Pain Management for LTC Residents

ALMDA Annual Meeting
Sandestin, FL

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Objectives …

- Describe the concept of Total Pain
- Understand the pathophysiology of physical pain and sensitization to chronic pain
- Know the steps of analgesic management
- List barriers to pain management and understand the concepts of addiction, tolerance, dependence

Outline

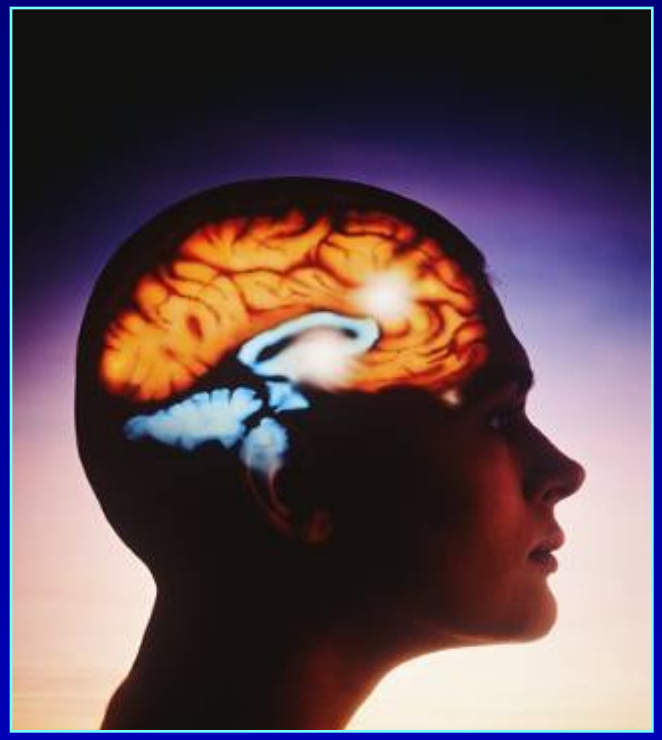
1. Pain in seniors: pathophysiology, assessment, & related management issues
2. Drug Treatment options
   - Non-opioids, Adjuvants, Opioids
3. Opioid side-effects and cautions
4. Non-pharmaceutical choices
5. Myths & Other Issues

Won't cover everything: TMM [Too Much Material]

1. Pain & Issues Affecting Mgmt

- Directed H & P
  - Look for treatable causes
  - **Severe Distress is an Emergency !!**
- Work w/ interdisciplinary team
  - symptoms are exacerbated by psychological, social, and spiritual stressors
- Communicate effectively
- Follow up: what did/did not work

What is Pain?



"Anything the patient says it is"

Pasero & McCaffery , 2011

An unpleasant sensory & emotional experience...

IASP, 1979

Common Sources of Chronic (Persistent) Pain in Older Adults

- Musculoskeletal (osteoarthritis, degenerative joint disease e.g., pain in back, hands, feet)
- Osteoporosis/compression fractures
- Peripheral vascular disease
- Neuropathies (e.g., diabetic neuropathy, post-herpetic neuralgia, post chemotherapy)
- Cancer
- Contractures
- Pressure ulcers/wounds

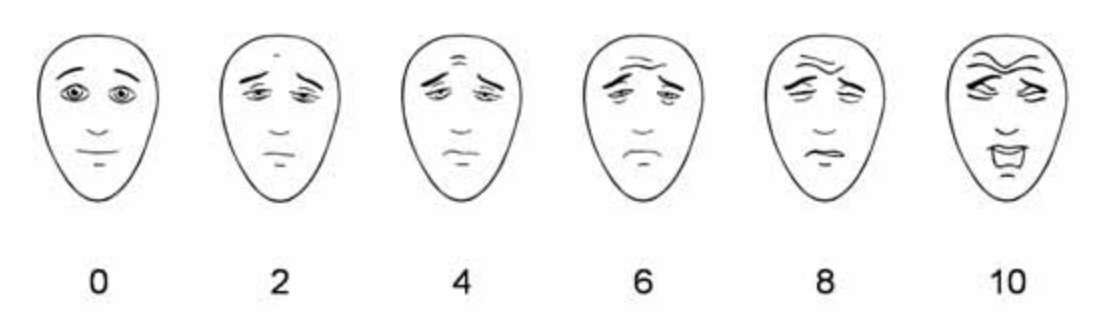
AGS, 2009; Hadjistavropolus et al., 2007; Herr, 2010

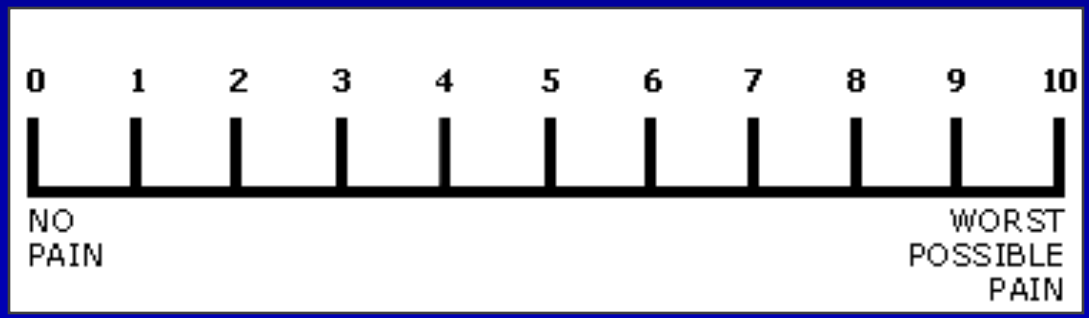
Assessing Pain: Chronic TOTAL PAIN

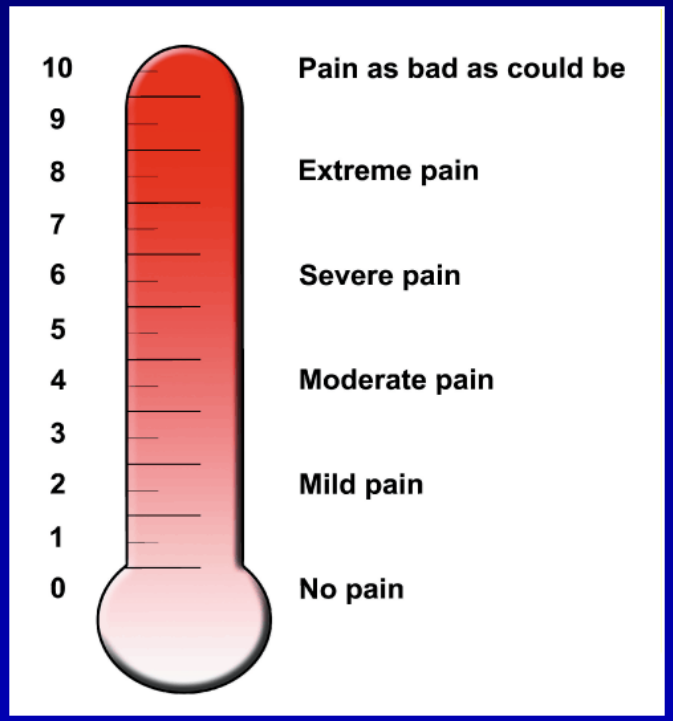
(Applies equally to any symptom assessment)

