



Complete Summary

GUIDELINE TITLE

The management of persistent pain in older persons.

BIBLIOGRAPHIC SOURCE(S)

AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002 Jun; 50(6 Suppl): S205-24. [126 references] [PubMed](#)

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: J Am Geriatr Soc 1998 May; 46(5): 635-51; Geriatrics 1998 Oct; 53(Suppl 3): S8-24.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory information has been released.

On September 30, 2004, Vioxx (rofecoxib) was withdrawn from the U.S. and worldwide market due to safety concerns of an increased risk of cardiovascular events. See the [U.S. Food and Drug Administration \(FDA\) Web site](#) for more information.

Subsequently, on April 7, 2005, after concluding that the overall risk versus benefit profile is unfavorable, the FDA requested that Pfizer, Inc voluntarily withdraw Bextra (valdecoxib) from the market. The FDA also asked manufacturers of all marketed prescription nonsteroidal anti-inflammatory drugs (NSAIDs), including Celebrex (celecoxib), a COX-2 selective NSAID, to revise the labeling (package insert) for their products to include a boxed warning and a Medication Guide. Finally, FDA asked manufacturers of non-prescription (over the counter [OTC]) NSAIDs to revise their labeling to include more specific information about the potential gastrointestinal (GI) and cardiovascular (CV) risks, and information to assist consumers in the safe use of the drug. See the [FDA Web site](#) for more information.

Most recently, on June 15, 2005, the FDA requested that sponsors of all non-steroidal anti-inflammatory drugs (NSAID) make labeling changes to their products. FDA recommended proposed labeling for both the prescription and over-

the-counter (OTC) NSAIDs and a medication guide for the entire class of prescription products. All sponsors of marketed prescription NSAIDs, including Celebrex (celecoxib), a COX-2 selective NSAID, have been asked to revise the labeling (package insert) for their products to include a boxed warning, highlighting the potential for increased risk of cardiovascular (CV) events and the well described, serious, potential life-threatening gastrointestinal (GI) bleeding associated with their use. FDA regulation 21CFR 208 requires a Medication Guide to be provided with each prescription that is dispensed for products that FDA determines pose a serious and significant public health concern. See the [FDA Web site](#) FDA Web site for more information.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **

SCOPE

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IMPLEMENTATION OF THE GUIDELINE

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT

CATEGORIES

IDENTIFYING INFORMATION AND AVAILABILITY

DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Persistent pain

GUIDELINE CATEGORY

Evaluation
Management

CLINICAL SPECIALTY

Family Practice
Geriatrics
Internal Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Health Plans
Managed Care Organizations
Nurses

Patients
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To update and revise previous recommendations from the clinical practice guideline titled "The Management of Chronic Pain in Older Persons," using the latest information about pain management in elderly persons
- To provide the reader with an overview of the principles of pain management as they apply specifically to older people and specific recommendations to aid in decision making about pain management for this population

TARGET POPULATION

Older persons with persistent pain

INTERVENTIONS AND PRACTICES CONSIDERED

1. Comprehensive pain assessment (interview, pain scales, direct observation or history from caregivers) including: medical history, physical examination, evaluation of the present pain complaint, thorough analgesic medication history, comprehensive physical examination, evaluation of physical and psychosocial function, a regular reassessment of pain
2. Pharmacologic treatments
 - Non-opioids:
 - Acetaminophen (Tylenol)
 - Nonsteroidal anti-inflammatory drugs (NSAIDs), specifically cyclooxygenase (COX)-2 selective agents (e.g., celecoxib [Celebrex], rofecoxib [Vioxx*]); nonacetylated salicylates (choline magnesium trisalicylate [Tricosal, Trilisate]; salsalate [e.g., Disalcid, Monogesic, Salflex])

*Note from the National Guideline Clearinghouse (NGC): On September 30, 2004, Vioxx (rofecoxib) was withdrawn from the U.S. and worldwide market due to safety concerns of an increased risk of cardiovascular events. See the [U.S. Food and Drug Administration \(FDA\) Web site](#) for more information.

- Corticosteroids (prednisone) (e.g., Deltasone, Liquid Pred, Orasone)
 - Tricyclic antidepressants, such as desipramine (Norpramin) and nortriptyline (Aventyl, Pamelor)
 - Anticonvulsants, such as carbamazepine (Tegretol), clonazepam (Klonopin), gabapentin (Neurontin), mexiletine (Mexitil), baclofen (Lioresal)
 - Opioids, including preparations for episodic (noncontinuous) pain, and long-acting or sustained-release analgesic preparations for continuous pain.
3. Nonpharmacologic interventions including patient education, physical activity or exercise, cognitive-behavioral therapies, and other modalities (e.g., heat,

- cold, massage, liniments, chiropractic, acupuncture, and transcutaneous electrical nerve stimulation)
4. Monitoring of response to medications for therapeutic and adverse effects
 5. Health systems considerations (structures and processes to ensure access and delivery of quality pain management services)

Notes:

- Guideline developers discussed, but did not recommend, placebos for the management of pain.
- Guideline developers considered, but did not make specific recommendations regarding the long-term use of complementary and alternative therapies, such as homeopathy, naturopathy, chiropractic, and spiritual healing.

