Pain Management in Older Adults

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Objectives

• Define pain and review basic mechanism of pain

• Describe key considerations associated with pain management in elderly patients

• Apply cultural sensitivity concepts to engage in discussions related to pain medication in elderly patients

• Determine optimal pain medication regimens for an elderly patient with a given clinical presentation
Pain Definitions

• **Pain**: An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage

• **Acute Pain**: A normal response to stimulus or disease process that produces tissue injury and that abates following remission of the stimulus or healing of the injury

• **Chronic Pain**: Pain that persist beyond resolution of an underlying disorder or healing of an injury
## Comparison of Acute and Chronic Pain

<table>
<thead>
<tr>
<th></th>
<th>Acute</th>
<th>Chronic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Duration</strong></td>
<td>Hours to days</td>
<td>Months to years</td>
</tr>
<tr>
<td><strong>Prognosis</strong></td>
<td>Predictable</td>
<td>Unpredictable</td>
</tr>
<tr>
<td><strong>Pathology</strong></td>
<td>Present</td>
<td>Usually none</td>
</tr>
<tr>
<td><strong>Confounding Problems</strong></td>
<td>Uncommon</td>
<td>Depression, anxiety, insomnia</td>
</tr>
<tr>
<td><strong>Autonomic Nervous System</strong></td>
<td>Present</td>
<td>Usually absent</td>
</tr>
<tr>
<td><strong>Social effects</strong></td>
<td>Uncommon</td>
<td>Often present</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Mainly anaglesic</td>
<td>Multimodal</td>
</tr>
</tbody>
</table>
Pain Classifications

Nociceptive
- Somatic
- Visceral

Neuropathic
- Central
- Peripheral
Pain Pathway

Trauma → Transduction → Transmission → Modulation → Perception

**Figure 1.** Transduction, transmission, and modulation targets of pain management drugs.

ASA, aspirin; CNS, central nervous system; GABA, γ-aminobutyric acid; LAs, local anesthetics; NMDA, N-methyl-D-aspartate; NSAID, non-steroidal anti-inflammatory drug; SC, subcutaneous; SNRI, serotonin norepinephrine reuptake inhibitors; SSRRI, selective serotonin reuptake inhibitors; TCA, tricyclic antidepressant.

Importance of Pain in the Elderly

• Pain syndromes are common in older adults and incidence increases with age
  ▫ Prevalence estimates range from 13-49% among those aged 65 years and older
  ▫ Rates higher (49-84%) among residents in long term care facilities
  ▫ A study in Canada found that 48% of adults aged 65 years and older experienced pain daily
  ▫ Other epidemiologic research showed symptomatic osteoarthritis of hand was present in 26% of women and 13% of men older than 71 years of age compared with prevalence of less than 7% in all adults aged 26 years and older

• Pain is often under-recognized and undertreated
  ▫ In one study 66% of geriatric nursing home residents had chronic pain, but in almost half of these cases (34%) it was not detected by treating physician

• Leads to greater functional limitations and decreased quality of life (QOL)
  ▫ Depression and decreased ability to socialize
  ▫ Poor mobility and increased fall
  ▫ Impaired sleep and malnutrition
Sources of pain in elderly

- Degenerative joint disease
- Spinal stenosis
- Fractures
- Pressure ulcers
- Post stroke symptoms
- Cancer pain
- Post-herpetic neuralgia
- Urinary retention
- Neuropathic pain
- Fibromyalgia
Barriers to Effective Pain Management: *Health Care Providers*

- Fear that prescribing, dispensing and administering drug will lead to addiction
- Risk of disciplinary action by federal or state regulators

- Lack of awareness of the extent to which pain can be managed with opioids
- Concern of excessive side effects from opioids

- Conventional belief that pain medication should be reserved for patient with only moderate-to-severe pain

- Inadequate education on pain and patient specific pain management therapy
- Failure to re-evaluate patient’s pain status
Barriers to Effective Pain Management: Legal and Regulatory Systems

- Federal and state controlled-substance laws and policies that restrict access to and amount of opioids that can be prescribed in a given time
- Malpractice insurance policies that create disincentives for practice of pain
- Increase scrutiny of CII drugs by the DEA
  - Limited stock of opioids due to concerns of possible abuse, diversion, or theft
- Duplicate/Triplicate/security prescription pads required by some state regulators to prescribe CII drugs are cumbersome to complete
Barriers to Effective Pain Management: Patients and/or Family Members

