

Geriatric Refresher Day Managing Pain in the Elderly March 2, 2016

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- **All Pharmaceutical** honorariums go to the **MGD Staff Education fund**

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Objectives

Upon completion of this program, participants will have a better understanding of:

- The **prevalence** of persistent pain in the older population, especially among residents in long-term care
- The **biopsychosocial approach** to persistent pain
- The **assessment** of pain in cognitively intact and impaired older persons
- **Clinical considerations** in the pharmacotherapy of pain in older persons
- Current guidelines for the use of **various** analgesic drug classes in the older patient

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Introducing Margaret

- 98 year old female
- Hx of Bilateral OA in knees, hypothyroidism, GERD, HTN, Dementia
- Medications:
 - Levothyroxine sodium, USP 0.025 mg once daily
 - Lorazepam 1mg, at bedtime
 - Donepezil 10mg, daily
 - Rabeprazole 20 mg once daily
 - Losartan 50 mg once daily
 - Vitamin D 2000 IU once daily
 - Vitamin C 500 mg once daily
 - Ferrous fumarate 300 mg once daily
 - Domperidone 10 mg TID
 - Acetaminophen 500 mg TID



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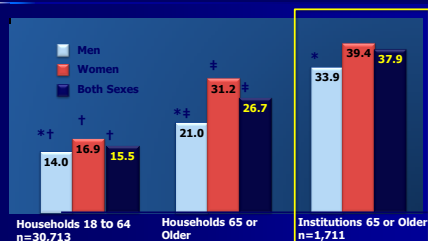
Pain in Canada

- Under recognized and undertreated
- Prevalence of chronic pain **increases** with age
- Prevalence of chronic pain as high as 65% in community dwelling seniors and 80% of older adults living in LTC facilities

Hadjistavropoulos, Marchildon et al.2009, Hadjistavropoulos, Gibson et al.2010

Increased incidence of chronic pain in institutionalized elderly patients

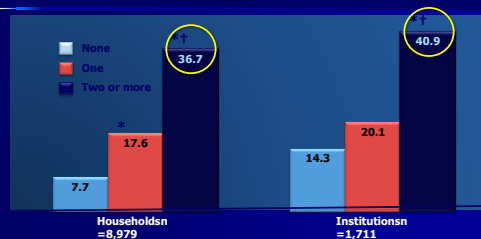
Data from Canadian Community Health Survey and National Population Health Survey



Ramage-Morin PL. Health Reports 2008;19(1):37

Increased incidence of chronic pain associated with medical comorbidities

Data from Canadian Community Health Survey and National Population Health Survey



* significantly different from estimate for "None" ($p < 0.05$)

* significantly different from estimate for previous category ($p < 0.05$)

Ramage-Morin PL. Health Reports 2008;19(1):37

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"Actual prevalence" of pain in LTC facilities is a moving target

In a literature review of 27 studies in nursing homes...

Research method	No. of studies	Prevalence
Residents' self-report	10	~60% – 70%
Chart review	8	3.7%* – 64%
Mixed method, ie, interview, observation, chart review	6	~40% – 60%
Observation	1	47%
Questionnaire to residents	1	66%
Questionnaire to LTC managers	1	37%

* This study looked at excruciating pain only

Pain prevalence derived from MDS data or chart review yielded the most varied results and tended to be low

Takai Y, et al. Pain Manag Nurs 2010;11:209

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Common causes of pain in the nursing home

Sources of pain	Frequency
Low back	40%
Arthritic (knee, hip, shoulder, neck)	29%
Previous fractures	14%
Neuropathies	11%
Leg cramps	9%
Foot	8%
Claudication	8%
Headache	6%
Generalized	3%
Neoplasm	3%

N=65 Winn PA, Dentino AN. J Am Med Dir Assoc. 2004 Sep-Oct;5:342

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Pain Prevalence in Older Adults and Gaps in Treatment Across Care Setting