- Treat all 4 components of Total Pain
  - **P** – physical
  - **A** – anxiety, anger, depression (emotional)
  - **I** – interpersonal (social) – financial/family
  - **N** – non-acceptance of EOL (spiritual)

Pain Assessment: Intensity Tools

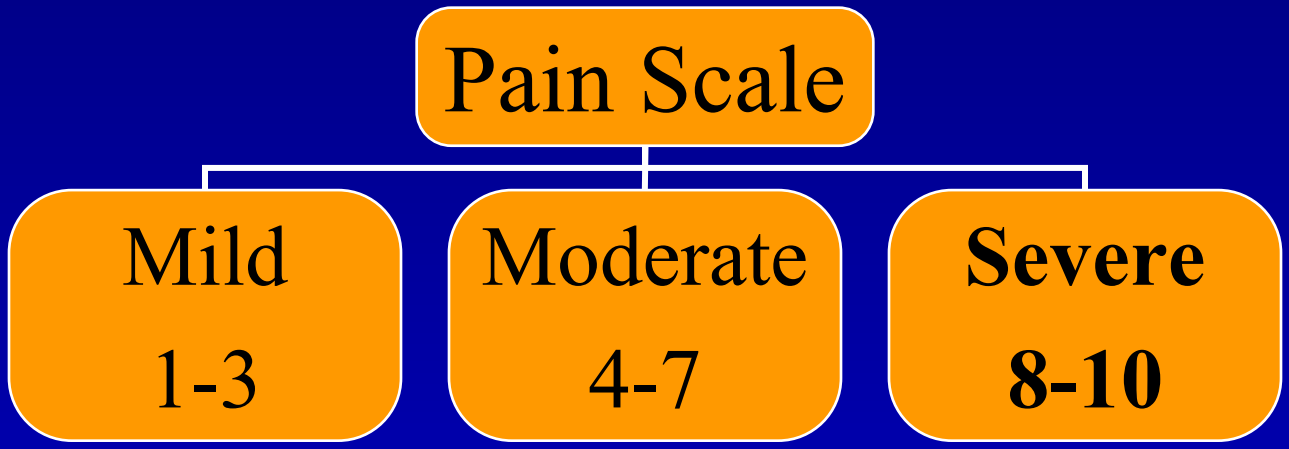






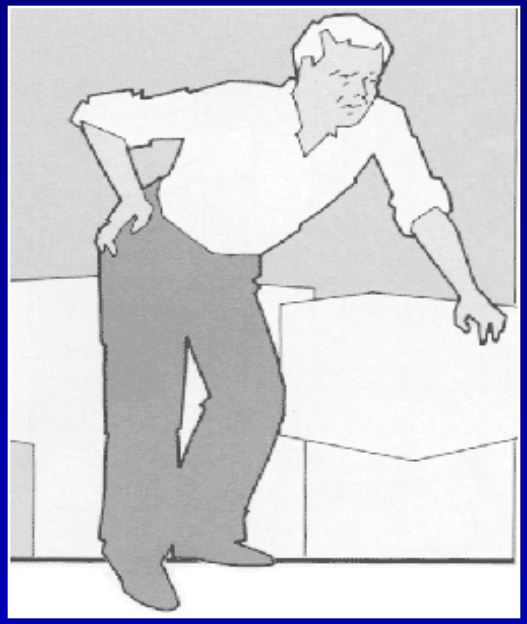
Fink & Gates, 2010; Herr et al., 2006a

Assessing Pain



Challenges: Assessing Pain in Older Adults

- Stoicism, not wanting to be a "complainer"
- Fears: procedures, side effects, addiction
- Fatalism: Pain is part of aging
- Cultural differences
- Cognitive or sensory impairments
- Depression
- Multiple causes of pain
- Concurrent illnesses
- Use of different words to describe pain, like my hip is "sore".



Challenges: Pain Assessment in Nonverbal Older Adults

- Advanced dementia
- Progressive neurological disease
- Post CVA
- Imminently dying
- Developmentally disabled
- Delirium

Differences in the Pain Experience of Older Adults with Dementia

- Dementia may alter response to acute pain
- Tolerance to acute pain possibly increases but pain threshold does not appear to change
- Cognitive impairment may decrease the perceived analgesic effectiveness
- Pain can negatively affect cognitive function

Can Older Adults with Cognitive Impairment (CI) Give Reliable Pain Reports?

- Various studies
  - CI residents slightly underreport pain, but their reports are valid
  - 83% of residents with mild to moderate CI could reliably complete at least one pain scale
  - 73% of post-op patients with moderate CI were able to complete a 4-point verbal descriptor scale

ASPMN Position Statement/Guideline

- All persons deserve prompt recognition and treatment of pain even when they cannot express their pain verbally
- Establish a pain assessment procedure
- Use Hierarchy of Pain Assessment Techniques
- **"Assume pain is present"**
- Use empirical trials
- Re-assess and document

American Society for Pain Management Nursing.