- Ideology that pain builds character
- Fear to discuss pain and death in general
  - Desire to be a good patient resulting in underreporting of pain
- Opiophobia, or generalized fear of taking medications, including legitimate use of analgesics
- Belief that opioid analgesics will cause mental confusion, personality change and drug seeking behaviors
  - Fear that use of opioid analgesics will lead family and friends to view patients as “druggies”
Steps to overcome medication barriers

<table>
<thead>
<tr>
<th></th>
<th>Steps</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Conduct a comprehensive pain history</td>
<td>Use same pain scale consistently</td>
</tr>
<tr>
<td>2</td>
<td>Review patient’s problem list</td>
<td>Use of multiple medications (DDI)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Multiple co-existing chronic conditions</td>
</tr>
<tr>
<td>3</td>
<td>Establish patient’s treatment goals</td>
<td>Shared decision making</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Identify realistic treatment goals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Increase satisfaction</td>
</tr>
</tbody>
</table>
Steps to overcome medication barriers

4. Identify barriers to initiating and adhering to therapy
   - Cognitive impairments
   - Sensory impairment
   - Socio-demographic factors
   - Health beliefs

5. DO
   “Start low and go slow”
   DON’T
   “Start low and stay low”

6. Assess for effects and outcomes
   Educate what adverse effects may occur and create a plan to address them if they do
Pain Assessment

• **PQRSTU:**
  - P: provokes/palliates
  - Q: quality—what does the pain feel like?
  - R: radiates/region—where is the pain? Does it spread?
  - S: severity
  - T: timing—onset, duration, frequency?
  - U: understanding—assess pt’s understanding

• **W-I-L-D-A**
  - Word to describe pain
  - Intensity of pain
  - Location
  - Duration
  - Adverse effects/aggravating or alleviating factors

• **4 As:**
  - Analgesia
  - Activities of daily living (ADLs)
  - Adverse drug reactions (ADRs)
  - Aberrant drug-taking behaviors

• **Follow up:**
  - Controlled Substance Utilization Review and Evaluation System (CURES)
  - UTOX screening
Pain Assessment Scales: Patient Report

- Numerical scale (0-10)
- Wong-baker Faces Pain Scale
- Visual Analog scale
- Verbal scale
- Functional Pain scale
UNIVERSAL PAIN ASSESSMENT TOOL

This pain assessment tool is intended to help patient care providers assess pain according to individual patient needs. Explain and use 0-10 Scale for patient self-assessment. Use the faces or behavioral observations to interpret expressed pain when patient cannot communicate his/her pain intensity.

<table>
<thead>
<tr>
<th>Scale</th>
<th>NO PAIN</th>
<th>MILD PAIN</th>
<th>MODERATE PAIN</th>
<th>MODERATE PAIN</th>
<th>SEVERE PAIN</th>
<th>WORST PAIN POSSIBLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal Descriptor Scale</td>
<td>No pain</td>
<td>Mild pain</td>
<td>Moderate pain</td>
<td>Moderate pain</td>
<td>Severe pain</td>
<td>Worst pain possible</td>
</tr>
<tr>
<td>Wong-Baker Facial Grinace Scale</td>
<td>Alert</td>
<td>No humor</td>
<td>Furrowed brow</td>
<td>Wrinkled nose</td>
<td>Slow blink</td>
<td>Eyes closed</td>
</tr>
<tr>
<td>Activity Tolerance Scale</td>
<td>Smiling</td>
<td>Serious</td>
<td>Breath holding</td>
<td>Raised upper lip</td>
<td>Open mouth</td>
<td>Crying</td>
</tr>
</tbody>
</table>

- **0** = No pain
- **1** = No pain
- **2** = Can be ignored
- **3** = Interferes with tasks
- **4** = Interferes with concentration
- **5** = Interferes with basic needs
- **6** = Bedrest required
Pain Assessment Scales: Direct Observation Tools

The Pain Assessment in Advanced Dementia (PAINAD)

The Pain Assessment Scale for Seniors with Severe Dementia-Dutch (PACSLAC-D)

Pain Assessment for the Dementing Elderly (PADE)

Checklist of Nonverbal Pain Indicators (CNPI)

Nursing Assistant-Administration Instrument to Assess Pain in Demented Individuals (NOPAIN)
# PAINAD Scale