MAJOR OUTCOMES CONSIDERED

- Patient-reported pain intensity recorded with standard pain scales (e.g., visual analogue scale, word descriptor scale, numerical scale)
- Validity and acceptability of pain scales
- Safety and adverse effects of pain medications
- Pain relief, quality of life, and functional capacity

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Citations were identified from sources, including computerized key word searches for each recommendation (PubMed), personal citation libraries of the panel members, and references from the texts of some individual articles. These citations were screened for evidence-based content related to the recommendations, and abstracts were obtained for further analysis by a panel member. Finally, full-text English-language data-based articles were obtained and summarized for detailed analysis by panel members.

NUMBER OF SOURCE DOCUMENTS

- More than 4,122 citations were identified from sources
- More than 2,089 abstracts were obtained for further analysis
- More than 520 full-text data-based articles were obtained and summarized for detailed analysis

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence

Level I: Evidence from at least one properly randomized, controlled trial

Level II: Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies, from multiple time-series studies, or from dramatic results in uncontrolled experiments

Level III: Evidence from respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Strength of Evidence

- A. Good evidence to support the use of a recommendation; clinicians "should do this all the time"
- B. Moderate evidence to support the use of a recommendation; clinicians "should do this most of the time"
- C. Poor evidence either to support or to reject the use of a recommendation; clinicians "may or may not follow the recommendation"
- D. Moderate evidence against the use of recommendation; clinicians "should not do this"
- E. Good evidence against the use of a recommendation, which is therefore "contraindicated"

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The following organizations with special interest and expertise in the management of pain in older persons provided peer review of a preliminary draft of this guideline: American Academy of Family Physicians; American Academy of Home Care Physicians; American Academy of Orthopaedic Surgeons; American Academy of Pain Medicine; American Academy of Physical Therapy; American Academy of Physical Medicine and Rehabilitation; American College of Clinical Pharmacy; American Medical Association; American Occupational Therapy Association; American Society of Anesthesiologists; American Society of Clinical Oncologists; American Society of Consultant Pharmacists; Hospice and Palliative Nurses Association; Oncology Nursing Society.

The guideline was approved by the American Geriatric Society (AGS) Board of Directors on April 8, 2002.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Definitions for the quality of evidence (Levels I-III) and strength of evidence (A-E) are presented at the end of the "Major Recommendations."

Summary of Key Recommendations

- The key to effective treatment of persistent pain lies in comprehensive assessment. All older persons should be screened for persistent pain on initial evaluation, on admission to any health care service, and periodically thereafter. Any persistent pain that has an impact on physical function, psychological function, or quality of life should be considered a significant problem
- The verbally administered zero to ten scale is a good first choice for assessment of pain intensity; however, other scales such as word descriptor scales, faces scales, or pain thermometers may be more appropriate for some patients.
- For those with moderate to severe cognitive impairment, assessment of behaviors and family or caregiver's observations are essential.
- The use of placebos in clinical practice is unethical and there is no place for their use in the management of persistent pain.
- Acetaminophen should be the first drug to consider in the treatment of mild to moderate pain of musculoskeletal origin.
- Traditional (i.e., nonselective) nonsteroidal anti-inflammatory drugs (NSAIDs) should be avoided in those who require long-term daily analgesic therapy. The selective NSAIDs, i.e., the COX-2 inhibitors, are preferable.
- Opioid analgesic drugs are effective, associated with a low potential for addiction, and overall may have fewer long-term risks than other analgesic

- drug regimens in older persons with persistent pain. As with all medication, careful monitoring for the development of adverse side effects is important.
- An individualized program of physical activity should be designed to improve flexibility, strength, and endurance, and should be maintained indefinitely.
 - Patient and caregiver education is an essential component in the management of persistent pain.
 - Health care facilities that care for older patients should routinely conduct quality assurance and quality improvement activities to enhance pain management.