Pain Behavior Assessment Tools-for Patients Who Cannot Self Report

- CNPI -Checklist for Nonverbal Pain Indicator
- PACSLAC – Pain Assessment Checklist for Seniors with Severe Dementia
- **PAINAD** – **P**ain **A**ssessment **I**n **A**dvanced **D**ementia

  [PAINAD: score /10, 5 items – breathing, neg.vocalizations, facial movements, body lang., consolable-ity]

Behavioral/Observational Cues

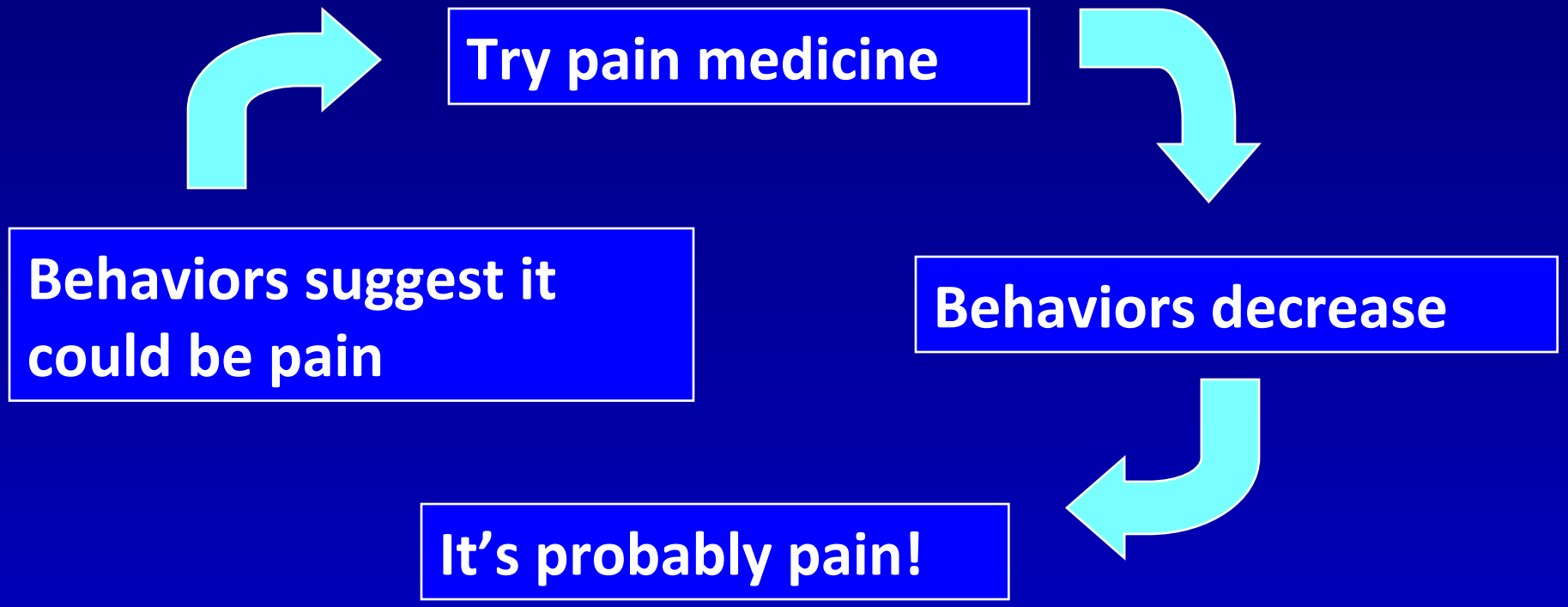
Obvious:

- **Grimacing or wincing**
- Bracing
- Guarding
- Rubbing

Less Obvious:

- Changes in activity level
- Sleeplessness, restlessness
- Resistance to movement
- Withdrawal/apathy
- Increased agitation, anger, etc.
- Decreased appetite
- Vocalizations

Analgesic/Empirical Trial in Nonverbal Older Adults for Pain Relief



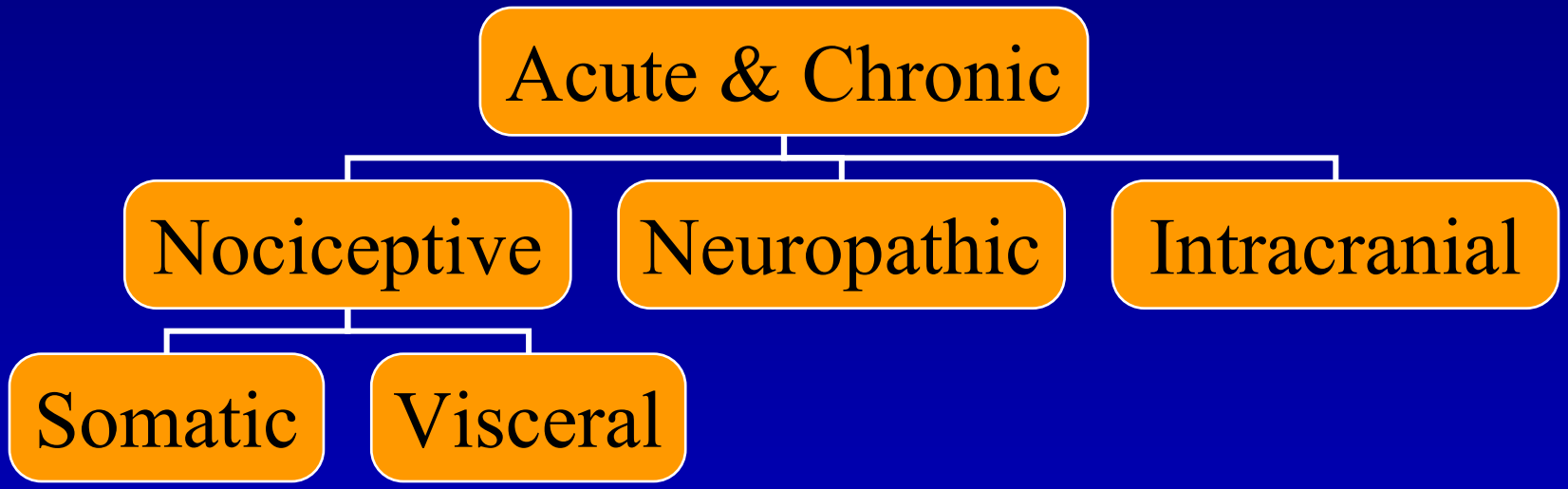
Consequences of Under Treated Pain

- Untreated pain can:
  - cause a patient's emotional and ***spiritual*** **death** long before the actual end of life,
  - result in **permanent nerve hypersensitivity**.
- Depression & Agitation/anxiety
- Sleep problems & Anorexia
- Decreased socialization/conditioning
- Therefore, **Do NOT withhold Rx waiting to identify cause !**

Pain pathophysiology

- Acute pain
  - identified event, resolves days–weeks
  - usually nociceptive
- Chronic pain
  - cause often not easily identified, multifactorial
  - indeterminate duration
  - Increased sensitization to all stimuli
    - Hyperalgesia – exaggerated response to noxious stim.
    - Hyperesthesia – exaggerated response to touch
    - Allodynia –non-nociceptive stim. perceived as painful
  - nociceptive and / or neuropathic

Types of Pain



Character/Quality of Pain

Nociceptive

- Sources: organs, bone, joint, muscle, skin, connective tissue
- Examples: arthritis, tumors, gall stones, muscle strain
- Character: dull, aching, pressure, tender
- Responds to traditional pain medicines & therapies

Neuropathic

- Source: nerve damage, e.g., peripheral nerve or CNS pathology
- Examples: postherpetic neuralgia, diabetic neuropathy, spinal stenosis, chemotherapy
- Character: shooting, burning, electric shock, tingling
- Requires different types of medications than nociceptive pain

Nociceptive pain . . .vs.

