# Pain Management in the Elderly: Walking the Tight rope

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## 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 <u>Persistent</u> 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.

<u>Fact</u>: 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

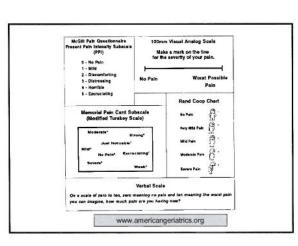
<u>Fact</u>: There are many reasons patients may be reluctant to complain, despite pain that significantly effects their functional status and mood.

### 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.



#### 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

- Gl:slowing of Gl 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
- 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.
- - 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 (SNRts) 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
- Cognitivebehavioral therapy
- Acupuncture
- TENS
- Alternative therapies
  - relaxation, imagery





# 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.