Specific Recommendations: Assessment of Persistent Pain (quality and strength of evidence ratings follow each recommendation)

- I. On initial presentation or admission of any older person to any healthcare service, a healthcare professional should assess the patient for evidence of persistent pain. (II B)
- II. Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem. (II A)
- III. All patients with persistent pain that may affect physical function, psychosocial function, or other aspects of quality of life should undergo a comprehensive pain assessment, with the goal of identifying all potentially remediable factors. (See Table 2 of the original guideline for sample pain interview questions.) Assessment should focus on recording a sequence of events that led to the present pain complaint, and on establishing a diagnosis, a plan of care, and likely prognosis: (III B)
 - A. History
 1. Initial evaluation of present pain complaint should include pain characteristics, such as intensity, character, frequency (or pattern, or both), location, duration, and precipitating and relieving factors. (III A)
 2. Initial evaluation should include a description of pain in relation to impairments in physical and social function (e.g., activities of daily living [ADLs], instrumental activities of daily living [IADLs], sleep, appetite, energy, exercise, mood, cognitive function, interpersonal and intimacy issues, social and leisure activities, and overall quality of life). (II A)
 3. Initial evaluation should include a thorough analgesic history, including current and previously used prescription medications, over-the-counter medications, complementary or alternative remedies, and alcohol use or abuse. The effectiveness and any side effects of current and previously used medications should be recorded. (III B)
 4. The patient's attitudes and beliefs regarding pain and its management, as well as knowledge of pain management strategies, should be assessed. (II B)
 5. Effectiveness of past pain-relieving treatments (both traditional and complementary or alternative) should be evaluated. (III B)
 6. The patient's satisfaction with current pain treatment or health should be determined and concerns should be identified. (III B)
 - B. Physical examination

1. Physical examination should include careful examination of the site of reported pain, common sites for pain referral, and common sites of pain in older adults. (IIIA)
 2. Physical examination should focus on the musculoskeletal system (e.g., myofascial pain, fibromyalgia, inflammation, deformity, posture, leg length discrepancy). Practitioners skilled in musculoskeletal examination should be considered for consultation (e.g., physical therapy, occupational therapy, physiatry). (IIIA)
 3. Physical examination should focus on the neurologic system (e.g., search for weakness, hyperalgesia, hyperpathia, allodynia, numbness, paresthesia, other neurologic impairments). (IIIA)
 4. Initial assessment should include observation of physical function (e.g., measures of ADLs, performance measures such as range of motion, get-up-and-go test, or others). (IIA)
- C. Comprehensive pain assessment should include results of pertinent laboratory and other diagnostic tests. Tests should not be ordered unless their results will affect decisions about treatment. (IIIB)
- D. Initial assessment should include evaluation of psychologic function, including mood (e.g., depression, anxiety), self-efficacy, pain coping skills, helplessness, and pain-related fears. (IIA)
- E. Initial assessment should include evaluation of social support, caregivers, family relationships, work history, cultural environment, spirituality, and healthcare accessibility. (IIB)
- F. Cognitive function should be evaluated for new or worsening confusion. (IIA)
- G. For the older adult who is cognitively intact or who has mild to moderate dementia, the practitioner should attempt to assess pain by directly querying the patient. (IIA)
1. Quantitative estimates of pain based on clinical impressions or surrogate reports should not be used as a substitute for self-report unless the patient is unable to reliably communicate his or her pain. (IIA)
 2. A variety of terms synonymous with pain should be used to screen older patients (e.g., burning, discomfort, aching, soreness, heaviness, tightness). (IIIA)
 3. A quantitative assessment of pain should be recorded by the use of a standard pain scale that is sensitive to cognitive, language, and sensory impairments (e.g., scales adapted for visual, hearing, foreign language, or other handicaps common in elderly persons). A variety of verbal descriptor scales, pain thermometers, numeric rating scales, and facial pain scales have acceptable validity and are acceptable for many older adults. (See Figure 1 in the original guideline document for examples of some commonly used pain-intensity scales.) (IIA)
 4. The use of a multidimensional pain instrument that evaluates pain in relation to other domains (e.g., the Pain Disability Index or the Brief Pain Inventory) should be considered. (IIB)
 5. Elderly persons with limited attention span or impaired cognition should receive repeated instructions and be given adequate time to respond. Assessment may be done in several

- steps; it may require assistance from family or caregivers, and planning in advance of the visit. (III B)
6. Patients should be queried about symptoms and signs that may indicate pain, including recent changes in activities and functional status; they should also be observed for verbal and nonverbal pain-related behaviors and changes in normal functioning. (See Table 3 in the original guideline document for some common pain indicators.) (II A)
 7. Patients can also be asked about their worst pain experience over the past week. (II B)
 8. With mild to moderate cognitive impairment, assessment questions should be framed in the present tense because patients are likely to have impaired recall. (II B)
- IV. For the older adult with moderate to severe dementia or who is nonverbal, the practitioner should attempt to assess pain via direct observation or history from caregivers. (See Figure 2 in the original guideline document for an algorithm for assessing pain in cognitively impaired persons.)
 - A. Patients should be observed for evidence of pain-related behaviors during movement (e.g., walking, morning care, transfers). (II A)
 - B. Unusual behavior in a patient with severe dementia should trigger assessment for pain as a potential cause. (II A)
 - V. The risks and benefits of various assessment and treatment options should be discussed with patients and family, with consideration for patient and family preferences in the design of any assessment or treatment strategy. (III C)
 - VI. Patients with persistent pain should be reassessed regularly for improvement, deterioration, or complications. (III A)
 - A. The use of a pain log or diary with regular entries for pain intensity, medication use, mood, response to treatment, and associated activities should be considered. (III C)
 - B. The same quantitative pain assessment scales should be used for initial and follow-up assessments. (III A)
 - C. Reassessment should include evaluation of analgesic and nonpharmacologic interventions, side effects, and compliance issues. (III A)
 - D. Reassessment should consider patient preferences in assessment and treatment revisions. (III B)

