Giovedì, 30 novembre 2017

Molecole antiche e moderne nella terapia farmacologica del dolore cronico

Renzo ROZZINI
Dipartimento di Geriatria - Istituto Ospedaliero Poliambulanza-Brescia
AIP - Sezione Lombardia
Gruppo di Ricerca Geriatrica

Di cosa voglio parlare

- La cura del sintomo e la geriatria
- Dolore e sofferenza nella vita della persona
- Dolore e sofferenza come linguaggio
- Lessico discreto e obiettivi di salute e cura
- Nuove terapie farmacologiche e mortalità
  - Nei giovani
  - Nei vecchi
- Linee guida della terapia del dolore
- Conclusioni

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THE NEW ENGLAND JOURNAL OF MEDICINE

SOUNDING BOARD

THE ILLNESS AS THE FOCUS OF GERIATRIC MEDICINE

MARK E. WILLIAMS, M.D. NORTIN M. HADLER, M.D.

June 2, 1983

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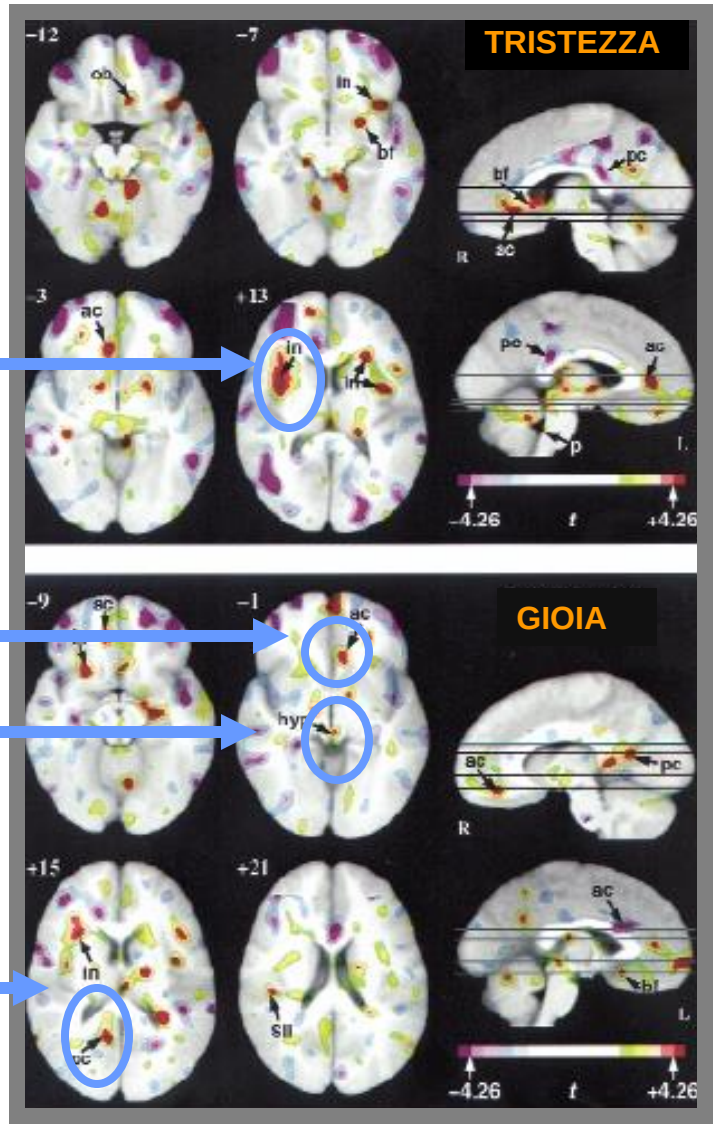
cingolo posteriore



Regioni cerebrali attivate durante la percezione di un sentimento di tristezza e di gioia, nel corso di una PET.

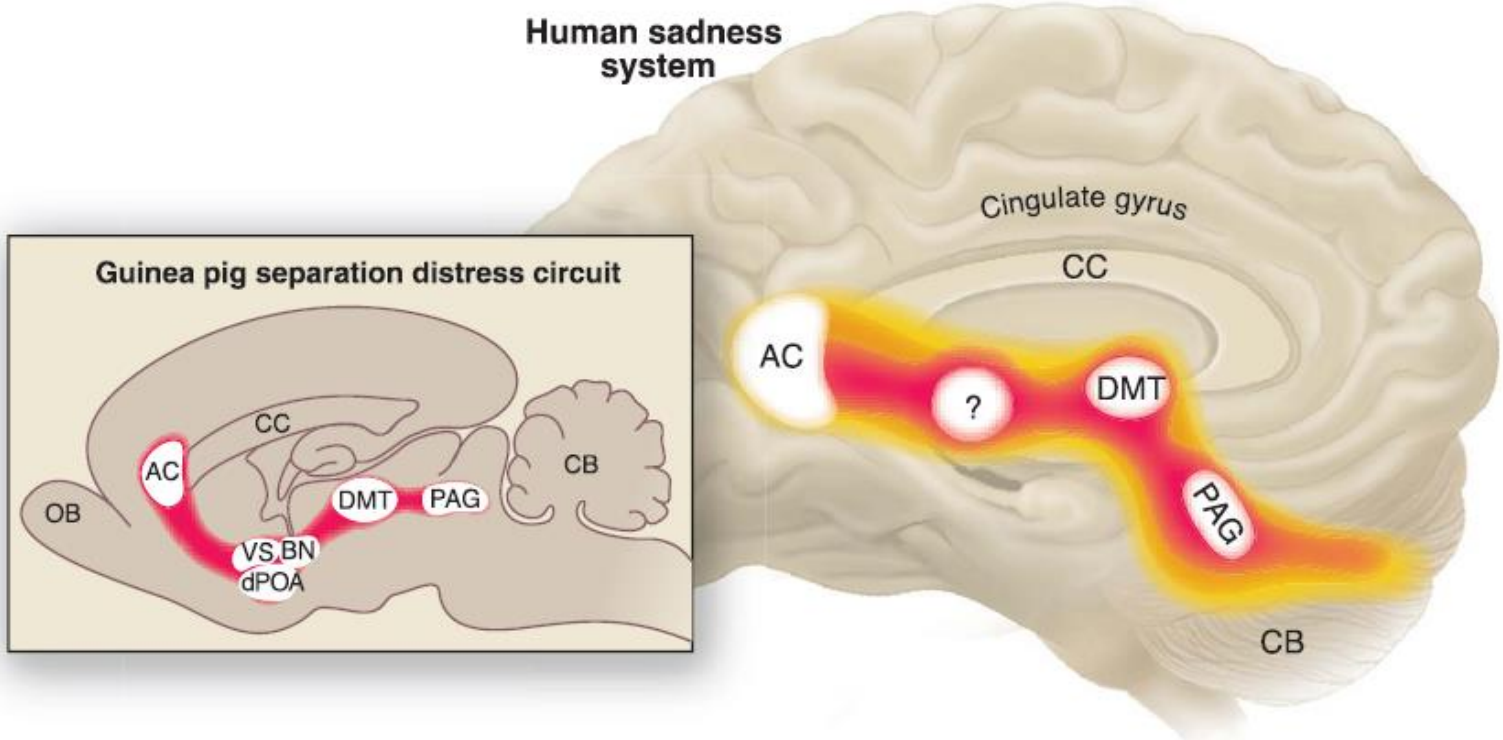
Antonio Damasio
Alla ricerca di Spinoza
2003, Adelphi

