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ELDER CARE

A Resource for Interprofessional Providers

Opioids in Older Adults: Initiating Therapy

David J. Horn, MD, University of Arizona

Background

Pain is a complex form of suffering that arises from the interplay of tissue injury, pre-existing disease processes, mental health problems, functional impairment, and social isolation. More than half of older adults experience pain, and the majority of these individuals report pain in multiple sites. Musculoskeletal pain is most common, especially in the back, knees and shoulders. Persistent pain in older adults can lead to financial costs and increasing disability. Yet only about one third of older patients with persistent pain are receiving sufficient analgesia.

Opioids are potent analgesics. They were traditionally used in a limited fashion for temporary treatment of acute pain, especially after surgery. In the 1990s and early 2000s, many adults were started on chronic opioids for treatment of persistent pain. Opioids were started under the assumption that they were not addictive if used for “legitimate” pain. White patients tend to receive higher opioid doses than non-whites, perhaps due to clinician biases about non-white individuals.

We now know, however, that opioid analgesics have significant habit-forming potential, and Medicare data has shown increased opioid use in older adults. This increased use confers a higher risk for serious complications, including increased rates of falls, fractures, and hospitalizations, along with increased overall healthcare utilization.

Nonetheless, if non-opioid pharmacotherapy has not treated pain adequately, and non-pharmacologic interventions (e.g., physical therapy) have not been successful, escalating therapy to opioids may be a reasonable next step. Initiation of opioids requires an individualized discussion of risks and benefits with your patient. Electing to start opioid treatment may decrease pain; however, opioids also cause sedation, cognitive impairment, constipation, and dependence. It is also important to recognize that polypharmacy, sarcopenia, and decreased hepatic and renal function can all contribute to altered opioid metabolism in older adults, thereby enhancing opioid side effects and increasing risk.

It is important to use accurate language when discussing pain and pain medications with your patients. Definitions for health professionals are presented below, but must be presented to patients in easy-to-understand terms.

Categories of Pain Types

- *Nociceptive Pain* arises from tissue damage or injury that is detected by nociceptors in the body.
- *Neuropathic Pain* is caused by primary injury to or dysfunction of somatosensory nerves.
- *Inflammatory Pain* is due to activation and sensitization of nociceptive pain pathways, caused by the local release of inflammatory mediators.
- *Mixed Pain* is pain resulting from a combination of nociceptive, neuropathic and/or inflammatory processes.
- *Total Pain* is from a combination of the aforementioned biological factors, plus psychological and social factors.
- *Malignant (Cancer) Pain* can be nociceptive, neuropathic and/or inflammatory. It is caused by cancer lesions and/or procedures used to diagnose or treat cancer.

Categories of Pain Duration

- *Acute pain* arises suddenly from a specific cause, typically related to localized injury to a discrete tissue.
- *Persistent pain* lasts longer than expected after an inciting illness or injury, but it likely will resolve at some point. See the Elder Care sheet on [Management of Persistent Pain](#) for more information.
- *Chronic pain*, on the other hand, is typically long-lasting and not expected to resolve. It may not have an identifiable cause.

Drug Definitions

- *Opioids* are a class of drugs and medications related in physiologic effect to opium, a chemical found naturally in the opium poppy plant.
- *Narcotic* is a term defined by United States law that includes both opioids and cocaine, though in common usage narcotics refers to opioids.

TIPS ABOUT OPIOID THERAPY IN OLDER ADULTS

- Consider opioid therapy only after non-pharmacologic treatments and non-opioid pharmacologic therapy have failed.
- Initiation of opioids should be performed with a specific treatment goal that is discussed with the patient.
- Initiation of opioids should be done using a structured risk assessment strategy.
- During opioid therapy consider non-opioid analgesics, adjuvants and non-pharmacologic treatments as a means to control pain. This may allow the patient to decrease or discontinue opioid use.

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Continued from front page

Structured Approach When Considering Opioid Therapy:

When considering opioid therapy, a structured approach is recommended (Table 1) to minimize risk of opioid use disorder, optimize safe prescribing, and assure that patient/family goals of care are met. Opioids are best used in the setting of clear expectations and limits.

1. Conduct a comprehensive pain history, including: <ul style="list-style-type: none">• Comorbidities, especially liver and renal dysfunction• Medications and non-pharmacologic treatments• Procedural interventions attempted• Previous experiences with opioids
2. Assess risk for opioid use disorder <ul style="list-style-type: none">• There are many validated tools to assess risk.• Consider using the revised opioid risk tool, which has a sensitivity of 85.4% and specificity of 85.1% in identifying patients who develop aberrant behaviors after initiating opioid therapy.
3. Check the prescription monitoring program (PMP)
4. Determine definite goals of care <ul style="list-style-type: none">• Clearly inform patients that opioids reduce but do not eliminate pain. Patients should identify what level of pain is tolerable.
5. Address risks, specifically: <ul style="list-style-type: none">• Falls, fractures and hospitalization• Constipation• Dependence• Oversedation and respiratory depression• Overdose and death (consider naloxone prescription)
6. Agree on monitoring plan as needed
7. Discuss what circumstances would lead you to discontinue opioid therapy <ul style="list-style-type: none">• Multiple falls• Emergency room visits for overdose• Receiving prescriptions from other clinicians• Diversion (illegally transferring the medication to others)

References and Resources

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Non-Opioid Pain Management

It is important to consider the interventions in Table 2, both before and during opioid therapy.

Table 2. Non-Opioid Interventions for Treating Pain

Non-Opioid Medications

- *Acetaminophen* can work synergistically with opioids and is generally well-tolerated. Consider scheduling dosing, rather than as-needed dosing. Maximum dose for older adults is 3,000 mg/day and less if hepatic dysfunction.
- *Oral non-steroidal anti-inflammatory drugs (NSAIDs)* can be tried in low doses, but they are associated with increased risk of gastrointestinal (GI) bleeding, renal dysfunction, and cardiovascular toxicity. They should be used on a temporary basis and in low doses, as bleeding can occur in older adults even at low doses.
- *Topical NSAIDs* are generally well-tolerated because they have low systemic absorption. They are just as effective as oral NSAIDs for improving pain-related physical dysfunction at one year.
- *Tricyclic antidepressants and anticonvulsants* (e.g., gabapentin and pregabalin) are effective for treating diabetic neuropathy, but sedation limits their use. Tricyclics also have strong anticholinergic effects.
- *Serotonin and norepinephrine reuptake inhibitors (SNRIs)* (e.g., duloxetine and venlafaxine) are effective in treating both neuropathic and musculoskeletal pain. They are generally well-tolerated. The most frequent adverse effects are hyponatremia and dizziness.

Other Approaches

- *Physical therapy (PT)* is recommended for patients with persistent pain, and for acute pain to decrease the risk of developing chronic pain. PT can provide safe exercise programs, reduce musculoskeletal pain, and improve function by increasing strength and endurance.
- *Interventional pain clinics* can provide injections to affected anatomical regions, which can decrease the need for opioids and improve function.
- *Psychological Counseling*, such as acceptance and commitment therapy, also has benefit for chronic pain.

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