Setting	Prevalence of pain	No Pain Treatment?
Nursing Home (551 OA/6 NHs) (Reynolds et al., 2008)	51.4% intact 47.7% impaired	20% intact 44% impaired
Hospital (367 OA/8 hosp) (Gianni et al., Arch Geront & Geriatrics, 2010)	67% pain present	51% no treatment or inadequate for intensity
Emerg Dept (1454 >65 hip fx) (Herr & Titler, Emerg Nsg, 2009)	Mean pain intensity=7	40% patients no analgesic ordered
Home Care (2779 OA) (Maxwell et al., 2008)	48% daily pain	22%

Prevalence, causes and consequences of pain *Teaching points*

- Prevalence of pain is high among older people, even higher among LTC residents
- Determining the actual incidence of pain depends on method, sensitivity, and consistency of assessment
- Multiple causes of pain among older patients; musculoskeletal disorders are most common
- The consequences of pain are often profound and severe; detrimental to psychosocial health and quality of life

"Normal" Aging: Changes in Brain Morphology

- Atrophy of prefrontal gray matter
– Raz et al, *Cerebral Cortex* 1997; 7: 268
- Atrophy of thalamus
– Van Der Werf et al, *Cog Brain Res* 2001; 11: 377
- Diminished frontal white matter integrity
– Pfefferbaum et al, *NeuroImage* 2005

Chronic Pain is associated with changes in Brain Structure and Function in Older Adults

Preliminary Evidence:

Older adults with CLBP have structural brain changes including significant reduction in Gray Matter Volume in the posterior parietal cortex and middle cingulate WM volume of the left hemisphere and impaired attention and mental flexibility.

Buckalew N, et al. Pain Med. 2008

Brain Structure and function is different in older patients with CLBP.

Deficits in brain morphology associated with pain duration and poor physical function.

Buckalew N, et al Pain Medicine 2010

IMPLICATIONS

- Pain is associated with WM damage over and above that associated with aging.
- Chronic non-malignant pain is associated with alterations in brain morphology in older adults, above and beyond those associated with normal aging.
- Understanding what biologically drives subjective pain-associated disability may open the door to newly targeted treatments.

INADEQUATE PAIN TREATMENT IN OLDER ADULTS

■ Consequences of untreated pain in older persons

- Impaired ambulation
- Depression, Anxiety
- Social isolation
- Sleep restriction
- Behavioural problems
- Anorexia, weight loss
- Deconditioning, increased falls

Additional Consequences:

- self tx with OTC medications, old Rx's, shared meds., or alcohol

Ann Intern Med. 2008;148:141-6
J Am Geriatr Soc. 2009;57:1331-6

Common misconceptions among patients and caregivers about pain

- *"Pain is an inevitable part of aging, and nothing can be done about it."*
- *"Elderly patients, especially those who are cognitively impaired, have a higher tolerance for pain."*
- *"Elderly patients and people who are cognitively impaired cannot be accurately assessed for pain."*
- *"Patients say they are in pain to get attention."*
- *"The patient doesn't look like he or she is in pain and therefore is probably not really in pain."*

American Medical Directors Association.
Pain management in the long term care setting. Columbia MD: 2012.

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More common misconceptions among patients and caregivers about pain

- *"Elderly patients are likely to become addicted to pain medications."*
- *"To acknowledge pain is a sign of personal weakness."*
- *"Acknowledging pain will mean undergoing intrusive and possibly painful tests."*
- *"Acknowledging pain will lead to a loss of independence."*
- *"Pain always indicates the presence of a serious disease."*
- *"Use of opioids is the only effective means for treatment of significant pain."*

American Medical Directors Association.
Pain management in the long term care setting. Columbia MD: 2012.

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Why assess pain?

"The most common reason for unrelieved pain is the failure of staff to routinely assess pain and pain relief"

— American Pain Society, 2003

"Assessment should not be viewed as a single event but as part of an ongoing process."

— Hadjistavropoulos T, et al. Clin J Pain. 2007;23(1 Suppl):S1

"Being sensitive and open to clues of suffering can also enhance the diagnostic yield of the history and reduce unnecessary diagnostic testing or treatments."

