Dear Dr. Jeff:

Our practitioners are totally confused. The facility monitors of our Four-Star ratings and pain consultants push us to prescribe more powerful pain medications, particularly in long-acting formulations. The hospice wants everyone on morphine. Meanwhile, the Food and Drug Administration warns that every mild analgesic has toxic side effects, while the Drug Enforcement Administration, local politicians, and the press say we are killing patients with painkillers. Our patients and families look to us for guidance but we don’t have answers. Do you?

Dr. Jeff responds:

When everyone, regardless of perspective and background, thinks we are doing a bad job, it is easy to feel defensive. However, sometimes when everyone else agrees, it is because they are right.

Due to the complex nature of the biology of pain, the multiple comorbidities, the multiple medications prescribed for frail seniors, and the altered neurobiology of aging, the effects of opioid and other analgesics in the individual nursing home resident may be uncertain or unpredictable or even downright dangerous, but, as with any treatment, risks, benefits, and alternatives must be considered.

Opioids for the Elderly

The use of opioids in the treatment of chronic pain in the elderly has been the flashpoint for some of this discussion. Data would suggest that their use for more than 90 days has doubled in the past decade. This may be more common in the community than in the institutional setting, but certainly prevalence rates have increased despite escalating prescription controls.

Some have blamed efforts that began in the 1990s to elevate pain to the “fifth vital sign,” a formulation that only seems to suggest that if one has no pain one must be dead. This was originally championed in the Veterans Health Administration, although follow-up studies failed to confirm that the concept lead to improved pain control. The Joint Commission’s 2001 requirements on pain assessment and control were interpreted to endorse this concept, although in April, The Joint Commission issued a frantic press release denying responsibility and highlighting the actual language in their requirements. Indeed, they had only required certified institutions, including hospitals and nursing homes, to have a system in place to assess pain. Using pain as the fifth vital sign was only offered as an example of one possible approach that might comply. Similarly, the commission never actually required that pain be eliminated, only that it be managed. The release also noted that the number of opioid prescriptions has been rising since 1990 with a marked upswing in 1998–1999, 2 years before their standards were issued. Just this year, the number of opioid prescriptions actually ticked down incrementally.

A larger culprit is probably the World Health Organization. Their three-step pain guidelines (or “ladder”) were actually developed for cancer pain but were adopted by many for pain of every etiology. The WHO analgesic ladder starts with the standards of acetaminophen or NSAIDs for mild pain, moves to codeine and its derivatives like oxycodone or hydrocodone with acetaminophen (e.g., Percocet or Vicodin) for moderate pain, before moving to medication for severe pain (e.g., morphine, methadone, and fentanyl). This is likely the source for the repeated assertion that morphine is the gold standard for narcotic analgesics. In fact, the major advantage advantages of morphine are familiarity and cost despite its serious adverse effects and the availability of multiple alternative preparations.

Part of this upswing in opioid prescriptions was a long campaign to encourage primary care physicians to feel comfortable prescribing them. It included major marketing campaigns from manufacturers and legal distributors of long-acting opioid preparations including capsules and transdermal preparations. Many of these, which have the greatest addiction and overdose potential, were dispensed by storefront “pain clinics” that often controlled adjacent pharmacies dispensing the immense quantities that they prescribed. Although many primary care physicians were uncomfortable with this trend, some acceded to the requests of established patients whose friends were already using opioids with what they considered to be good responses, or they continued such prescriptions in the interest of ongoing pain control and avoiding withdrawal symptoms.

Up to 80% of older residents in long-term care do experience substantial pain. Indeed, it may be a concern equally large or larger for residents who are unable to rate their pain on a Likert scale due to cognitive impairment, and who may not be counted by the Centers for Medicare & Medicaid Services. They are just as likely to have pain as their more verbally responsive peers. Extensive literature documents the assessment of pain in adults with severe cognitive impairment, and all practitioners and clinical staff should be familiar with it. Undiagnosed pain can contribute to anorexia and weight loss, resistance to care, inactivity, social isolation, agitation, aggression, and depression. Regrettably, multiple studies show that even cognitively impaired patients with known painful conditions are less likely to receive analgesics and are prescribed lower doses than their cognitively intact peers.

