Pain Management and EOL Care in the Older Adult

Bonnie Freeman DNP, RN, ANP, ACHPN
Supportive Care Medicine NP
City of Hope

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Objectives

- Increase understanding of the specific pain management needs of the aging.
- Identify common cultural and social barriers to effective pain management in the older adult.
- Emphasize the importance of a focus on safety when prescribing pain medication for the older adult.
- Identify most common management needs of the dying older adult.

“ Persistent pain in older adults, particularly those who are frail or who have dementing illness, is at best under diagnosed and undertreated and, at worst, ignored.”

Weiner, Herr, & Rudy, 2002, p. 5

“The effects of aging on pain are less important than the effects of pain on aging.”

Weiner, Herr, & Rudy, 2002, p. 6

Pain Management in the Older Adult

- If left uncontrolled can:
  - Cause hypertension and tachycardia
  - Postpone healing
  - Cause respiratory complications
  - Increase confusion and restlessness
  - Root cause of delirium
  - Increase depression
  - Reduce peristalsis
  - Increase cortisol levels
  - Decreased socialization
  - Impacts QOL

Herr& Arnstein, 2016; Pasero & McCaffery, 2011; Mattson Porth, 2011

Pain Management Concerns for the Older Adult

- By 2030, 1 in 5 (20%) of our population will be over 65.
- After age 75, illness, mortality and social problems rise rapidly.
- Stoicism, and not wanting to complain.
- Belief that pain is a part of aging.
- Had pain so long think its normal.
- Cognitive and sensory impairment increases with pain.

Bruckenthal, Marino, & Snelling, 2016; Pasero & McCaffery, 2011

Geriatric patients commonly have:

- Multiple co-morbidities
- A variety of meds that can interact with opioids
- Altered metabolism and organ impairment
- Reduced ability to achieve homeostasis
- Altered pain perceptions
- Reduced ability to care for themselves
- Loss of muscle tone and strength

Fishman, Ballantyne, & Rathmell, 2010; McCleane & Smith, 2006

Common Sources of Pain in the Older Adult

- Musculoskeletal:
  - Arthritis, inflammation degenerative discs, ischemia, surgery, trauma, fibromyalgia, and vertebral compressions.
- Neuropathic:
  - Diabetic neuropathies, phantom limb pain, post CVA, and post-herpetic neuralgia.
- Osteoporosis, compression fractures, osseous fx.
- Pressure ulcers/wounds.