Feeling the Pain of Social Loss

Jaak Panksepp

The Greek philosopher Zeno of Citium (356 to 264 B.C.), the founder of Stoicism, considered pain to be one of nine forms of grief. We often speak about the loss of a loved one in terms of painful feelings, but it is still not clear to what extent such metaphors reflect what is actually happening in the human brain? Enter Eisenberger and colleagues (*1*) on page 290 of this issue with a bold neuroimaging experiment that seeks to discover whether the metaphor for the psychological pain of social loss is reflected in the neural circuitry of the human brain. Using functional magnetic resonance imaging (fMRI), they show that certain human brain areas that "light up" during physical pain are also activated during emotional pain induced by social exclusion.

...i risultati indicano che la sofferenza legata all'esclusione sociale e il dolore fisico coinvolgono le stesse aree cerebrali.



The emotional pain of social loss. There are remarkable similarities between regions of the guinea pig brain that when activated provoke separation distress and areas of the human brain that are activated during feelings of sadness. During separation distress in guinea pigs, the most responsive brain areas are the anterior cingulate (AC), the ventral septal (VS) and dorsal preoptic areas (dPOA), the bed nucleus of the stria terminalis (BN), the dorsomedial thalamus (DMT), and the periaqueductal central gray area of the brain stem (PAG) (*18*, *19*). In

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Il dolore psicologico, specialmente la sofferenza provocata dal sentirsi soli e rifiutati dagli altri, coinvolge gli stessi meccanismi cerebrali che elaborano il dolore fisico.

SCIENCE VOL 302 10 OCTOBER 2003

INVITED COMMENTARY

Analgesic Use in the Elderly

The "Pain" and Simple Truth

To describe his frustration with treating pain, Sir William Osler once famously quipped, "When I see a patient with arthritis coming in the front door, I leave by the back door."[1] More than 100 years later, chronic musculoskeletal pain remains an equally frustrating and challenging condition for practitioners to diagnose and treat.

Parlare della terapia del dolore (nelle cure di fine vita) impone una riflessione che inquadri la questione del soffrire in un campo di connessioni dove malattia e vissuto, cura e prendersi cura sono concepiti come parti di un unico sistema e malato e familiare, medico e paziente sono riconosciuti come protagonisti di un'esperienza profondamente umana e soggetti in relazione con sé e con gli altri.

Non esistono malattie se non ci sono uomini e donne che le vivono, caricate del loro peso che spesso dura anni.
Non possiamo considerare la malattia fuori dalla persona cui inerisce e dal suo contesto affettivo e simbolico.

Gruppo di studio SIGG
"LA CURA NELLA FASE
TERMINALE DELLA VITA"

Nella fase avanzata di una malattia, quando si giunge in prossimità della fine della vita, si fa urgente ed essenziale il bisogno di connettere

- **sensazioni (il dolore fisico)**
- **pensieri (il senso del soffrire)**
- **sentimenti (paura, angoscia)**

che fino a quel momento sono stati divisi o contrapposti o ignorati. Ogni elemento si travasa e si confonde nell'altro e permea il tutto della persona, specie quando il dolore diventa "smisurato" e si impadronisce dell'anima oltre che del corpo.

Il livello fisico (*disease*) dello stare male si intreccia con il vissuto di malattia (*illness*) e genera un malessere (*sickness*) in cui si condensa la storia personale del soggetto.

Non è indifferente ciò che sono stato, ciò che pensavo della vita, della malattia, della morte, della vecchiaia e del dolore, quando mi trovo a vivere la mia fine, anche quando non ne ho coscienza o quando mi trovo davanti al finire di un altro a cui sono legato.

Si richiede all'équipe di cogliere l'unicità dell'esperienza della persona, oltre le categorizzazioni di paziente, non autosufficiente, demente, morente … Si richiede la capacità di decifrare le parole o i tumultuosi silenzi con cui la persona esprime il suo stare male.

