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ELDER CARE

A Resource for Interprofessional Providers

Pain - Management of Persistent Pain in Older Adults

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Pain is estimated to affect over half of older adults in the community and up to 80% of those in long-term care facilities. Pain is a complex biopsychosocial disease that requires an interprofessional team to manage effectively. Older adults with long-term pain have a higher likelihood to report suffering, disability, or social isolation. More than half of older adults who are dying suffer from pain.

Pain can be broadly classified as acute or persistent. Persistent pain, which is the topic of this Elder Care, is defined as a painful sensation that continues for at least 3 months. It may or may not be associated with an identifiable disease process. Chronic pain places older adults at an increased risk of cognitive decline and premature death.

In adults 65 years and older, approximately 32% of women and 21% of men report persistent pain in three or more sites. The most common types of persistent pain in these individuals are musculoskeletal, neuropathic and cancer-related pain.

Persistent pain in older adults is often not identified or adequately treated, resulting in unnecessary suffering, depression, anxiety, impaired ambulation, sleep disturbances, impaired cognition, poor appetite, weight loss, decreased social interaction, and increased disability and use of health care services. Unrelieved pain is also associated with a 9-fold increased in the rate of delirium.

Challenges

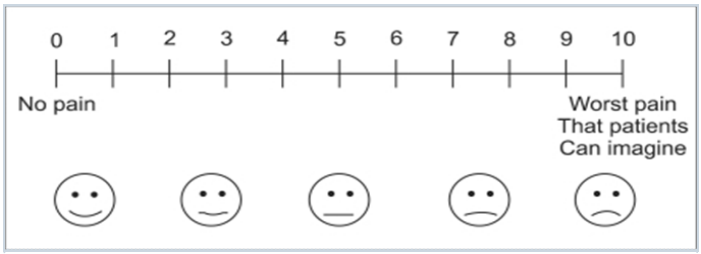
Effective management is important to improving quality of life for individuals with persistent pain. But, there are challenges to assessing and treating pain in older adults.

Many older adults are concerned about addiction to, and side effects of, pain medications, making them reluctant to bring pain to their clinician's attention. They may also not want to be seen as a "complainer." Presentation of pain syndromes in older adults may be atypical, making it difficult to identify potentially reversible causes of pain. Furthermore, some older adults have cognitive or sensory impairments that make them unable to explain the degree and nature of their pain.

Older adults are at increased risk for analgesic-related adverse effects for a variety of reasons. They have an increased sensitivity to pain medications, making them more susceptible to sedation and other side effects. There is also the potential for drug-drug interactions in those taking multiple medications.

Pain Assessment

For patients with good cognitive status, pain assessment often relies simply on the patient's self-report. Patients can quantify and rate their pain severity using an image-based visual analog scale (Figure).



From: NLM Open-i. Kim S, et al, 2011

For patients with cognitive impairment, the presence of pain must often be inferred from non-verbal indicators such as wincing, moaning, tears, or immobility, as well as caregiver reports and responses to empiric therapy. Patients may also display disruptive or combative behaviors, or appetite, mood, and/or sleep changes in the presence of pain.

Pain Treatment

Pain treatment begins by establishing a method, such as the pain scale noted above, for assessing pain severity at baseline so that comparisons can be made after treatment is instituted. If a pain scale cannot be used because of the patient's cognitive status, establish the words or signals that the patient uses to express pain. Teach caregivers to identify those words or signals so they can administer pain medications when a patient has pain and track functional status (i.e., weight or mood changes).

TIPS FOR MANAGEMENT OF PERSISTENT PAIN IN OLDER ADULTS

- Ask older adults about pain, as patients may not tell you about their pain, and it often goes unrecognized.
- Establish a way to quantify the severity of a patient's pain so you can judge whether treatment is effective. Use a visual analog scale in patients who are cognitively intact. In patients with cognitive impairment, rely on behaviors, facial expressions, crying, and caregiver reports.
- Don't be afraid to prescribe opioids if a patient's pain is not relieved by non-opioid analgesics. But, be alert for side effects ranging from constipation to delirium, and reduce the dose or discontinue opioids if needed.