McCleane & Smith, 2006; Pasero & McCaffery, 2011

Drugs based on Assessment

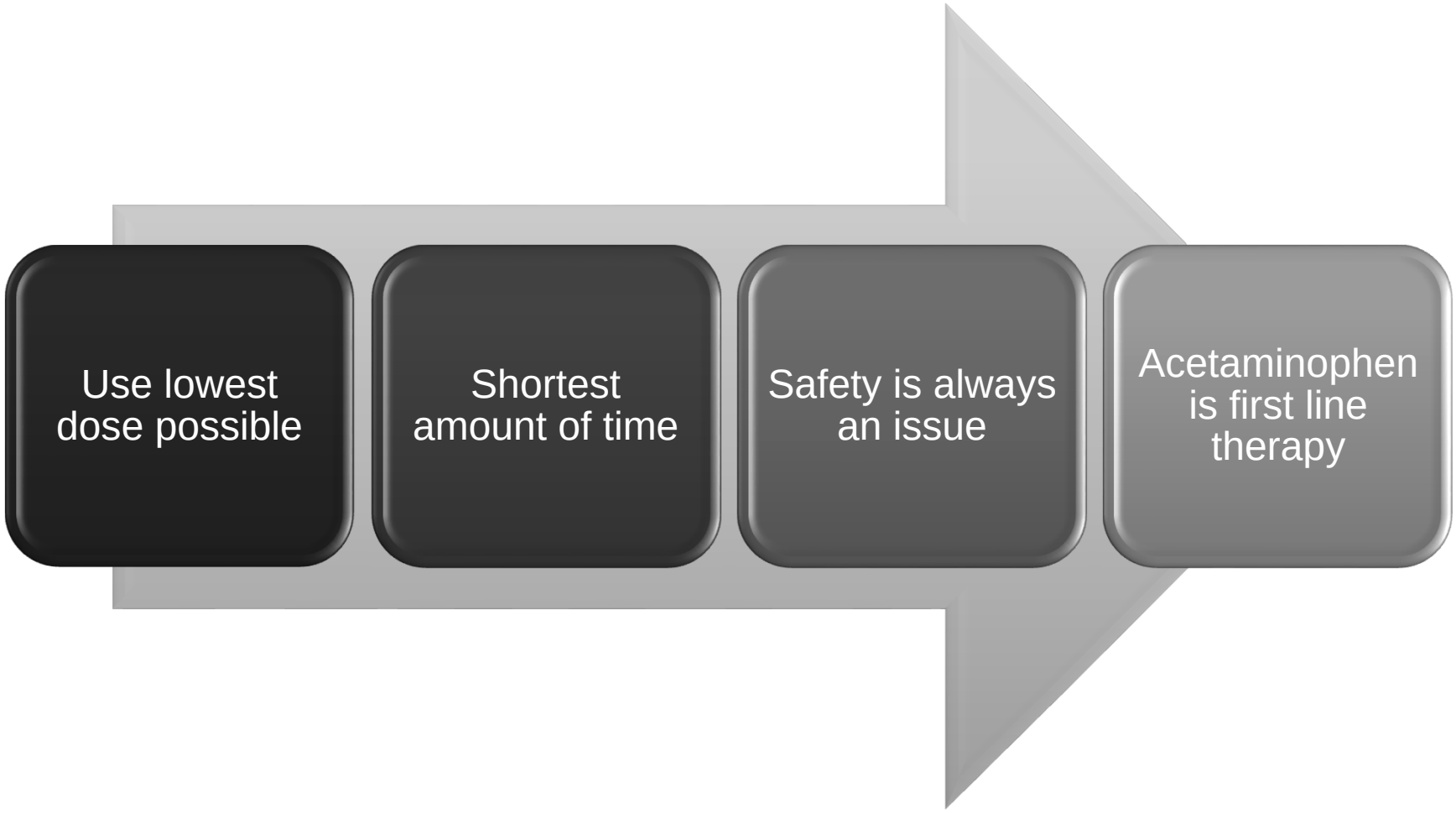
- Bone pain
  - Steroids
  - Antinflammatories
- Nociceptive (Somatic and Visceral)
  - Antinflammatories
  - Adjuvants
  - Opioids
  - Steroids
- Neuropathic
  - Like nociceptive management
  - Need long term and breakthrough management
  - Need Mu and NMDA receptor agonists