Gruppo di studio SIGG
"LA CURA NELLA FASE
TERMINALE DELLA VITA"

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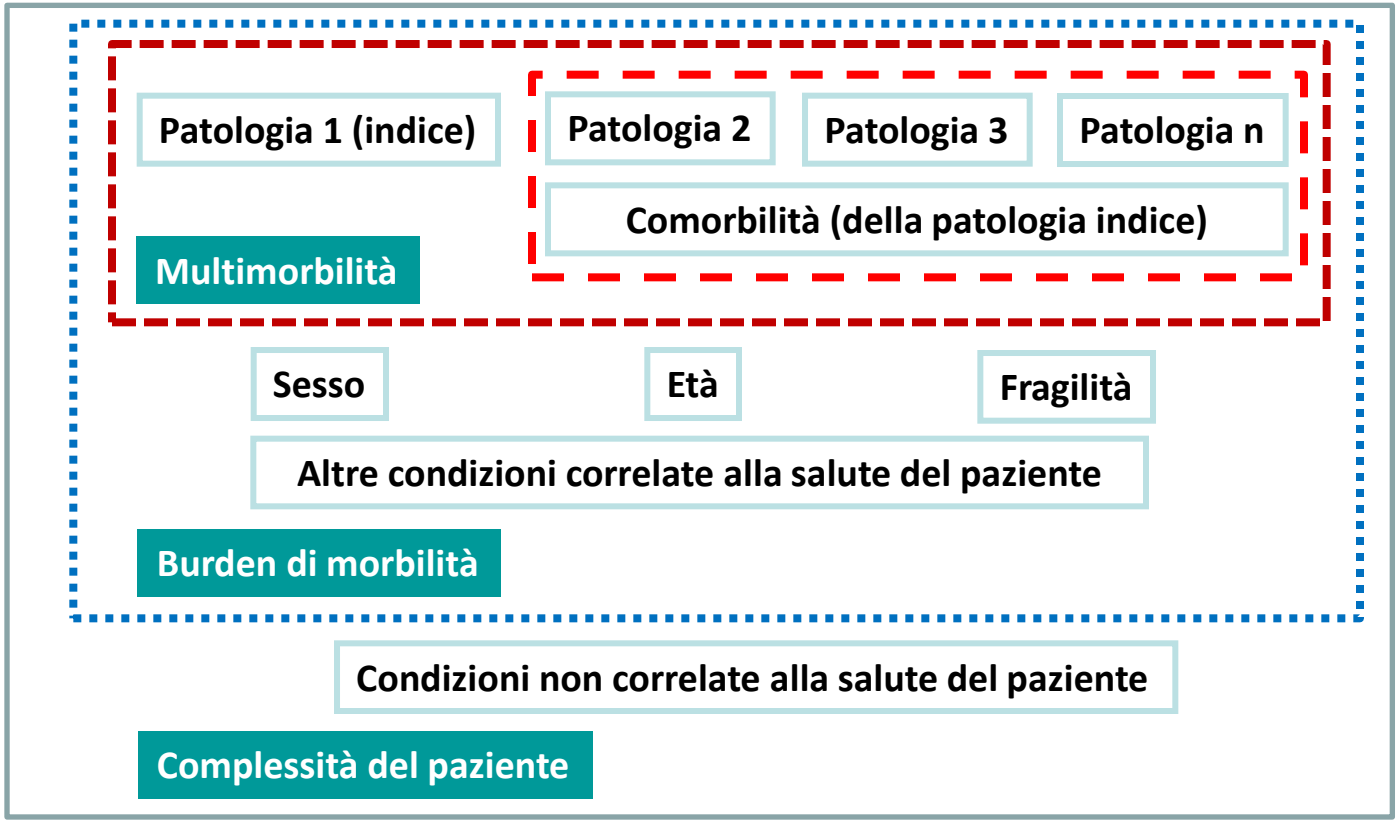
I costrutti della comorbilità



Comorbilità: presenza di una patologia aggiuntiva rispetto a una patologia indice
Multimorbilità: presenza di più patologie in uno stesso paziente
Burden di morbilità: impatto complessivo di diverse patologie in un paziente che tiene in conto la loro gravità
Complessità del paziente: impatto complessivo di diverse patologie in un paziente che tiene conto della loro gravità e di altri fattori correlati alla salute

Finalità di una procedura diagnostica/trattamento nell'anziano (da condividere con paziente e famiglia)

- **Prolungamento della vita**
- **Miglioramento dello stato funzionale e dell'autonomia**
- **Mantenimento dell'integrità dello stato mentale**
- **Comfort**

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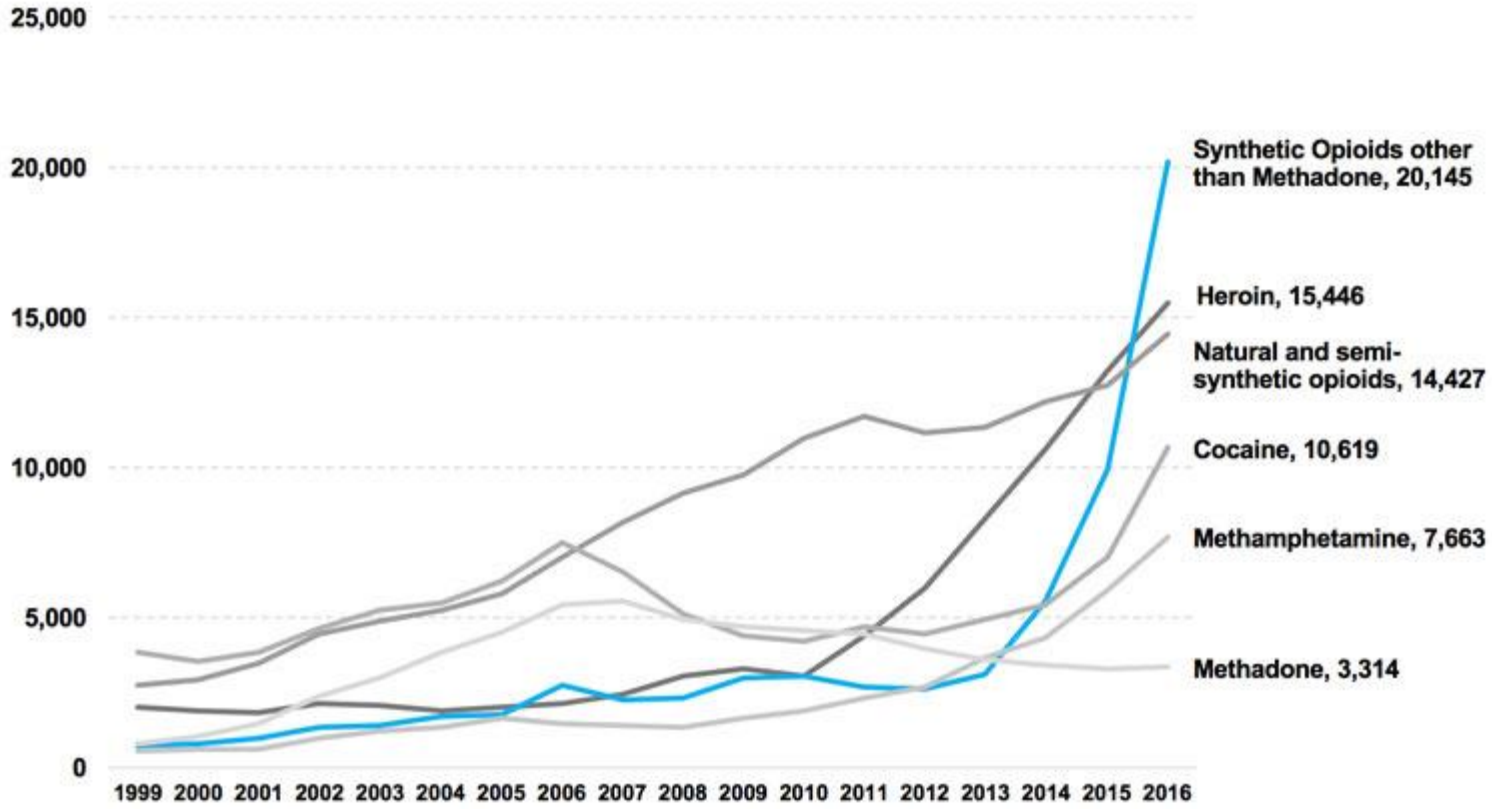
Drugs Involved in U.S. Overdose Deaths, 2000 to 2016



