Yes, Pain Management Can Be Painfully Difficult

Dear Dr. Jeff: Adequate control of pain in the elderly is a quality measure, but the means to get there are becoming increasingly confusing. Ibuprofen and the other nonsteroidal pain medications are on the Beers list of inappropriate drugs, which makes them a red flag for surveyors. So is tramadol, while codeine is poorly tolerated and frequently ineffective.

The consulting pharmacist is on a campaign in our state to slow our sloshing of acetaminophen, which he says damages the liver. My state is taking major steps to discourage physicians from prescribing narcotics for chronic pain. Besides, I worry about using narcotics in cognitively frail seniors. These are all the choices on the World Health Organization pain ladder. What do you suggest?

Dr. Jeff responds: First, it is wonderful to see that the transformation in the care of the elderly has brought issues of pain control out in the open. We have gone from an era in which experts tried to persuade practitioners that pain is a significant issue to a new era in which pain management scores are reported and posted on the Web.

No one ever said practicing medicine was easy. But the situation is not nearly as bleak as you suggest, particularly if we listen more to our patients, carefully review the evidence, and perhaps worry less about regulations. I believe that the risks of many of the alternatives that you discuss are overblown, particularly when they are individualized to the patient. All these medications are readily available throughout most health systems and most (except tramadol and certain rarely used nonsteroidal anti-inflammatory drugs [NSAIDs] or narcotics) are relatively inexpensive.

Moreover, the choices available are much more extensive than those listed above. Many other modalities are (or should be) available to the postacute and long-term care resident.

The World Health Organization pain ladder was designed to guide practitioners through internationally available pain medications for the treatment of cancer pain. Its authors suggest that cancer patients quickly get pain medications, starting with acetaminophen or NSAIDs. If or when these are ineffective, the guidelines suggest adding mild narcotics such as codeine or tramadol.

When pain worsens or is uncontrolled, the mild narcotic is to be replaced by a stronger narcotic, such as morphine. Much cancer pain arises from the visceral organs, nerves, or bones, so a stepwise medication regimen is entirely appropriate. But this was not a pattern designed for typical residents.

Of course, we have some advanced cancer patients in nursing homes. They may be appropriate candidates for the proposed ladder. When simple approaches are ineffective, it is wise to use the expertise of pain or palliative care specialists. Hospice programs also help manage pain, as well as other common symptoms, while allowing seniors to stay in their familiar surroundings.

But most of the pain that needs to be controlled in postacute and long-term care is not cancer pain. Instead, it is the chronic musculoskeletal discomfort typically associated with aging. This includes arthritis, back pain often complicated by osteoporosis or spinal stenosis, polymyalgia, and a wide variety of other disorders of the joints, muscles, liga- ments, bursae, and tendons. Even pain that is typically transitory in patients after fractures or surgeries will persist in elderly skilled nursing patients and, at times, cause more discomfort than the acute problem.

Most of these painful conditions are neither new nor life-threatening. They are the residue of lifetimes of wear and tear on the body and of chronic diseases lasting decades. But they do significantly affect our patients’ quality of life. Those of us who frequently make home visits know that frail elders’ homes are typically outfitted with a variety of do-it-yourself pain-relief modalities. These include hot water bottles, heating pads, neck pillows, slings, liniments, salves, ace bandages, ice packs, and that oxymoronic substance called “Icy Hot.” My wife’s grandmother never wanted to travel too far from the hydrocortisone she used for her sore shoulder. For those unfamiliar with this common piece of physical therapy equipment, it is basically a tub that produces warm, moist heating pads.

What Works, Works

Many residents can describe the various maneuvers they used for pain control at home. Often, it was one technique for a shoulder and something different for the knees. If the resident is too cognitively impaired to give a pain control history, family caregivers or home health aides often know the details of the daily ritual. Yet, in doing medication reconciliations and taking medical histories, we rarely, if ever, inquire about these modalities.