Direct stimulation of intact nociceptors*

[*group of cells that acts as a receptor for painful stimuli]

- Transmission along normal nerves
- sharp, aching, throbbing
  - somatic
    - easy to describe, localize
  - visceral
    - difficult to describe, localize

. . .*Neuropathic* pain . . .

Disordered or damaged peripheral or central nerves

- Compression, transection, infiltration, ischemia, metabolic injury
- Varied types
  - peripheral, deafferentation, complex regional syndromes

. . . Neuropathic pain

- Pain may exceed observable injury
  - E.g. diabetic neuropathy
- Described as burning, tingling, shooting, stabbing, electrical
- Management
  - opioids
  - adjuvant / co-analgesics often required

Pain assessment - duration

- Constant pain has diurnal/circadian pattern
  - Worse during night (distraction during day?)
- Incidental pain
  - Severe aggravation w/ movement
  - Short duration (seconds – minutes)
- Breakthrough pain

- Tx: try to avoid sedation threshold

2. Treatment of Chronic Pain

Principles:

- By mouth
- By the clock – not prn
- By the WHO ladder
- Individualize Rx & Monitor response
- Use Adjuvant drugs
- *For 'constant pain', need to Rx 'constantly'*
  - 10-30% pts have uncontrolled pain due to s/e
- Anticipate nausea & constipation w/ opioids

WHO Analgesic Ladder Rx

Start @ #1, push to maximum, then #2,etc.

1. Non-opioid + adjuvant
2. Mild opioid + non-opioid + adjuvant
3. Strong opioid + non-opioid + adjuvant

* Purpose of Step 2 is to go to step 3 !
* **Frail elders = start low & go slow !**

Chronic PAIN types – Rx Guide*

1. Somatic/tissue & bone
   - Opioids; Bone often needs NSAID or steroid
2. Neuropathic
   - opioid + anticonvulsant +/or TCA
3. Visceral
   - Opioid + anticholinergic

Principles of Analgesics Use in the Tx of Acute Pain and Cancer Pain. Am.Pain Soc., 1999.

Fine PG. Chronic pain management in older adults. J Pain & Symp.Management. 2009 .

Morrison LJ. Pall.care and pain mgmt. Med.Clinics North Am. 2006

Analgesic Options

- Non-opioids
  - Acetaminophen (max. 4gm/day but seniors 3gm/day)
- Adjuvants
  - NSAIDS; Steroids; benzo's; neuroleptics;
  - antidepressants; anti-convulsants
- Opioids [3 classes] [* synthetic]

1) morphine, codeine, Dilaudid*, hydrocodone, oxycodone*, tramadol [Ultram]
2) Fentanyl*, meperidine* [Demerol]
3) Methadone*, propoxyphene* [Darvon]

Hospice & PC Formulary USA 2nd Ed. 2008

Adjuvants: NSAIDs. . .

- Step 1 analgesic, co-analgesic
- If one class ineffective, change to dif. class
  - E.g. ibuprofen [Motrin] to diclofenac [Voltaren]
- Inhibit cyclo-oxygenase (COX 1 & 2) [PG's]
  - vary in COX-2 selectivity
- All have analgesic ceiling effects
  - effective for bone, inflammatory pain
  - individual variation, serial trials

…NSAID adverse effects

- Renal insufficiency & edema
  - maintain adequate hydration
  - COX-2 selection inhibitors
- Inhibition of platelet aggregation
  - assess for coagulopathy - GI Bleed
- Confusion/delirium in elders
- Avoid in DM2 and CHF – and in elders !

