Pain
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Managing Chronic Pain in Older Adults: Taking a Holistic and Individualized Approach

By Christine Kilgore

Chronic pain — the complex, multidimensional, highly personal experience that affects more than half of nursing home residents — demands assessment of both the physical causes and the emotional and psychosocial components. Holistic management incorporates nonpharmacological approaches, experts and practitioners from various disciplines told *Caring.*

And when medications are needed, each clinician has to "use a very holistic individualized framework to grapple with the question of what can my patient tolerate for the kind of pain we think they're having," said Barbara J. Zarowitz, PharmD, MSW, BCPS, CGP, senior advisor to the Peter Lamy Center on Drug Therapy and Aging at the University of Maryland School of Pharmacy.

Pharmacologically, practice is moving "more and more toward medication safety," she said. And "awareness about the predisposition of older adults to the adverse consequences of pain medications is creating impetus for improved pain assessment, diagnosis, and treatment."

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The complex experience of chronic pain requires an individualized, holistic framework to effectively manage pain in post-acute and long-term care.

In interviews about chronic pain and its diagnosis and management — both pharmacological and nonpharmacological — sources shared their experiences and reflected on what's changing and what may be underappreciated.

The Importance of First Acknowledging Pain

Connie S. Cole, PhD, DNP, APRN, has worked in nursing homes for

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The Case Against Universal Vitamin D Supplementation in Older Adults

By Daniel Haimowitz, MD, FACP, CMD, Carmen Witsken, PharmD, Emily Cofsky, Brittany Henault, Emily Hajjar, PharmD, MS, BCPS, BCACP, BCGP

Vitamin D is frequently seen as part of the medication list of older adults, particularly those in long-term care (LTC). The LTC population is more at risk of vitamin D deficiency due to factors such as little or no sunlight exposure, malabsorption, frailty, and other comorbidities. Our clinical experience has been that vitamin D supplementation is ordered either because levels were found to be low or simply as a vague expectation that it can't hurt or that it's a "best practice." But is there evidence that truly supports its universal use?

Purported Benefits of Vitamin D

Vitamin D deficiency is extremely common, affecting an estimated 50% of the U.S. population, 50% to 60% of institutionalized older persons, and up to 1 billion people worldwide ("Vitamin D Deficiency," StatPearls, July 27, 2022, https://www.ncbi.nlm.nih.gov/books/NBK532266/). Additional vitamin D offers a plethora of potential benefits;

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Pain

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years, first as a nursing assistant and now as a postdoctoral research fellow at the University of Colorado, where she focuses on improving access to palliative care. In a systematic literature review of the prevalence of pain in nursing home residents and associated factors published last year in *JAMDA*, Dr. Cole and her co-investigators found a prevalence of current pain of 22% to 85% and a prevalence of chronic pain of 56% to 58% (*J Am Med Dir Assoc* 2022;23:1916–1925).

She's learned through her research that pain tends to be undertreated in older adults in the nursing home setting in part because some patients "don't report pain even though they experience it [and suffer from it]." Residents "think it's part of the aging process, or they're afraid of pain medicines. Some are worried about becoming addicted," Dr. Cole said.

Moreover, the perception and experience of pain are influenced by culture, trauma history, socialization, and other factors. Paige Hector, LMSW, a post-acute and long-term care speaker and educator based in Arizona, noted that in some cultures "it's not acceptable to acknowledge pain." And some people have a "fear of being judged" if they report it.

Moreover, Alzheimer's disease and moderate–severe dementia are well-reported risk factors for underreported and undertreated pain.

All of this means that, beyond the Minimum Data Set (MDS) screening for pain — at admission, on a change of condition, quarterly, and annually — interdisciplinary teams must surveille. For instance, they must look for possible pain-related behaviors like grimacing, bracing, or withdrawing during movement or when being approached. Use of multidimensional behavioral assessment tools like the PAINAD (Pain Assessment in Advanced Dementia Scale) can be helpful, sources said; but most important is a culture of observation and engagement in the staff who routinely care for the residents or work with them in therapy and other activities.

Of particular importance are the nursing assistants. Dr. Cole pointed to a study of pain in nursing home residents with dementia where the nursing assistants' estimates of the residents' pain severity were closer to those of the research experts who did comprehensive assessments than were the nurses' estimates (*J Am Geriatr Soc* 2020; 68:794–802).

Types of Pain, Homing in on Causes

Chronic pain is pain that persists for more than three months, and, according to AMDA – The Society of Post-Acute and Long-Term Care Medicine's recently revised clinical practice guideline (CPG) on pain management, it may not be associated with a specific identifiable cause or defined tissue damage. It is "almost always associated with diverse physiological and psychological changes," the CPG says.

This doesn't mean, however, that the underlying causes and issues cannot often be identified. The Society's CPG describes a systematic approach to pain assessment and to the differentiation of underlying causes, and it emphasizes not jumping from reports of pain to treatment. [The CPG is cited throughout this issue and can be found here: https://bit.ly/painCPG. There is also an accompanied publication in *JAMDA* (2015;22(12):2407) available at: https://bit.ly/3Yl8HXJ.]

