Pain Management in the Elderly: Walking the Tight rope

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March 4, 2010

Today's session:

- Effects of pain on elderly
- Common causes of pain
- Myths/misconceptions about pain
- Barriers to reporting pain
- What can we, as healthcare providers, do:
  - Appropriate medication
  - Alternative therapies
  - Individual/family/caregiver education & support

"For all the happiness mankind can gain...

It's not in pleasure, but in rest from pain."

John Dryden, 1660.

Effect of pain on elderly:

- Pain is the most feared complication of illness
- Pain is the second leading complaint in physicians' offices
- Often under-diagnosed and under-treated
- Effects on mood, functional status, and quality of life
- Associated with increased health service use

Effects of poorly managed pain:

- Sleep disturbance
- Decreased appetite
- Mobility impairment
- Depression, anxiety
- Decreased social contacts
- Skin breakdown

Common Causes of Persistent Pain In Elderly Persons

- Osteoarthritis
  - back, knee, hip
- Night-time leg cramps
- Claudication
- Neuropathies
  - diabetic, herpes zoster (shingles)
- Cancer

MISCONCEPTIONS ABOUT PAIN

Myth: Pain is expected with aging.

Fact: Pain is not normal with aging.

Elderly tend to be more complex:

- Multiple causes re: concurrent illnesses, physiological changes of aging;
- Medication related side-effects;
- Potential for complications/adverse reactions to diagnostic procedures;
- Often unwilling to "bother" healthcare provider with complaint of pain.

MISCONCEPTIONS ABOUT PAIN

Myth: If they don't complain, they don't have pain

Fact: There are many reasons patients may be reluctant to complain, despite pain that significantly effects their functional status and mood.

REASONS PATIENTS MAY NOT REPORT PAIN

- Fear of diagnostic tests
- Fear of medications
- Fear meaning of pain
- Perceive physicians and nurses too busy
- Complaining may effect quality of care
- Believe nothing can or will be done

The most reliable indicator of the existence pain and its intensity is the patient's description.

McGill Pain Questionnaire Present Pain Intensity Subscale (PPI)

0 - No Pain
1 - Mild
2 - Discomforting
3 - Distressing
4 - Horrible
5 - Excruciating

100mm Visual Analog Scale

Make a mark on the line for the severity of your pain.

No Pain — Worst Possible Pain

Memorial Pain Card Subscale (Modified Turskey Scale)

Moderate* Strong* Just Noticeable* Mild* No Pain* Excruciating* Severe* Weak*

Rand Coop Chart

No Pain
Very Mild Pain
Mild Pain
Moderate Pain
Severe Pain

Verbal Scale

On a scale of zero to ten, zero meaning no pain and ten meaning the worst pain you can imagine, how much pain are you having now?

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General approach to pain management

- Any pain complaint affecting physical function or quality of life IS significant.
- Weigh risks & benefits of pharmacotherapy
- Comfort goals need to be mutually determined
- Recognize analgesic sensitivity
- "start slow, start low" (dosage)

Pharmacological changes with aging

- GI:slowing of GI transit time may effect absorption (think: timed release meds)
- Opioids: bowel dysmobility = constipating
  Disorders/disease affecting gastric pH may reduce absorption, as may surgically altered anatomy (ostomies, bowel resection)
- Transdermal: temperature, circulation
- Fat/lean distribution may affect absorption (eg lengthen effective half life of drug)
- Liver function: may lengthen half-life of drug
- Renal: glomerular filtration rate slows: decreased excretion of drug
- Anticholinergic side effects: increased confusion, constipation, incontinence, movement disorders; enhanced by neurological disease processes

Other considerations:

- Route
  - Oral, IV, transdermal, rectal, etc.
- Timing
  - Type of pain (episodic, spontaneous, continuous)
  - Beware of "breakthrough pain"

Complementary therapies

- Physical therapy
- Yoga, meditation
- Acupuncture
- Cognitive behavioural therapy
- Education about pain management
- Rational polypharmacy (2 drugs working synergistically)

Analgesic Drugs

- Acetomenophen
  - Osteoarthritis & low back pain
  - Few side effects
  - Educate to take max (less than 4g/24h) safely in most patients (all sources of acetomenophen); 1 g at one time.

NSAIDs

- Chronic inflammatory pain (eg, RA)
- short term effectiveness (less than 6 weeks) for osteoarthritis
- Watch for low creatinine clearance, GI problems, CHF, CVD
- Adverse drug reactions re: NSAIDs as causative factor in older adult hospitalization:23%

Opioids

- Useful for persistent cancer/non-cancer pain, osteoarthritis, postherpetic neuralgia, diabetic peripheral neuropathies
- Important to identify potential adverse effects:
  - Constipation
  - Respiratory depression
  - Fatigue, depression, decreased libido
  - Addiction--less likely in the elderly, but often more reason for avoidance

Under-use of opioids

- Lower risk for opioid abuse/misuse in elderly;
- Under-use related to fear of addiction, cost, fear of constipation, negative social stigma
- Important to encourage discussion with patient/family re: thoughts about opioids

Adjuvant drugs

- Pain reduction using drugs from different classes work for postherpetic neuralgia & neuropathy & fibromyalgia :
  - Anti-convlusant agents, e.g. gabapentin, pregabalin
  - Antidepressants work for postherpetic neuralgia & neuropathy & fibromyalgia
    - Newer serotonin & norepinephrine-uptake inhibitors (SNRIs) duloxetine, venlafaxine work better with fewer side-effects than older anti-depressants

Deciding on treatment:

- Comorbidities
- Concomitant medications
- Associated risk factors
- Benefits/risk profile

CAUTION

- Meperidine (Demerol)
- Butorphanol (Stadol)
- Pentazocine (Talwin)
- Propoxiphene (Darvon)
- Methadone (Dolophine)
- Transderm Fentanyl (Duragesic)

Non-Drug Strategies

- **Exercise**
  - **PT, OT, stretching, strengthening**
  - **general conditioning**
- **Physical methods**
  - **ice, heat, massage**
- **Cognitive-behavioral therapy**
- **Acupuncture**
- **TENS**
- **Alternative therapies**
  - **relaxation, imagery**
  - **herbals**

PATIENT AND CAREGIVER EDUCATION

- Diagnosis, prognosis, natural history of underlying disease
- Communication and assessment of pain
- Explanation of drug strategies
- Management of potential side-effects
- Explanation of non-drug strategies
- EVALUATION and FOLLOW-UP

REFERENCE

- Pharmacological Management of Persistent Pain in Older Persons, American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons, *Journal of the American Geriatrics Society*, Aug. 2009, Vol 57(8), 1131-1346.