Pain Management in Older Adults

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## Cause of Death/ Demographic and Social Trends

<table>
<thead>
<tr>
<th></th>
<th>Early 1900s</th>
<th>Current</th>
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<tr>
<td><strong>Medicine's Focus</strong></td>
<td>Comfort</td>
<td>Cure</td>
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<tr>
<td><strong>Cause of Death</strong></td>
<td>Infectious Diseases/Communicable Diseases</td>
<td>Chronic Illnesses And Cancer</td>
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<tr>
<td><strong>Death rate</strong></td>
<td>1720 per 100,000 (1900)</td>
<td>799 per 100,000 (2010)</td>
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<tr>
<td><strong>Average Life Expectancy</strong></td>
<td>50</td>
<td>78.7 (2010)</td>
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<td><strong>Site of Death</strong></td>
<td>Home</td>
<td>Institutions</td>
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<tr>
<td><strong>Caregiver</strong></td>
<td>Family</td>
<td>Family/Strangers/Health Care Providers</td>
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<td><strong>Disease/Dying Trajectory</strong></td>
<td>Relatively Short</td>
<td>Prolonged</td>
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Varying Trajectories of Dying

- Sudden Death
- Predictable Decline (cancer)
- Hospice Chronic
- Longstanding Chronic

Time

Functional Status

Number of people age 65 and over, by age group, selected years 1900-2000 and projected 2010-2050

Note: Data for 2010-2050 are projections of the population.
Reference population: These data refer to the resident population.
Source: U.S. Census Bureau, Decennial Census and Projections.
Chronic Conditions

The most common chronic conditions among Medicare beneficiaries are:

High blood pressure (58%),
High cholesterol (45%),
Heart disease (31%),
Arthritis (29%) and
Diabetes (28%).
Number of Chronic Conditions

For Medicare recipients, among the 15 chronic conditions examined, the prevalence of multiple chronic conditions was high, with over two-thirds of beneficiaries having two or more chronic conditions and 14% having 6 or more chronic conditions.
Number of deaths for leading causes of death (2010)

- Heart disease: 597,689
- Cancer: 574,743
- Chronic lower respiratory diseases: 138,080
- Stroke (cerebrovascular diseases): 129,476
- Accidents (unintentional injuries): 120,859
- Alzheimer's disease: 83,494
- Diabetes: 69,071
- Nephritis, nephrotic syndrome, and nephrosis: 50,476
- Influenza and Pneumonia: 50,097
- Intentional self-harm (suicide): 38,364
Palliative care (from Latin palliare, to cloak) is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.
The Cure - Care Model: The Old System

Life Prolonging Care

Palliative/Hospice Care

Disease Progression
A New Vision of Palliative Care

Modifying Therapy, Curative, restorative intent

Risk

Disease

Life Closure

Condition

Palliative and Hospice Care

Death & Bereavement

NHWG; Adapted from work of the Canadian Palliative Care Association & Frank Ferris, MD
Definition of Pain

Unpleasant sensory and emotional experience  \textit{or}

Anything the person says it is
Incidence of Pain in Older Adults

Research has shown that 50 percent of older adults who live on their own and 75-85 percent of the elderly in care facilities suffer from chronic pain. Yet, pain among older adults is largely undertreated, with serious health consequences, such as depression, anxiety, decreased mobility, social isolation, poor sleep, and related health risks.

(NIH Medline Plus)
Sources of Pain

- Peripheral Vascular Disease
- Poststroke Syndrome
- Improper Positioning
- Chronic Leg Cramps
- Decubitus Ulcers
- Oral/Dental
- Amputation
- Contractures
- Headaches
- Degenerative Joint Disease
- Rheumatoid Arthritis
- Neuropathic Pain
- Lower Back Pain
- Crystal-Induced Arthropathies
- Osteoporosis
- Myofascial Pain
Consequences of Pain

- Untreated Pain
- Exacerbation of comorbidities
- Increased Healthcare Utilization/Costs

CONSEQUENCES

- Sleep Disturbance; Malnutrition
- Decline in Social & Recreational Activities
- Physical Function Decline
- Depression; Anxiety; Impaired Cognition
Pain Assessment

