Considerations for Treating Pain in the Older Cancer Patient

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Pain in older cancer patients is a common event, and many times it is undertreated. Barriers to cancer pain management in the elderly include concerns about the use of medications, the atypical manifestations of pain in the elderly, and side effects related to opioid and other analgesic drugs. The care of older cancer patients experiencing pain involves a comprehensive assessment, which includes evaluation for conditions that may exacerbate or be exacerbated by pain, affecting its expression, such as emotional and spiritual distress, disability, and comorbid conditions. It is important to use appropriate tools to evaluate pain and other symptoms that can be related to it. Pain in older cancer patients should be managed in an interdisciplinary environment using pharmacologic and nonpharmacologic interventions whose main goals are decreasing suffering and improving quality of life. In this two-part article, the authors present a review of the management of pain in older cancer patients, emphasizing the roles of adequate assessment and a multidisciplinary team approach.

Drs. Delgado-Guay and Bruera note that an increasing average life span will inevitably lead to increased numbers of elderly patients being diagnosed and treated for cancer. As a result, health-care professionals will need to become more informed about the physiologic changes that occur with aging and the unique requirements of this population. This article deals with one aspect of elder cancer care—namely, the common problem of pain, as associated with both cancer and longevity. As a geriatrician with a special interest in the older person with cancer and a geriatric psychiatrist with an interest in end-of-life care, we recommend this review as an excellent source document for the oncologist.

The older cancer patient typically has a multitude of comorbid medical conditions. The average older person will have at least four medical problems that will require attention during their cancer treatment, and which in many cases will guide oncologic treatment choices (eg, the person with advanced dementia and colorectal cancer). It is important to recognize that age alone should not be used as a factor in determining cancer treatment, nor should it limit curative treatment options. With this said, many older persons cannot tolerate the rigors of curative cancer treatment. The clinician is then faced with modifying care to follow the palliative model. Palliative medicine is an emerging field that has developed its own standards. For further information, the reader is referred to the American Academy of Hospice and Palliative Medicine website (www.AAHPM.org).

Pain Expression

Pain can be a part of the malignant process in addition to a frequent side effect. Pain is a unique symptom, best treated with a comprehensive approach directed by an interdisciplinary team. In part 1 of the article, in the authors’ Table 1 (Comprehensive Assessment of Pain in Older Cancer Patients), we would add a note about the expression of pain, indicating that pain resulting from noncancer etiologies might be severe enough to necessitate other medications or treatments separate from cancer treatment or palliation.

Pain perception and its expression in the elderly, particularly in various ethnic and age groups, remains to be further clarified. In our studies,[1] elder Hispanics living in Albuquerque reported pain similarly to Caucasians of the same age in this community. Ferrell et al[2] noted that in a large population of nursing home residents, pain could be determined accurately using tools appropriate to the individuals being studied. Clinicians should be aware that the expression of pain can depend on many factors other than those mentioned. Therefore, a variety of pain tools are required for the clinician to assess the pain being experienced—not just the pain that is overtly expressed or observed by staff.

Other illnesses will influence pain and its expression. Dementia, for example, can be a major barrier to pain assessment and its treatment. People with cognitive impairment often underestimate their pain. Further research is needed to determine whether pain sensory information is obfuscated during
the cognitive decline of dementia in a way similar to other agnosias. That aside, the undertreatment of pain in the cognitively impaired is well documented. Bernabei et al reported that only one-quarter of demented individuals identified as experiencing pain received analgesics.[3] Even more alarming, Morrison and Siu documented that among patients hospitalized after hip fracture surgery, those who were cognitively impaired received one-third the opioid analgesics administered to similarly diagnosed cognitively intact patients.[4]

As one ages, alterations can occur in numerous physiologic functions. In addition, the older person may be taking a variety of alternative therapeutic agents, including many "natural" products. These can alter the pharmacokinetics of traditional medications (eg, the interaction between St. John's wart and methadone). Another major issue in the use of analgesics is the concomitant use of illicit drugs and/or alcohol. It is suggested that the CAGE questionnaire might not be sensitive in the elderly, and some authors suggest the use of the Alcohol-Related Problems Survey instead.[5]

Drug Therapy

The authors' section on pain medication is comprehensive. We suggest that the reader be familiar with the use of adjuvant medications in the older person with cancer-related pain. For example, the gnawing, burning pain related to invasion of the celiac plexus in patients with metastatic pancreatic carcinoma is best treated with medications such as nortryptyline. Opioids can be used in this clinical situation, but only as an adjuvant measure in addition to these other medications. Similarly, fentanyl should be used in the elderly only after the patient is stable on one of the many opioids listed in the article. In 1994, Holdsworth and Forman published the kinetics of low-dose transdermal fentanyl in opioid-naive elderly patients.[6] They noted a rapid, toxic response to this regimen. Only recently, lower initial dosing recommendations have been instituted for this agent.

Methadone has become a popular analgesic primarily because of its low cost. It has a very complex pharmacology, and we would suggest that older patients should rarely receive this medication. This should be accompanied by very cautious restriction of other medications being used for nonrelated medical conditions.

The route of administration is critical to obtaining the blood levels needed for a therapeutic response. The rectal route, although utilized by many clinicians, can have many potential problems. The complex anatomy of the venous drainage in this area can deliver the medication in doses that are either too high or too low depending on the particular placement of a suppository in the rectum. The major and most debilitating side effect of the opioids including methadone is constipation. As discussed in the article, an opioid and a laxative often must be prescribed at the same time. The use of complementary and alternative medicine (CAM) is coming of age, and numerous methods such as acupuncture, acupressure, massage, and herbal preparations are commonly employed. The available data on these measures are limited, but the clinician planning to prescribe CAM as part of the treatment regimen should search the literature for guidance.

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