Recognition and Treatment of Pain in Elderly People

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DECISION TO PRESCRIBE

Have I identified the cause of the pain?

- Treat the disease rather than the symptoms where possible.

What am I trying to achieve?

- Pain relief to improve quality of life.
- Increased function and wellbeing.

Is this what the patient wants?

- Some elderly people are reluctant to disclose pain and may perceive it as normal or that nothing can be done about it. Discussion with older patients about pain may help to reveal undiagnosed pain.

Is there evidence drugs will help achieve this?

- There is good evidence for regular use of analgesics, especially paracetamol.
- Short bursts of NSAID use may be acceptable for management of exacerbations of painful inflammatory conditions such as gout.
- Opioids at low doses are effective for long term pain control.

Are there non-drug therapies?

- Some elderly people will find non-drug therapies such as exercise, weight loss and alternative therapies more acceptable than medication.
- Often for elderly people it is the loss of function and interference with normal life that is more important than the pain itself. These issues can often be addressed separate to the pain itself.

Do the potential benefits outweigh harms?

- Untreated pain can cause significant suffering and reduce quality of life.

Chronic pain is often under-treated in elderly people

Chronic pain affects between 20–50% of elderly people and is more common in women. However, pain is often unrecognised, treated sub-optimally or not treated at all.[1,2]

Pain may significantly reduce quality of life and lead to depression, anxiety, increased suicide risk, increased dependence, reduced appetite, impaired gait, sleep disturbances and other problems.[1]

Reasons for under-treatment

There are many reasons why pain may be unrecognised or under-treated

- **Disclosure**. Patients do not or are reluctant to disclose pain. For example, an older person may perceive that pain is "normal". Elderly people often view pain as being less important than other medical problems.
- **Poor communication**. Cognitive impairment, hearing and speech problems may lead to poor pain assessment in elderly people. One study showed that people with cognitive impairment were prescribed less opioids by doctors and administered less opioids by nurses.[4]
- **Polypharmacy concerns**. Doctors may be reluctant to add another drug to an existing regimen due to concerns about interactions and adverse effects.
- **Inadequate risk/benefit analysis**. Using anything other than a simple analgesic may be mistakenly viewed as being too risky due to adverse effects and the possibility of drug related harm. For example, the use of an opioid often raises concerns about tolerance dependence, addiction and safety. This level of pain control may be necessary and the benefit outweighs the risk of adverse effects.

Recognition of pain in elderly people

Elderly people may not report pain

Pain may manifest as inactivity, agitation, unexplained decreased function or a lack of sleep. Studies show that older people may not mention pain without being prompted. Asking elderly people or their carers about pain and using an appropriate pain rating scale is a useful way of identifying people who may have undiagnosed pain.

Pain often goes unrecognised in people with dementia. However, even people with moderate to severe dementia are able to complete a verbal pain rating scale, which is more effective than just asking if pain is present.

The pain assessment tools used in one study included: [3]

- Verbal Rating Scale: none, mild, moderate and severe
- Numerical Rating Scale: 1–10 horizontal scale
- Faces Pain Scale: 7 faces
- Colour Pain Analogue Scale: graduated from white to red, no pain to worst possible pain
- Mechanical Visual Analogue Scale

Drug treatment of pain in elderly people

A good history will aid good management

Make a firm diagnosis of the reason for the pain. This can be difficult but management of the underlying disorder may be necessary. For example, spinal stenosis can cause excessive pain and decreased function and surgery may be helpful. Knowing the diagnosis and prognosis helps with decisions about long term management.

If the diagnosis is in doubt and pain is difficult to manage ask for help from a pain specialist or relevant diagnostician.

Identifying previous analgesic use, determining effective treatments, how previous treatments were taken, and if any side effects were experienced, can help to determine the appropriate analgesic and the correct dose.

Principles of analgesic use in elderly people

- Start low, go slow

A low initial dose, followed by slow titration to response, careful monitoring and regular review helps to optimise safe and effective drug therapy if indicated.

- Review and monitor use of analgesics regularly.

Effective monitoring involves not only measuring pain relief and adverse effects, but also monitoring functional status and quality of life. Regular review to adjust dose can result in more effective control of pain and minimise adverse effects.

