Perceptions of Pain Medication in the Elderly

Pain is a variable condition that is influenced by many individualized factors. Older patients may downplay acute or minor pain. It is hypothesized that older patients have adapted to their pain or limitations and feel less compelled to report their pain at the same degree or with the same frequency as younger patients. Overcoming the barriers that exist in the treatment of patients with chronic pain is a challenge for many patients and health care professionals. Elderly patients often have fears associated with treating their pain, such as the cost of treatment, prognostic consequences of reporting pain, fear of being labeled a hypochondriac, potential for opioid addiction, and loss of their independence. Cognitive, as well as hearing and speaking impairments, are also barriers to successfully managing pain in elderly patients. Studies have also shown that patients with cognitive impairments are prescribed and administered significantly less analgesic medications than patients without such impairments. Understanding patients’ pain, their perception of the variety of treatment options, as well as the barriers that affect their response to the pain, are critical to the efficacy of the treatment methods. A proper grasp on how pain is assessed and why elderly patients prefer certain treatment options will result in more successful therapeutic outcomes and the realization of treatment goals.

Personal stressors such as loss of a spouse, jobs, friends, homes, or health have the potential to contribute to physical pain, adding to the difficulty in differentiating the true source of an elderly individual’s pain. These confounding factors have the potential to manifest in the form of pain or contribute to already existing pain. Comorbidities have also been linked to poorly controlled pain, including: emotional distresses, depression, activity restriction, sleep disturbances, fatigue, and decreased physical or mental functioning. Pain is considered a negative life event and has been shown to increase depressive symptoms. In a study of nursing facility residents, self-reported depression scores were highest among residents whose pain was under-detected by the nursing aides. In contrast, the nursing facility residents with low depression scores experienced an over-reporting of their pain by the nursing aides. Not only has depression been linked to underdetected pain, but depression also can increase risk of acute-onset pain as well as the development of chronic pain. Thus properly evaluating and treating depression is an important element of comprehensive pain management.

Pain variability may be related to the gap in perception of pain among geriatric patients and their caregivers or health care providers. A study of pain-correlation scores between nursing facility patients and their nursing aides found that 48.9% of nursing facility patients reported pain in the week prior to the interview, but nursing aides reported pain in only 35.6% of patients. In regards to postoperative pain, a study of elderly patients (mean age 82.5 years) showed that nurses only correlated with patients on pain scores about 35% of the time, resulting in 45% of pain being underestimated (20% was overestimated). As a general trend, less experienced nurses were more likely to overestimate and more experienced nurses were more likely to underestimate a patient’s pain. Research has shown that nurses tend to more accurately assess acute pain than chronic pain with elderly patients. Various forms of dementia have the potential to influence the perception of pain and result in physical alterations of pain pathways in the elderly. Pain is processed through many areas of the brain, including the prefrontal cortex, anterior cingulate cortex, and the hippocampus. These regions of the brain are affected during the course of Alzheimer’s disease (AD) and may contribute to the alteration seen in

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It is estimated that as many as 80 percent of residents in long-term care facilities suffer from at least one condition associated with pain. Unfortunately, there are often barriers to the recognition and treatment of pain in the LTC setting associated with the nature of pain and societal attitudes towards pain. AMDA–Dedicated to Long Term Care Medicine™, has noted in its Clinical Practice Guideline on Pain Management in the Long Term Care Setting many of the myths that persist about pain in the elderly population, including:

- Pain is an inevitable part of aging, and nothing can be done about it.
- Elderly patients, especially those who are cognitively impaired, have a higher tolerance for pain.
- Elderly patients and people who are cognitively impaired cannot be accurately assessed for pain.
- Patients say they are in pain to get attention.
- The patient “doesn’t look like” he or she is pain and therefore is probably not really in pain.
- The patient’s vital signs are normal, so he or she must not be in significant pain.
- Elderly patients are likely to become addicted to pain medications.
- To acknowledge pain is a sign of personal weakness. (Conversely, to bear pain without complaint denotes strength of character.)
- Pain is a punishment for past actions.
- Acknowledging pain will mean undergoing intrusive and possibly painful tests.
- Acknowledging pain will lead to a loss of independence.
- Pain means death is near.
- Pain always indicates the presence of a serious disease.
- Use of opioids is the only effective means for treatment of significant pain.

Just as myths exist about pain in the elderly population, so do the complexities regarding the appropriate use of opioids, a type of narcotic pain medication (which includes drugs, such as morphine and oxycodone) because of the risk of serious side effects if not used correctly, including addiction and abuse. The Food and Drug Administration (FDA) approved a Risk Evaluation and Mitigation Strategy for extended-release and long-acting opioids that included voluntary prescriber training, although the agency said it would like to make the training mandatory by linking it to Drug Administration Enforcement registration.
To fully understand the challenges of managing pain in the LTC setting and debunk the myths associated with treating pain, experts in the field of pain management, geriatrics and long-term care medical direction were asked the following two questions:

1. Do you think opioids are over prescribed in long-term care?
2. What is your choice for pain management to treat chronic non-cancer pain?

Their comments:

"Chronic non-cancer pain in long-term care is most often found to be undertreated, but overtreatment is also possible. LTC providers should refer to AMDA’s Clinical Practice Guideline on Pain Management for excellent advice on recognizing, assessing and treating pain in the long term care setting. The AMDA guideline emphasizes that when managing pain, it is always important to assess the patient for causes of pain and plan treatment using both non-pharmacologic and pharmacologic interventions. One should work with the patient and together decide goals of therapy, weighing the pros and cons of each pain management option, including opioid therapy. Typically, the goals of pain treatment are to alleviate suffering and to maximize functioning and independence.