Specific Recommendations: Pharmacologic Treatment (quality and strength of evidence ratings follow each recommendation)

- I. All older patients with functional impairment or diminished quality of life as a result of persistent pain are candidates for pharmacologic therapy. (I A)
- II. There is no role for placebos in the assessment or management of pain. (I C)
- III. The least toxic means of achieving systemic pain relief should be used. When systemic medications are indicated, the noninvasive route should be considered first. (III A)
- IV. Acetaminophen should be the first drug to consider in the treatment of mild to moderate pain of musculoskeletal origin. (I B)
- V. Traditional (nonselective) NSAIDs should be avoided in treating patients who require long-term daily analgesic therapy. The COX-2 selective agents or nonacetylated salicylates are preferred for older persons who require NSAIDs. (I A)

- VI. Opioid analgesic drugs may help relieve moderate to severe pain, especially nociceptive pain. (IA)
- A. Opioids for episodic (noncontinuous) pain should be prescribed as needed, rather than around the clock. (IA)
 - B. Long-acting or sustained-release analgesic preparations should be used for continuous pain. (IA)
 - 1. Breakthrough pain should be identified and treated by the use of fast-onset, short-acting preparations. There are three types of breakthrough pain: (IA)
 - a. End-of-dose failure is the result of decreased blood levels of analgesic with concomitant increase in pain before the next scheduled dose. If this occurs routinely, consider decreasing the interval between doses of continuous-release agents. Increasing the dose of the continuous-release agent is another consideration, but this may cause undesirable effects, such as sedation. (III B)
 - b. Incident pain is usually caused by activity that can be anticipated and pretreated. (I B)
 - c. Spontaneous pain, common with neuropathic pain, is commonly fleeting and difficult to predict. (I C)
 - 2. Titration should be conducted carefully. (IA)
 - a. Titration of the maintenance dose should be based on the persistent need for and use of medications for breakthrough pain. (IA)
 - b. Titration should be based on the pharmacokinetics and pharmacodynamics of specific drugs in the older person, the propensity for drug accumulation, interactions with other drugs, and each patient's unique clinical and social circumstances. (III A)
 - c. The potential adverse effects of opioid analgesic medication should be anticipated and prevented or treated promptly. (II A)
 - 3. Constipation and opioid-related gastrointestinal symptoms should be prevented. (IA)
 - a. Assessment of bowel function should be part of the initial assessment and of every follow-up visit for all patients receiving analgesics. (IA)
 - b. A prophylactic bowel regimen should be initiated with the commencement of persistent opioid therapy. (IA)
 - c. Bulking agents should be used cautiously in patients who are immobile and where adequate hydration is questionable. (III B)
 - d. Adequate fluid intake should be encouraged. (III B)
 - e. Exercise, ambulation, regular toileting habits and patterns, and physical activity should be encouraged. (III B)
 - f. If fecal impaction is present, it should be relieved by enema or manual removal. (III A)
 - g. A stimulant (e.g., senna) should be prescribed to provide regular evacuation. Doses of this agent need to be titrated against desired effect. (II B)