McCleane & Smith, 2006; Pasero & McCaffery, 2011

Adjuvant Therapies

- Nortriptyline (Pamelor)
- Gabapentin (Neurontin)
- Pregabalin (Lyrica)
- Duloxetine (Cymbalta)
- Venlafaxine (Effexor)
- Steroids (Dexamethasone)

PEARLS



McCleane & Smith, 2006; Pasero & McCaffery, 2011

Pain Management in the Older Adult

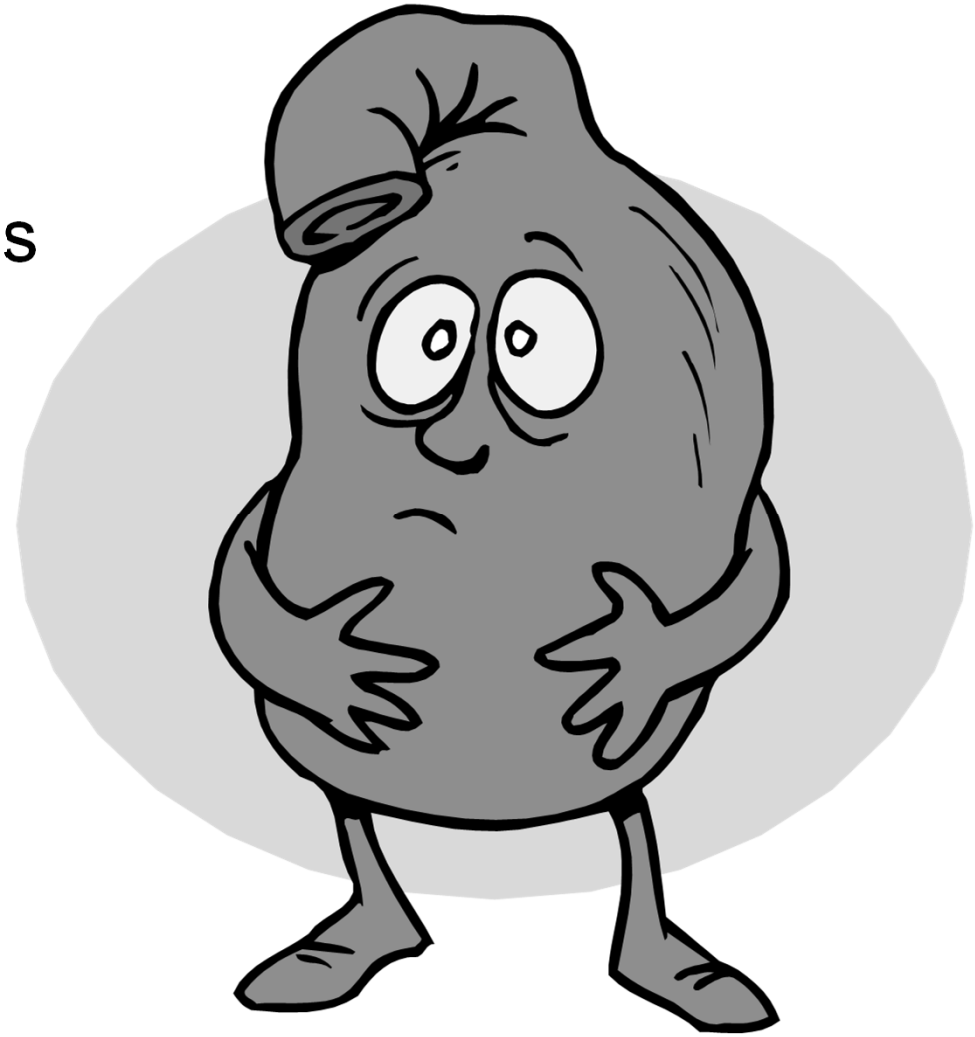
Considerations:

- Reduce opioid dosage with renal failure.
- Consider ability to follow directions for medications.
- Polypharmacy is a concern.
- More prone to side effects.
- Fears of addiction.
- Fears of worsening disease.
- Vision difficulties and fall prevention.
- Supervision and/or help.
- Preserving independence and dignity.

Pasero & McCaffery, 2011

Side Effects

- GI
  - Reduced peristalsis
  - Ileus
  - GI bleeding
  - Nausea/vomiting
  - Loss of appetite



Pasero & McCaffery, 2011

Confusion/ Disorientation

Pasero & McCaffery, 2011

Constipation

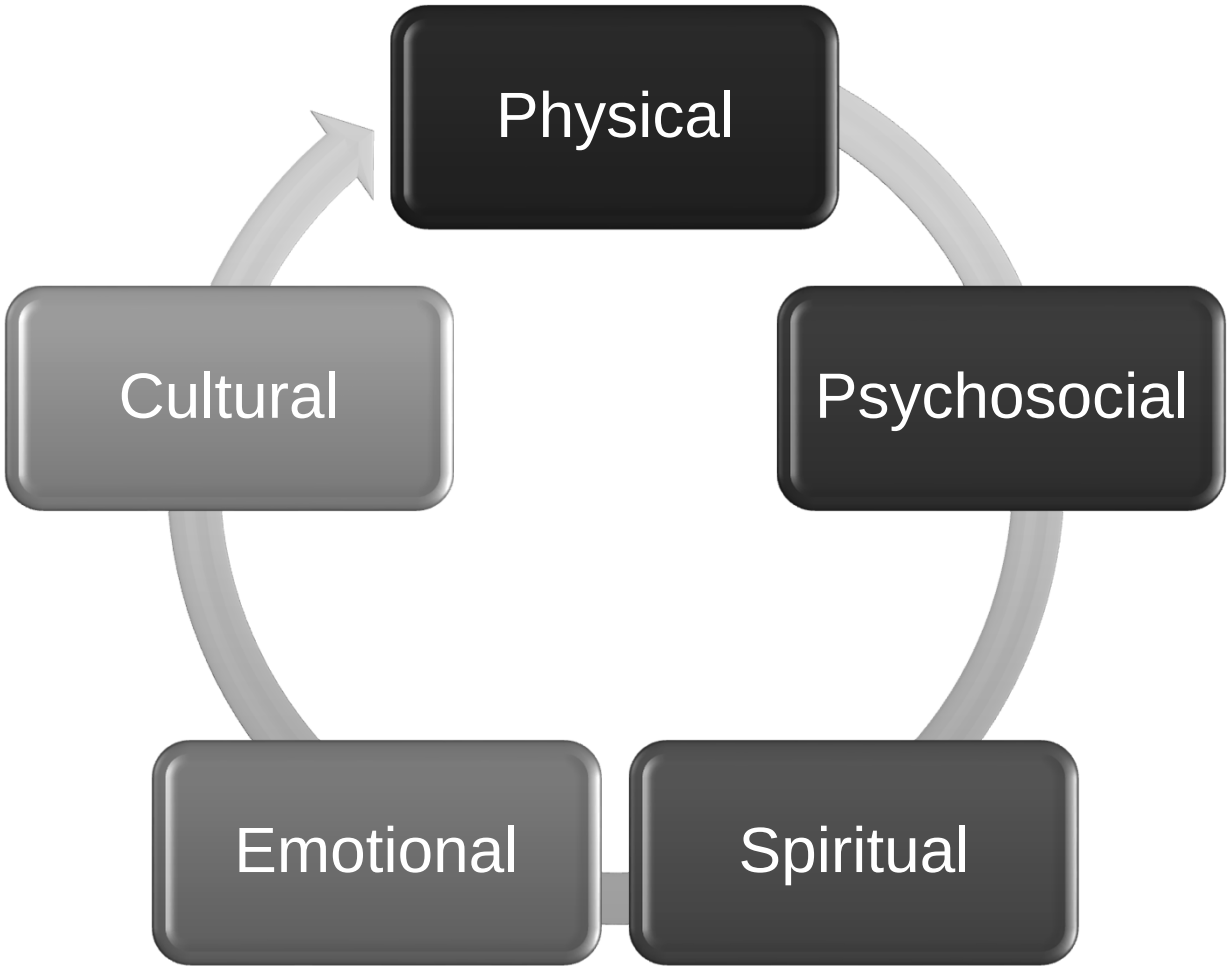
Pasero & McCaffery, 2011

Check List for Older Adult Opioid Dosing

1. Is the use of a strong opioid the best treatment?
2. Will this opioid interact with other medication?
3. Can other agents help reduce the dose ?
4. Can the risk of opioid tolerance be minimized ?
5. What can be done to minimize side effects?
6. Which route is most appropriate?
7. What dose will be initiated?
8. How long is the treatment?
9. Will dose escalation be a concern?
10. Will limitations on dosage be required?
11. How will effectiveness be measured?

McCleane & Smith, 2006

Holistic Pain Management



Pasero & McCaffery, 2011

Alternative Pain Management

- Diversion/distraction
- Aromatherapy
- Exercise, yoga,
- Acupuncture
- PT/OT
- Meditation, CBT,
- Deep breathing
- SC nerve stimulators
- Massage
- IT pain pumps

Bruckenthal, Marino, & Snelling, 2016: & Fishman, Ballantyne, & Rathmell, 2010

Pain Management for the Terminally ill and Dying Older Adult

- Focus is no longer curative.
- Care must be personalized and based on desired quality of life.
- Consider:
  - Hepatic and renal function
  - Opioid tolerance
  - Psycho-social concerns
  - Cognitive function

Byock, 2012, & Freeman, 2015

Common Symptom Management needs of the Dying

- **C**omfort
- **A**irway
- **R**estlessness and delirium
- **E**motional and spiritual
- **S**elf-Care

Freeman, 2013

Comfort

- Concept of intent
- There will always be a last dose
- Remember they are terminally ill
- Educate about normal dying process
  - Fluids
  - Food
- Provide time for closure

Ferrell & Coyle, & 2010; Freeman, 2015

Airway

- Suffering vs normal dying process.
- Morphine is the gold standard
- Control death rattle
- Focus shifts to family
- Emphasize use of touch.