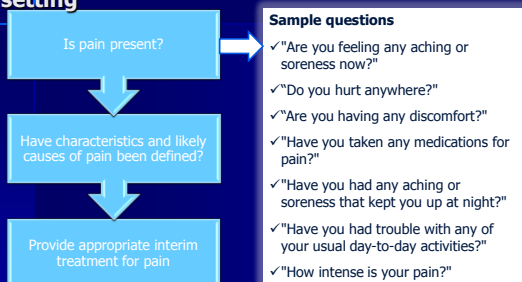
"Recognizing that a patient is suffering can increase patient rapport, confidence, and compliance."

— Lesho Ep. Arch Intern Med 2003; 163:2429

AMDA PAIN MANGEMENT GUIDELINES 2009

- Recognition
- Assessment
- Treatment
- Monitoring

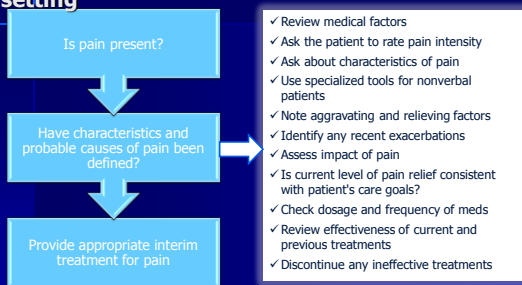
The AMDA Guidelines (2012) Steps in the evaluation of pain in the LTC setting



American Medical Directors Association.
Pain management in the long term care setting. Columbia MD: 2012

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The AMDA Guidelines (2012) Steps in the evaluation of pain in the LTC setting

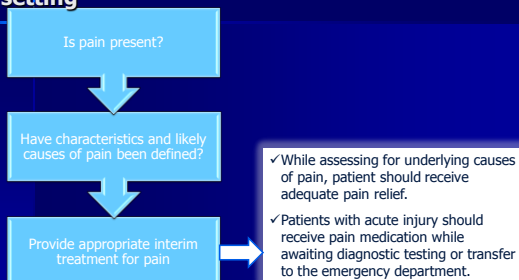


American Medical Directors Association.
Pain management in the long term care setting. Columbia MD: 2012

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The AMDA Guidelines (2012)

Steps in the evaluation of pain in the LTC setting



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American Medical Directors Association.
Pain management in the long term care setting. Columbia MD. 2012

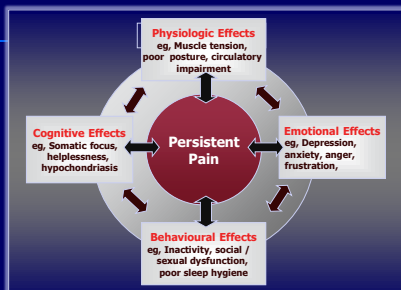
PAIN IN OLDER PERSONS

RECOGNITION

Non-specific signs and symptoms suggestive of pain:

- Frowning, grimacing, fearful facial expressions, grinding of teeth
- Bracing, guarding, rubbing
- Fidgeting, increasing or recurring restlessness
- Striking out, increasing or recurring agitation
- Eating or sleeping poorly

A biopsychosocial approach recognizes the total pain experience



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Barkin RL, et al. Clin Geriatr Med 2005;21:465

A biopsychosocial approach to pain

Teaching points

- Feelings of social isolation and depression share similar neurobiological and chemical pathways as pain
- A biopsychosocial approach recognizes the individual's total pain experience
- A commitment to an interdisciplinary care model can optimize the management of pain, suffering, and related disability among the elderly

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Pain Assessment Tools



Unidimensional scales¹

- Numeric Rating Scale
- Verbal Rating Scale
- Visual Analog Scale
- Faces Pain Rating Scale