- h. Stimulant laxatives are contraindicated when signs or symptoms of bowel obstruction are present. (IIIA)
 - 4. Mild sedation and impaired cognitive performance should be anticipated when opioid analgesic drugs are initiated or escalated. Until these side effects cease: (IIIC)
 - a. Patients should be instructed not to drive. (IIIB)
 - b. Patients and caregivers should be cautioned about the potential for falls and accidents; appropriate precautions should be taken. (IIIA)
 - c. Monitoring for profound sedation, unconsciousness, or respiratory depression (defined as a respiratory rate of < 8 per minute or oxygen saturation < 90%) should occur during rapid, high-dose escalations. Naloxone should be used very carefully, titrated in low incremental doses, to avoid abrupt, complete opioid antagonism and the precipitation of autonomic crisis. (IA)
 - 5. Patients who experience unremitting opioid-induced sedation or fatigue that limits quality of life or dose escalation to provide optimum pain control may require switching to an alternate opioid, or they may be candidates for opioid rotation or use of short term, low-dose psychostimulant therapy (e.g., methylphenidate), or both. (IB)
 - 6. Severe or persistent nausea may need to be treated with anti-emetic medications, as needed. (IIIB)
 - a. Mild nausea usually resolves spontaneously in a few days. (IIIB)
 - b. If nausea persists, a trial of an alternative opioid may be appropriate. (IIIB)
 - c. Anti-emetic drugs should be chosen from those with the lowest side-effect profiles in older persons. (IIIA)
- VII. Fixed-dose combinations of opioid with acetaminophen or NSAIDs may be useful for mild to moderate pain. (IA)
- A. The maximum recommended dose should not be exceeded, to minimize acetaminophen or NSAID toxicity. (IA)
 - B. If a maximum safe (nontoxic) dose is reached without sufficient pain relief because of limits imposed by the maximum safe acetaminophen or NSAID dose, switching to noncombination preparations is recommended. (IA)
- VIII. Patients taking analgesic medications should be monitored closely. (IA)
- A. Patients should be reevaluated frequently for drug efficacy and side effects during initiation, titration, or any change in dose of analgesic medications. (IA)
 - B. Patients should be reevaluated regularly for drug efficacy and side effects throughout long-term analgesic drug maintenance. (IIIA)
 - 1. Patients on long-term opioid therapy should be evaluated periodically for inappropriate or dangerous drug-use patterns. (IIIA)
 - a. The clinician should watch for indications of the use of medications prescribed for other persons or of illicit drug use (the latter being very rare in this population). (IIIC)
 - b. The clinician should ask about prescriptions for opioids from other physicians. (IIIA)

- c. The clinician should watch for signs of opioid use for inappropriate indications (e.g., anxiety, depression, grief, loss). (III A)
 - d. Requests for early refills should include evaluation of tolerance, progressive disease, inappropriate behavior, or drug diversion by others. (III A)
 - e. These evaluations need to take place with the same medical equanimity accompanying similar evaluations for long-term management of other potentially risky medications (i.e., antihypertensive medications) in order not to burden the patient with excessive worry or unnecessary fears, or to promote "opiophobia." (III A)
 - f. The use of a written "medication agreement" is advised when there are concerns about appropriate use or adherence to the plan of care (III C).
 - 2. Patients on long-term NSAIDs should be periodically assessed for symptoms or signs of gastrointestinal blood loss, renal insufficiency, edema, hypertension, and drug-drug or drug-disease interactions. (I A)
- IX. Non-opioid analgesic medications may be appropriate for some patients with neuropathic pain and some other persistent pain conditions. (I A)
 - A. Agents with the lowest side-effect profiles should be chosen preferentially. Patients with intact skin who have localized or regional pain syndromes (e.g., post-herpetic neuralgia) may benefit from commercially available topical therapies (e.g., capsaicin cream, lidocaine patch). (I B)
 - B. Agents may be used alone but often are more helpful when used in combination and to augment other pain management strategies. (II B)
 - C. Therapy should begin with the lowest possible doses and increased slowly because of the potential for toxicity of many agents. (I A)
 - D. Patients should be closely monitored for side effects. (I A)
- X. Clinical endpoints should be decreased pain, increased function, and improvements in mood and sleep, not decreased drug dose. (II B)

Specific Recommendations: Nonpharmacologic Strategies (quality and strength of evidence ratings follow each recommendation)

- I. A physical activity program should be considered for all older patients. (I A)
 - A. Physical activities should be individualized to meet the needs and preferences of each patient. (I A)
 - B. For some older adults with severe physical impairments, a trial of supervised rehabilitation therapy is appropriate, with goals to improve joint range of motion and to reverse specific muscle weakness or other physical impairments associated with persistent pain. (I A)
 - C. For healthy individuals who are currently sedentary or deconditioned, referral should be made to a group exercise program (e.g., YMCA classes) for a moderate program of physical activity. (III C)
 - D. For those who are incapable of strenuous training, initial training should be conducted over 8 to 12 weeks and should be supervised by a professional with knowledge of the special needs of older adults. (I A)

- II. Moderate levels of physical activity (leisure-time or utilitarian) should be maintained. (IIC)
- III. Any physical activity program for older patients should include exercises that improve flexibility, strength, and endurance. (IA)
- IV. Patient education programs are integral components of the management of persistent pain syndromes. (IA)
 - A. Content should include information about self-help techniques (e.g., relaxation, distraction), the known causes of their pain, the goals of treatment, treatment options, expectations of pain management, and analgesic drug use. (IIA)
 - B. Educational content and the patient's self-help efforts should be reinforced during every patient encounter. (IIIA)
 - C. Focused patient education should be provided prior to special treatments or procedures. (IIC)
 - D. Patients should be encouraged to educate themselves by using available local resources (e.g., local hospitals, support groups, and disease-specific organizations). (IIC)
- V. Formal cognitive-behavioral therapies are helpful for many older adults with persistent pain. (IA)
 - A. Cognitive-behavioral therapy conducted by a professional should be applied as a structured program that includes education, a rationale for therapy, training in cognitive and behavioral pain coping skills, methods to generalize coping skills, and relapse prevention. (IIIA)
 - B. Plans for coping with pain exacerbations should be a part of this therapy to prevent self-defeating behavior during such episodes. (IIC)
 - C. Spouses or other partners can be involved in cognitive-behavioral therapy. (IA)
- VI. Other modalities (e.g., heat, cold, massage, liniments, chiropractic, acupuncture, and transcutaneous electrical nerve stimulation) often offer temporary relief and can be used as adjunctive therapies. (IIC)

