</td>
<td>Slow onset of action</td>
</tr>
<tr>
<td>Fentanyl Transmucosal</td>
<td>25-50 µg</td>
<td>q 72 h</td>
<td>Slow onset of action</td>
</tr>
<tr>
<td>Codeine</td>
<td>5-10 mg</td>
<td>q 3-4 h</td>
<td>Combination with acetaminophen or NSAIDs; constipation a major problem</td>
</tr>
<tr>
<td>Methadone Tablet</td>
<td>2-4 mg</td>
<td>q 4-12 h</td>
<td></td>
</tr>
<tr>
<td>Methadone Liquid</td>
<td>2-4 mg</td>
<td>q 4-12 h</td>
<td></td>
</tr>
</tbody>
</table>

#### Non-Opiates

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acetaminophen</td>
<td>Maximum dose 4 g/24h; Dose regular 4 to 6 hr; use extended release for overnight coverage</td>
</tr>
<tr>
<td>Dronabinol</td>
<td>GI bleeding</td>
</tr>
<tr>
<td>Baclofen</td>
<td>Renal failure Note: Equivalent analgesic and functional effects</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>GI bleeding</td>
</tr>
</tbody>
</table>

#### Cyclo-oxygenase Inhibitors

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-specific</td>
<td>GI bleeding</td>
</tr>
<tr>
<td>COX-2 inhibitors</td>
<td>Renal failure Note: Equivalent analgesic and functional effects</td>
</tr>
</tbody>
</table>

#### Aspirin

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tramadol</td>
<td>50 to 100 mg q 4 to 6 h with maximum dose 400 mg. Can cause delirium</td>
</tr>
</tbody>
</table>

### Adjuvant Analgesic Drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prednisone</td>
<td>Carbamazepine</td>
</tr>
<tr>
<td>Desipramine</td>
<td>Dronabinol</td>
</tr>
<tr>
<td>Norryptilene</td>
<td>Baclofen</td>
</tr>
<tr>
<td>Gabapentin</td>
<td>Dronabinol</td>
</tr>
</tbody>
</table>

### Notes:
1. Avoid butorphanol, meperidine, nalbuphine HLC, pentazocine, and propoxyphene
2. Sorbitol or lactulose preferred to prevent opiate-induced constipation
3. For nausea consider compazine, metoclopramide, or scopolamine TD patch

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**Aging Successfully, Vol. XI, No. 3**  
**Questions? FAX: (314) 771-8575 • email: agingsuccess@slu.edu**
The numeric scale is a Likert scale that allows the rating of pain on a scale of 1-10, with 0 indicating no pain and 10 indicating the worst pain imaginable. The faces scale, originally used with children who were too young to read, is a depiction of 6 faces ranging from smiling (a rating of 0) to crying (a rating of 5). Figure 2, which compares the level of pain indicated using the face (Y axis) scale versus the numeric (X axis) scale shows that the patients’ responses to the faces indicated that higher levels of pain were being experienced than their responses to the numeric scale indicated. In order to determine which scale more accurately depicted the level of pain actually being experienced, comparisons were also made to determine whether their self-reported quality of health (question 3) and quality of life (question 4) correlated with their self-reported levels of pain (question 1a: numeric Likert scale and question 1b: face scale). The responses to the face scale were more highly correlated to the responses to their quality of life question (Figure 3) than were their responses to the Likert scale. In addition, the face scale was better correlated with their responses to the quality of health question than was the numeric scale.

This study also shows that the vast majority of people complaining of pain received prescriptions for pain medication (Figure 4). There was, however, a difference in the use of scheduled versus PRN prescriptions. Eighty percent of non-steroidal anti-inflammatory drugs (NSAIDs) were scheduled and 20% were prescribed to be taken on an as-needed basis. However, only 34% of Tylenol® prescriptions were scheduled and 66% were PRN.

In conclusion, the face scale is more accurate in measuring level of pain experienced by the older patient. Whether this is due to poor eyesight (perhaps due to not bringing reading glasses to the appointment) or to confusion about how to quantify pain on a scale of 0-10, is not known and was not tested. Perhaps both reasons play a role. Regardless of the reason, elderly patients use the face scale with more accuracy than the Likert scale. Therefore, in the GRECC clinic, providers will continue to use the face scale to assist them in assessing the level of pain being experienced by the patient.

Finally, medications prescribed for pain relief are too often being prescribed on an as-needed basis rather than on a scheduled basis. This is especially true of Tylenol®. Providers in the GRECC will be educated about these findings and encouraged to provide more guidance to the patients about pain relief by writing more scheduled and fewer PRN prescriptions. The next chart review will determine whether this educational process was effective.

---

**It’s NEW! GEROPADY!**

**GEROPADY**, the game that tests your knowledge in geriatrics and gerontology! The game uses the format of the popular television game show, Jeopardy. The **GEROPADY** kit includes loose-leaf notebook, instructions, questions and answers, five game board transparent overheads, a “Final GEROPADY” overhead, and materials. PLUS new questions are available on a new CD version of the game. $25 for the regular version or $30 for both.

**ORDER INFO:**
Make checks payable to: SLU-HSC – Geriatrics
St. Louis University Health Sciences Center
Division of Geriatric Medicine
1402 S. Grand Boulevard, Room M238
St. Louis, Missouri  63104

**GEROPADY** is produced by the Missouri Gateway Geriatric Education Center, the Division of Geriatric Medicine at Saint Louis University, and the Geriatric Research, Education, and Clinical Center (GRECC), St. Louis Veterans Affairs Medical Center.