Multidimensional scales

- Brief Pain Inventory¹
- McGill Pain Questionnaire¹
- Neuropathic Pain Scale²

1. Brunton S. *J Fam Pract.* 2004;53(suppl 10):S3
2. Galer BS et al. *Clin J Pain.* 2002;18:297

Unidimensional pain assessment scales

Verbal Pain Intensity Scale

No pain Mild pain Moderate pain Severe pain Very severe pain Worst possible pain

*Incapacitating. God awful, soul stealing

Visual Analog Scale

No pain Pain as bad as it could be

* Length of line is irrelevant beyond discrimination

0-10 Numerical Rating Scale

0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Worst possible pain

*Limits people to 11 "intensities"

Faces Rating Scale

0 1 2 3 4 5
No hurt Hurts little bit Hurts little more Hurts even more Hurts whole lot Hurts worst

*Intended for children; "used" with nonverbal patients

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McLafferty E, Farley A. *Nursing Standard* 2008;22:42

Abbey Pain Scale
For measurement of pain in people with dementia who cannot verbalise.

How to use scale: While observing the resident, score questions 1 to 6

Name of resident: _____

Name and designation of person completing the scale: _____

Date: _____ Time: _____

Latest pain relief given was: _____ at _____ hrs.

Q1. Vocalization
eg. whimpering, groaning, crying
Absent 0 Mild 1 Moderate 2 Severe 3

Q2. Facial expression
eg. looking tense, frowning, grimacing, looking frightened
Absent 0 Mild 1 Moderate 2 Severe 3

Q3. Change in body language
eg. fidgeting, rocking, guarding part of body, withdrawn
Absent 0 Mild 1 Moderate 2 Severe 3

Q4. Behavioural Change
eg. increased confusion, refusing to eat, alteration in usual patterns
Absent 0 Mild 1 Moderate 2 Severe 3

Q5. Physiological change
eg. temperature, pulse or blood pressure outside normal limits, perspiring, flushing or pale
Absent 0 Mild 1 Moderate 2 Severe 3

Q6. Physical changes
eg. skin tears, pressure areas, arthritis, contractions, previous injuries
Absent 0 Mild 1 Moderate 2 Severe 3

Add scores for 1 – 6 and record here Total Pain Score

Now tick the box that matches the Total Pain Score

0 – 2	3 – 7	8 – 13	14+
No pain	Mild	Moderate	Severe

Finally, tick the box which matches the type of pain

Chronic	Acute	Acute on Chronic
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Abbey Pain Scale

Brief, 6-item scale that takes only a few minutes to complete. Items of the APS measure aspects of the pain experience on a 4-point scale of severity:

- Vocalizations
- Facial expressions
- Changes in body language
- Behavioural changes
- Physiological changes
- Physical changes.

The Total Pain Score provides an indication of pain severity as below:

0 – 2	3 – 7	8 – 13	14+
No pain	Mild	Moderate	Severe

Abbey, J, De Bellis, A, Pillar, N, et al. Funded by the JH & JD Gunn Medical Research Foundation 1998 – 2002

PAINAD Scale

The Pain Assessment in Advanced Dementia (PAINAD) Scale*

Items	0	1	2	Score
Breathing independent of vocalization	Normal	Occasional labored breathing. Short period of hyperventilation.	Noise labored breathing. Long period of hyperventilation. Chryse-Brown respirations.	
Negative vocalization	None	Occasional moan or groan. Low-level speech with a negative or disapproving quality.	Repeated troubled calling out. Loud moaning or groaning. Crying.	
Facial expression	Smiling or inexpressive	Sad, Frightened, Frown	Facial grimacing.	
Body language	Relaxed	Tense. Disturbed posing. Fidgeting.	Rigid. Fluty detached. Knees pulled up. Pulling or pushing away. Striding out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
				Total

The total score ranges from 0-10 points. Scores may be interpreted as follows:

- 1-3=mild pain
- 4-6=moderate pain
- 7-10=severe pain

This is a 5-item scale that assesses the following:

- Breathing
- Vocalization
- Facial expression
- Body language
- Consolability

Each item is scored on a 0-2 scale, with higher scores indicating greater pain intensity.

