The Conundrum of Treating Chronic Pain in Older Adults

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Introduction

The recent release of CDC guidelines for managing chronic pain may create a challenge for those treating older adults who have been maintained on stable doses of opioids for months or years. Clinicians will need to balance concerns about the potential harms of unrelieved pain, with the potential harms of initiating or continuing opioids. According to these guidelines, opioid therapy should be tapered and stopped in patients who do not continue to sustain a 30% reduction in both pain intensity and disability. To date, no available treatment has been shown to yield these sustainable effects in older adults. Intense or prolonged exposure to pain creates degenerative changes throughout the nervous system, which intensifies, prolongs and spreads it [1,2]. The loss of brain gray matter with persistent pain greatly outpaces that seen with normal aging in patients with persistent pain [3-5]. Emerging research suggests this loss may be partially reversible with effective treatment [6-8].

Persistent severe pain in older adults has been linked to a loss of retirement savings and increasing frailty [9-11]. Patients with persistent severe pain are significantly more likely to attempt suicide than those without pain. In particular, pain intensity, mental defeat, functional limitations, and being perceived as a burden to others is strongly associated with suicidal ideation and attempts [12-14]. Even after controlling for life-limiting diseases, those with severe chronic pain die at a 50% higher rate (especially from cardiovascular events) over 10 years than those without pain [15]. Thus it is currently unclear what is a greater threat to the health and longevity of older adults: severe, persistent pain or the medications used to treat it. Regardless of age, patients with a substance use disorder have a 2-4 higher prevalence of overdoses than those without this risk factor, and it is unclear what percentage of these deaths are intentional versus unintentional [16]. Although most of the addiction and overdose deaths that gave rise to the attention paid to the opioid crisis occur at a younger age; older adults are also vulnerable to these problems [17,18]. Yet non-opioid pharmacologic therapies, particularly in older patients, and those with certain co-morbidities such as cardiovascular, renal, gastrointestinal, and liver disease also raise the risk of unintentional poisonings or death [16,19].

The CDC guidelines call for opioids to be used after non-opioids and non-drug therapies have failed [16]. For older adults, opioids have until recently been considered second-line for chronic pain after acetaminophen and/or adjuvant drugs fail [20]. Acetaminophen has either not been studied, or is ineffective in treating the most common painful conditions affecting older adults [21-23]. Common adjuvant drugs (e.g. anticonvulsants, antidepressants) can require sequential trials lasting several weeks or months to achieve therapeutic doses in older adults; often hampered by adverse effects such as sedation, dizziness and impaired age-related renal function [16,24]. Unfortunately, these adjuvants work in fewer than a third of cases [23,25] and should be avoided in older adults with a history of certain illnesses, past falls or fractures [26]. Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) should not be used chronically unless alternatives fail to be effective; and gastroprotection is used [20,26]. However, a history of cardiovascular, gastrointestinal or kidney disease precludes the use of NSAIDs and proton pump inhibitor gastroprotection can be hazardous for older adults [26]. Nondrug treatments including chronic pain programs have emerged as promising therapeutic options to help older adults better function and cope despite the persistence of pain. These approaches are limited by program heterogeneity, accessibility, attrition and difficulty sustaining modest therapeutic gains [27-33]. Internet, smart phone and/or tablet computer technologies are being introduced to address barriers and enhance treatment effects with the potential to transform the way chronic pain is understood and managed by patients [34-38]. These are increasingly viable ways to engage older adults in therapy that has traditionally been difficult for them to benefit from by overcoming transportation, cost and other barriers to access in this population [39-41]. Continued development of safer, effective treatments and our system of providing pain relief to older adults is needed because continuing to ignore the harmful effects of severe persistent pain is unconscionable [42,43]. Paul Arnstein, RN, PhD, FAAN is a Clinical Nurse Specialist for Pain Relief at Massachusetts General Hospital in Boston Massachusetts; a Mayday Pain and Society Fellow; and a contributor to the National Pain Strategy. He wishes to acknowledge the Connell Nursing Research Scholar program that has supported his investigation of Technology-assisted Pain Relief Programs for older adults.

Abstract:

Despite remarkable advances in healthcare, chronic pain afflicting millions of older adults remains poorly treated. Intense or prolonged exposure to pain creates degenerative changes throughout the nervous system, which intensifies, prolongs and spreads it. The loss of brain gray matter with persistent pain greatly outpaces that seen with normal aging and can explain the learning, memory and emotional difficulties experienced. This loss can be partially reversed with effective treatment.

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