Although guidelines from the Centers for Disease Control and Prevention regarding opioid prescribing exempt those at the end of life, these medications are rarely an ideal choice in our population. The WHO ladder may be appropriate for patients with advanced cancer, particularly those for whom other treatments would not be effective or appropriate, but cancer is rarely the underlying pain etiology for nursing home residents. Even cancer patients with severe bone pain should be considered for a brief course of radiation (usually three to five treatments) for painful bone metastases, as this is usually more effective than morphine. Steroids also may be very effective in the treatment of pain from increased intracranial pressure. But often opioids are an ideal approach, and they should be monitored and progressively increased until the desired effect is reached.

Options and Answers

Every resident with pain deserves a thoughtful evaluation of the source of their pain based on a comprehensive history and physical exam. To go back to basics, excellent places to start would be the article by Steven Levenson, MD, CMD (Levenson S. Pain needs to be managed one step at a time. Caring for the Ages 2007;8:14–5) and the Society’s Clinical Practice Guideline on pain management. The June 2016 issue of Consumer Reports has an excellent cover story with a remarkably balanced discussion of common sources of pain and typically effective and ineffective therapies.

SNFs have access to a variety of nonpharmacologic modalities for pain relief, but these typically are underutilized. Gentle exercise regimens have demonstrated remarkable success in relieving chronic low back pain. When my wife’s grandmother entered a nursing home, she was astounded that the facility lacked a hydrocollator (device to produce warm moist heating pads), which had been her mainstay for control of her evening shoulder pains. Heat and cold can be extremely effective for some residents, whereas many seniors are comfortable with familiar liniments, positioning devices such as cervical pillows, and even copper bracelets (even if they only serve as an effective placebo). Since chronic pain in the nursing home typically starts before the resident is admitted, it is a good start to ask the resident and family about what worked for them in the past. Injection of trigger points in fibromyalgia; injection of painful knees with steroids or lubricants; and use of ultrasound, transdermal electrical nerve stimulators, and a variety of other treatments are often effective for selected residents. Clinicians need to collaborate with rehabilitation therapists for optimal pain relief. Some facilities have access to massage or acupuncture, which can be effective for some patients.

Whole Patient Approach

Our approach to pain control has to treat the whole patient, including the social and emotional components of pain. Even opioids do not eliminate the sensation of pain; they interfere with the pathways that connect the sensations of pain with the profound emotional reactions they elicit. Stress increases the severity of a variety of diseases, from muscular disorders to rheumatoid arthritis. Serotonin raises the pain threshold, and SSRIs and serotonin norepinephrine reuptake inhibitors are sometimes used with pain as a primary indication. Although certain preparations have been marketed specifically with this indication, it is not clear that they are more effective than others in their class. Cognitive behavioral therapy has been shown to be effective in the management of a variety of chronic pain syndromes. Meditation, hypnosis, or visualization techniques can be effective for some patients. One randomized controlled trial demonstrated that prayer can decrease pain levels, while another study suggested that prayer may have effects on serotonin receptors in the brain.

Treat your patients the way good practitioners always should. Assess everyone for the potential for pain, analyze the probable cause or causes, treat the whole patient, avoid unnecessary drugs while looking for non-pharmacologic approaches, ignore “experts” without meaningful long-term care experience and all pharmacologic advertisements, reevaluate periodically, and readjust treatment based on outcomes. Don’t be confused by all the contradictory pressures, just do the right thing for your residents — and that will certainly require opioids at times.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board.

### Pain Management Still a Pain

**Jeffrey Nichols, MD, CMD**