PAINAD = Pain Assessment in Advanced Dementia

Warden V, et al. J Am Med Dir Assoc 2003; 4:9

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Form 1-1 Brief Pain Inventory

Date: ____/____/____ Time: ____:____:____

Name: _____

1) Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and backaches). Have you had pain other than these everyday kinds of pain today?
1. Yes 2. No

2) On the diagram shade in the areas where you feel pain. Put an X on the area that hurts the most.

3) Please rate your pain by circling the one number that best describes your pain at its worst in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No pain as bad as you can imagine

4) Please rate your pain by circling the one number that best describes your pain at its least in the past 24 hours.
0 1 2 3 4 5 6 7 8 9 10
No pain as bad as you can imagine

5) Please rate your pain by circling the one number that best describes your pain on the average.
0 1 2 3 4 5 6 7 8 9 10
No pain as bad as you can imagine

6) Please rate your pain by circling the one number that tells how much pain you have right now.
0 1 2 3 4 5 6 7 8 9 10
No pain as bad as you can imagine

7) What treatments or medications are you receiving for your pain?

8) In the past 24 hours, how much relief have pain medications or medications provided? Please circle the one percentage that most closely shows how much relief you have received.
0% 10 20 30 40 50 60 70 80 90 100%
No relief Completely relieved

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:
A. General activity
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

B. Mood
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

C. Walking ability
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

D. Normal work (includes both work outside the home and housework)
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

E. Relations with other people
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

F. Sleep
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

G. Enjoyment of life
0 1 2 3 4 5 6 7 8 9 10
Does not interfere Completely interferes

Brief Pain Inventory (BPI)

The BPI measures pain and its functional impact, on a 0-10 scale:

- a) Pain intensity
- Worst
 - Least
 - Average
 - Right now
- b) Interference with:
- General activity
 - Mood
 - Walking ability
 - Normal work
 - Social relations
 - Sleep
 - Enjoyment of life

Higher total scores BPI indicate greater pain interference.

Developed by Dr Charles Cleeland

Margaret: Signs of agitation

Physical exam

- Range of motion has visibly decreased; extreme difficulty stretching both knees

Behaviours observed

- Wincing, groaning, rigidity, irritability

Recent symptoms of verbal agitation

- Frequent requests for attention, complaining

MMSE score: 12



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Are pain self-reports valid in the cognitively impaired? Here's a rule of thumb

- MMSE scores ≥ 18 : typically capable of providing valid self-report
- MMSE scores ≤ 13 : least likely to provide valid reports.
- Nonetheless, self-report should be attempted with all patients
 - Some individuals with low MMSE scores can self-report pain
 - Use single-answer, close-ended questions (and patience) to elicit information

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Hadjistavropoulos T, et al. Clin J Pain. 2007;23(1 Suppl):S1

Consequences of unrelieved pain in persons with dementia

Physical	Psychosocial
Gait impairment	Decrease in daily activities
Decreased appetite	Impaired cognition
Sleep disturbances	Verbal aggression
Agitation	Depression
Physical combativeness	Social isolation
Wandering	Learned helplessness

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Shega J, et al. J Pain. 2007;8:373

What is the role of pain in disruptive behaviours?

Wandering	Pain severity is negatively associated with the frequency of wandering behaviors (Odds Ratio = 0.77, $p < .001$ 95% CI = 0.73, 0.81)
Aggression	Pain severity is positively associated with the frequency of aggressive behaviors (Odds Ratio = 1.04, $p < 0.001$, 95% CI = 1.01, 1.08)
Agitation	Pain severity is positively associated with the frequency of agitated behaviors (Odds Ratio = 1.17, $p < 0.001$, 95% CI = 1.13, 1.20)

Ahn H, Horgas A. BMC Geriatr 2013;13:14

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KEY COMPONENTS OF PAIN ASSESSMENT

- **Measurement of Pain:**
 - Using standardized scales in a format that is accessible to the individual.
- **Cause of Pain:**
 - Examination and investigation to establish the cause of pain.

Pain Assessment Tool

"... it is important to utilize a scale that is **appropriate** for the individual and **document** and use the **same** tool with **each** assessment."

