Pain Management in Older Adults

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KEYWORDS

• Pain • Pain management • Pain treatment • Older adults

KEY POINTS

- Managing pain in older adults can be complex because of the age-related physiologic changes, comorbidities, and polypharmacy.
- The goal of pain management is to maximize function and quality of life by minimizing pain.
- Treatment plans should include pharmacologic and nonpharmacologic strategies.
- Patient and family education is important for safe and effective pain treatment.

INTRODUCTION

Managing pain in older adults can be a challenging process. Many older adults have different types of pain simultaneously (eg, nociceptive and neuropathic, acute and persistent) and may have other conditions that complicate pain treatment (eg, dementia, kidney, and cardiovascular disease). Balancing treatment across these different dimensions can be complex.[1] Pain management is further complicated by age-related physiologic changes that alter gastrointestinal drug absorption, distribution, liver metabolism, and renal excretion.

The primary goal of pain management in older adults is to maximize function and quality of life by minimizing pain to the extent possible.[2] Pain relief is one of the most common goals of older adults, although complete pain relief is not always possible.[1,3] It is important to understand patients' pain control goal (eg, sleep comfortably, perform activities) and pain intensity goal (0–10).[3]

A multimodal approach to pain management that includes pharmacologic and nonpharmacologic therapies is recommended.[2] Pharmacologic interventions are an integral component of pain management in older adults.[4] However, selection of pharmacologic therapies must include a risk and benefit analysis that considers the potential benefits of pain relief versus the potential risks of pain medications on

This article is the companion to the article "Pain Assessment in Older Adults " by Ann L. Horgas published in the *Nursing Clinics of North America* issue devoted to geriatric syndromes (September 2017, Volume 52, Issue 3).
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Nurs Clin N Am 52 (2017) e1–e7
http://dx.doi.org/10.1016/j.cnur.2017.08.001 **nursing.theclinics.com**

cognition and organ systems.[5] Side effects must be monitored, prevented when possible, and treated proactively when they occur.[6] It should be emphasized that pharmaceutical pain management is often more imperative in older adults with dementia because their ability to participate in nonpharmacologic pain management strategies, such as self-management or cognitive behavioral therapy, may be limited by their cognitive capacity.[7]

Several excellent pain management guidelines and protocols are available to guide pain management in older adults. These guidelines and protocols include guidelines from the American Geriatrics Society,[8,9] American Pain Society,[10] British Geriatric Society,[11] and the Gerontological Society of America.[12] Other resources are available that focus specifically on pain treatment. The World Health Organization (WHO) provided a consensus statement on the use of step III opioids for chronic, severe pain in older adults, which provides detailed guidelines on the use of opioids for cancer and non–cancer-related pain.[13] Some published guidelines focus on pain associated with specific diseases, such as osteoarthritis[14]; others focus on pain treatment in people with dementia.[2,15–17] The geriatricpain.org website, developed at the University of Iowa, is an excellent resource for pain management in older adults, as it includes downloadable assessment forms, measurement tools, instructional guides, and educational materials. Jablonksi and colleagues[18] also provide a comprehensive pain assessment and treatment algorithm. All of these guidelines and protocols recommend using a collaborative interprofessional team (eg, nursing, medicine, physical therapy, social work, and psychology) that considers biopsychosocial factors that influence a person's pain experience to develop a multimodal pain treatment approach (eg, pharmacologic and nonpharmacologic).[3] The reader is referred to these excellent clinical guidelines and consensus statements for detailed information. In the following section, key points about pharmacologic and nonpharmacologic pain treatment are summarized.

PHARMACOLOGIC PAIN TREATMENT

Pharmacologic pain management centers on several key principles. These principles are as follows: (1) by mouth: use the oral route whenever possible; (2) by the clock: for persistent pain, provide analgesics at regular intervals (around the clock) as opposed to as needed; and (3) by the ladder: referring to the WHO 3-step analgesic ladder. The WHO ladder characterizes types of analgesic medications in a hierarchical approach: nonopioids + adjuvant drugs, opioids for mild to moderate pain, and opioids for moderate to severe pain.[19] This guideline was developed for cancer pain but is also widely used for guiding noncancer pain treatment. It should be noted that this pain treatment ladder is nonspecific to older adults, but rather addresses pain treatment in general. The ladder provides guidelines for combining and advancing medications based on pain severity in order to maximize treatment effectiveness and minimize side effects.

When introducing analgesic treatment, the recommendation is to start at the lowest possible dose and titrate upward, while monitoring and managing side effects. The adage *start low and go slow* is often used. However, as Guerriero and colleagues[3] point out, it is important to not start low and *stay* low. Makris and colleagues[1] provide a treatment algorithm for nociceptive and neuropathic pain disorders in older adults. They highlight the continuous process of assessment and treatment to attain optimal pain control.

STEP 1 DRUGS: MILD TO MODERATE PAIN

Nonopioid Medications

Acetaminophen is the first-line treatment of mild to moderate pain in older adults.[1,9] Acetaminophen is considered a safe and effective drug when used correctly. Because