Freeman, 2015

Restlessness and Delirium

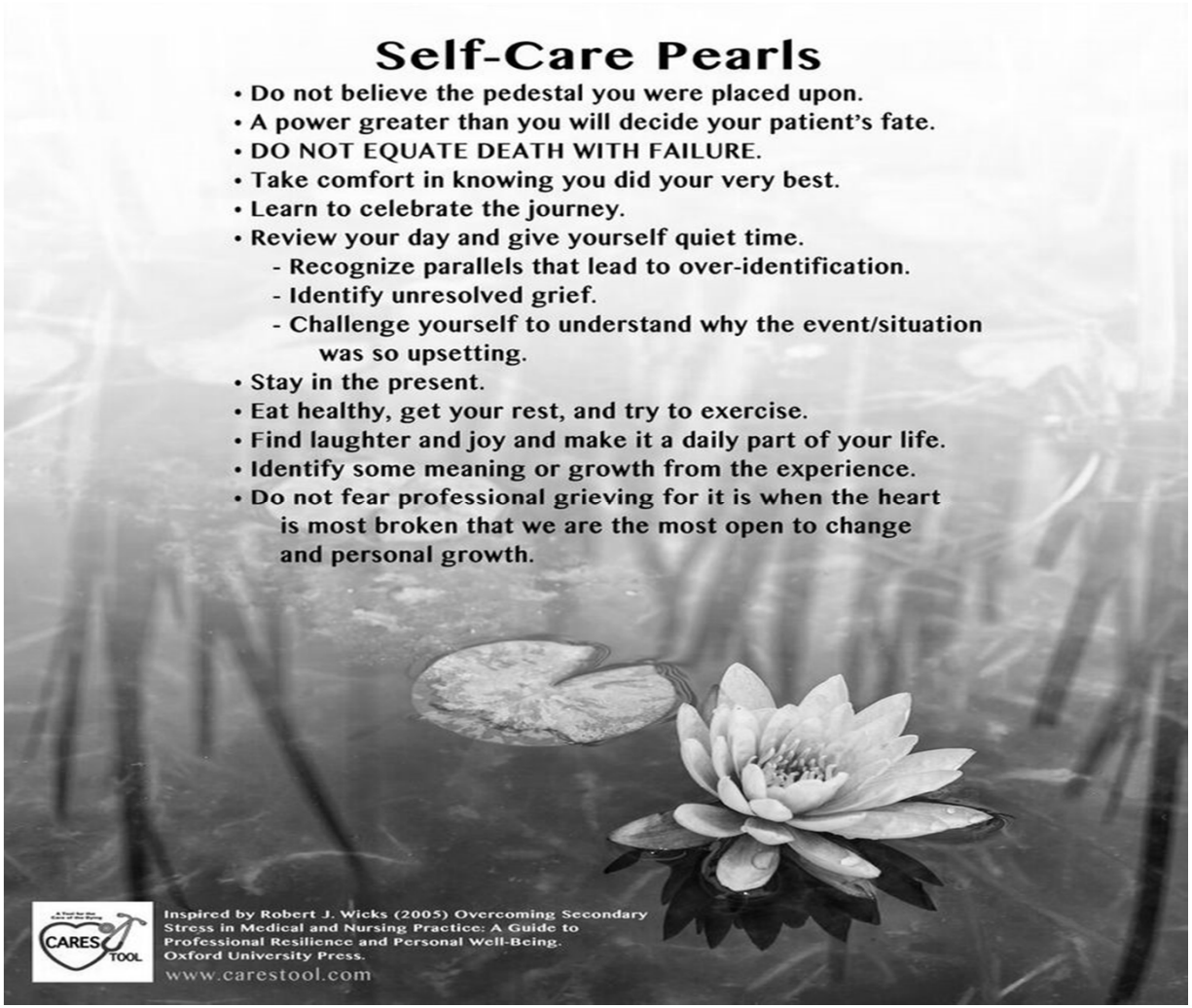
- Most common causes:
  - Pain
  - Bladder distention
  - Polypharmacy
  - Circulating toxins
  - Unfinished business
  - Anxiety
  - Cellular death

Emotional and Spiritual Support

- May need permission to let go.
- Familiar music, smells, and voices
- Need to feel valued, loved, and respected.
- Always work to preserve dignity
- Assist with closure
- Insure clear communication between all parties

Freeman, 2015; & Pulchalski & Ferrell, 2010

Self-Care


Self-Care Pearls
• Do not believe the pedestal you were placed upon.
• A power greater than you will decide your patient's fate.
• DO NOT EQUATE DEATH WITH FAILURE.
• Take comfort in knowing you did your very best.
• Learn to celebrate the journey.
• Review your day and give yourself quiet time.
- Recognize parallels that lead to over-identification.
- Identify unresolved grief.
- Challenge yourself to understand why the event/situation was so upsetting.
• Stay in the present.
• Eat healthy, get your rest, and try to exercise.
• Find laughter and joy and make it a daily part of your life.
• Identify some meaning or growth from the experience.
• Do not fear professional grieving for it is when the heart is most broken that we are the most open to change and personal growth.
CARES TOOL
Inspired by Robert J. Wicks (2005) Overcoming Secondary Stress in Medical and Nursing Practice: A Guide to Professional Resilience and Personal Well-Being. Oxford University Press.
www.carestool.com

“Its All About the Journey.”

- Be pro-active and anticipate.
- Request a Palliative Care consult.
- Celebrate the person- they are not their disease.
- Nurses cannot change the fact their patient will die but they have **everything** to say about the journey.