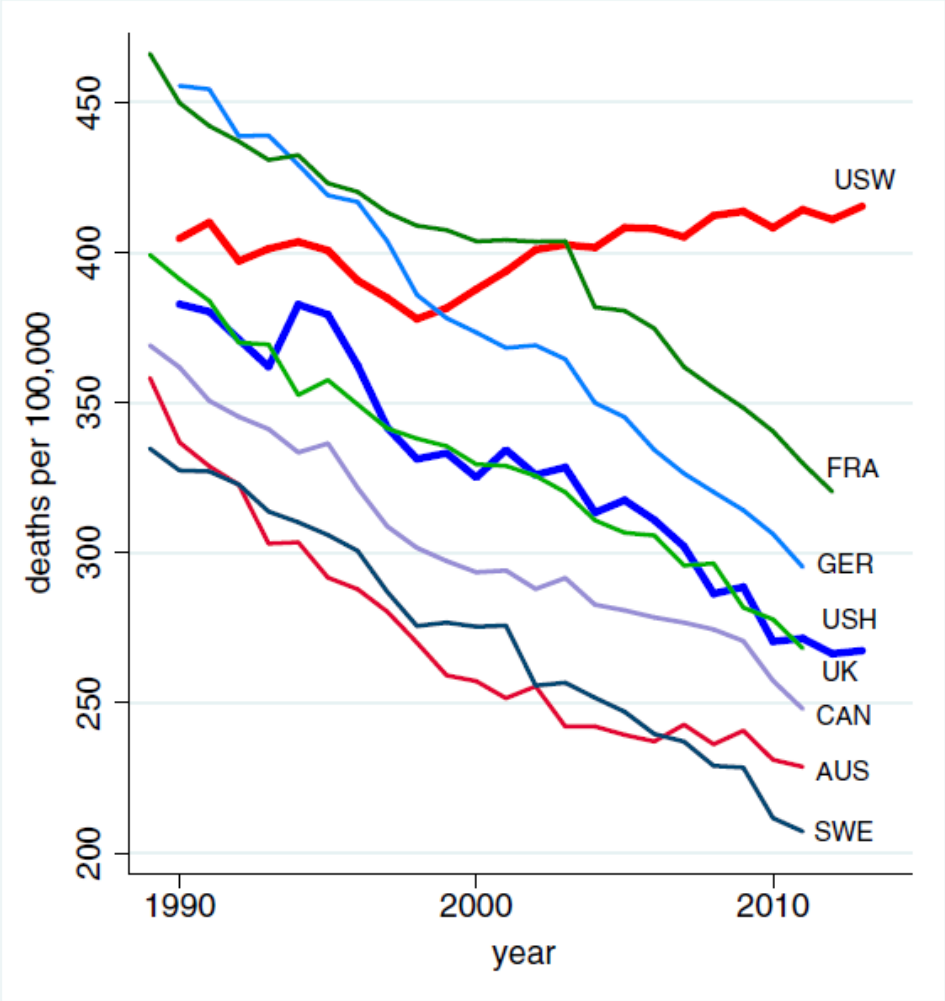


Fig. 1. All-cause mortality, ages 45–54 for US White non-Hispanics (USW), US Hispanics (USH), and six comparison countries: France (FRA), Germany (GER), the United Kingdom (UK), Canada (CAN), Australia (AUS), and Sweden (SWE).

EDITORIAL

The CDC Guideline on Opioid Prescribing
Rising to the Challenge

Yngvild Olsen, MD, MPH

The CDC guideline for prescribing opioids for chronic pain is an important and essential step forward. With support from physicians across the country, as well as from policy makers at all levels, implementation of the recommendations in this guideline has the potential to improve and save many, many lives.

JAMA Published online March 15, 2016

Special Communication

CDC Guideline for Prescribing Opioids for Chronic Pain—United States, 2016

Deborah Dowell, MD, MPH; Tamara M. Haegerich, PhD; Roger Chou, MD

JAMA. doi:10.1001/jama.2016.1464
Published online March 15, 2016.