Verbal Pain Intensity Scale

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

Visual Analog Scale

No pain  Worst possible pain

0–10 Numeric Pain Intensity Scale

No pain  Moderate pain  Worst possible pain

Faces Pain Scale - Revised (FPS-R)

0 2 4 6 8 10
Neuropathic Pain Assessment

Discriminative and Quantitative

Numbness: Yes/No

0
none

100
worst imaginable

Tingling pain: Yes/No

Increased pain due to touch: Yes/No

Presence of all 3 qualities: sensitivity, 64.5%; specificity, 78.6%; total predictive accuracy, 73.0%
Attitudes that Hinder Pain Reporting, Assessment & Treatment in Older Adults

- Stoicism, not wanting to be a “complainer”
- Concerns about addiction, side effects, tolerance
- Pain in old age is inevitable
- Nothing can be done to relieve pain
- Older adults cannot tolerate strong analgesics
- Older adults are less sensitive to pain
What Descriptors Do Older Adults Use For Pain?

- Soreness
- Ache

Assess for functional limitations...
Behavioral Pain Indicators

- Grimacing or wincing
- Bracing/Guarding
- Rubbing
- Changes in activity level
- Sleeplessness, restlessness
- Resists movement
- Withdrawal/apathy
- Increased agitation, anger, etc.
- Decreased appetite
- Vocalizations (e.g., moans)
Pain Assessment & Monitoring

Pain assessment must be

- appropriate
- ongoing
- with frequent evaluation of effectiveness
- adjustment of treatment as needed
Choosing Analgesics

- Begin treatment for mild to moderate pain with a nonopioid
- Add an opioid for moderate to severe pain
- Administer acetaminophen or NSAID with an opioid (unless contraindicated)
- Consider previous experience with other analgesics in choosing agents
- Check liver and renal function
WHO-3 Step Ladder

First Line
- Acetaminophen
- Aspirin/NSAIDs
- ± Adjuvants

2nd Line or Pain out of Control
- Opioids
  - sustained-release
  - immediate-release
- ± NSAIDs
- ± Adjuvants

Refractory Pain
- Spinal/Epidural Opioids
- ± clonidine
- ± local anesthetic
- Selective nerve blocks
- Neuroablative procedures
- Ketamine
- Total Sedation
Opioids

- Opioids can be used in the management of moderate to severe acute pain in older adults
- Begin with opioids with short half-lives (e.g., morphine, hydromorphone, oxycodone)
- May want to use the term “opioid” rather than “narcotic”
Opioids

- Morphine sulfate is the opioid analgesic of choice
- Hydromorphone and oxycodone are acceptable alternatives to morphine
- Hydrocodone is an acceptable opioid for short term mild and some moderate acute pain in older adults
- Avoid codeine use (less potent & more side effects)
Side Effects of Opioids

- Sedation
- Nausea and vomiting
  - Orthostatic hypotension
- Urinary retention
- Dysphoria or euphoria
- **Constipation**
- Respiratory depression
- Pruitus
Opioids and Delirium

- Delirium may be caused by factors other than opioids.
- Post-op delirium associated with unrelieved pain rather than opioid use.
- If other causes of delirium are not found and pain is effectively managed, consider decreasing the opioid dose.
- Consider short-term use of haloperidol; caution – may mask pain behaviors.
Adjuvant Therapies for Neuropathic Pain

- Corticosteroids (e.g. Dexamethasone)
- Anti-convulsants (e.g. Gabapentin)
- Tricyclic antidepressants (e.g. Nortriptyline)
- Local anesthetics (e.g. Lidocaine)
- Anticancer (e.g. radiation therapy, surgery)
Nondrug Pain Management

- Education
- Exercise
- Cognitive-Behavioral Support
- Physical modalities (heat, cold, massage)
- Physical or occupational therapy
- Chiropractic
- Acupuncture
- Transcutaneous Electrical Nerve Stimulation
- Relaxation and Distraction
Nonpharmacologic Interventions Should Be Used Only When Optimal Analgesia Has Been Achieved……
Summary...

• Palliative care, including pain management, improves quality of care for our sickest and most vulnerable patients and families.
• Pain is a universal human experience and universal health professional obligation.
Questions?