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When appropriate, consider non-drug approaches to pain management. These include physical therapy, exercise programs such as resistance-based strength training, low-impact exercises like Tai Chi, cognitive behavioral therapy, acupuncture, and education of caregivers about helping patients to avoid pain. Topical analgesics (e.g., diclofenac) are also a good alternative to systemic drugs for treatment of localized pain (e.g., arthritis).

Non-drug and non-opioid treatments are preferred for persistent pain in older people. Consider opioid use only if moderate or severe pain affects patient function and quality of life, where benefits outweigh risks.

The Analgesic Ladder. Medication regimens are often based on the World Health Organization's (WHO) Analgesic Ladder (see resource list).

For patients with mild-to moderate pain, a non-opioid analgesic, such as acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs), with or without an adjuvant. Acetaminophen is an effective and relatively safe analgesic but should not be used in severe liver dysfunction. NSAIDs should only be used short term with monitoring in older adults because of concerns about renal and gastrointestinal side effects, and fluid retention that can exacerbate hypertension and heart failure.

If pain persists or increases despite treatment, the next step is adding an opioid intended for treating moderate pain, such as hydrocodone. Older adults are more susceptible to opioid-induced adverse effects, such as hypotension, constipation, sedation, and respiratory depression. It is important to start at a low dose and titrate gradually as needed to decrease risk of adverse events such as drug accumulation.

The third step is use of a stronger opioid medication such as oxycodone. Adjuvant medications can be continued if they have been helpful.

Assuming pain is continuous, medications should be administered around the clock, often with long-acting agents once a patient's dose requirements have been determined and do not cause undo sedation There should also be a short-acting agent available for breakthrough pain.

Special Considerations for Episodic Pain. When pain is episodic, medications can be prescribed on an as-needed basis, though as-needed treatment is not a good choice for patients with cognitive impairment who cannot request medications. Scheduled administration before anticipated pain episodes is a better approach for them.

Special Considerations for Prescribing Opioids. Initiate opioid therapy at a dose 25-50% lower than what is recommended for younger adults. Carefully titrate the dose upwards with frequent assessments of the need for dose adjustments based on pain relief and side effects. All patients taking opioid medications and their caregivers should be educated on symptoms of overdose and how to administer life-saving naloxone.

Many clinicians avoid opioids in older adults for fear of causing delirium. Keep in mind, though, that while opioids can cause delirium, delirium is more often caused by unrelieved pain.

Fentanyl is ill-advised for chronic pain management in older adults. Patch and buccal absorption are unpredictable.

Finally, opioids are a major cause of constipation in older adults. Bowel regimens containing a stimulant laxative (stool softeners alone are inadequate) should be started concomitantly with opioid therapy.

Examples of Analgesics Used and Studied for Treating Persistent Pain in Older Adults

Medication Class	Medications	Medication Class	Medications
Non-Opioids	• *Acetaminophen* • *Selective COX-2 inhibitor Celecoxib* • *Non-Steroidal Anti-Inflammatory Drugs (long-term use not recommended)* Etodolac Ibuprofen Naproxen	Adjuvants	• *Serotonin-Norepinephrine Reuptake Inhibitors* Duloxetine Venlafaxine • *Anticonvulsants for neuropathic pain* Gabapentin Pregabalin
Opioids	• *Weaker Opioids* Hydrocodone tramadol morphine tapentadol • *Stronger Opioids* Oxycodone hydromorphone	Others with Special Indications	• *Muscle Relaxants:* Baclofen, Tizanidine • *Cannabinoids* Dronabinol, Nabilone • *Local Injections:* Corticosteroids • *Topical agents:* Capsaicin, Lidocaine, NSAIDSs

Other medications in each class, not listed in this table, can be considered for use in patients refractory to the listed medications after considering benefits vs risks.

References and Resources

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