AGS Guidelines. J Am Geriatr Soc. 2002;50(6 Suppl):S205

Cognition	Verbal Communication	Scales
Intact	Intact	Numeric Rating Scale (NRS) Verbal Descriptor Scale (VDS)
Intact	Limited	Faces Pain Scale Faces Pain Scale Revised (FPS-R)
Impaired	Intact	Pain Assessment in Advanced Dementia (PAINAD)
Impaired	Limited	Pain Assessment Checklist for Seniors with Limited Ability to Communicate (PACSLAC)

http://www.geriatricpain.org/Content/Assessment/Impaired/Documents/PACSLAC_Tool.pdf

Treating Pain in the Elderly

- ▶ **Considerations in the elderly**
- ▶ **The Analgesic Ladder**
 - Which drug?
 - Safe prescribing
 - Dosing
- ▶ **Dealing with agitation**



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Margaret: Pain profile

- Pain scores:
 - Worst pain 9/10
 - Least pain 6/10
 - Average pain: 8/10
- Pain is described as generalized and widespread, but worse in knees
- Difficulty sleeping; no interest in social activities
- MMSE score: 22
- BPI score: 47/70

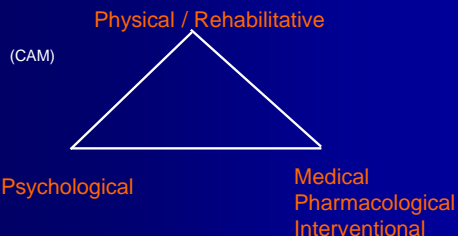


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Pain Management Goals

- Decrease pain
- Improve function
 - Physical
 - Psychological
 - Social
- Minimize risk
 - Patient
 - Physician
 - Society

IDEAL TREATMENT OF PERSISTENT PAIN



Mixed Pain Concept

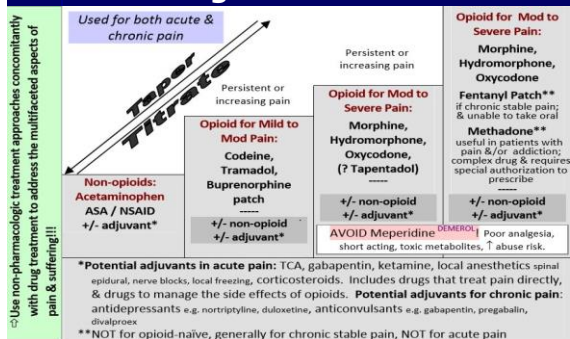
Nociceptive pain:
Caused by activity in neural pathways in response to potentially tissue-damaging stimuli



Neuropathic pain:
Pain arising as a direct consequence of a lesion or disease affecting the somatosensory system

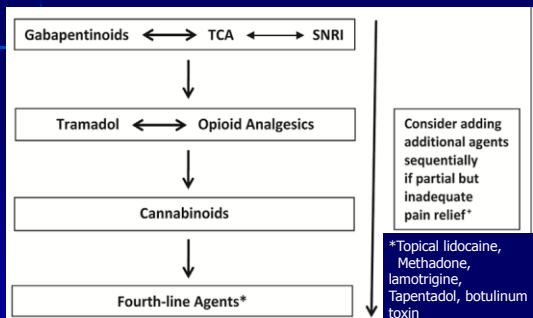
Woolf CJ. *Ann Intern Med* 2004;140:441
Trends RD, Jensen TS. *Neurology* 2008;70:1630
Portenay R. *Curr Med Res Opin* 2005;27:1555

Analgesic Ladder



Adapted from WHO and Canadian Guideline for CNCP
Geri-RxFiles, Assessing Medications in Older Adult, 22A, pg.1, March 2014

Canadian Pain Society Pharmacological Management of Chronic Neuropathic Pain



Pain Res Manag Vol 19 No 6 Nov/Dec 2014

AGS RECOMMENDATIONS

- **Initial and Maintenance** - Acetaminophen particularly for musculoskeletal pain
- **Acute Flares** - NSAIDS AND COX-2 selective inhibitors may be considered **RARELY**
 - Exercise caution due to ↑ CV/GI risk):
 - Limit 7-10 days: Consider topical NSAID
- Opioids for all patients with **moderate-to-severe** pain

