

Pain Management in Older Adults

Deborah Whittemore, ANP, MS, CWCN, RN
Valerie C. Sauda, RN-BC, MS, MGSF

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Learning Outcomes



1. Identify assessment tools/resources to assess chronic, acute, and end of life pain in older adults.
2. Identify trends in use of pain medications in older adults.
3. Identify non-pharmacological pain management concepts in managing pain in older adults.

What is pain?

“Pain is defined as

- the physical feeling caused by disease, injury, or something that hurts the body
- mental or emotional suffering : sadness caused by some emotional or mental problem
- someone or something that causes trouble or makes you feel annoyed or angry”

Nursing process and pain management

Pain can be:

- Physical
- Psychological/Emotional

Nursing needs to EFFECTIVELY use nursing process to identify and manage pain:

1. Assess
2. Diagnose
3. Plan
4. Act
5. Evaluate

Assessment of pain

Key principles in the assessment of pain include:

- Intensity/severity
- Pain relief measures
- Impact on function
- Improvement in pain intensity



Choosing a pain scale

Identify best scale for use:

Based on cognitive and developmental level, acute vs. chronic, quality of life pain levels, and/or potential for addiction

PAIN RATING FACE SCALE



0
No Hurt



2
Hurts Little Bit



4
Hurts Little More



6
Hurts Even More



8
Hurts Whole Lot



10
Hurts Worst

Choosing a pain scale

Identify best scale for use:

- WILDA pain assessment guide
- Wong-Baker
- Verbal scale
- Analog scale
- Pain scale for person with dementia
- Pain scales for person with substance abuse

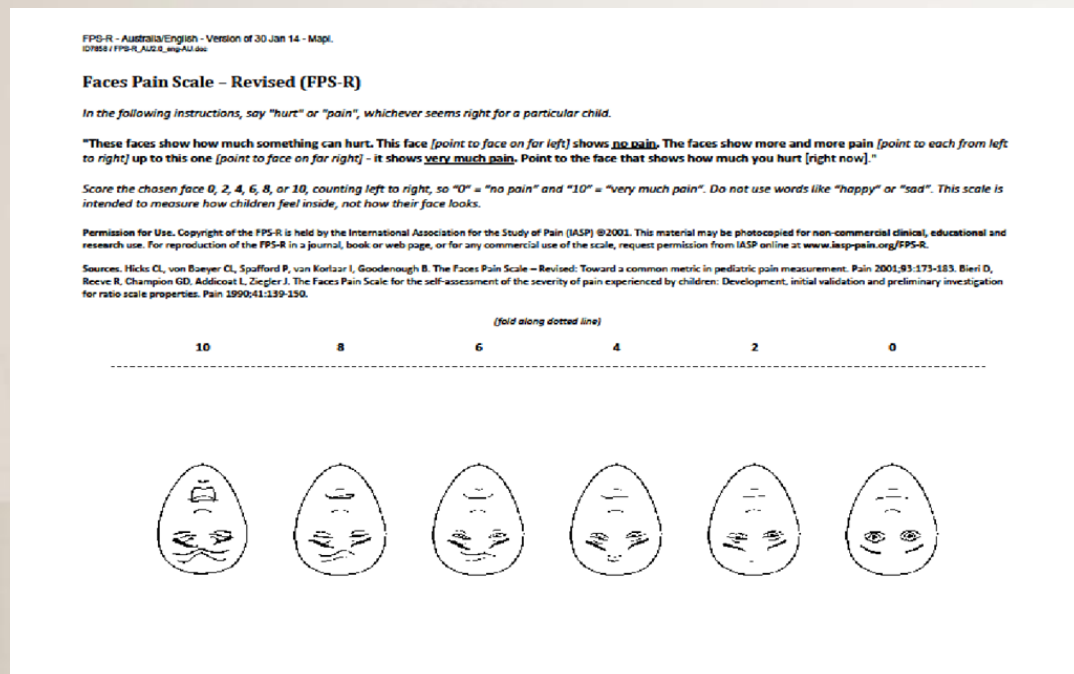
WILDA pain assessment

- **Words** to describe pain (aching, throbbing, crampy, shooting, sharp, etc.)
- **Intensity** (1-10) (What is your pain now?)
- **Location** (Where is your pain?)
- **Duration** (Is pain always there? Does pain come and go (breakthrough)?)
- **Aggravating/Alleviating Factors** (What makes pain better? What makes pain worse?)

