Symptom Management in the Older Adult: 2015 Update

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KEYWORDS

• Pain management • Palliative care • Pharmacologic management
• Nonpharmacologic management • Older adults • Depression • Delirium

KEY POINTS

- At least for cancer patients, being older is no longer associated with pain medication underprescribing; however, moderate to severe pain is still prevalent.
- Physician barriers include reluctance to prescribe opioids, inadequate training, fear of complications, fear of regulatory oversight, and drug interactions.
- The first principle of pain management is classification: neuropathic, and everything else.
- Symptom management continues to improve, but many more improvements are needed.

PAIN MANAGEMENT

Pain Is Still Common, and Commonly Undertreated

Dr von Roenn wrote in 2002 that, "Pain is the most common symptom for which patients seek medical attention and is one of the most frequent complaints of older adults."[1] That has not changed. The good news is that, at least for cancer patients, being older is no longer associated with pain medication underprescribing,[2] as it was in 1994. The bad news is that moderate to severe pain is still as prevalent as it was in the 1990 despite a 10-fold increase in opioid prescribing.[3]

Dr Thomas Finucane covers the important elements of pain relief elsewhere in this issue. This article reviews some of the barriers to pain and symptom management and concentrate on nonpain symptoms, in which there has been significant progress. Recent reviews of management in older adults stress the multimodality approach.[4] Barriers to pain management in older adults remain much the same as in 2002. Patient barriers include at least the following:

- Reluctance to complain
- Underreporting of pain

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- Interpretation of pain as other words such as “discomfort”
- Reluctance to take analgesics
- Comorbidities that make prescribing more difficult
- The high cost of some pain medications, added to the cost of other medications. For instance, the price of each generic extended release oxycodone 20 mg pill is about $5, and a 75 mg pregabalin (Lyrica) capsule costs about $1.50 apiece.[5]

Physician barriers remain the same as well, including reluctance to prescribe opioids (although more patients die of complications from nonsteroidal anti-inflammatory drugs [NSAIDs] than from opioids), inadequate training, fear of complications, fear of regulatory oversight, and drug interactions.

For Pain: Classify, Classify, Classify

The first principle of pain management is classification: neuropathic, and everything else. Damage to afferent nerve fibers produces neuropathic pain, at least at the start. A distinguishing characteristic of most neuropathic pain is that it becomes amplified long after the initial insult is gone. Imagine touching a hot plate with your fingers: immediate withdrawal from the heat (mediated by the fastest, nonmyelinated Adelta fibers), then near immediate sensation of pain (mediated by the slower myelinated C fibers), then moving away from the hot plate, then blaming your son-in-law for leaving the hot plate on. Then, imagine that pain becoming worse over the next years long after the burn has healed.

Neuropathic Pain

The exact mechanisms by which neuropathic pain becomes amplified and persistent is complicated and not easily explainable. At a minimum, there are increased nerve transmitter molecules and receptor sensitivity; extra nerve “channels” or amplification along the nerve pathway, which are far more plastic than imagined 20 years ago; heightened sensitivity to chronic pain that never remits; and “wind-up” of the nerve pathways in both the spinal cord and the brain.[6] Suffice it to say that nerve pain is often out of proportion to the original pathology.

The mechanism of nerve injury matters, too. For instance, chemotherapy has become a major producer of nerve pain, chemotherapy-induced peripheral neuropathy (CIPN). Drugs like bortezomib (Velcade) used in myeloma, paclitaxel (Taxol) or eribulin (Halaven) used in breast cancer, and any platinum drug such as oxaliplatin (Oxali) used in colon cancer can cause dose-limiting neuropathy in 70% of patients. In oxaliplatin CIPN, the longest nerves actually die and drop out, leading to lowered epidermal nerve fiber density.[7] In paclitaxel neuropathy, the longest nerves are damaged, with up to 25% of the damage happening in the year after the chemotherapy has stopped, but the nerves may recover. In diabetic nerve damage, the nerve death and damage seems to be nutritional rather than toxic, but the nerves are still dead or damaged.

Neuropathic pain is also easy to “score” with the 0 to 10 scale, just like usual pain. Remember to ask all the important questions for billing (and for patient care!): when did it start, what brings it on, what relieves it, what does it feel like, and are there any associated symptoms? Neuropathic pain is typically described as sharp, burning, itching, or hot, with associated numbness and tingling. If life were fair, nerves that were absent or damaged would just give numbness, but all too often numbness and tingling are associated with the worst nerve pain. There are useable, validated research scales such as the European Organization for Research and Treatment of Cancer CIPN-20 or the DN4 questionnaire, but they are not in widespread use outside of clinical trials.[8]