Table 4. Morphine Milligram Equivalent Doses for Commonly Prescribed Opioids[a]

Opioid[b]	Conversion Factor
Codeine	0.15
Fentanyl transdermal, μg/h	2.4
Hydrocodone	1
Hydromorphone	4
Methadone, mg/d	
1-20	4
21-40	8
41-60	10
≥61-80	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3
Tapentadol[c]	0.4

[a] Adapted from Von Korff M, Saunders K, Ray GT, et al. *Clin J Pain*. 2008;24:521-527, and Interagency Guideline on Prescribing Opioids for Pain. Washington State Agency Medical Directors' Group. http://www.agencymeddirectors.wa.gov/Files/2015AMDGOpioidGuideline.pdf. Accessed February 19, 2016.

[b] All doses are in mg/d except for fentanyl, which is μg/h. Multiply the daily dosage for each opioid by the conversion factor to determine the dose in morphine milligram equivalents (MME). For example, tablets containing hydrocodone, 5 mg, and acetaminophen, 300 mg, taken 4 times a day would contain a total of 20 mg of hydrocodone daily, equivalent to 20 MME daily; extended-release tablets containing oxycodone, 10 mg, and taken twice a day would contain a total of 20 mg of oxycodone daily, equivalent to 30 MME daily.

[c] Tapentadol is a μ-receptor agonist and norepinephrine reuptake inhibitor. Morphine milligram equivalents are based on degree of μ-receptor agonist activity, but it is unknown if this drug is associated with overdose in the same dose-dependent manner as observed with medications that are solely μ-receptor agonists.

The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL REPORT

A Proactive Response to Prescription Opioid Abuse

Robert M. Califf, M.D., Janet Woodcock, M.D., and Stephen Ostroff, M.D.

A key lesson learned during the development of the CDC guideline is that there is very little research on the long-term benefits of opioids for treating chronic pain. There is, however, growing evidence of harms associated with such use, and of the benefits of other nonopioid treatment alternatives.

N ENGL J MED 374;15 NEJM.ORG APRIL 14, 2016

The FDA has approved nonopioid medications for treatment of various chronic-pain syndromes, including gabapentin (Neurontin), pregabalin (Lyrica), milnacipran (Savella), duloxetine (Cymbalta), and others, and a number of promising development programs are in the pipeline. But we need more. The FDA will use all the tools at its disposal to move these alternatives along as expeditiously as possible, while remaining mindful that all medicines have risks. For example, although nonsteroidal antiinflammatory drugs do not carry a risk of addiction, we now know that they carry increased risks of myocardial infarction, stroke, and serious gastrointestinal bleeding.

Does paracetamol still have a future in osteoarthritis?

*Nicholas Moore, Francesco Salvo, Mai Duong,
Sinem Ezgi Gulmez

A crucial need remains to find new painkillers for osteoarthritis. Have any new analgesics been released since ibuprofen and diclofenac came out in the early 1970s, apart from the clinically minor COX-2 selective NSAIDs? All existing painkillers are merely minor variations on those early NSAIDs or opioids. Can't we do better?

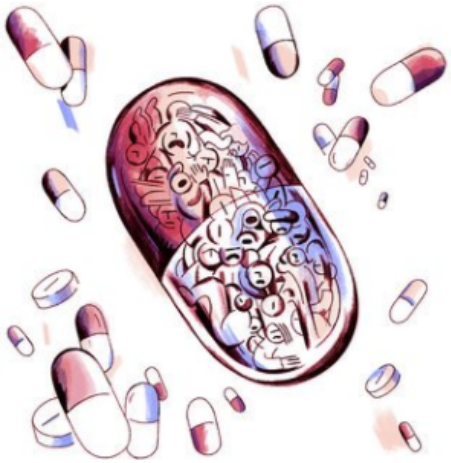
www.thelancet.com **Published online March 17, 2016 http://dx.doi.org/10.1016/S0140-6736(15)01170-8**

The New York Times

Opinion | LETTERS

Pain Management and the Opioid Crisis

NOV. 19, 2017



Niv Bavarsky

To the Editor:

Re "Taxpayer-Funded Addiction" (editorial, Nov. 11):

Effectively addressing the opioid crisis requires a comprehensive approach that meets immediate needs and invests in future solutions for patients.

In criticizing the administration's public-private partnership, you created a false dichotomy between immediate efforts to address the crisis and the long-term solutions offered by the public-private partnership; we can do both.

New treatments that reduce the risk for abuse, addiction and overdose — including the development of nonopioid alternatives — are a critical component of any public health solution. In this area the biopharmaceutical industry can and should play a unique role.

Our industry is developing 40 nonopioid analgesics and has an additional 40 addiction recovery treatments in the pipeline. The National Institutes of Health and the National Institute on Drug Abuse are wrestling with this problem as well, and working in partnership we can solve it.

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Editorial

Pain Management in the Elderly

Angela M. Sanford MD *

Division of Geriatric Medicine, Saint Louis University School of Medicine, St. Louis, Missouri

Although it is true that opioids have many unfavorable side effects, such as constipation, appetite suppression, increased risk of falls, and potential of developing increased tolerance and addiction, their positive effect on quality of life often outweighs the risk of their adverse effects.[8] Similarly, while opioid tolerance may occur, many nursing home residents do not have the life expectancy required to develop tolerance to escalating doses of medication. The principal goal in caring for nursing home patients is to provide the best quality of life possible. If this necessitates prescribing a scheduled opioid three times daily with the purpose of keeping a patient functional and pain-free enough to ambulate to the dining room for meals, the benefits likely outweigh the risks. It is worth noting that the CDC recently released guidelines regarding the prescribing of opioids in non—cancer-related pain.[9] These guidelines, which exclude those who are near the end of life or are on palliative care, are designed primarily to discourage opioid use for routine pain management in those with chronic pain. They cannot be applied to the general nursing home population, where the aim in most patients is more palliative, focusing on quality of life in these patients with limited life expectancies.

