Managing Pain in the Elderly

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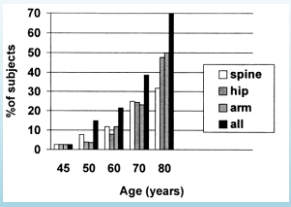
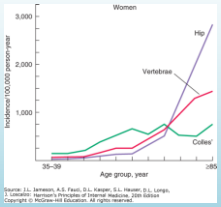
The Pain Deck is Stacked Against the Elderly

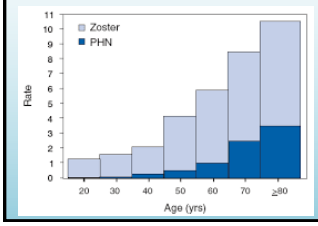
Osteoporosis



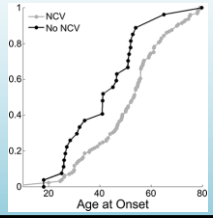
Fractures



Zoster & PHN



Trigeminal Neuralgia



Verne

- 81-year-old veteran with PD and type 2 DM; he has burning and shooting pain in both feet; his joints ache—especially his hips and knees; pain is bad at night, but can flare up first thing in the morning and also when he walks any distance
- He was widowed in the past year and moved to an assisted living apartment; he has fallen a few times, sustaining soft tissue injuries, but no fracture
- Ibuprofen and acetaminophen with codeine were ineffective; hydrocodone/APAP made him confused and constipated
- Oxycodone is better-tolerated and he is taking about 8-10 tablets a day. "Doc, it doesn't do that much– just takes the edge off, but it's all I've got. It helps me so I can relax and sleep. Can we move the dose up a little?"
- He jokes, "Otherwise, you might as well put me in the pine box right now"

DM=diabetes mellitus. PD=Parkinson's disease
APAP=acetaminophen

Verne's Examination

- Jovial affect discordant with his depressed mood
- Gait is shuffling and wide-based with postural instability
- Joint deformities in the hands and knees consistent with OA
- Sensory loss to pin and vibration in the feet and distal legs; positive Romberg sign; absent DTRs at the Achilles tendons;
  feet are sensitive to light touch

Making a Pain Assessment that Guides Treatment Choices

- Pain intensity and impact measures
- Pain physiologic types
- Contributing factors
- Barriers
- Disease burden

Self-Report

- 0-10 NRS
- Faces scales
- Mild-Moderate-Severe
- Pain or No Pain

Functional Pain Assessment

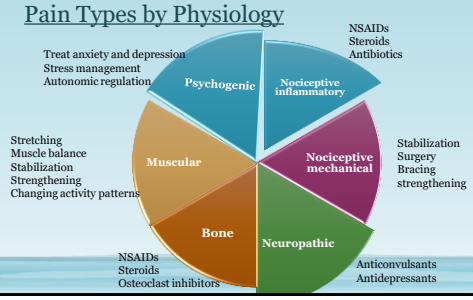
- How much does pain interfere with…
  - Transferring
  - ADLs
  - Activity
  - Socializing

PAINAD Scale

Table 2: Pain Assessment in Advanced Dementia (PAINAD)

Items	0	1	2	SCORE
Breathing (Independent of vocalization)	Normal	Occasional labored breathing. Short period of hyperventilation.	Noisy labored breathing. Long period of hyperventilation. Cheyne-stokes respirations.	
Negative vocalization	None	Occasional moan or groan. Low level of 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. Distressed pacing. Fidgeting.	Rigid. Fists clenched. Knees pulled up. Pulling or pushing away. Striking out.	
Consolability	No need to console	Distracted or reassured by voice or touch.	Unable to console, distract or reassure.	
TOTAL				

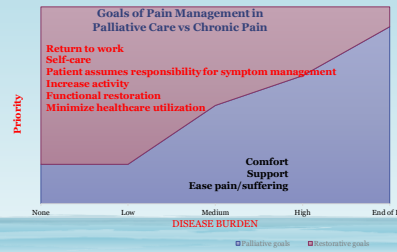
Pain Types by Physiology



Contributing Factors and Barriers

- Contributing factors amplify or perpetuate pain
  - Depression or anxiety
  - Posture
  - Intercurrent illness
- Barriers interfere with pain assessment or with implementing appropriate treatment
  - Insurance non-coverage/resource access
  - Low motivation
  - Personality disorder
  - Chemical dependency
  - Language or communication difficulty
  - Conflicting medical therapies

Assess Disease Burden



Verne's Case Formulation

- Painful diabetic polyneuropathy
- Muscular dysfunction/pain due to PD
- Joint pain (inflammatory) due to OA

- Contributing factors:
  - Grief and loss
  - Depression
  - Bradykinesia
- Barriers
  - Bradykinesia
  - Risk of falls
  - Intolerance to some analgesics with reliance on oxycodone
- Disease burden: fairly high—take a mixed rehabilitative and palliative approach