Hartford Grant Will Allow All Medical Students at Saint Louis University To Become More Geriatric Savvy

We all want the most competent doctor, but we also want a doctor that will listen to us, and understand why our problems are important to us. We would like him or her to know that no matter what age we are, we want to feel as good as possible so that we can do what we want to do, whether it is going out to lunch with friends, playing with grandchildren, or just being able to live in our own home as long as possible.

If your doctor graduates from Saint Louis University School of Medicine in the coming years, there is a good chance that he or she will be able not only to treat your direct medical problems, but also to understand how these medical problems affect your lives, dreams and desires as well. This is because Dr. Joseph Flaherty of the Division of Geriatrics has been awarded a two-year, $100,000 grant called, “Enhancing Gerontology/Geriatric Medicine in Undergraduate Medical Education” from the John A. Hartford Foundation. It is one of 10 such grants awarded to the Association of American Medical Colleges in 2001 for the purpose of stimulating geriatric curriculum development in the U.S. medical schools.

The grant will support an enhanced curriculum in which all students who graduate, whether they become heart surgeons or family practitioners, will have increased exposure to geriatric issues. In year one, students will interact with healthy seniors. They will also be taught proper interviewing techniques through interactions with “standardized” older patients (senior “actors” trained to be patients). The grant also allows first and second year students to do house calls in St. Louis City.

In year two, as students learn more about actual diseases in the classroom, they will be required to work through complicated clinical cases that involve older patients. For example, as students learn about Parkinson’s Disease or emphysema, they will learn about geriatric syndromes that complicate such diseases. Students will have to “take care of” (in class) a patient with Parkinson’s Disease who might also have dementia, delirium, loss of function, incontinence, weight loss, falls or medication issues. Also in year two, the “Death and Dying” course will be expanded to include multiple issues pertinent to geriatrics, such as Advanced Directives, “Delivering Bad News,” Pain Management, and Nutrition and Hydration issues. Toward the end of year two, students will learn to do history and physicals on actual patients. As part of this experience, which traditionally took place totally in a hospital, students at Saint Louis University will also visit nursing homes.

If your doctor graduates from Saint Louis University School of Medicine in the coming years, there is a good chance that he or she will be able not only to treat your direct medical problems, but also to understand how these medical problems affect your lives, dreams and desires as well.

During these patient encounters they will learn not only the basics of how to interview and examine a patient, but will perform a comprehensive geriatric assessment (which includes the Mini-Mental Status Exam, the Geriatric Depression Scale, and...
the deaths of our loved ones, and our own deaths. Second, we need to use our experiences in ways that help our patients without falling into the trap of assuming that the only way to come to terms with death is the way that worked for us. I do believe that the concept of “To love well is to live forever” can be comforting to many, and perhaps almost all, of our patients with life-threatening illnesses. But there is no reason to stop at one paradigm that provides solace. Let us find others as well.

I will close with the following anecdote. I recently went to the visitation for one of my patients who died and who was an absolutely wonderful person. We who were at the visitation resolved to have her live on in our hearts and remembrances and were comforted by her continued presence.

Published originally in *Supportive Voice* 2001 (Winter); 7(1):1-3, with minor modifications. The SCD Coalition’s permission to reprint the article is appreciated.
evaluations for gait and balance and for pain). These nursing home visits will teach young medical students that healthy and functional older persons live in nursing homes.

During years three and four (the “clinical” years) all students will get more experience in home care, and will learn about hospice. They will also care for patients on the Acute Care for the Elderly (ACE) Unit, a specialized floor in the hospital that promotes function while treating the acute illness. The students will participate in the daily ACE Unit interdisciplinary team meetings.

Before graduating, all students will be evaluated using the “Clinical Skills Exam” (CSE). Saint Louis University is one of only ten pilot sites for the National Board of Medical Examinations in the U.S. that is testing all medical students in this observational hands-on way. This goes beyond the traditional written exams. Thus, we can ensure that students have the attitudes and skills, not just the knowledge, that future physicians need to take care of older persons.

Lastly, with the support of the grant, various educational materials will be made available to students through the University web site. Materials will include case-based problems, geriatric crossword puzzles, numerous geriatric problem-solving mnemonics and links to www.cyberounds.com and www.americangeriatrics.org.

This new geriatric curriculum ensures that an older patient who seeks medical help, whether in the emergency department, at the ophthalmologist’s office or in a general physician’s office, will encounter a doctor with not only the skill to treat the problem, but also the understanding of how this problem can seriously affect the patient’s life. Such understanding ensures better care and better outcomes.

### Hartford Grant (continued from page 21)

**Acybersite for seniors has been developed in collaboration with Saint Louis University and the Gateway Geriatric Education Center. Besides articles written by geriatric experts, this site provides health updates and an interactive question and answer section. The address for this site is www.thedoctorwillseeyounow. See you in cyberspace!**
SuccessFully Aging

Division of Geriatric Medicine
Saint Louis University School of Medicine
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St. Louis, Missouri 63104

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Saint Louis University School of Medicine
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St. Louis Veterans Affairs Medical Center
Gateway Geriatric Education Center of Missouri and Illinois (Gateway GEC)
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