The Hype about the Opioid Epidemic Risks Harming Older Persons

Data pubblicazione 20 novembre 2017

Dr. John Morley | Segui
Professor at Saint Louis University morley@slu.edu

Pain is one of the most common human experiences. Over 100 million adults in the United States suffer from chronic pain. Low back pain is the most common cause of chronic pain. Other causes are headaches, neck and facial pain. Chronic pain is the primary cause of disability in the United States. Persons with chronic pain are often depressed and have their sleep disrupted by the pain.

Older women have the most chronic pain so it is not surprising that they have the highest opioid use, based on prescription data monitoring.
Is this bad? While one can question the effectiveness of opioids in being used for chronic pain, they generally work better than non-opioid analgesics, and usually are only used after these drugs have failed. In addition, in older persons NSAIDs (motrin/ibuprofen) have a variety of side effects including worsening high blood pressure, kidney damage, bleeding from the gut and other places, heartburn, gastric ulcers and allergic reactions. In contrast, opioids in reasonable doses only produce constipation and possibly respiratory depression and sedation in reasonable doses.
Long term use can lead to physical dependence and addiction, but this is much rarer in older persons.
Opioid addiction generally starts in adolescents or young adults NOT old people. Even if addicted, older persons rarely move on to heroin or street drugs, provided that they continue to get their pain medications.
Only 13% of persons treated in emergency departments for opioid overdoses have a chronic pain problem. Also, people who become addicted to drugs often have mental illness as the cause.

Despite the lack of evidence to condemn opioid use in older persons, politicians, lawyers and news organizations have declared that we have an opioid epidemic – not an increase in the use of illegal drugs.

For older people, requiring them to come to see the physician monthly to receive their prescription is very difficult, particularly as many of them are functionally impaired, and even getting out of the house can be difficult. Also, demanding regular urine tests in older persons is demeaning and clearly not cost effective.

We should be focusing on the real problem, which is opioid addiction in young people, NOT deciding that older persons with real pain should not receive appropriate treatment. Yes, I know that massage and other behavioral treatments may work as well, if not better, for pain, but then we need to make these easily available and cheap for older persons.

E John Morley è uomo d’onore

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Clinical Review & Education

Care of the Aging Patient: From Evidence to Action

Management of Persistent Pain in the Older Patient
A Clinical Review

Una E. Makris, MD; Robert C. Abrams, MD; Barry Gurland, FRCPhysicians, FRCPsychiatry; M. Carrington Reid, MD, PhD

CONCLUSIONS AND RELEVANCE Treatment planning for persistent pain in later life requires a clear understanding of the patient's treatment goals and expectations, comorbidities, and cognitive and functional status, as well as coordinating community resources and family support when available. A combination of pharmacologic, nonpharmacologic, and rehabilitative approaches in addition to a strong therapeutic alliance between the patient and physician is essential in setting, adjusting, and achieving realistic goals of therapy.

JAMA. 2014;312(8):825-836. doi:10.1001/jama.2014.9405

Box 1. Key Points Regarding Overall Approach to Management of Persistent Pain in the Older Adult

1. Determine patient's comorbidities, cognitive and functional status, treatment goals and expectations, and social and family supports prior to initiating treatment
2. Intervene using a multimodal approach, including pharmacologic and nonpharmacologic treatments as well as physical and occupational rehabilitation modalities
3. Develop and enrich therapeutic alliance between patient and physician (physician must respond promptly and reliably to patient calls and provide backup coverage when away; consider all patient input seriously; encourage hope without overpromising therapeutic success)
4. Be willing to revisit previously used pharmacologic and nonpharmacologic treatment modalities with indicated modifications
5. Involve and engage caregivers and seek out other resources (eg, community-based programs) that can help to reinforce treatment adherence and maintain treatment gains
6. Reinforce positive outcomes at each visit

JAMA. 2014;312(8):825-836. doi:10.1001/jama.2014.9405

Box 2. Key Points Regarding Pharmacologic and Nonpharmacologic Approaches

1. Link potential treatment benefits with important patient goals (eg, increased ability to perform activities of daily living)
2. Use medication combinations (in which each analgesic works by a different mechanism) to enhance analgesic effectiveness
3. Acetaminophen remains first-line pharmacologic treatment for older adults with mild-to-moderate pain
4. Avoid long-term use of oral nonsteroidal anti-inflammatory drugs, given their significant cardiovascular, gastrointestinal, and renal risks
5. Trial of opioid is appropriate for patients not responsive to first-line therapies and who continue to experience significant functional impairment due to pain
6. Consider serotonin-norepinephrine reuptake inhibitors or selective serotonin reuptake inhibitors in patients with comorbid depression and pain
7. Implement surveillance plan (ie, efficacy, tolerability, adherence) with each new treatment
8. Physical activity (including physical therapy, exercise, or other movement-based programs such as tai chi) constitutes a core component of managing persistent pain in older patients
9. Educate older patients about safety and efficacy of cognitive behavioral and movement-based therapies and identify local practitioners or agencies that provide them
10. Determine whether treatment goals are being met; if goals are not met, medication should be tapered and discontinued, physical and occupational therapy prescription modified, or both

Table 1. Efficacy and Safety Data and Guideline Recommendations Regarding Frequently Prescribed Pharmacologic Treatments for Persistent Pain in Older Adults