American Medical Directors Association. Pain management in the long term care setting. Columbia MD: 2012
AGS 2012 Beers Criteria Update Expert Panel. J Am Geriatr Soc 2012;60:616

Pharmacological changes in the elderly

Concern	Normal aging	Possible effects
GI function	<ul style="list-style-type: none"> • ↑ GI transit times • Possibly enhanced opioid-related dysmotility 	<ul style="list-style-type: none"> • ↑ effects of oral CR drugs
Transdermal Absorption	<ul style="list-style-type: none"> • Mostly unchanged 	N/A
Distribution	<ul style="list-style-type: none"> • ↑ fat:lean ratio 	<ul style="list-style-type: none"> • ↑ volume of distribution for lipophilic drugs; ↑ drug $t_{1/2}$
Anticholinergic effects	<ul style="list-style-type: none"> • Confusion, constipation, incontinence, movement disorders 	<ul style="list-style-type: none"> • Risk enhanced by neurologic disease

American Geriatrics Society Guidelines. J Am Geriatr Soc 2009;57(8):1331

Pharmacological changes in the elderly

Concern	Normal aging	Possible effects
Hepatic metabolism	↓oxidation (variable) NB: Unchanged conjugation and first-pass effect	• ↑ drug $t_{1/2}$
Renal excretion	↓GFR	↓ excretion, prolonged effect of active metabolites

American Geriatrics Society Guidelines. J Am Geriatr Soc 2009;57(8):1331

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Opioid Therapy

- Opioid therapy for elderly patients can be **safe & effective** (Grade B) provided that appropriate precautions are taken:
 - Lower starting doses
 - Slower titration
 - Longer dosing interval
 - More frequent monitoring
 - Tapering of benzodiazepines (Grade C). (2010 Opioid Guidelines for CNCP)
- Consider opioids for all patients with
 - Moderate-severe pain
 - Functional impairment or decreased QOL due to pain
 - Efficacious for nociceptive and neuropathic pain conditions

American Geriatrics Society Guidelines. J Am Geriatr Soc 2009;57(8):1331; American Medical Directors Association. Pain management in the long-term care setting. Columbia MD. 2012

Initiating opioid therapy in older adults

Opioid-naïve patients

- "Start low, go slow"
- Begin with an **immediate-release** preparation
- Once total daily dose is established, convert to an equivalent dose of a **long-acting formulation** when possible
- **PRN meds**: Treat breakthrough pain—prescribe a short-acting, immediate-release preparation
 - Dosing: **~10% to 15%** of the total daily opioid dose every hour

National Opioid Use Guideline Group. 2010
American Medical Directors Association. Pain management in the long-term care setting. Columbia MD. 2012

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OPIOID TREATMENT IN OLDER PERSONS : Oral Options

- Assess presence of renal insufficiency as **some** opioids (or their metabolites) are cleared renally and can **accumulate**:
 - Oxycodone • Morphine
 - Propoxyphene • Meperidine
- Dose adjustments are necessary for patients with renal insufficiency
- Hydromorphone a preferred choice in patients with renal impairment
- M-Eslon can be opened and put in G-Tubes

OPIOID TREATMENT IN OLDER PERSONS : Transdermal

- **Fentanyl Patch**
 - Provides around-the-clock pain control
 - Patch changed Q 48-72 H
 - FDA (2005) advises that Fentanyl should only be initiated in opioid tolerant patients who *"who have demonstrated opioid tolerance and require a daily dose of at least 25 mcg/hr"*
 - ISMP (US) Medication Safety Alert! (Aug 8 2013)
- **Buprenorphine Patch**
 - once weekly for moderate pain

What is an optimal dose?

The optimal dose is reached with a balance of three factors:

- 1) **Effectiveness**: improved function or at least **30% to 50% reduction** in pain intensity
- 2) **Plateauing**: effectiveness plateaus—increasing the dose yields negligible benefit, and
- 3) **Adverse effects/complications**: adverse effects or complications are manageable.