* Hospice & Palliative Care Formulary USA, 2nd edition. 2008

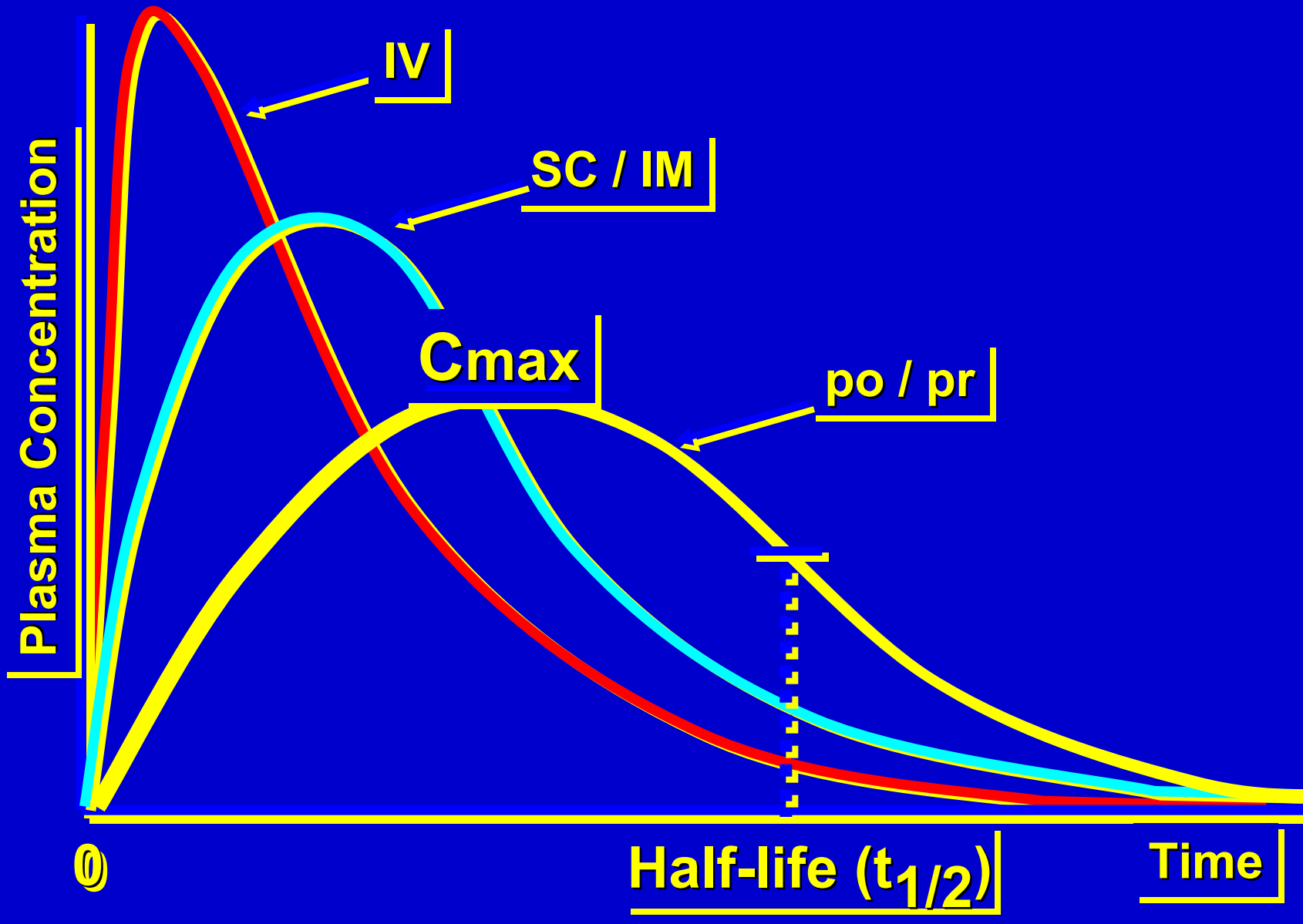
Opioids

- Preferred – **Morphine = gold standard**
  - No upper limit dosage e.g. 50mg/hr IV/SC !!
- Discouraged: Demerol
- Equianalgesic doses* (for morphine 10mg)
  - Morphine 10mg po = 3mg IV/SC [3:1]
  - Hydrocodone 10mg
  - Oxycodone 6mg
  - Dilaudid 2.5mg po = 0.5mg IV/SC [5:1]

[*Prescriber's Letter, Sept.2004. AAHPM Equianalgesic Table for Adults. 2003]

Opioid pharmacology

- Steady state after 4–5 half-lives
  - steady state after 1 day (24 hours)
- Duration of effect of "immediate-release" formulations (except methadone)
  - 3–5 hours po / pr
  - shorter with parenteral bolus


IV
SC / IM
Cmax
po / pr
Plasma Concentration
0
Half-life ($t_{1/2}$)
Time

Opioid Dosing: Routine oral
immediate-release preparations

- Codeine, hydrocodone, **morphine**, hydromorphone, oxycodone
  - dose q 4 h
  - adjust dose daily
    - mild / moderate pain ↑ 25%–50%
    - severe / uncontrolled pain ↑ 50%–100%
  - adjust more quickly for severe uncontrolled pain

Opioid Dosing: Routine oral
extended-release preparations

- Improve compliance, adherence
- No better analgesia or reduced S/E

  + 5 times more expensive in USA !
- Dose q 8, 12, or 24 h (product specific)

  –don't crush or chew tablets

  –may flush time-release granules down FT
- Adjust dose q 2–4 days (once steady state reached)

Opioids: Breakthrough dosing [BTD]

- 90% controlled w/ oral/SC opioids
- If >3 BT doses/day, increase base rate
- Use immediate-release opioids only
  - 10% of 24 hr dose q1h
    - If IV/subQ, can give ¼ of 10%, q15min prn
  - offer after Cmax reached
    - po / pr ≈ q 1 h
    - SC, IM ≈ q 20-30 min
    - IV ≈ q 10–15 min
- Do NOT use extended-release opioids for BTD

Opioids - Why not Demerol??

- Low potency – but addictive!
- Short duration
- Medical myth re pancreatitis & biliary colic
- Toxic metabolite – normeperidine
  - CNS Excitation (Serotonin) Syndrome – tremors, myoclonus, delirium, seizures

Opioids - Why not Demerol, cont'd

- Am.Pain Soc. Recommends "…meperidine should not be used >48hrs for acute pain in pts w/o renal or CNS disease, or at doses >600mg/24hrs, and should not be RX for chronic pain."
- Not recommended by any national CPG since 1990, for elders, >3days, CPS, CRI
- More hospitals removing from formulary

Also Not Recommended

- Mixed agonist-antagonists
  - Pentazocine [Talwin], butorphanol [Stadol], nalbuphine [Nubain], dezocine
    - compete with agonists → withdrawal
    - analgesic ceiling effect
    - high risk of psychotomimetic adverse effects with pentazocine, butorphanol
- Propoxyphene [Darvon] – off US formulary 2011

Pain poorly responsive to opioids

- As dose escalates → adverse effects; so…
  - more sophisticated therapy to counteract adverse effect
  - alternative
    - route of administration
    - **opioid ("opioid rotation" - <u>methadone</u>)**
  - Adjuvants
  - use a non-pharmacologic approach
  - **Look for other causes/factors**

Methadone: why it's ***better***

- Mu opioid agonist & NMDA [N-Methyl-d-Aspartate] receptor antagonist; inhibits reuptake serotonin, NE
- No active metabolites
- Better pain control than morphine, but more sedation [* do not wake to take Rx!!!*]
- Reduce risk of opioid induced neurotoxicity
- Low cost !!

[Bruera et al, 2000; Hospice & PC Formulary USA. 2nd Ed. 2008; Cleary JF. Methadone: the ideal long-acting opioid? AAHPM Bulletin, winter 2002.]

Ongoing assessment !!!