- Good education is the key

Good education about the most appropriate way to use analgesics is essential to gain effective pain relief for elderly people. This is particularly the case with opioids.[1] A study investigating pain in arthritis found that self management improves pain control.[5]

Regular analgesic treatment preferred to 'as required' treatment

Regular analgesia is more effective than waiting for pain to break through. Adherence problems can be addressed by stressing the importance of regular doses to patients or caregivers.

Paracetamol is an effective analgesic in many cases, especially if given regularly instead of 'as required'.

Opioids are effective for non-malignant pain.

There is often a reluctance to use opioids for non-malignant pain but opioids can be very effective in managing other chronic pain conditions such as neuropathic pain if alternative agents have been unsuccessful.[1]

NSAIDs are effective and may be safe in short courses for acute exacerbations of inflammatory conditions. However, they are no safer than opioids and may in fact pose greater long term risks in elderly people than the appropriate use of opioids.[6]

International guidelines state that "opioid treatment should be considered for both continuous neuropathic and nociceptive pain if other reasonable therapies fail to provide adequate analgesia within a suitable timeframe." [7]

Codeine is normally used as initial therapy when opioids are indicated. Stronger opioids such as morphine or dihydrocodeine may be indicated for non-malignant pain that has not responded to other analgesics. Regular use of opioids is more effective for controlling pain than waiting for pain to break through.

Features of neuropathic pain

Neuropathic pain is commonly described as burning, cold, numb or stabbing in the distribution of a peripheral nerve or nerve root. It may be accompanied by paraesthesia, hypersensitivity or allodynia (pain on light touch). Involvement of the sympathetic system is indicated by a vascular distribution of the pain accompanied by localised pallor, flushing and/or disturbances of sweating.

Features of nociceptive pain

Nociceptive pain results from stimuli that damages or has the potential to damage normal tissues. When it arises from bone, joints, muscle or skin it is usually described as aching or throbbing and is well localised. Pain from visceral organs such as the GI tract may radiate to other areas of the body.

Adverse effects of opioids can be minimised and managed

Adverse effects can be minimised by starting with a low dose and slowly titrating to the optimal analgesic effect. Using the lowest effective dose can help minimise dose related adverse effects such as constipation and sedation. Constipation is often an inevitable side effect of opioid treatment and can be managed with a stimulant containing laxative (senna or bisacodyl, see Constipation BPJ 9), increased fibre, water and exercise.

Opioids increase the risk of falls. Those using them benefit from falls prevention strategies such as lower leg strengthening and balance retraining or home hazard assessment and modification.

Alternatives for neuropathic pain

Tricyclic antidepressants and anticonvulsants can be effective for neuropathic pain. These drugs interfere with the pain pathway and can make disabling pain bearable.

While they are effective they may cause sedation and/or postural hypotension and can increase the risk of falls. This can be minimised by using low doses. Amitriptyline is commonly used for neuropathic pain, however nortriptyline is equivalent and may be preferred as it is less sedating and causes less postural hypotension.[8]

Some analgesics are best avoided

- NSAIDs and COX-2 inhibitors can have adverse effects on renal function, particularly in elderly people. They are best avoided unless they are specifically indicated such as for people with bony secondaries or acute inflammatory pain. In those who need them, it is appropriate to use the lowest effective dose, review regularly and monitor renal function. NSAIDs and COX-2 inhibitors increase the risk of drug interactions therefore it is appropriate to review other medication before initiating therapy.
- Dextropropoxyphene with paracetamol is commonly prescribed in elderly people but the combination has negligible, if any, analgesic benefits over regular paracetamol. Dextropropoxyphene is best avoided as it causes sedation, dizziness, increases fall risk and interacts with many other drugs (see page 43).
- Pethidine is best avoided in elderly people as it has a toxic metabolite which can accumulate with impaired renal function.
- Tramadol has been associated with early reports of hallucinations and confusion.[9] This may be more of an issue in older people because of higher plasma concentrations than in younger people.[10]

Other treatments for specific pain syndromes

For some causes of knee pain, including osteoarthritis, exercise can be as effective as regular pain relief. Combinations of exercise, supports and strapping, TENS (Transcutaneous Electric Nerve Stimulator) and physiotherapy have anecdotal support in pain control. Each patient will respond to pain treatments in differing ways and trying different therapies can help in pain management.

Referral to a pain clinic

This may be necessary and should be offered if the cause of pain is untreatable and the pain is unmanageable with standard approaches.

Often appropriate management of depression will enable pain to be more easily controlled. An emphasis on self management techniques empowers the patient to increase function while managing pain.

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