# Pharmacological Management of Persistent Pain in Older Persons

*AGS Panel on Pharmacological Management of Persistent Pain in Older Persons*

## Guideline Recommendations

### Non-Opiods

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)**