- Increase analgesics until pain relieved or adverse effects unacceptable
- Be prepared for sudden changes in pain
- BEWARE: sedation does not = analgesia !!
  - E.g. benzo's

Alternative routes…

- Transdermal Patch: Fentanyl
  - peak effect after application ≈ 24 hours
  - patch lasts 48–72 hours
  - ensure adherence to skin
  - NOT for opioid naïve !!!
  - Overrated and $$$ [$370/mo 50mcg; $750/mo 100mcg (generics ~1/2)]

FYI: Route affects Opioid Costs

- Morph.liq.20mg/ml 60mg/day = $2.40/day
- Morph.MSIR 15mg '' = $1.50/day
- Methad.liq.10mg/ml 30mg/day= $2.08/d
- Methad.tabs 10mg '' **= $ .60/d**
- Fent.patch 50mcg q3d = $5.66/d
- Duragesic 50mcg = $10.60/d
- Fentanyl buccal [Fentora 100mcg] = $20 each
- Dilaudid liq 1mg/ml 15mg/day= $4.37/d
- Dilaudid tab 2/4/8mg 16mg/day= $6.00/d
- Lorcet 10/325 qid = $1.21/d
- Morph.pump at home = $30/day pump only
- Morph.10mg/ml PLO [topical] 60mg = $5.40/day

* Avg.Retail Cost – changes !

Parenteral: Hypodermoclysis

- For subQ meds and fluids
  - continuous infusion or intermittent
  - easier to administer - more even pain control
- Fluids for rehydration – NS, D5/NS
  - Up to 125ml/hr, +/- KCl; equal absorption
- Meds = anything that can be given IV except abx and a few others [Thorazine, AED]
  - Place #23-25 butterfly access – chest best; change only if red/draining
  - Rarely need IV; **No IM injections**

- *AAHPM Bulletin, Winter 2003*

Problem: Bolus effect?

- Swings in plasma concentration cause:
  - drowsiness ½ –1 hour after ingestion, then
  - pain before next dose due
- Can move to
  - extended-release preparation, or
  - continuous SubQ, IV infusion

Changing routes of administration

- Equianalgesic table
  - guide to initial dose selection
  - Switching from po to SubQ [mostly at EOL]
- Significant *first-pass metabolism* of po / pr doses require increased po dose:
  - codeine, hydromorphone, morphine
  - po / pr to SC, IV, IM
  - 2–3 ≈ 1

Opioid Equianalgesic doses*

po / pr (mg)	Analgesic	SC / IV / IM (mg)
100	Codeine	60
15	Hydrocodone	-
4	Hydromorphone	1.5
15	Morphine	**5**
10	Oxycodone	-
150	Meperidine	40
25mcg	Fentanyl	= 50mg/day MS

Methadone – see separate formula scale.

*[*Prescriber's Letter, Sept.2004. AAHPM Equianalgesic Table for Adults. 2003]*

Case – PAIN Exercise

- Mrs. Osteoporositis – severe pain in back/hips
  = 7-8 /10 most days
- Controlled on po morphine 6mg qid + 2 doses prn/d
- **Convert to subQ at EOL to maintain comfort:**
  6mg po = ~ 2mg subQ, q4h, + 1mg q1h prn
  - **Round off**

Adjuvant analgesics

- Medications that supplement primary analgesics
  - may themselves be primary analgesics
  - use at any step of WHO ladder
  - Most helpful for bone and neuropathic pain

Neuropathic pain = Burning, tingling

- TriCyclic Antidepressants [TCA]
- Gabapentin (anticonvulsant)
- [Methadone – particularly effective opioid]
- Ketamine
- SSRIs usually not so useful
  - SNRIs better [venlafexine]

Tricyclic antidepressants for burning pain . . .

Nortriptyline > Amitriptyline

- 10–25 mg po q hs, titrate (escalate q 4–7 d)
  - analgesia in days to weeks
  - Fewer anticholinergic adverse effects, cardiac toxicity
  - Sedation helpful at hs
  - Bind plasma protein, displace morphine causing increased analgesia !

Neuropathic pain…

- Anticonvulsants
  - Gabapentin [Neurontin]
    - 100 mg po q8h, titrate up [3600mg max/d]
  - Carbamazepine [Tegretal]
    - 100 mg po bid, titrate
  - valproic acid [Depakote]
    - 250 mg po q hs, titrate

Adjuvant

…Gabapentin (Neurontin)
for burning pain

- Anticonvulsant
  - 100 mg po q d to Q8h, titrate
  - increase dose q 1–3 d
  - usual effective dose 900–1800 mg / d; max may be > 3600 mg / d
  - minimal adverse effects
    - nausea/drowsiness, tolerance develops within days
    - [also good for resistant cough & hiccups !]

Bone pain . . .

- Constant, worse with movement
- Metastases, compression or pathologic fractures
- Prostaglandins from inflammation, metastases

- Management
  - **opioids**
  - NSAIDs
  - **corticosteroids**
  - bisphosphonates
  - Calcitonin [nasal]

Adjuvant

Corticosteroids . . .

- Many uses [bone pain, nausea, appetite]
- Dexamethasone [Decadron]
  - long half-life (>36 h), dose once / day
  - Don't give later in day – insomnia inducer
  - minimal mineralocorticoid effect
  - doses of 2–20 + mg / d [wean down after 2wks]

Adjuvant

Nebulized and Sublingual Opioids

- Nebulized opioids: no advantage over IV for dyspnea or pain (except: home hospice convenience)
- Sublingual morphine
  - Morphine only 18%
  - Fentanyl 51%
  - Buprenorphine 55%
  - **Methadone 34%**
  - Oxycodone 16%

Dudgeon , 2010;
Gordon & Weissman, 2005

Topical Agents: Lidocaine Patch

- Lidocaine 5% patch, ointment
- FDA-approved for post-herpetic neuralgia
- Clinical trials show effectiveness in other neuropathic pain syndromes
- Effective adjuvant for osteoarthritis and back pain
- Local side effects: redness, edema, abnormal sensations at site

Topical Agents: Capsaicin

- Active ingredient of hot chili peppers
- Clinical trials show effectiveness for diabetic neuropathy, osteoarthritis, and rheumatoid arthritis
- Common adverse effects: burning pain at application site, sneezing and coughing
- Dosed q 6h, may take 2—4 weeks to work
- Start low: 0.025%, then 0.075% crm

3. Opioids: adverse effects & cautions

Common	Uncommon
Constipation	Bad dreams / hallucinations
Dry mouth	Dysphoria / delirium
Nausea / vomiting	Myoclonus / seizures
Sedation	Pruritus / urticaria
Sweats	Respiratory depression
	Urinary retention

Opioid: allergy?

- Nausea / vomiting, constipation, drowsiness, confusion
  - adverse effects, not allergic reactions
- Anaphylactic reactions are the only true allergies
  - bronchospasm
- Urticaria, bronchospasm can be allergies; need careful assessment

…Opioid: Urticaria, pruritus

- Mast cell destabilization by morphine, hydromorphone
- Treat with routine long-acting, nonsedating antihistamines
  - fexofenadine, 60 mg po bid, or
  - Loratadine [Claritin]
- Sedating antihistamines or doxepin if sleep desired

Opioid: Constipation . . .