Treatment	Efficacy	Level of Evidence[a]	Safety Issues	Guideline Recommendations	Recommended Starting Dose(s)[b]
Pain Medications					
Acetaminophen/paracetamol	Reduces pain relative to placebo (effect size, 0.21 [95% CI, 0.02-0.41])[33]; inferior when compared with oral NSAIDs for pain reduction, stiffness, and physical functioning[34]	Ia	Acetaminophen toxicity remains leading cause of acute liver failure in United States; unintentional overdose is leading cause of acetaminophen-induced hepatotoxicity[35]	Recommended as first-line therapy, given excellent overall safety profile[13,25,26]	325 mg every 4 h; maximum daily dose, 3250 mg
Oral NSAIDs	Reduce pain (effect size, 0.32 [95% CI, 0.24-0.39]) and functional disability (effect size, 0.29 [95% CI, 0.18-0.40]) relative to placebo[36]	Ia	Established gastrointestinal, renal, and cardiovascular toxicity; gastrointestinal bleeding risk increases with age; patients taking long-term therapy should be monitored closely for gastrointestinal, renal, and cardiovascular adverse effects[13,26]	Should be used with caution and for the shortest time possible, given related risks; use only when other therapies have failed or continuing therapeutic goals not met[13,25,26]	Naproxen sodium: 220 mg every 12 h Ibuprofen: 200 mg every 8 h Diclofenac extended release: 100 mg every 12 h Celecoxib: 100 mg every 12 h
Topical NSAIDs	Reduce pain (effect size, 0.41 [95% CI, 0.14-0 .68]); improve physical function (effect size, 0.44 [95% CI, 0.16-0.71]) and stiffness (effect size, 0.43 [95% CI, 0.15-0.70]) relative to placebo[37]; equivalent to oral NSAIDs in terms of pain reduction at 1 y[38]	Ib	Generally well tolerated, given lower systemic absorption; however, safety of topical NSAIDs in patients taking anticoagulation therapy or with renal impairment remains unknown[39]	Consider as alternative to oral NSAIDs, particularly if pain is localized[13,25,26]	Volataren gel/ diclofenac gel: apply 4 g to affected area every 6 h; maximum daily dose, 32 g
Tramadol	Reduces pain relative to placebo (visual analog score at day 7, $P = .002$; day 14, $P = .01$). At day 14, mean decrease in pain intensity of 2.43 cm in tramadol group compared with 1.55 cm in placebo group (VAS, 0-10 cm). No difference between groups for functional index score[40]	Ib	Adverse effects include constipation, nausea/ vomiting, dizziness, headache, somnolence[41] Potential drug interactions and increased risk of seizures or serotonin syndrome when used with antidepressants, especially monoamine oxidase inhibitors, serotonin reuptake inhibitors, and tricyclic antidepressants.[42]	Monitor for adverse effects[25,26]	50 mg every night, then 25-50 mg immediate release every 6 h; maximum daily dose, 400 mg
Opioids	Reduce pain (effect size, 0.56; $P < .001$) and functional disability (effect size, 0.43; $P < .002$) relative to placebo[43]	Ia	Established risk of fall or fracture[44,45]; increased risk of hospitalization relative to nonselective NSAIDs[45]; constipation and other adverse effects (eg, lethargy, nausea/vomiting) constitute major causes of treatment failure[46]	Consider for use in older patients with moderate-to-severe pain or with substantial impairments in physical functioning or quality of life that have failed other treatments[13,25,26]	Oxycodone: 2.5 mg every night, then 2.5-5.0 mg every 4-6 h Hydrodocone: 2.5 mg every night, then 2.5-5.0 mg every 4-6 h

Table 1. Efficacy and Safety Data and Guideline Recommendations Regarding Frequently Prescribed Pharmacologic Treatments for Persistent Pain in Older Adults (continued)

Treatment	Efficacy	Level of Evidence[a]	Safety Issues	Guideline Recommendations	Recommended Starting Dose(s)[b]
Adjuvant Medications					
Tricyclic antidepressants	Amitriptyline reduces pain relative to placebo in patients with diabetic neuropathy (67% of patients reported moderate or greater pain relief)[47]	Ib	Adverse effects (particularly anticholinergic and noradrenergic) limit use; QTc prolongation risk requires ECG monitoring; monitoring serum levels is recommended given substantial potential for toxicity at higher doses[13,26]	Tertiary tricyclics (eg, amitriptyline, doxepin) should be avoided because of high incidence of adverse effects[25,26]	Nortriptyline: 25 mg every night to start; maximum daily dose, 200 mg (if comorbid depression is present and depending on serum level)
Anticonvulsants	Pregabalin and gabapentin both reduce pain relative to placebo among patients with diabetic neuropathy, 25% average pain reduction for patients taking pregabalin,[48] whereas 52% of patients treated with gabapentin reported moderate or greater pain relief[47]	Ib	Adverse effect profile can limit use in older patients (eg, sedation, dizziness, peripheral edema); dose adjustment of gabapentin and pregabalin necessary in those with renal impairment[13,26,49]	Recommended for use in older patients with neuropathic pain[13,25,26]	Pregabalin: 50 mg every night, then 50 mg every 8 h; maximum daily dose, 300 mg Gabapentin: 100 mg every night, then 100 mg every 8 h; maximum daily dose, 3600 mg
Serotonin-norepinephrine reuptake inhibitors	Duloxetine reduces diabetic neuropathic pain (50% reduction in average pain score achieved by ≈50% of duloxetine-treated vs 26% of placebo-treated patients)[50]; duloxetine also superior to placebo for pain reduction and improved physical functioning in patients with knee osteoarthritis[51]	Ib	Generally well tolerated, but adverse effects include hyponatremia, dizziness, abdominal pain, and nausea[13,26]	Recommended for use in older patients with neuropathic pain[13,25,26]	Duloxetine: 20 mg daily; maximum daily dose, 60 mg Venlafaxine: 37.5 mg daily; maximum daily dose, 300 mg (if comorbid depression is present)
Serotonin reuptake inhibitors	Did not identify any studies that met age criterion	NA	NA	Not recommended for use as analgesic[13]	NA
Topical lidocaine	Among patients with osteoarthritis of the knee, at least 50% improvement in symptom severity reported by 40% for pain, by 40% for stiffness, and by 38% for increased physical functioning[52]	IIb	Generally well tolerated; most commonly reported adverse effect is headache[52]	Consider for use in older patients with localized neuropathic pain[13,25,26]	Apply patch daily to affected area for 12-h period

Abbreviations: ECG, electrocardiography; NA, not applicable; NSAID, nonsteroidal anti-inflammatory drug; VAS, visual analog scale.

