

Pharmacological Management of Persistent Pain in Older Persons

AGS Panel on Pharmacological Management of Persistent Pain in Older Persons

Guideline Recommendations

Non-Opioids

I. Acetaminophen should be considered as initial and ongoing pharmacotherapy in the treatment of persistent pain, particularly musculoskeletal pain, owing to its demonstrated effectiveness and good safety profile. **(high quality of evidence; strong recommendation)**

A. Absolute contraindications: liver failure **(high quality of evidence, strong recommendation)**

B. Relative contraindications and cautions: hepatic insufficiency, chronic alcohol abuse/dependence **(moderate quality of evidence, strong recommendation)**

C. Maximum daily recommended dosages of 4 gm per 24 hours should not be exceeded and must include “hidden sources” such as from combination pills. **(moderate quality of evidence, strong recommendation)**

II. Nonselective NSAIDs and COX-2 selective inhibitors may be considered rarely, and with extreme caution, in highly selected individuals. **(high quality of evidence, strong recommendation)**

A. Patient selection: other (safer) therapies have failed; evidence of continuing therapeutic goals not met; ongoing assessment of risks/complications outweighed by therapeutic benefits. **(low quality of evidence, strong recommendation)**

B. Absolute contraindications: current active peptic ulcer disease (**low quality of evidence, strong recommendation**), chronic kidney disease (**moderate level of evidence, strong recommendation**), heart failure (**moderate level of evidence, weak recommendation**).

C. Relative contraindications and cautions: hypertension, *H. pylori*, history of peptic ulcer disease, concomitant use of corticosteroids or SSRIs (**moderate quality of evidence, strong recommendation**)

III. Older persons taking nonselective NSAIDs should use a proton pump inhibitor or misoprostol for gastrointestinal protection. (**high quality of evidence, strong recommendation**)

IV. Patients taking a COX-2 selective inhibitor with aspirin should use a proton pump inhibitor or misoprostol for gastrointestinal protection. (**high quality of evidence, strong recommendation**)

V. Patients should not take more than one nonselective NSAID/COX-2 selective inhibitor for pain control. (**low quality of evidence, strong recommendation**)

VI. Patients taking ASA for cardioprophylaxis should not use ibuprofen. (**moderate quality of evidence, weak recommendation**)

VII. All patients taking nonselective NSAIDs and COX-2 selective inhibitors should be routinely assessed for gastrointestinal and renal toxicity, hypertension, heart failure, and other drug-drug and drug-disease interactions. (**weak quality of evidence, strong recommendation**)

Opioids

VIII. All patients with moderate-severe pain, pain-related functional impairment or diminished quality of life due to pain should be considered for opioid therapy.

(low quality of evidence, strong recommendation)

IX. Patients with frequent or continuous pain on a daily basis may be treated with ATC time-contingent dosing aimed at achieving steady state opioid therapy.

(low quality of evidence, weak recommendation)

X. Clinicians should anticipate, assess for, and identify potential opioid-associated adverse effects. **(moderate quality of evidence, strong**

recommendation)

XI. Maximal safe doses of acetaminophen or NSAIDs should not be exceeded when using fixed-dose opioid combination agents as part of an analgesic regimen.

(moderate quality of evidence, strong recommendation)

XII. When long-acting opioid preparations are prescribed, breakthrough pain should be anticipated, assessed, prevented and/or treated using short acting immediate release opioid medications. **(moderate quality of evidence, strong**

recommendation)

XIII. Methadone should be initiated and titrated cautiously only by clinicians well versed in its use and risks. **(moderate quality of evidence, strong**

recommendation)

XIV. Patients taking opioid analgesics should be reassessed for ongoing attainment of therapeutic goals, adverse effects, and safe and responsible medication use. **(moderate quality of evidence, strong recommendation)**

Adjuvant

XV. All patients with neuropathic pain are candidates for adjuvant analgesics.

(strong quality of evidence, strong recommendation)

XVI. Patients with fibromyalgia are candidates for a trial of approved adjuvant analgesics. **(moderate quality of evidence, strong recommendation)**

XVII. Patients with other types of refractory persistent pain may be candidates for certain adjuvant analgesics (e.g., back pain, headache, diffuse bone pain, temporomandibular disorder). **(low quality of evidence, weak recommendation)**

XVIII. Tertiary tricyclic antidepressants (amitriptyline, imipramine, doxepin) should be avoided because of higher risk for adverse effects (e.g., anticholinergic effects, cognitive impairment). **(moderate quality of evidence, strong recommendation)**

XIX. Agents may be used alone, but often the effects are enhanced when used in combination with other pain analgesics and/or non-drug strategies. **(moderate quality of evidence, strong recommendation).**

XX. Therapy should begin with the lowest possible dose and increase slowly based on response and side effects, with the caveat that some agents have a delayed onset of action and therapeutic benefits are slow to develop. For example, gabapentin may require 2-3 weeks for onset of efficacy. **(moderate quality of evidence, strong recommendation)**

XXI. An adequate therapeutic trial should be conducted before discontinuation of a seemingly ineffective treatment. **(weak quality of evidence, strong recommendation)**

Other Drugs

XXII. Long-term systemic corticosteroids should be reserved only for patients with pain-associated inflammatory disorders or metastatic bone pain.

Osteoarthritis should not be considered an inflammatory disorder. (**moderate quality of evidence, strong recommendation**)

XXIII. All patients with localized neuropathic pain are candidates for topical lidocaine (**moderate quality of evidence, strong recommendation**)

XXIV. Patients with localized non-neuropathic pain may be candidates for topical lidocaine (**low quality of evidence, weak recommendation**)

XXV. All patients with other localized non-neuropathic persistent pain may be candidates for topical NSAIDs (**moderate quality of evidence, weak recommendation**)

XXVI. Other topical agents may be considered for regional pain syndromes including capsaicin or menthol. (**moderate quality of evidence, weak recommendation**)

XXVII. Many other agents for specific pain syndromes may require caution in older persons and merit further research (e.g., glucosamine, chondroitin, cannabinoids, botulinum toxin, alpha-2 adrenergic agonists, calcitonin, vitamin D, bisphosphonates, ketamine). (**low quality of evidence, weak recommendation**)