One facility where I worked had a large resident population born in Southern China. Nearly a third of the residents had routinely or periodically used tiger balm prior to admission (an inexpensive topical preparation that is primarily menthol and camphor with some added herbal ingredients – the name relates to similar preparations produced over a thousand years ago that reportedly used ground tiger bones as an ingredient). They were mystified that our pharmacy didn’t routinely supply it.

But even the products that are nearly universal among physical trainers are missing from postacute and long-term care, even though they minimize the potential for drug interactions, have no long-term toxicity, and are inexpensive.

Unfortunately, in nursing homes, all these treatments require a physician’s order and some are considered beyond the scope of routine nursing practice. A 90-year-old great-grandmother can apply a warm, moist towel to her neck at home, but in our regulated environment, a nurse would need (or at least want) an order that specified the temperature and length of time for the application. And the skilled caregiver might be uncomfortable preparing the towel or even be forbidden to use the equipment required to prepare it.

In some facilities, the physical therapy staff will prepare such treatments before they leave, allowing the nursing staff to apply them in the evening, when musculoskeletal pains tend to be worst. Where policies and procedures are arranged to allow this scenario, the orders usually should be “for routine use” not “as needed” because, with medication, heat and ice and balloons are most effective when used before the pain becomes severe. Furthermore, cognitively impaired residents may have difficulty understanding or expressing their need for pain therapy.

Pharmacological analgesics certainly have a place in postacute and long-term care pain management. Despite Food and Drug Administration (FDA) concerns about acetaminophen toxicity, the orders I have seen for this useful medicine are frequently underdosed. The usual half-day between doses vastly exceeds the medication’s half-life, leaving the resident with extended periods of breakthrough pain. Much of the FDA concern prompting a maximum-daily-dose reduction from 4 to 3 g (for which the agency’s expert panel was sharply divided) relates to acute liver damage from excessive dosing. Patients are obviously at risk when so many common drugs (combination analgesics and over-the-counter cough-and-cold preparations, sleep medications, and headache preparations) also contain acetaminophen or the drug by its European name, paracetamol, or even its FDA-banned biologically active precursor, phenacetin.

However, in the controlled environment of a nursing home, these risks are minimal to nonexistent. Also, the FDA’s concerns about blood tests suggesting liver toxicity from high doses of acetaminophen may be an issue primarily for patients who abuse alcohol (which is not easy to do in the nursing home).

In theory, one might order liver function tests for signs of toxicity. For patients whose pain was well controlled on the 4 g daily dose, but poorly controlled after a decrease to the FDA’s recommended 3 g maximum, I would encourage a return to the effective dose with such monitoring – of course, with chart notations explaining awareness of the FDA’s and consulting pharmacist’s concerns, but justifying the use in this particular patient.

Real and Unreal Risks

Concerns regarding the use of narcotics in the elderly, and particularly in those with dementia, are also greatly overblown. Although narcotics appear on nearly every list of medications possibly producing delirium, a careful reading of the literature would show that the justification for this is almost always very old articles referencing meperidine (Demerol). This medication, which is not and should not be used under normal circumstances, had significant anticholinergic properties that placed its recipients at significant risk for confusion.

This was exacerbated by meperidine’s metabolic pathways, which included multiple active metabolites that needed to be cleared by the kidney and could persist in an elderly body for days. The oral narcotics usually needed by postacute and long-term care residents, such as oxycodone and hydromorphone, are generally well tolerated by the elderly and do not appear on the updated 2012 Beers Criteria of medications inappropriate for use in the elderly. Of course, as with so many medications prescribed for the elderly, your mantra should be “Go low, go slow.”

Unaddressed pain is, by itself, a risk factor for delirium. More importantly, for frail seniors near the end of life, it is certainly a major quality of life issue. Studies show that confused elderly patients are still at risk for being undertreated for pain in emergency and hospital settings. There is no excuse for this to happen in postacute and long-term care.

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