The *International Classification of Diseases, Eleventh Revision* (ICD-11), released last year, includes two general categories of chronic pain: chronic primary pain, which has an unknown etiology or established pathophysiology, and chronic secondary pain, whose etiology or pathophysiology is known. Chronic musculoskeletal pain can fall in the primary category (e.g., chronic back pain) or the secondary category (e.g., osteoarthritis, polymyalgia rheumatica).

Most of the chronic pain in long-term care and in older adults in general is musculoskeletal, and "musculoskeletal pain is a huge heterogeneous thing" that needs to be teased apart through thorough assessment, said Debra K. Weiner, MD, professor of medicine, psychiatry, anesthesiology, and clinical and translational science at the University of Pittsburgh, whose research and clinical practice focuses on pain in older adults. Dr. Weiner served as the medical director of a long-term care facility in the 2000s.

Musculoskeletal pain is a major type of nociceptive pain, which should be distinguished from neuropathic pain in order to select treatment. Nociceptive pain — both somatic and visceral — implies tissue injury that directly stimulates pain receptors along normally functioning nerve pathways. Neuropathic pain, on the other hand, appears to result from abnormal functioning of the peripheral or central nervous system, according to the CPG.

Neuropathic pain has classic pain descriptions (e.g., burning, stabbing, shooting), but these pain symptoms aren't necessarily limited to neuropathic conditions, Dr. Weiner cautions. Myofascial pain, a condition characterized by tight muscles and areas of enhanced sensitivity called trigger points, often involves pain that's referred beyond the trigger point and can mimic neuropathic conditions like radiculopathy, she said. Myofascial pain is "extremely common," she said, and can be driven by many things, such as muscle overuse, emotional stress, and abnormal body mechanics (e.g., following a hip or knee replacement).

"The way I think about pain has been mostly driven [not by research] but by listening to patients' stories and putting my hands on them," said Dr. Weiner, who is also the associate director for research at the Geriatric Research, Education and Clinical Center of the VA Pittsburgh Healthcare System.

In assessing pain, Dr. Weiner said, it's important to take a "whole-person, life view" of the patient, given that chronic pain often has emotional, spiritual, and psychological components. Early-life trauma, she noted, can predispose people to pain conditions later in life. Ms. Hector agrees, and noted that there are many ways practitioners can integrate psychosocial pain assessments into the treatment plan. (See Ms. Hector's article "Integrating Psychosocial Elements for Comprehensive Pain Management" in this issue.)

Pharmacological Tools

Identifying neuropathic pain is important because it "opens up less toxic pathways of treatment — alternatives like lidocaine patches, which don't have all the associated adverse events that opioids and NSAIDs [nonsteroidal anti-inflammatory drugs] have," said Dr. Zarowitz, who is working on a Medicare quality improvement project to reduce adverse drug events, including those from opioids, in nursing homes. (Lidocaine patches are also used off-label for musculoskeletal pain.)

The antidepressant duloxetine can be effective for neuropathic pain and is preferred over tricyclic antidepressants because it has fewer side effects. (Duloxetine is approved by the US Food and Drug Administration for musculoskeletal as well as neuropathic pain.) And traditional anticonvulsants such as gabapentin and pregabalin "can be very effective for neuropathic pain," she said.

All these oral systemic medications still have potential deleterious effects, however, Dr. Weiner said. Starting with a topical and then adding to it as necessary is often a good approach. "Say [a topical medication] is doing something [but not enough]. You could then add gabapentin," she said. "And if that helps a bit more but the patient is still up at night [with distressing neuropathic pain], then adding an opioid at bedtime could be considered."

The opioid crisis unfortunately has spurred a "black and white mentality about opioids," Dr. Weiner said. "Not all [regimens] are bad. With any chronic pain management, you

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must personalize the treatment to the patient and their contributing conditions, comorbidities, and risk factors for adverse events."

According to the Society's CPG, the "strongest indications" for opioids are chronic cancer-related pain, end-of-life pain, and selected cases of more severe chronic visceral, somatic, or neuropathic pain in patients with coexisting severe illnesses. Nonpharmacologic and non-opioid medications should be tried first or used concurrently; they "may help reduce the dosage, frequency, and duration of treatment" if opioids are eventually indicated, the CPG says.

The critical guiding principles for opioids, Dr. Zarowitz said, include using the lowest possible morphine equivalence for the shortest amount of time — and always starting with a short-acting opioid. After a week, she said, "then and only then, if they're not treated sufficiently and you know what their pain needs will be, you can consider converting a substantial part of [the regimen] to a long-acting agent, with a little short-acting for breakthrough pain."

These principles are articulated by the Centers for Disease Control and Prevention in its 2022 guideline for prescribing opioids for pain (*MMWR Recomm Rep* 2022;71[3]:1–95, http://bit.ly/3Wbn4Ml), which Dr. Zarowitz said provides more emphasis on medication safety than its last guideline update in 2016. (See also "Pain Management, CDC Guidelines, and CMS Requirements in the Era of the Opioid Crisis" by Robert Accetta in this issue.)