[a] Level of evidence ratings: Ia, evidence from meta-analysis of randomized controlled trials; Ib, evidence from at least 1 randomized controlled trial; IIa, evidence from at least 1 controlled study without randomization; IIb, evidence from at least 1 type of quasi-experimental study; II, evidence from nonexperimental studies, such as comparative studies, correlation studies, and case-control studies.[17]

[b] Dosing recommendations based on American Geriatrics Society clinical guideline[26] and the author's clinical experience. Maximal ceiling doses are reported when present.

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CLINICAL REVIEW

Management of chronic pain in older adults

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Box 2 Key elements of a comprehensive pain assessment

- *Administering standardized pain assessment tools*—this can provide additional information above and beyond what is generated by the interview and physical examination. Table 1⇓ includes measures that are for the most part simple, brief, and appropriate for being self administered. The brief pain inventory-short form and the geriatric pain measure are recommended for routine use in practice because they are easy to complete, have been successfully used in studies of older adults, and assess multiple salient dimensions of the pain experience. It is important to employ assessments that older patients can do without difficulty and to use the same tools at each visit to assess for change in a given outcome over time
- *Ascertaining the impact of chronic pain on functioning*—for example, activities of daily living, social functioning, sleep
- *Identifying attitudes and beliefs about pain, as well as treatment goals and expectations*—many older patients endorse beliefs that operate as important barriers to engagement with and adherence to treatment. Older patients' goals may or may not be the same as the healthcare provider's goals. In addition, patients may have unrealistic (for example, expect complete pain relief) or negative (for example, treatments will not help) expectations that can serve as targets for intervention[16]
- *Gathering data from family members and paid caregivers*—gathering information from third parties about an older patient's response to pain and the impact it has at home may be essential, particularly when patients cannot provide this information because of difficulties with communication as a consequence of stroke or advanced dementia
- *Identifying resources to include family members, other caregivers, and faith communities, when appropriate*—these can provide emotional or instrumental support and help to reinforce engagement with and adherence to treatment
- *Reviewing comorbidities and drugs*—some chronic conditions might be made worse by starting a particular analgesic agent and some drugs may constitute a contraindication to initiating a specific analgesic trial

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Box 3 Elements of a comprehensive geriatric pain assessment

Sensory

Please tell me all of the places you experience pain or discomfort. What does it feel like? What words come to mind?

Is your pain or discomfort with you all of the time or does it come and go? How long has it been present? What makes it better, what makes it worse?

Emotional impact

Has pain affected your mood, sense of wellbeing, energy level?

Are you worried about your pain or what may be causing it?

Functional impact

Has pain affected your ability to do every day activities? To do things you enjoy?

How about relating with others? If so, how?

Sleep

Has pain affected your sleep?

Do you have trouble falling asleep or need to take drugs to help you sleep on account of your pain?

Attitudes and beliefs

Do you have any thoughts or opinions about experiencing pain at this point in your life that you believe would be important for me to know?

Do you have any thoughts or opinions about specific pain treatments that you believe would be important for me to know?

Coping styles

What things do you do to help you cope with your pain? This could be listening to your favorite music, praying, sitting still, or isolating yourself from others

Treatment expectations and goals

What do you think is likely to happen with the treatment I have recommended?

What are the most important things you hope will happen as a result of the treatment?

Resources

Is there anyone at home or in the community that you can turn to for help and support when your pain is really bad?

Table 2| **Guideline recommendations for drug management of chronic pain**

Analgesic class	Recommendation*	Safety concerns	Quality of evidence†
Paracetamol (acetaminophen)	Use for mild to moderate pain	Liver toxicity a concern at higher doses, particularly from unintentional overdose	High
Oral NSAIDs	Use for shortest time possible; may be appropriate when other treatments have failed	Selective and non-selective NSAIDs associated with adverse gastrointestinal, renal, and cardiovascular side effects	High
Topical NSAIDs	Use as alternative to oral NSAIDs, particularly when pain is localized	Safety of topical NSAIDs in patients receiving anticoagulation or with renal impairment remains unknown	Moderate
Tramadol	Consider for use in patients who do not respond to paracetamol/NSAIDs	Increased risk of seizures or serotonin syndrome when used with antidepressants; side effect profile similar to that of opioids	Not reported
Opioids	Use for moderate to severe pain or with substantial impairments in functioning or quality of life and when other treatments have been unsuccessful	Side effects limit use (constipation, sedation, nausea)	Low
Tricyclic antidepressants	Avoid tertiary tricyclics (for example, amitriptyline) because of concerns over adverse side effects; consider trial of secondary amine (nortriptyline) for neuropathic pain	Side effects limit use, electrocardiographic monitoring required owing to risk of QTc prolongation; serum level monitoring also recommended	Moderate
Anticonvulsants (for example, pregabalin, gabapentin)	Use for neuropathic pain	Side effects limit use (for example, sedation, peripheral edema); dose adjustment necessary in those with renal impairment	Moderate

NSAIDs=non-steroidal anti-inflammatory drugs.

*Recommendations present in both UK and US guidelines.[2 3]

†Quality of evidence ratings are from the 2009 American Geriatrics Society guideline.

Di cosa voglio parlare

- La cura del sintomo e la geriatria
- Dolore e sofferenza nella vita della persona
- Dolore e sofferenza come linguaggio
- Lessico discreto e obiettivi di salute e cura
- Nuove terapie farmacologiche e mortalità
  - Nei giovani
  - Nei vecchi
- Linee guida della terapia del dolore
- **Conclusioni**

Finalità di una procedura diagnostica/trattamento nell'anziano (da condividere con paziente e famiglia)

- **Prolungamento della vita**
- **Miglioramento dello stato funzionale e dell'autonomia**
- **Mantenimento dell'integrità dello stato mentale**
- **Comfort**

Zero Pain Is Not the Goal

Thomas H. Lee, MD, MSc

What should health care be trying to accomplish? This question becomes increasingly important as research advances, the population ages, and financial pressures intensify. Simple measures for which 100% is the target cannot define performance for the complex work of health care. Quality does not mean the elimination of death or perfect compliance with guidelines. Efficiency does not mean the elimination of all spending or even 100% elimination of all wasteful spending. And compassion for patients does not mean the elimination of all pain.

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