Geriatric Pain EM Guideline: Start Low, Go Slow, But Get Somewhere

I. Description

The American College of Emergency Physicians recommends an evidence-based approach to acute pain management in the emergency department that prioritizes non-opioid pharmacologic agents, multimodal strategies, and careful consideration of patient-specific risk factors including advanced age.[3]

Due to physiologic changes, the geriatric population may have exaggerated responses to medications and require adjusted dosing.[1] These guidelines serve as a recommendation for medications that can be used safely and effectively in older adults while also helping to minimize potential risks.

II. Rationale

It is important to manage acute and chronic pain appropriately, taking into consideration the consequences of both undertreatment leading to inadequate pain control and overtreatment leading to adverse effects. Appropriate selection of analgesics takes into consideration age, renal function, hepatic function, drug interactions, etc. Treating the older adult with a multimodal analgesic approach and having increasing monitoring /counseling of side effects can help mitigate these concerns.[2]

III. Multimodal analgesia

Pharmacologic treatment should optimally begin with a non-opioid agent for many acutely painful conditions. Oral or rectal acetaminophen is recommended as a good initial analgesic for mild-moderate pain, with intravenous acetaminophen having similar effects but reserved for patients who cannot take medications by mouth or per rectum due to significantly higher cost.[3]

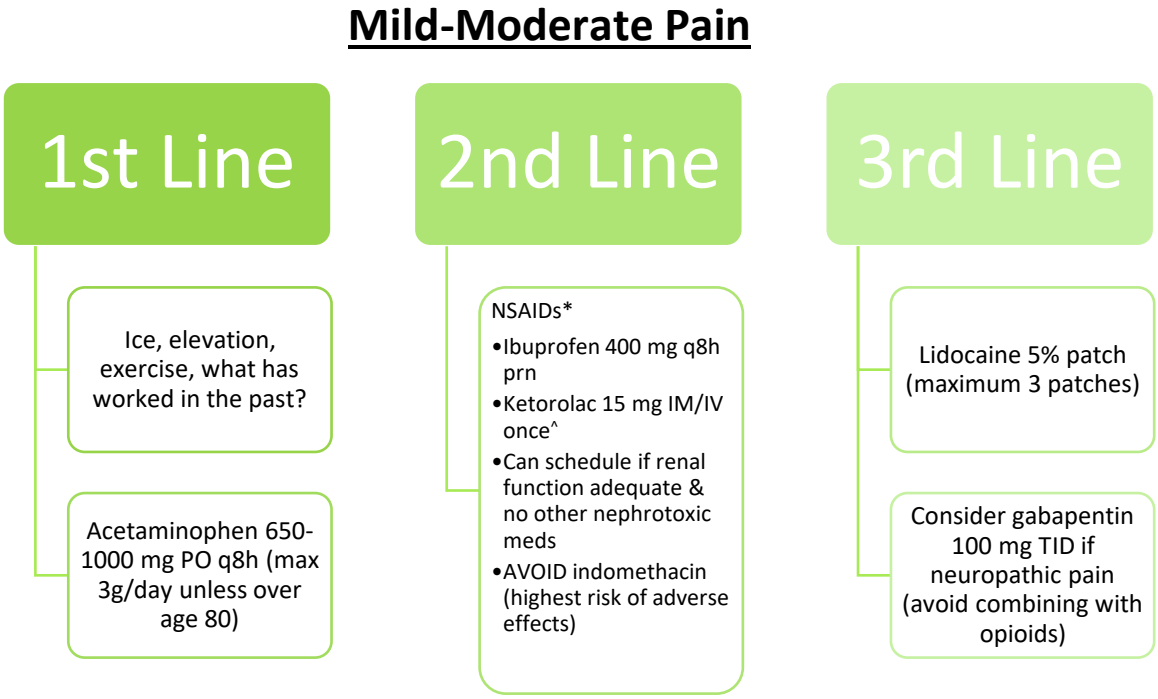
Acetaminophen is appropriate for mild to moderate pain. Dosing should have a daily maximum of 2000 mg, especially for patients >80 years old due to decreased clearance. Special precaution should be taken in patients with preexisting hepatic dysfunction or significant alcohol consumption.

NSAIDs should be chosen based on their analgesic ceiling dose (which is lower than anti-inflammatory maximal doses) and prescribed at the lowest effective dose for the shortest expected duration to avoid complications.[3] Specifically caution in elderly patients with pre-existing renal insufficiency, heart failure, or predisposition to gastrointestinal hemorrhage.

Regional anesthesia techniques, including nerve blocks may be used for certain acutely painful conditions either alone or as part of a multimodal approach to pain relief.[3]