When NSAIDs are needed, they should be used for the shortest amount of time and at the lowest dose possible, Dr. Zarowitz said. The preference today for older adults is to use a longer-acting NSAID; for instance, naproxen "has the same risk as ibuprofen of potentially causing GI [gastrointestinal] irritation and bleeding, but may be a safer consideration because you may need to use less of it." Protection against GI side effects is achieved with a protein pump inhibitor started on the same day. "It will dramatically reduce the risk of a GI bleed or a GI ulceration," she said.

Acetaminophen has been shown to be as effective as NSAIDs and opioids for general musculoskeletal pain, and it can be safely used long term in many residents so long as the total daily dose is kept under 3,000 mg. A daily morning dose "sometimes allows them to get up and be more active," Dr. Zarowitz said, and a nighttime dose for those residents who have pain-associated symptoms at night may be beneficial.

"We should always be reassessing the need for pain therapy and looking for opportunities to deprescribe ... even for something as simple as Tylenol," she added.

Reducing "Pain Interference," Nonpharmacologic Approaches

Considering pain as a vital sign, with a goal of elimination, may be appropriate for acute pain but not for pain that's chronic. "Patients with chronic pain cannot expect to become pain-free," said Dr. Weiner. "The goal is to reduce as much as possible pain interference, meaning interference with emotional functioning and physical functioning and quality of life."

For some, she said, addressing depression and anxiety is key. Depression was one of the clinical conditions and factors that had the strongest association with pain across the 26 studies included in Dr. Cole's review of pain in nursing home residents. Arthritis, dementia, cognitive impairment, and impairment of activities of daily living were also strongly associated with pain.

Much of the goal "is often about how to cope with chronic pain," said Barbara Resnick, PhD, RN, CRNP, professor and Sonya Ziporkin Gershowitz chair in gerontology at the University of Maryland School of Nursing in Baltimore. "There's more openness today about the use of behavioral interventions for chronic pain." In nursing homes, this may often mean "personalized distraction": more conversation, music, and activities instead of formal psychotherapy or cognitive behavioral therapy.

To help reduce pain interference, said Dr. Cole, one needs to look beyond the pain itself and understand how the patients' pain is interfering with the activities that are most important to them. She recalled a patient with such severe neuropathy in her hands that she could not hold the phone to talk with her daughter. "It led to a spiral. She was depressed because she couldn't talk with her family, which increased her pain," Dr. Cole said. "Once we got her some adaptive equipment ... her pain improved" without other changes in her regimen.

"I think we're recognizing pain more, but what we're truly missing is the ability to understand the patient's experience with chronic pain — what it means to live with it," she said.

In her systematic review, Dr. Cole found that, across studies, 44% to 76% of residents with pain were using nonpharmacological treatments, most commonly topical analgesic ointments, massage, heat, or physical therapy. (All the nonpharmacological studies were done outside the United States, she noted.)

A separate systematic review and meta-analysis of the management of chronic pain in nursing homes, also published in *JAMDA* in 2022, found that nondrug treatments had moderate to large treatment effects. Exercise was the most common intervention, followed by acupressure and then humor therapy (*J Am Med Dir Assoc* 2022;23:1507–1516).

"Exercise and positioning are some of the best approaches in the nursing home, because so much of the chronic pain stems from sitting still and from osteoarthritis," Dr. Resnick said.

Considering the shutoff and temperature control features of today's devices, heat should be built into personalized care plans, Dr. Resnick said. Yet in reality many nursing homes have policies that disallow the use of heating packs or pads at the bedside.

However, cold water therapy can also be helpful and is underutilized, said Travis Neill, PA-C, MMS, who practices with Rocky Mountain Senior Care and serves as an assistant medical director for nursing homes in the Denver, CO, area. He has successfully urged facilities to purchase "cold water therapy ice machines," which circulate ice-chilled water through tubes in a pad that's placed on the body.

"The benefit is you can keep adding ice to the machine and keep it circulating for longer periods of time," he said. "Someone with low back pain, for instance, can have 30 to 60 minutes [of the therapy] and get relief for much of the day."

Therapies like cold water therapy are usually "not the end-all and be-all," Mr. Neill said. "They're a supplement to someone's pain regimen, that almost always, in my experience, can reduce their dependence on medications. This is how we should [view] all the nonpharmacological therapies."

His facilities have also hired massage therapists and acupuncturists to visit occasionally and make rounds on patients who are signed up. After initial lulls, both therapies "have caught on," and the massage therapy has been a bit more popular, he said.

Massage therapy has broad benefits, Mr. Neill said. Residents who have neuropathic pain "almost always have a musculoskeletal component because they're walking or sitting differently to try to compensate for the pain," he said. "And there's also the attention, the touch, that's effective."

Topical pain relievers like lidocaine cream and other over-the-counter preparations also are roundly beneficial, Mr. Neill and Dr. Resnick both emphasized, noting that they fit well conceptually into the nonpharmacological toolbox. Mr. Neill instructs staff to massage topicals into the skin for a few minutes to achieve the powerful pain management components of touch and attention and "the feeling of being cared for."

Christine Kilgore is a freelance writer based in Falls Church, VA.

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