Specific Recommendations: Recommendations for Health Systems That Care for Older Persons (quality and strength of evidence ratings follow each recommendation)

- I. Healthcare facilities should support policies and procedures for routine screening, assessment, and treatment of persistent pain among all older patients. Health organizations should include pain management as a major domain in the development of clinical pathways. (IIB)
- II. Attention should be devoted to pain across the continuum of care and should not be limited to those patients who are near the end of life. (IIB)
- III. Ambulatory care facilities, hospitals, nursing homes, assisted-living facilities, and home-care agencies should routinely conduct quality assurance and quality improvement (QA and QI) activities in pain management. (IIB)
 - A. QA and QI activities should include appropriate structure and process indicators of pain assessment and treatment activities. (IIC)
 - B. Benchmarks for quality improvement should be established internally and should include quantifiable pain outcomes, which may include, but should not be limited to, patient satisfaction. (IIB)

- IV. Healthcare financing systems (third-party payers, managed-care organizations, and publicly financed programs) should extend resources for persistent pain management. (IIC)
 - A. Present diagnosis-driven reimbursement systems should be revised to improve incentives for time-consuming pain management. (IIC)
 - 1. The safest and most effective pharmacologic and nonpharmacologic strategies for pain management should be provided. (IIC)
 - 2. Reimbursement systems must not result in the inaccessibility of effective treatment or in needless suffering. (IIC)
 - 3. Reimbursement systems should promote adequate compensation for all providers who can contribute to effective pain management (e.g., physical therapy, nursing, psychology, social work, occupational therapy). (IIC)
 - B. Reimbursement should be appropriate for the increased time and resources often necessary for the care of frail, dependent, and disabled older patients in all settings. (IIC)
- V. Health systems (especially integrated networks and community health planners) should ensure accessibility to specialty pain services. (IB)
- VI. Specialty pain services should be accredited and adhere to guidelines defined by quality review organizations. (IIB)
 - A. Services should include medicine, pharmacy, mental health, nursing, physical therapy, and occupational therapy. (IIC)
 - B. These services should also be available outside a coordinated multidisciplinary pain service. (IIC)
- VII. Education in pain management for all healthcare professionals should be improved at all levels. (IB)
 - A. Professional curricula should provide substantial training and experience in pain management for older adults. (IIC)
 - 1. Curricula should adhere to published general curriculum guidelines until those specific to older adults have been developed (e.g., those of the International Association for the Study of Pain). (IIC)
 - 2. Trainees should demonstrate proficiency in pain assessment and management. (IIC)
 - B. Health systems should provide continuing education in pain assessment and management to health professionals at all levels. (IB)
 - C. Accreditation bodies should include pain management curriculum content as evaluation criteria. (IIC)
- VIII. Pain management should be included in consumer information services. (IIB)
 - A. Healthcare systems should encourage patients and their surrogates to advocate for more effective pain management. (IIC)
 - B. Healthcare systems should provide educational materials (posters, pamphlets, Internet resources) that encourage patients to discuss pain with their providers. (IIC)
- IX. Programs and regulations designed to decrease illicit drug use should be revised to eliminate barriers to persistent pain management for the older patients. (IIB)
 - A. State license boards should publish professional standards or guidelines for prescribing controlled substances for pain, including professional standards for chronic use, expectations for medical record documentation, and standards for professional conduct review. (IIC)

- B. State medical license boards must work to eliminate clinicians' trepidation over conduct review that has become a major barrier to the prescription of effective pain medications. (I I I C)
- C. Law and drug enforcement agencies should recognize their role in facilitating and providing easy access to the legitimate use of controlled substances by patients in pain. (I I I C)
- D. Law and drug enforcement agencies should publish information for clinicians and the public regarding the legal and illegal prescribing, as well as the dispensing, storage, disposal, and use of controlled substances for pain management. (I I I C)

Definitions:

Quality of Evidence

Level I: Evidence from at least one properly randomized, controlled trial

Level II: Evidence from at least one well-designed clinical trial without randomization, from cohort or case-controlled analytic studies, from multiple time-series studies, or from dramatic results in uncontrolled experiments

Level III: Evidence from respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Strength of Evidence

- A. Good evidence to support the use of a recommendation; clinicians "should do this all the time"
- B. Moderate evidence to support the use of a recommendation; clinicians "should do this most of the time"
- C. Poor evidence either to support or to reject the use of a recommendation; clinicians "may or may not follow the recommendation"
- D. Moderate evidence against the use of recommendation; clinicians "should not do this"
- E. Good evidence against the use of a recommendation, which is therefore "contraindicated"

CLINICAL ALGORITHM(S)

The original guideline contains a clinical algorithm for assessment of pain in elderly persons with severe cognitive impairment.