BEERS Criteria

Medication	Recommendation	Rationale
NSAID	Avoid	GI, renal, HTN
Muscle relaxants	Avoid	CNS ADR
TCAs	Avoid	Orthostasis, Antichol, Arrhythmia
Benzodiazepines	Avoid	Resp dep, CNS, interact
Opioids	Avoid except acute severe	Resp dep, CNS, constip
Gabapentin/pregabalin	Avoid with opioid or benzo	Increased OD risk

Tricks of the Trade

- Topical agents
- Gabapentin dosing
- Opioids
- Complementary therapies

Topical Agents

- Diclofenac 1% gel and 1.3% patch
- Ketoprofen gel (compounded to 10%)
- Gabapentin gel (compounded to 8%)
- Lidocaine patch or ointment (4%-5%)
- Morphine 0.1% wgt-wgt in Intrasite gel

Pressure Ulcer on Coccyx Treated with Topical Morphine

Gabapentin Renal Dosing

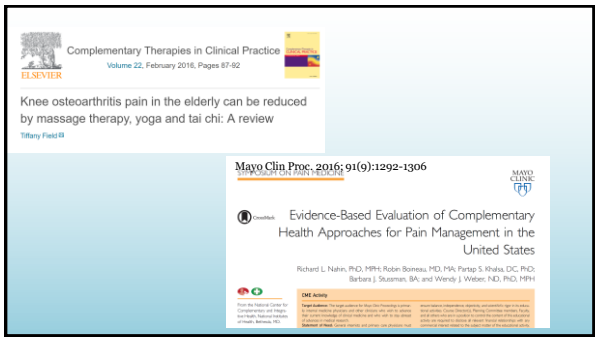
- 20% of the creatinine clearance in mg per day
- Pregabalin dosing = 10% of CrCl in mg per day
- In Dialysis pts give post dialysis

Opioids

- Tramadol
  - Much less respiratory depression
- Buprenorphine patch
  - 7 day patch 5, 10, 15, 20 mcg/hr
  - Much less resp depression
- Avoid morphine in elderly due to M-3-G

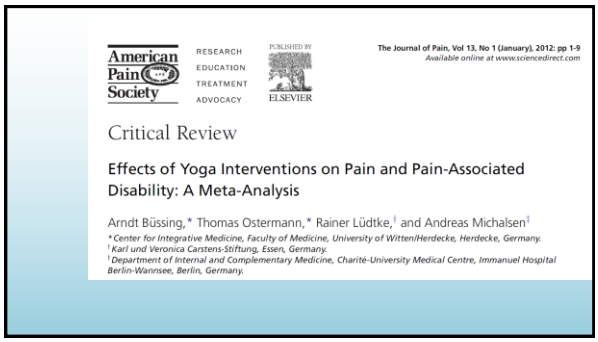
Complementary Therapies

- Acupuncture
- Massage
- Movement-based
  - Tai Chi
  - Yoga
  - Xi Gong



Selecting Complementary Therapies Based on Diagnosis

Migraine	DJD	Fibromyalgia	Back/neck pain
Biofeedback	Acupuncture	Tai Chi	Spinal manip
Neutriceuticals	Glucosamine chondroitin	Relaxation	Acupuncture
Acupuncture	Yoga	Acupuncture	Massage



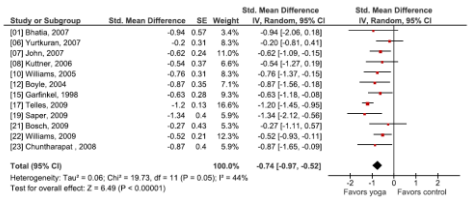


Figure 2. Standardized mean differences on pain. The size of circles represents the weight of the study in meta-regression.

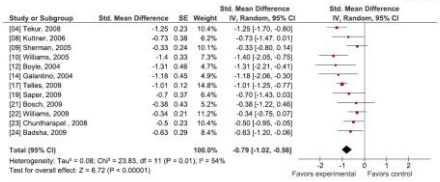
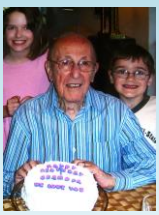


Figure 3. Standardized treatment effects (SMD and confidence intervals) on pain-related disability. The size of circles represents the weight of the study in meta-regression.

Verne's Plan of Care



- Gabapentin for DPNP (renal dose)
- Taper oxycodone by one tab per day each week
- Consider tramadol or Buprenorphine patch for its opioid effect as well as SNRI
- Encourage wheeled walker to prevent falls
- Optimize Parkinson's management for mobility
- Topical Diclofenac for joint pain
- Warm pool or other movement Therapy for OA and social benefit

- Doing much better
- Has a girlfriend
- "I have things to live for"