- Common to all opioids
- Opioid effects on CNS, spinal cord, myenteric plexus of gut
- Easier to prevent than treat
- Goal: have bm QOD – Q3days

…Constipation

- Prokinetic agent - Metoclopramide [Reglan]
- Osmotic laxative
  - MOM, lactulose, sorbitol,
  - Miralax 17-68gm/250ml water
- Bulk forming agents **not** recommended
  - E.g. metamucil
- Stimulant laxative
  - **senna**, bisacodyl, glycerine, casanthranol, etc
- Stool softener [docusate] rarely helpful !
  - No benefit to Senna-S !

Opioid: Nausea / vomiting

- Onset with start of opioids
  - tolerance develops within days
- Prevent or treat with dopamine-blocking antiemetics
  - Prochlorperazine [Compazine], 10 mg q 6 h
  - Haloperidol [Haldol], 1 mg q 6 h !
  - Metoclopramide [Reglan], 10 mg q 6 h

Opioid: Sedation . . .

- Onset with start of opioids
  - distinguish from exhaustion due to pain !!
    - May sleep most of first day
  - tolerance develops within days
- If persistent, alternative opioid or route of administration
- Psychostimulants may be useful
  - Methylphenidate [Ritalin], 2.5 mg q am and q noon, titrate

Opioid: Delirium

- Presentation – hyper/hypo/mixed
  - confusion, bad dreams, hallucinations
  - Inattentiveness – fluctuating !!
  - restlessness, agitation, depressed LOC
  - myoclonic jerks, seizures
  - respiratory depression

  Treatment: rotate opioids v. Haldol

  - melatonin qhs [prevents and reduces delirium]

Opioid: Respiratory depression . . .

- Opioid effects differ for patients treated for pain
  - pain is a potent stimulus to breathe
  - loss of consciousness precedes respiratory depression
  - pharmacologic tolerance rapid

. . . Respiratory depression

- Management
  - identify, treat contributing causes
    - reduce opioid dose
    - observe
  - if unstable vital signs
  - naloxone [Narcan], 0.1-0.2 mg subQ q 5 min
    - Small dose – don't want to reverse all analgesia

4. Nonpharmacologic Mgmt of Pain

- Psychological approaches
  - cognitive therapies (relaxation, imagery, hypnosis)
  - Biofeedback & behavior therapy, psychotherapy
- Physical therapy - exercise, heat, cold
- Neurostimulation - TENS, acupuncture
- Complementary therapies
  - Massage; 'distraction'
  - art, music, aroma therapy
  - Comfort foods !

…Non-Drug Techniques

Physical

- **Distraction**
- Massage
- Cold
- Heat
- Vibration
- Positioning
- Exercise

Psychological

- **Distraction**
- Relaxation
- Music
- Comfort Foods
- Imagery
- Controlled Breathing

Distraction: Visual & Physical

1) Visual - pictures used to focus attention on something other than pain. By decreasing concentration on pain, it becomes more bearable.
   - Have patient describe picture by:
     - Talking about the picture
     - Pretending they are in the picture
     - Telling a story about the picture
   - Choose a new picture as soon as their interest decreases in the current one

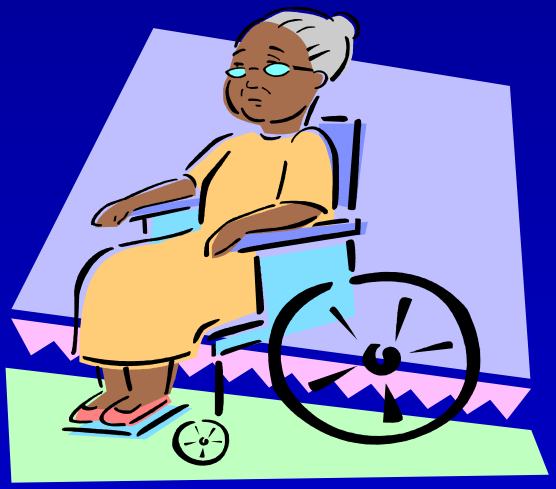
2) **Physical - Use topical mentholated rubs**

5. Barriers, Myths & Other Issues

Myth	Reality
If people can be distracted from their pain, the pain isn't "real" or it's not as bad as they are saying.	People can be distracted from pain because distraction is an effective nondrug therapy

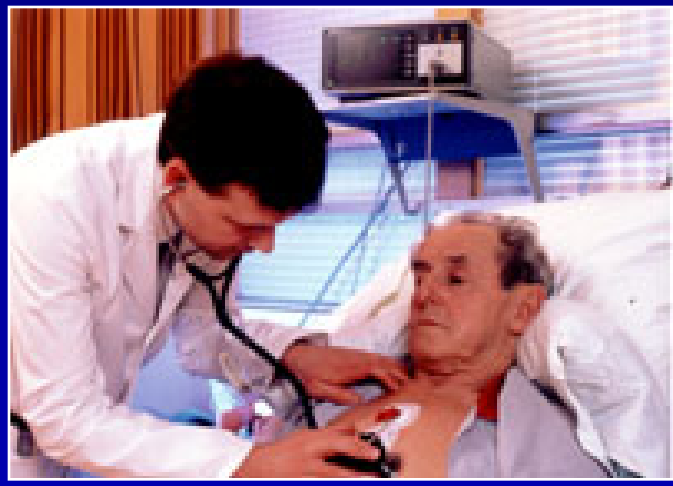
More Myths About Pain in Older Adults

- Pain is a natural part of growing old.
- Older people are less sensitive to pain.
- If an older person doesn't report pain, that person doesn't have pain.
- If a person can sleep or be distracted from pain, that person doesn't really have pain.



…Myths About Pain in the Older Adult

- Strong pain medicine, like morphine, can't be used safely for the older adult because they are too sensitive to dangerous side effects.
- People who use morphine-like drugs become addicted to them.



…More Myths About Pain in Older Adults

- People with dementia and other brain conditions don't feel pain.
- People with dementia and other brain conditions can't reliably report their pain.

Addiction + . . .