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Appropriate pain evaluation and effective pain management in older adults
- Improved sense of dignity, functional capacity, and overall quality of life

POTENTIAL HARMS

Adverse Effects of Drugs

- Selective COX-2 inhibitors. Higher doses are associated with a higher incidence of gastrointestinal side effects.
- Opioids. Physical dependency is an inevitable consequence of continuous exposure to opioids and is managed by gradual dose reduction (tapering) over the course of several days to weeks if indications for opioid therapy no longer exist. True addiction (drug craving and continued use despite known harms) in older patients with persistent pain syndromes is probably rare in comparison with the known prevalence of undertreated debilitating pain.

Side effects of opioid therapy may include gait disturbance (ataxia), dizziness, falls, pruritus, constipation, abdominal distention or discomfort, nausea, sedation, and impaired concentration. Serious side effects, such as myoclonus, impaired consciousness or delirium, and hypoxia or life-threatening respiratory depression, are rare, especially when doses are started low and escalated slowly, allowing for steady-state blood levels to be reached at each dose prescribed.

- Tramadol. Rarely, seizures may occur.
- Adjuvant drugs. All of the currently available pain-modulating drugs, including antidepressants, anticonvulsants, antispasmodics, antiarrhythmics, and local anesthetics, have side effects that require careful titration, frequent monitoring until steady-state maintenance levels are achieved, and regular follow-up visits to assess therapeutic and adverse effects.

Subgroups Most Likely to be Harmed:

- Patients taking opioids who have borderline mobility capabilities and a propensity for falls must be monitored carefully for increasing gait and balance disturbances.
- Tramadol should be used with caution in patients with a history of seizure disorder or those taking other medications that lower seizure thresholds.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This guideline is not meant to be an exhaustive treatise on the subject, but rather, a practical guide for clinicians.

- Readers should recognize that medical science is a constantly changing field. As new data are accumulated and re-analyzed, clinicians must keep abreast of new developments as evidence emerges that may have important implications for implementation of specific recommendations contained in this guideline. These recommendations are meant to serve as a guide and should not be used in lieu of critical thinking, sound judgment, and clinical experience.
- Existing evidence-based literature on the assessment and management of persistent pain specifically in older people was found to be very limited in sample and design. Much of the literature presents persistent pain in a disease-specific approach, and the number of pain-producing diseases reported is very large. Few randomized clinical trials consisting entirely of subjects aged 75 years and over were identified, and no formal meta-analyses of multiple studies of older subjects could be found. The majority of controlled trials and meta-analyses were derived from samples consisting of younger patients. The panel occasionally drew on data derived from studies of younger patients that could be reasonably extrapolated to older persons. However, data describing persistent pain in younger populations could not always be easily extrapolated to the oldest old or to care settings where older patients are often encountered.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

IMPLEMENTATION TOOLS

Clinical Algorithm
Patient Resources

For information about [availability](#), see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

BIBLIOGRAPHIC SOURCE(S)

AGS Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. J Am Geriatr Soc 2002 Jun;50(6 Suppl):S205-24. [126 references] [PubMed](#)

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1998 Oct (revised 2002 Jun)

GUIDELINE DEVELOPER(S)

American Geriatrics Society - Medical Specialty Society

SOURCE(S) OF FUNDING

The development of this guideline was supported by unrestricted educational grants from Janssen Pharmaceutica, McNeil Consumer Products Company, Ortho-McNeil Pharmaceutical, Inc., Pharmacia Corporation, and Purdue Pharma L.P.

GUIDELINE COMMITTEE

American Geriatrics Society (AGS) Panel on Persistent Pain in Older Persons

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Members: Bruce Ferrell, MD (Chairman); David Casarett, MD; Jerome Epplin, MD; Perry Fine, MD; F. Michael Gloth, III, MD; Keela Herr, PhD, RN; Paul Katz, MD; Francis Keefe, PhD; Peter J.S. Koo, PharmD; Michael O'Grady, MD; Peggy Szwabo, PhD, LCSW, RN; April Hazard Vallerand, PhD, RN; Debra Weiner, MD