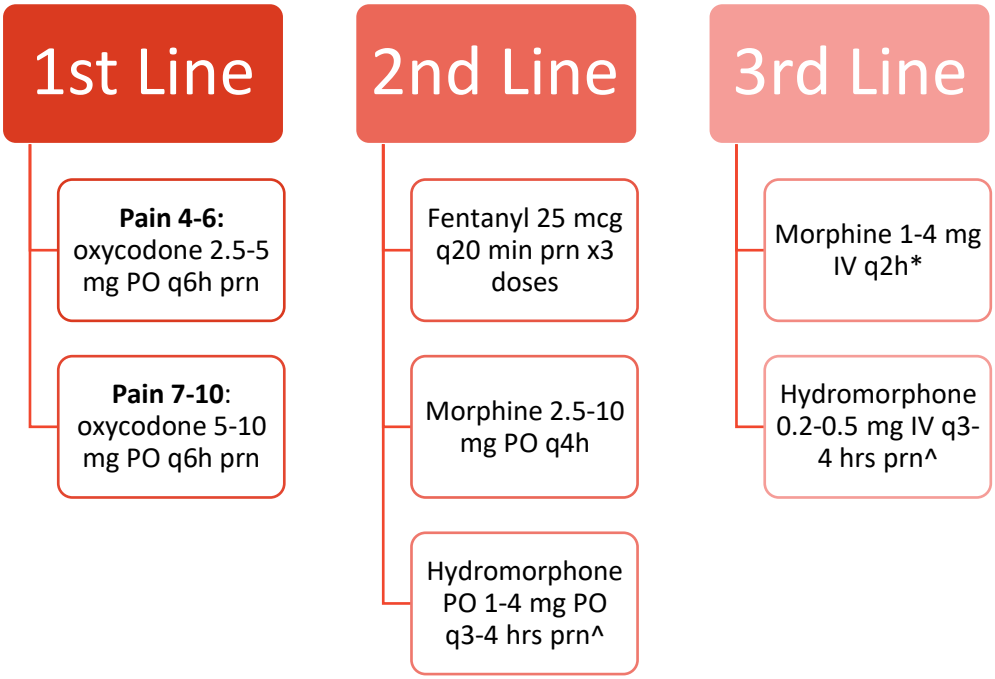
IV. Guideline Procedure

IN HOSPITAL



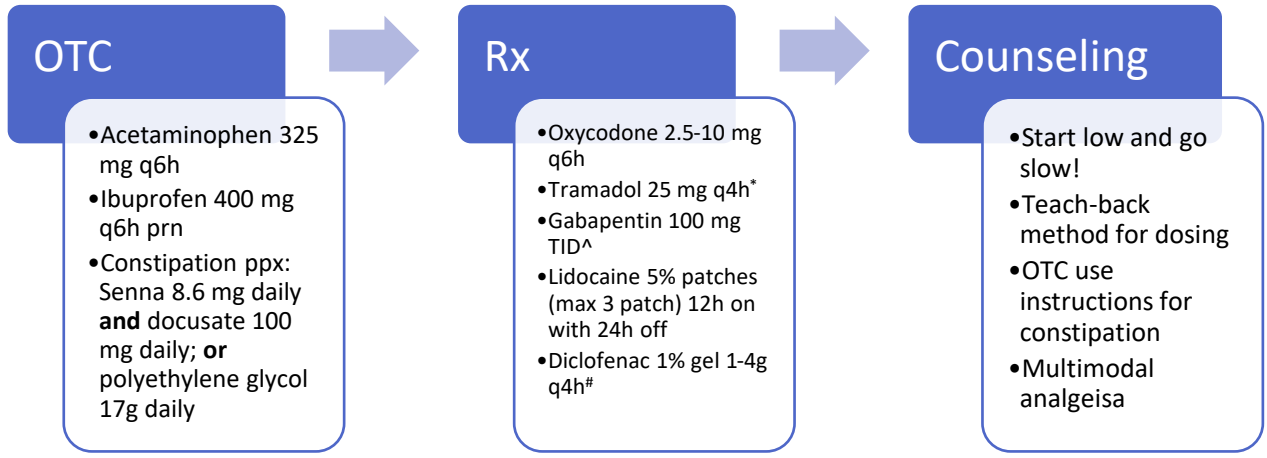
**caution renal function, CHF, GIB hx; ^can schedule if renal function adequate and no significant GI co-morbidities*

Moderate-Severe Pain



**caution in renal function d/t active metabolites; ^preferred i r n enal dysfunction*

OUTPATIENT



**reserve for previously tolerated; ^if neuropathic pain and NOT in combination with opioids; #do not combine with oral NSAIDs*

V. Education

Nursing and providers are updated and educated on new guidelines and management of pain. Providers are encouraged to utilize order sets and guidelines, consult ED pharmacy team, and discuss benefits/risks with patients. Nurses are educated on adverse effects and monitoring of patients sensitive to opioids such as the older patient population.

AGS Beers Criteria - alternative medications & 2023 AGS Beers Criteria for more information!

VI. Counseling

The older patient population is at increased risk of experiencing side effects of opioids, muscle relaxing agents, and even non-opioid analgesics. As health care providers we have a responsibility to counsel adults on the risks associated with these medications, especially at discharge. At least one potential opioid-related ADE occurred within 30 days of hospital discharge in 1,604 (7.0%) hospitalizations. [4]

Common adverse reactions/side effects of opioids:

- Respiratory depression, increased risk in sleep apnea, underlying pulmonary conditions, concomitant benzodiazepines, or sedatives
    - A case-control analysis found that age ≥55 years was associated with increased risk for life-threatening respiratory/central nervous system depression or overdose[2]
- Neuropsychiatric effects such as delirium, confusion, sedation, and hallucinations are clinically important
    - Patients with dementia/delirium are associated with a 38% increased risk of opioid-related adverse events after hospital discharge
- Falls and fractures occur due to the drowsiness and orthostatic hypotension
- Constipation is one of the most common adverse effects, occurring in most patients following opioid initiation or dose increases, and typically does not resolve with continued exposure
    - Prescribing a bowel regimen empirically can help prevent this inevitable and potentially serious complication

VII. References

1. Geriatric Trauma Management Best Practice Guidelines. ACS 2023
2. CDC Clinical Practice Guideline for Prescribing Opioids for Pain. MMWR 2022
3. Optimizing the Treatment of Acute Pain in the Emergency Department. ACEP 2018
4. J Am Geriatr Soc. 2022 Jan;70(1):228-234.doi: 10.1111/jgs.17453. Epub 2021 Sep 15.

VIII. Reviewed & Approved by:

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