"With elderly patients, there are practical limitations when managing pain with medications. NSAIDs are generally not appropriate because of adverse cardiac, gastrointestinal and renal effects. My first tier of treatment includes physical therapy, topical lidocaine cream and acetaminophen. My next step is to add tramadol, and if that is ineffective, then opioids can be substituted for tramadol.

"Opioids can be quite beneficial when prescribed appropriately and dosed judiciously, but they do have potential adverse effects such as confusion and constipation. While many prescribers are concerned about the potential for opioid diversion, most long-term care facilities have the ability to store opioids securely and monitor appropriate administration. Opioid abuse and addiction are also possible, but these issues are less common in the LTC setting, can be detected clinically and should not deter providers from providing appropriate pain relief."

Source: William D. Smucker, MD, CMD

Soon you will see Linzess (lin-ZESS, linaclotide) for irritable bowel syndrome with constipation or chronic constipation in adults. It is similar to lubiprostone (Amitiza) as both work locally in the GI tract to increase intestinal fluid and GI transit. 5 to 8 IBS patients will likely need to be treated with Linzess for up to 6 months for one to have significantly less abdominal pain and at least one additional bowel movement per week. It's recommended to focus on dietary changes and laxatives (psyllium, Miralax, etc) for constipation first. An antispasmodic (dicyclomine, etc) or sertraline for patients who need Rx therapy for irritable bowel with constipation is suggested. It's expected that patients who try Linzess to get 145 mcg/day for chronic constipation or 290 mcg/day for IBS with constipation. It should be taken at least 30 minutes before their first meal and that taking it with food can cause loose stools. Keep Linzess in its original bottle with the desiccant as the capsules are sensitive to moisture.

Source: Medscape.com
Consultant Pharmacists.....Dispensing Knowledge

CMS Memorandum Summary

CMS has recently provided clarification on three specific topics related to medication errors and pharmacy service in a memorandum dated November 2, 2012; Ref: S&C: 13-02-NH:

- **Medication Errors:** Potential medication errors related to medication administration via feeding tube and administration timing for metered dose inhalers and proton pump inhibitors and survey implications.
- **Medication Administration Practices:** The practice of “borrowing” medications and issues related to diversion, control, reconciliation and disposal of medications, including fentanyl patches.
- **Medication Regimen Reviews for Stays under 30 days and/or Changes in Condition:** The need for pharmacist medication regimen reviews when a resident experiences a change in condition and/or for residents admitted for less than 30 days.

Source: CMS.hhs.gov

People with hypertension are at a greater risk of other serious illnesses. “As blood pressure rises, so does the risk of heart attack, stroke, and kidney disease,” explains Lawrence Appel, MD, MPH, professor at the Johns Hopkins Bloomberg School of Public Health. Hypertension is treatable, however. By following some simple dietary guidelines, you can minimize your high blood pressure and better protect your health.

The American Heart Association estimates that one-third of adults have high blood pressure, and the problem isn’t going away on its own; the rate of death due to hypertension has risen by 25 percent since 1995. But this could be avoided. “Blood pressure, by some estimates, is the most modifiable risk factor out there for death by heart disease,” Dr. Appel says. “When you look at sources of mortality, heart disease just hasn’t caught the attention of public health policy makers.” Diet plays a major role in lowering blood pressure. “There are several dietary approaches,” says Appel. Each one targets a different contributor to high blood pressure: Sodium reduction. “Sodium has been a major focus, and many people think that every other approach revolves around it, that all are indirectly mediated by a change in how the kidneys process sodium,” Appel says. “The problem with sodium is that food supply producers have stacked the deck against us.” Sodium acts as a preservative, so it is often found in excess quantities in processed foods. Read labels carefully. For an individual serving, Appel recommends that you aim for less than 200 mg of sodium, while an entire meal, like a frozen dinner, should not exceed 600 mg of sodium. Of course, the more fresh foods you eat, the less sodium you eat, too.

Weight loss. Overall weight loss seems to have a positive effect on blood pressure. Rapid weight loss followed by rapid regain, on the other hand, can have harmful consequences for your body image and mental health, and may actually contribute to high blood pressure and other physical health problems.

Regulation of alcohol intake. Excessive use of alcohol has a negative impact on blood pressure. One strategy is to limit alcoholic beverages to two drinks per day for men and one for women. One overall approach that has had much success is the DASH (Dietary Approaches to Stop Hypertension) diet. DASH changes the way you eat, focusing on fresh fruits and vegetables, whole grains, low-fat dairy, and lean meats. Although the DASH diet requires multiple dietary changes, the best way to get started is to include fruit and vegetables at every meal and low-fat dairy at most meals. There is a lot of evidence to support DASH. “Unlike other diets, we know that it can be sustained throughout a lifetime,” says Appel. "Blood pressure slowly rises over time — it starts with infants and continues through life." While some blood pressure increase is inevitable, DASH is proven to minimize this natural increase. “According to the best available evidence, if you get started with these habits early in life you can keep your blood pressure lower throughout your lifetime,” he says.

While dietary changes can be a big help to many people, not everyone will be able to manage their blood pressure using diet alone. Some people will need medication to keep their blood pressure in check. “We shouldn’t demonize medication. There are benefits of drug therapy,” Appel says. “Drug therapy and diet are complementary, not mutually exclusive. The point is lower blood pressure. That’s the goal.”

Source: Everydayhealth.com