- Psychological dependence
- Compulsive use: behavioral !
- Loss of control over drugs w/ continued use of drugs in spite of harm
- Loss of interest in pleasurable activities
- A rare outcome of pain management
  - particularly, if no history of substance abuse

. . . Addiction

- Consider
  - substance use (true addiction)
  - pseudoaddiction (under treatment of pain)
  - behavioral / family / psychological disorder
  - drug diversion

Tolerance

- Reduced effectiveness to a given dose over time
- 9 different mu receptors
  - opioids bind in different proportion often leading to tolerance to one opioid
  - rotating opioids helps treat tolerance
- Usually not clinically significant with chronic dosing
- If dose increasing, suspect disease progression

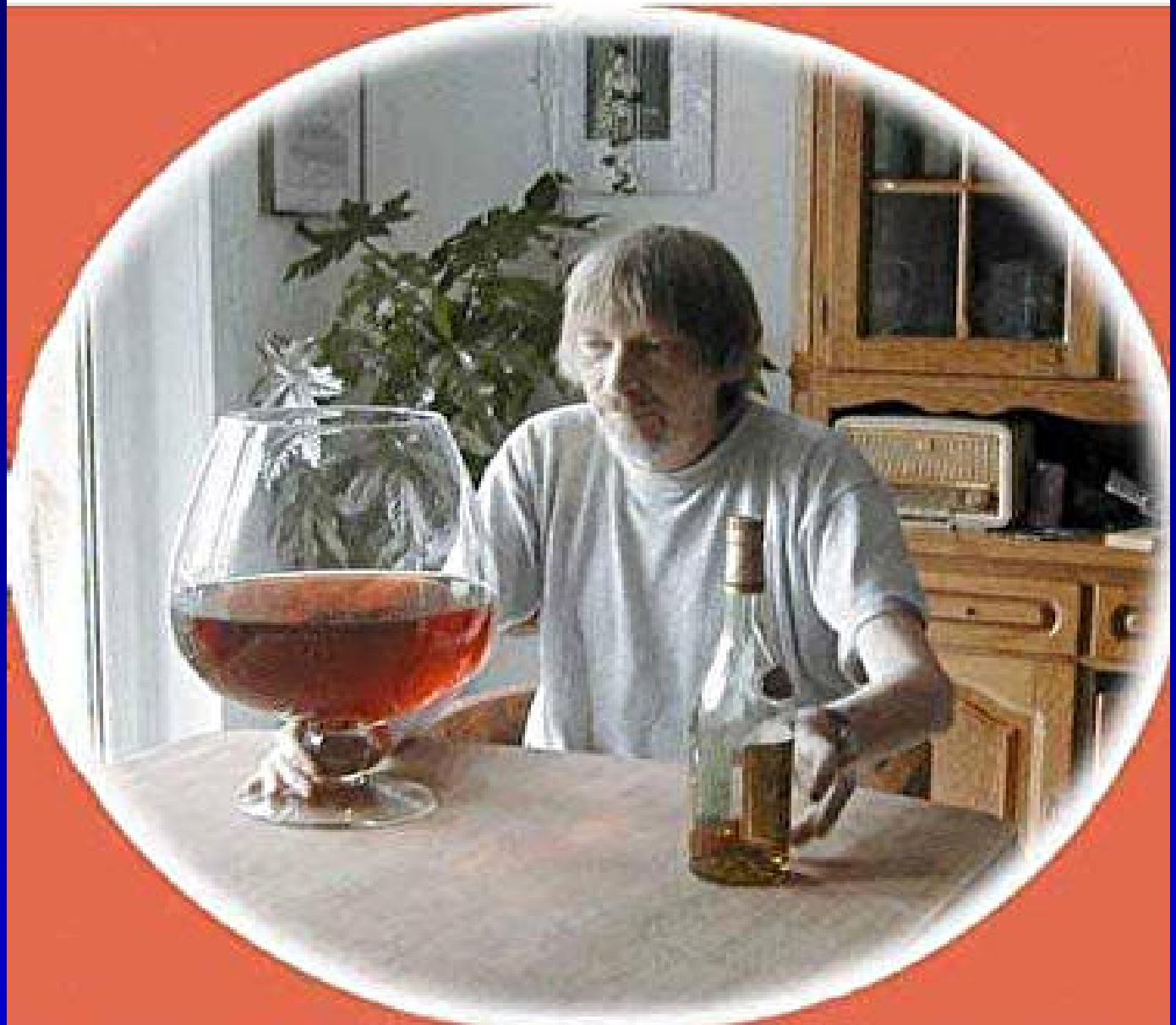
Physical dependence

- A physiologic process of neuroadaptation
  - Explain every body develops dependence when taking scheduled drugs – e.g. BBlockers
- Abrupt withdrawal may → abstinence syndrome
- If dose reduction required, reduce by 50% q 2–3 days
  - avoid antagonists

Chronic Pain Syndrome [CPS]

- Substance users & CPS have pain!
- Chronic Pain Syndrome?
  - Pain history NB
  - CAGE score 2+ = poor pain control
- Treat with compassion
- Protocols, contracting
- Be honest: ***will always have some pain***; concept of "Total Pain"

My Doctor said "Only 1 glass of alcohol a day". I can live with that.



Barriers to pain control . . .

- "Not important"
- Poor assessment
- Lack of knowledge
- Fear of [by pt/family/MD/RN !]
  - addiction
  - tolerance
  - adverse effects

. . . Barriers

- Regulatory oversight !!! [#?$@#%]
- Patients unwilling to report pain
- Patients unwilling to take medicine
  - *"I can't take morphine; the last time I did, it gave me rigor mortis"!!*

Pain Management Associated Problems – Mrs. Osteoporositis

- NB to document doses and responses !!!
- Started on morphine po 3mg bid & hs (8/10)
  - Compazine 5mg po q8h & senokot 10mg qhs [anticipatory - reduce or wean off compazine after a week]
- Added Motrin 400mg q8h [+ Pepcid 10mg qhs]
- Pain still 5/10, & not sleeping; (goal=3/10)
  - **Add nortriptyline 25mg hs = slept and 3/10**
  - **After 1-2wks, wean off Motrin if possible**

Summary & Pearls

- Severe pain is an EMERGENCY !
- “Total Pain” concept of tx
- No Demerol for Chronic Pain
- Scheduled Tx – Morphine = Gold Std.
  - Start low, go slow !
- Methadone good option
- Anticipate S/E of constipation, nausea
- Use SubQ route & NO IM’s

“Growin’ old ain’t for sissies”

- Bette Davis

THANK YOU !