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# GERIATRIC EMERGENCY DEPARTMENT NEWSLETTER

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## Treatment of Older Adults in the Emergency Department with Moderate to Severe Pain

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Older adults often present to the ED for evaluation and management of acute pain. Many older adults have different types of pain simultaneously (nociceptive and neuropathic, acute and persistent). The initial assessment may be complicated by multiple comorbid illnesses and challenges in understanding the individual's baseline cognitive and functional status. Age-related physiologic changes that alter gastrointestinal drug absorption, distribution, liver metabolism, and renal excretion can make pain management tricky. Further, a long list of home medications increases the risk of adverse drug events or drug-drug interactions.

Those with moderate to severe pain require initial treatment, concurrent diagnostic evaluation, and repeated evaluation of the response to treatment. The primary goal of pain management in older adults is to maximize function and quality of life by minimizing pain. It is important to incorporate both pharmacological and nonpharmacological pain interventions. Patient and family education are important for safe and effective pain treatment. Family caregivers at the bedside are particularly concerned that care is coordinated and effective.

## *Ten key Emergency Department practice strategies for treatment of older adults with moderate to severe pain:*

1. Comprehensively describe the pain: Acute-v-exacerbation of persistent pain, location, onset, duration, frequency, what makes the pain better or worse? This information will guide physical examination, diagnostic evaluation, imaging, and intervention strategies.
2. Quantify the severity and functional impact of pain: Use the Numeric Rating Scale to have the patient assess the severity of their pain, with "0" being no pain and "10" being the worst pain possible. Those with difficulty self-reporting may use a verbal adjectival scale, such as a pain thermometer, or faces pain scale. An observational scale, such as PAINAD or AlgoPlus, may best serve patients with advanced Dementia. Understand how the pain is affecting sleep and the ability to perform ADLs/iADLs.
3. Define the type of pain: Nociceptive pain is pain that occurs from stimulation of specialized nerve endings, nociceptors, which conduct to the dorsal horn. Nociceptive pain includes somatic and visceral pain. Psychogenic pain is pain caused by prolonged psychological and spiritual distress. Neuropathic pain arises from diseases or injury to the somatosensory system anywhere from the peripheral nerve to the spinal cord and brain.
4. Determine what was done prior to the ED visit and comorbidities: Define the last dosage of medications and any alcohol/substance abuse which were taken prior to the ED visit. Determine baseline function and cognition. Carefully consider if there was trauma, falls, cognitive impairment, end of life needs, baseline renal function, heart failure, etc.
5. Work with the patient and caregiver to develop a plan: Include nonpharmacologic approaches, such as positioning and ice, as well as a tiered medication approach. Medications may include topicals, acetaminophen, NSAIDS, and opioids. Short acting and intermediate acting opioids are often used with careful consideration to start low and go slow, being mindful of the patient's comorbidities and opioid tolerance. Morphine should be used with caution in those with renal impairment. Oxycodone is effective in moderate to severe pain and has a short half-life with little to no toxic metabolites. Hydromorphone is a prodrug that is used for moderate to severe pain. It is reported to have fewer gastrointestinal side effects.
6. Reassess response to treatment: Pain should be reassessed in 15 to 30 minutes for intravenous opioid medications and in 60 minutes for oral medications. Repeated assessments should be documented before the patient is discharged home and/or has a prolonged stay in the ED. Perform a test of function, such as the Get Up and Go test or "Road Test", prior to discharge.
7. Determine if a dosage adjustment or second agent is warranted. The dosage of opioids can be increased if the patient does not respond. Patients should be monitored for side effects including respiratory depression and drowsiness. The underlying cause(s) of the pain should concurrently be reassessed. Avoid potentially inappropriate analgesics as outlined by the AGS Beers Criteria.
8. Coordinate care beyond the ED: Identify the patient's preferences and goals. Describe the care plan to the patient and family caregivers. Integrate information from the primary care provider and specialists into the care plan.
9. Use clear instructions: The patient may not need narcotic RX after the initial treatment. Describe how many times per day a drug should be taken. Initiate a bowel regimen (e.g. Senna) with opioids. Be careful with NSAIDS, especially in repeated doses.
10. Watch for special considerations: Older adults who present with moderate to severe pain are at particular risk for life threatening conditions. Comprehensive evaluation is key.

Gleason LJ, Escue ED, Hogan TM. Older adult emergency department pain management strategies in Clin Geriatr Med 34 (2018) 491-504.

## *Aurora Geri ED Sites*

**Aurora Baycare Medical Center**
2845 Greenbrier Rd, Green Bay, WI

**Aurora Medical Center Grafton**
975 Port Washington Rd, Grafton, WI

**Aurora Medical Center Kenosha**
10400 75th St, Kenosha, WI

**Aurora Medical Center Oshkosh**
855 N Westhaven Dr, Oshkosh, WI

**Aurora Sheboygan Memorial Medical Center**
2629 N 7th St, Sheboygan, WI

**Aurora Sinai Medical Center**
945 N 12th St, Milwaukee, WI

**Aurora St. Luke's South Shore**
5900 S Lake Dr, Cudahy, WI

**Aurora Medical Center Summit**
36500 Aurora Dr, Oconomowoc, WI

**Aurora Medical Center Washington County**
1032 E Sumner St, Hartford, WI

**Aurora West Allis Medical Center**
8901 W Lincoln Ave, West Allis, WI

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