

# PAIN CONTROL AND OPIOID USE IN GERIATRIC POPULATIONS

## OVERVIEW



Chronic pain is present in **25-50% of older** adults and increases with age.

## SCREENING

Be suspicious of increases in pain above baseline as pathologic pain promoters are much more likely with advanced age.



Utilize similar screening tools for general **screening, addiction risk, opiate withdrawal, ongoing assessment and monitoring.**



**Co-occurring Mental Health Conditions and Sleep:**



Geriatric Depression Scale (GDS)



GAD-7 Anxiety



PC-PTSD



SLUMS



MoCA



STOP-Bang Questionnaire (OSA)

**Dementia Pain Scale**  
**PAINAD**

## GENERAL CONSIDERATIONS

If giving opioids draft a safety plan for safe storage and administration

Stay with the least complicated regimen

Think about respiratory risk (COPD) and sleep apnea before prescribing opioids

Always co-prescribe Naloxone with opioids

Follow universal precautions outlined in the life saver steps

## TREATMENTS

**Treatable not curable.**

**Set realistic goals with patients**

- Improvement versus zero pain
- Functionality versus zero pain



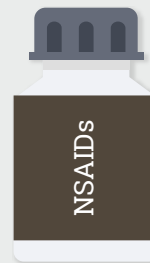
**Use modalities other than medication:**

PT, OT, CBT, biofeedback, meditation, sleep restoration, nutrition, stress reduction, massage, acupuncture, music, movement, etc.

## NON-OPIOIDS

Preferred over opioids

Acetaminophen 1st line treatment for mild chronic pain.



Start low and go slow

No greater than two weeks of use

Tailor to cardiac and GI risks

Prescribe gastro-protective agent

Antidepressants used for pain in elderly all have increased side effects



SSRIs & SNRIs best for neuropathic pain



TCAs-Use caution associated with cardiac risks

## Anticonvulsants

Little utility due to side effects and risks

Transdermal lidocaine-useful to treat neuropathic and localized nociceptive pain

## OPIOID

Geriatric patients are more sensitive to the effects of opioids.

Start low-Use 30-50% of recommended doses and titrate slowly (no more than 25% increases)

Opioids can cause mental clouding

Use for short durations, no greater than 7 days

To avoid opioid constipation, use prophylactic laxative therapy

Risk for Falls-Avoid prescribing opioids



**Medicated Assisted Therapy for Opioid Use Disorder** Avoid Methadone. Buprenorphine acceptable

