Key principles for managing pain in older people

When considering medications as part of the management of pain in older people, consider the whole person (as per the bio-psycho-social model, Chapter 2).

1. Who is the PERSON?

- Age, psycho-social profile
  - Consider anxiety or depression as a comorbid state
  - Their understanding about pain
- Cardio-respiratory status
  - Sleep disordered breathing, hypertension
- Cognitive status, including impairment/dementia, especially if any behaviours such as aggression or sundowning (confusion later in the day) occur
- Mobility, including falls risk

2. What are the potential MECHANISMS OF THE PAIN?

- What type of pain is the resident experiencing?
  - Is it acute or chronic?
  - Is it due to cancer or does it have a non-cancer origin?
  - Is it nociceptive – ongoing tissue damage (for example, arthritic conditions, cancer)?
  - Is it neuropathic –damage or disease of the somatosensory nervous system (for example, post shingles pain)?
  - Or does it have a mixed pattern (for example, back pain with nerve injury, cancer with treatment related nerve injury)?
  - Is there central nervous system sensitisation (hyperalgesia)?
  - Prolonged, severe pain (for example, musculoskeletal) and/or prolonged opioid exposure (opioid induced hyperalgesia) will increase pain sensitivity
- Are there any neuro-psychological contributions (for example, anxiety) which can heighten the pain experience?

3. What is the IMPACT OF PAIN and (potential) treatments?

- Limiting physical function, mobility
- Sleep disturbance
- Distress, including mood disorder
- Behaviours such as hitting, aggression or extra wandering

In relation to medication management for pain:

- Analgesic medications relieve symptoms but there is little evidence they can change the underlying mechanisms of pain
- Combining medication and non-medication approaches may allow lower doses to be used, potentially reducing side effects
- Better pain relief with lower medication doses may be possible by combining medications of different classes (multi-modal); this may reduce side effects of each medication, though there is potential for a greater range of side effects
- Consideration must be given to age-related changes in medication sensitivity, efficacy, metabolism and potential for side effects
- The goal(s) of analgesic therapy need to be identified, such as reduced pain severity, improved sleep, improved mobility. Considerations should include:
  - The side effects of the pain medication may be more troublesome than the pain
  - Significant pain relief may be harder to achieve with neuropathic pain
  - Non-cancer pain requires a balance between pain relief, maintaining function and potential medication side effects
  - Residents need to be reminded that while decreased pain is very likely, attaining complete pain relief is unlikely (“less pain” rather than “no pain”)
  - In the terminal phases of cancer and other end of life situations, the goal may be to relieve pain even if function is compromised

Key principles for managing pain in older people *continued*

- The timing and compliance of pain medications is often as important as which medication is chosen:
  - A short acting analgesic should be used for infrequent or incident pain
  - Slow release analgesics are best given regularly (around the clock) for persistent or frequently recurring pain (leading to improved compliance). However, regular short acting (immediate release) analgesia is a potential alternative
  - Short acting analgesics may be necessary when slow release analgesics do not control the pain adequately (breakthrough pain)
  - It may be preferable to avoid breakthrough pain by minimising the activity that caused the pain, for example, by better pacing or even avoiding (or finding an alternative to) the activity that causes the pain. The regular use of opioids for breakthrough pain may contribute to tolerance and dose escalation and is not recommended. This is especially so for non-cancer pain
  - For predictable or incident pain, analgesics are often more effective when given before an activity that is known to induce or aggravate pain (for example, wound dressing, showering)
  - The pharmacist should be asked to provide regular reviews of any complex medication regimes and to comment on mode, timing and the ideal combination. This can be discussed with senior nursing staff and the GP to provide multidisciplinary expertise on the administration of complex pain regimens
- Medications for pain should be commenced at a low dose, monitored (using a suitable assessment chart, see Appendix 7, page 161) and then titrated slowly, as required. More frequent monitoring, dose adjustment and potential higher doses should be implemented for severe pain
- Symptoms other than pain, such as constipation, insomnia and depression, may significantly impact on a resident. Careful monitoring, using a recommended assessment chart, should be undertaken until the effects are fully understood. Treatment of these symptoms is an important part of a resident's pain management
- Constipation should be expected with opioid therapy and the resident's toileting care plan – specifically their bowel regimen (Table 15, Bowel Regimen for Constipation) – should be adapted to control for this side effect
- Referral to a pain specialist, geriatrician or multidisciplinary pain service should be considered if troublesome pain persists after reasonable trial(s) of medication and non-medication therapies
- Organisations should have regular external agencies who can attend to residents with ongoing pain and these should be offered to residents and their families
- Discussion with the resident's family should occur on a regular basis to ensure that pain management is having the desired effect on their function and wellbeing
- A clear policy which mandates what symptoms require escalation and the type of escalation (i.e. call the GP, call emergency services) should be in place. Nursing staff should have a prominent and visible guideline chart on warning signs to monitor (worsening pain, unexpected drowsiness, unacceptable side effects, etc.)

NOTE: The Australian Government's Department of Health document, "Guiding principles for medication management in residential aged care facilities – 2012"[4] recommends a Residential Medication Management Plan (RMMR) and medication reconciliation program should be implemented for residents of aged care facilities who are receiving regular analgesics