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Dr. Ferrell is a member of the speaker's bureau for Purdue Pharma; Dr. Fine is a member of the speaker's bureau for Merck, Janssen, Purdue Pharma, Cephalon and Orthobiotech; Dr. Casarett has received research support from the National Institutes of Health (NIH), Greenwall Foundation, Hartford Foundation, Department of Veterans Affairs and Commonwealth Fund, and is a paid consultant for Janssen, Novartis, Merck, Procter & Gamble, Purdue Pharma, Pfizer and McNeil, and is a member of the speaker's bureau for Janssen, Novartis, Merck, Procter & Gamble, Purdue Pharma, Pfizer, and Beckman Coulter; Dr. Katz has received grants from Bureau of Health Professions and the Hartford Foundation; Dr. Herr has received grants from Robert Wood Johnson, the Agency for Healthcare Research and Quality (AHRQ) and NIH, she is a member of the

speaker's bureau for Janssen Pharmaceutica and Purdue Pharma; Dr. Koo is a paid consultant for Syntex Pharmaceuticals, Abbott Pharmaceuticals, Chorin Biotech, Ligand Pharmaceuticals and Ortho McNeil Pharmaceuticals, he has received grants from the National Cancer Institute, Jessen Pharmaceuticals, Purdue Pharma and Endo Pharmaceuticals, and is a member of the speaker's bureau for Pfizer, Merck, Adolor, Kaiser Foundation Hospital; Dr. Keefe is a paid consultant for Wayne State University, and has received grants from NIH, Fetzer Institute, Arthritis Foundation; Dr. Weiner has received grants from the National Institute on Aging; Dr. Szwabo is a paid consultant for Blanchard and Loeb Publishers and a member of the speaker's bureau for Janssen, Lilly, Abbott, Pharmedia, Pfizer and Merck and the Association on Aging with Developmental Disabilities; Dr. O'Grady has received grants from Emory University; Dr. Hazard Vallerand is a paid consultant for Elan Pharmaceuticals, has received grants from Janssen Pharmaceutica and is a member of the speaker's bureau for Janssen Pharmaceutica.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previously released version: J Am Geriatr Soc 1998 May;46(5):635-51; Geriatrics 1998 Oct;53(Suppl 3):S8-24.

GUIDELINE AVAILABILITY

Electronic copies: Available to subscribers of the Journal of the American Geriatrics Society, on the [American Geriatrics Society \(AGS\) Web site](#).

Print copies: Available from the American Geriatrics Society, The Empire State Building, 350 Fifth Avenue, Suite 801, New York, NY 10118; Phone: 212-308-1414, Fax: 212-832-8646; Email: info@americangeriatrics.org; Web site: www.americangeriatrics.org.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- AGS clinical practice guideline: the management of persistent pain in older persons. Executive summary, 2002.

Electronic copies: Available from the [American Geriatrics Society \(AGS\) Web site](#).

Print copies: Available from the American Geriatrics Society, The Empire State Building, 350 Fifth Avenue, Suite 801, New York, NY 10118; Phone: 212-308-1414, Fax: 212-832-8646; Email: info@americangeriatrics.org; Web site: www.americangeriatrics.org.

PATIENT RESOURCES

The following is available:

- Assessing pain in loved ones with dementia: A guide for family and caregivers. New York (NY): American Geriatrics Society (AGS), AGS Foundation for Health in Aging, 2002.
- The patient education forum. Persistent pain. New York (NY): American Geriatrics Society (AGS), AGS Foundation for Health in Aging, 2002.
- Medications for persistent pain. An older adult's guide to safe use of pain medications. New York (NY): American Geriatrics Society (AGS), AGS Foundation for Health in Aging, 2002.
- Daily pain diary. New York (NY): American Geriatrics Society (AGS), AGS Foundation for Health in Aging, 2002.
- My drug and supplement diary. New York (NY): American Geriatrics Society (AGS), AGS Foundation for Health in Aging, 2002.

Electronic copies available from the [AGS Foundation for Health in Aging Web site](#).

Please note: This patient information is intended to provide health professionals with information to share with their patients to help them better understand their health and their diagnosed disorders. By providing access to this patient information, it is not the intention of NGC to provide specific medical advice for particular patients. Rather we urge patients and their representatives to review this material and then to consult with a licensed health professional for evaluation of treatment options suitable for them as well as for diagnosis and answers to their personal medical questions. This patient information has been derived and prepared from a guideline for health care professionals included on NGC by the authors or publishers of that original guideline. The patient information is not reviewed by NGC to establish whether or not it accurately reflects the original guideline's content.

NGC STATUS

This summary was completed by ECRI on July 26, 1999. The information was verified by the guideline developer as of August 13, 1999. This summary was updated on December 7, 2002. The updated information was verified by the guideline developer on April 9, 2003. This summary was updated by ECRI on January 12, 2005 following the release of a public health advisory from the U.S. Food and Drug Administration regarding the use of some non-steroidal anti-inflammatory drug products. This summary was updated on April 15, 2005 following the withdrawal of Bextra (valdecoxib) from the market and the release of heightened warnings for Celebrex (celecoxib) and other nonselective nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI on June 16, 2005, following the U.S. Food and Drug Administration advisory on COX-2 selective and non-selective non-steroidal anti-inflammatory drugs (NSAIDs).

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Date Modified: 7/17/2006