Wong-Baker FACES scale

- Originally developed for pediatrics
- Has use in older adult population
- Tip: Not to be used by just looking at older adult's face and recording facial expression, ask the older adult how they feel inside

Retrieved 4/20/2015
from
<http://www.iasp-pain.org/Education/Content.aspx?ItemNumber=1519>



Verbal/analog scales

Very common in all healthcare settings:

Analog scale=0-10 scale (0 being no pain and 10 is the worst possible pain)

Verbal descriptor pain scale=no pain, mild, moderate, severe, pain as bad as it could be

May not be effective in assessing older adult pain

Pain scale for person with dementia

Looks at the following: Breathing, negative vocalization, facial expression, body language

Find tool at:

http://consultgerirn.org/uploads/File/trythis/try_this_d2.pdf

Pain assessment for people with substance abuse history

- There are evidence based tools developed to help identify people who are at risk for substance abuse
- Personal values and judgment are of significant nursing consideration in working with people with substance abuse histories
- Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP[®]-R)
- Current Opioid Misuse Measure (COMM)[™]

Chronic pain assessment

- American Chronic Pain Association
<http://www.theacpa.org/>
- Multiple tools to help measure impact of pain:
 - Quality of Life
 - Arthritis/fibromyalgia pain monitoring
 - Pain logs

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Scheduling of nursing assessments

- At each change in shift
- At each time a nursing action to relieve pain is taken
- Pre- and post-administration of pain medications
- When an unstable or inconsistent pain issue occurs (like a fall or acute injury)

Acting on pain

- Administration of medications, particularly opioids/narcotics has often been first line of defense.
- Suggest use of non-pharmacological interventions in addition to opioid use depending on type of pain

Administration of opioids

Identify your own myths and beliefs

Review medication side effects and use if
unsure

Start low, go slow

Ensure physical safety of medications through
following policy/procedures

Administration of opioids

- Rely on objective assessment data
- Encourage scheduled pain medication administration
- Be vigilant about process-complete all steps during the administration-immediately document

Administration of opioids

- Monitor for side effects, assess for pain relief
- Communicate, communicate, communicate with:
 - Resident
 - Primary Care provider/pain management team
 - Family or caregivers
 - Healthcare team members

To improve pain management nursing systems:

- Pain rounds
- Pain interprofessional team meetings
- Use of pain management/palliative care consultants

Pain in Older Adults

- ❖ 50% of community dwelling are affected by pain
- ❖ 80% of nursing home residents are affected
- ❖ Treatment needs to be focused on improving function more than reducing pain
- ❖ Cognitive function and mobility/balance must be assessed as part of pain management
- ❖ Most common misdiagnosed conditions include myofascial pain syndrome, chronic low back pain, lumbar spinal stenosis, and fibromyalgia syndrome. (Up to Date.com 11/014)

Nonsteroidal Anti-inflammatory Drugs

Use Only 1-2 Weeks

Naproxen sodium	220mg BID	Less CV toxicity
Ibuprofen	200mg TID	Short half life Avoid use with low dose aspirin
Celecoxib	100mg daily	Reduction in GI toxicity CV risk is higher No effect on platelet functioning May need to continue low dose aspirin with PPI

Use of proton pump inhibitor or misoprostol reduces but does not eliminate GI risk

Systemic corticosteroids, anticoagulants, antiplatelet drugs increase risk

Risks include GI, cardiac, and renal

Risks to kidney are lessened by avoiding dehydration and concomitant use of ACE Inhibitors and diuretics

What About Acetaminophen?