National Opioid Use Guideline Group, 2010
American Medical Directors Association. Pain management
in the long term care setting. Columbia MD: 2012

What is a "watchful dose"?

Chronic non-cancer pain can typically be managed effectively in most patients with morphine (or equivalent) in doses of ≤ 120 mg/day (ASIPP 2012) or ≤ 200 mg/day (Canadian Opioid Guideline).

"Consideration of a higher dosage requires careful reassessment of the pain and of risk for misuse, and frequent monitoring with evidence of improved patient outcomes."
(Canadian Opioid Guideline).

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Monitor and Manage: Adverse Effects of Opioids

- Confusion
- Constipation
- Drowsiness
- Hallucinations
- Itching
- Nausea
- Postural hypotension
- Urinary retention
- Vertigo

• Most of these adverse effects—**apart from constipation**—tend to be transient

• The consequences of some of these effects on the elderly require special attention (eg, **cognitive impairment, risk of falls**)

American Geriatrics Society Guidelines. J Am Geriatr Soc 2009;57(8):1331
American Medical Directors Association. Pain management in the long-term care setting. Columbia MD: 2012

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TOPICAL ANALGESIC AGENTS

Lidocaine 5%, Amitriptyline 5%,

Ketoprofen 7.5%, Ketamine 10%

In PLO Gel or Lidoderm TID-QID

NEWER DRUGS

- **Buprenorphine Trans Dermal**
 - good for moderate pain in opioid naïve. Patch changed every 7 days
- **Oxycodone /Naloxone**
- **Oxycodone CR**
- **Tapentadol – IR/CR**
- **Fentanyl buccal soluble film**
 - Oral patch for breakthrough palliative care

Treatment Considerations for Persistent Pain in Older Adults

Goal: Optimal Pain Relief



- *Quality/frequency of assessments
- *Optimized nondrug approaches
- *Balance risk/benefits and optimize use
- *Minimize ADR/misuse/abuse
- *Monitor & document outcomes

(ACS Panel on the Pharmacological Management of Persistent Pain in Older Persons. JGIM. 2009;24(7):1331-1346; Amsterdam. Pain Manage Hosp. 11(7):511-522; Bruckenthal P, et al. Pain Medicine. 2009;10(5):540-549)

Avoid in Elderly



- Meperidine (Demerol)
- Pentazocine (Talwin)
- **Long acting** Benzodiazepines (eg. diazepam, clonazepam)
- **High dose** acetaminophen ($\geq 2.6\text{g/day}$)
- NSAIDs
- Skeletal muscle relaxants
- Codeine

Analgesic medications for older adults Summary

- Use acetaminophen as initial and ongoing agent especially for musculoskeletal pain
- Avoid NSAIDs and coxibs for long-term use
- Use opioids for patients with moderate-to-severe pain; titrate slowly and monitor for adverse effects
- Use adjuvants for neuropathic pain, usually in combination with other analgesics

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Margaret

- Physical findings of OA in both knees and restricted to wheelchair
- Difficulty sleeping, waking up around 3:00 am and mobilizing in morning.
- Stopped lorazepam and started Melatonin 3mg.



Margaret

- Initially oxycodone hydrochloride 2.5mg/acetaminophen 325 mg for 3 weeks then increased to 5.0 mg
- Switched to transdermal buprenorphine 5 mcg/hr. for 1 month - increased to 10 mcg/hr. Acetaminophen 500mg at 6:00 am.



SUMMARY

- A combination of non-pharmacologic and pharmacologic interventions can effectively reduce pain and its burden
- Consider physiological characteristics in older patients
- Pharmacologic modalities can be used safely and effectively to treat pain in older patients

Pain in Older People: Summary

- Ask about pain regularly
- Assess pain systematically
- Believe the patient's and family's reports of pain and what relieves it
- Choose appropriate pain control options
- Deliver interventions in a timely, logical and coordinated fashion
- Empower patients and their families

Geriatric Refresher Day Managing Pain in the Elderly March 2, 2016

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