- Less significant anti-inflammatory properties
- Less effective for chronic pain than NSAID's(The Lancet 2014 no better than placebo for back pain)
- Maximum dose of 3GM in 24 hours 65 and up
- Less than 2GM in frail elderly and over 80
- Component in many OTC medications
- FDA now encouraging development of single entity opioids such as Hysingla(oxycodone bitartrate)

Topical NSAID's

Diclofenac topical gel	3-4 times daily	Useful for Rx of OA of superficial joints
Diclofenac topical patch	One patch twice daily	In combination with acetaminophen /Tramadol
Diclofenac topical solution	2 -4 times daily	Minimal systemic absorption
Diclofenac topical spray	4 sprays up to 3 times daily	Local skin irritation

Moderately effective: Useful in combination **with systemic** therapies for reducing medication load and side effects and potentially useful for adults with localized pain.

Limitations of topical NSAID's include cost, erratic local absorption, variable depth of penetration, inaccuracy of dosing, and frequent applications.

Topical preparations are meant to penetrate the skin and tissue but not enter the plasma.

Opioids and corticosteroid injections provide more pain relief but topical NSAID's more effective in improving function and stiffness in hip and knee osteoarthritis.

Opioid Analgesics

- There is no evidence that long term opioid therapy produces long lasting benefits for individuals with chronic pain
- Only considered in moderate to severe pain
- Around the clock dosing for frequent or continuous pain
- Breakthrough pain must be anticipated
- Opioid adverse effects must be anticipated
- Potentially serious opioid abuse is not rare
- Must assess balance in elderly prior to initiating
- Decrease dose by 50% to start

Tramadol and Tapentadol

- ❖ Synthetic opioids with combined mechanisms of action
- ❖ By acting on μ -opioid receptors and inhibiting reuptake of norepinephrine. Tramadol also blocks reuptake of serotonin
- ❖ Used as a step up from acetaminophen prior to more potent opioid analgesics
- ❖ Fewer serious adverse effects
- ❖ Respiratory depression rare
- ❖ Caution with seizures and serotonin syndrome with SSRI's (Tramadol)
- ❖ 5-15% no response with Tramadol due to poor metabolism (CYP2D6 enzyme)
- ❖ Tapentadol only FDA approved drug for neuropathy (schedule II)

Recommended Opioids

- Morphine-avoid in renal dysfunction
- Oxycodone-good choice due to short half life and no toxic metabolites
- Buprenorphine(Suboxone) Patch- is partial agonist/antagonist
 - Decreased nausea, vomiting, constipation, respiratory depression
 - Large study demonstrated 80% good to very good pain relief
 - Less addiction potential, euphoria, and withdrawal effects
 - Safe with renal impairment
- Hydromorphone- use short-acting formulation for breakthrough pain
- Fentanyl Patch- short acting and transdermal patch(not in opiate naïve)

Drugs to Avoid

- Muscle relaxants due to increased dizziness, sedation and anticholinergic effects(Baclofen, cyclobenzaprine, methocarbamol)
- Methadone- due to variable pharmacodynamics and pharmacokinetics and difficulty dosing. Increased risk of accumulation, overdose, and prolongation of QT interval
- Codeine- weak analgesic which is metabolized to morphine. Increased nausea and constipation. Ineffective in many patients due to genetic CYP2D6 metabolic status
- Meperidine- long half life and toxic metabolites
- Limited evidence for efficacy of anticonvulsants and antidepressants and significant potential for adverse events

For further information:

- Deborah Whittemore whittemored@husson.edu
 - Office telephone 207-941-7189
- Valerie Sauda, saudav@husson.edu
 - Office Telephone 207-941-7036