<table>
<thead>
<tr>
<th>Breathing Independent of vocalization</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td></td>
<td>Occasional labored breathing</td>
<td>Noisy labored breathing</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Short period of hyperventilation</td>
<td>Long period of hyperventilation</td>
<td></td>
</tr>
</tbody>
</table>

| Negative vocalization                | None | Occasional moan or groan | Repeated troubled calling out |
|                                      |      | Low level of speech with a negative or dissapproving quality | Loud moan, groan, or cry |

| Facial Expression                    | Smiling or inexpressive | Sad, frightened, frown | Facial grimacing |

| Body Language                        | Relaxed | Tense, distressed pacing or fidgeting | Rigid, fists clenched |
|                                      |         |                                      | Knees pulled up, or pulling away |
|                                      |         |                                      | Striking out |

| Consolability                        | No need to console | Distracted or reassured by voice or touch | Unable to console, distract or reassure |
Pathophysiologic changes in the elderly

- Central nervous system
  - Many have neurologic disease and dysfunction
  - Strokes, TIA, dementia, movement disorders

- Hepatic
  - May decrease metabolism or prolong clearance of drugs

- Renal
  - Decline after the age of 40 at a rate of ~1% per year or 1ml/min per year decline in creatinine clearance
  - May decrease the rate of drugs excreted in urine
WHO Analgesic Ladder

1. Pain persisting or increasing
   - Non-opioid
   ± Adjuvant

2. Pain persisting or increasing
   - Opioid for mild to moderate pain
   ± Non-opioid
   ± Adjuvant

3. Freedom from cancer pain
   - Opioid for moderate to severe pain
   ± Non-opioid
   ± Adjuvant
Non-opioids

- APAP
- NSAIDs
- Adjuvants
NSAIDs

- Salicylates
  - Aspirin

- Non-salicylates
  - Non-selective
    - Ibuprofen, naproxen, indomethacin
  - Semi-selective
    - Meloxicam, etodolac, nabumetone
  - COX-2 selective
    - Celecoxib
    - Fewer GI adverse events
    - Associated with increase risk for cardiovascular toxicity
NSAID Precautions

- Hypertension
- Renal impairment
- Edema
- GI impairment
  - Increase risk of GI irritation, inflammation, ulceration and perforation
  - Incidence: non-selective > semi-selective > COX-2 selective
  - Risk factors: high dose, h/o ulcer, *advance age*, multiple NSAIDs, NSAIDs + corticosteroid or anticoagulant/antiplatelets
  - Use H$_2$RA or PPI
- CV/CHF
  - Particular caution with COX-2 selective
Adjuvants

- **Antidepressants**
  - Tricyclic Antidepressants (TCA): nortriptyline, desipramine
  - Other: duloxetine, vanlafaxine, milnacipran

- **Anticonvulsants**
  - Gabapentin, pregabalin

- **Local Anesthetics (LA)**
  - Lidocaine patch, capsaicin

- **Muscle relaxants**
  - Baclofen, tizanidine

- **NMDA receptor antagonists**
  - Ketamine, dextromethorphan

- **Bisphosphonates**

- **Corticosteroids**

- **α₂-agonists**
TCA: Tricyclic Antidepressants
SNRI: Serotonin Norepinephrine Reuptake Inhibitors

**Mechanism**
- NE and Serotonin activity

**Side Effects**
- Anticholinergic effects

**Mechanism**
- NE and Serotonin activity

**Side Effects**
- HTN, Drug-drug and drug-disease interxn

**Mechanism**
- Na channel blockade
  - GABA agonist

**Side Effects**
- Psycho-motor effects

**Mechanism**
- Na and Ca channel blockade
  - Substance P

**Side Effects**
- Confusion, arrhythmias, and burning sensations
Opioids Analgesics

A trial of opioid therapy for older patients with moderate to severe persistent pain should be considered guided by the following sets of questions:

I. Initial Evaluation
   (1) What is conventional practice for this type of pain or patient?
   (2) Is there an alternative therapy that is likely to have equivalent or better therapeutic index for pain control, functional restoration, and improvement in QOL?
   (3) Does the patient have medical problems that may increase the risk of opioid-related adverse effects?
   (4) Is the patient likely to manage the opioid therapy responsibly?

II. Role of consultant or specialist
   (1) Am I able to treat this patient without help?
   (2) Do I need help of a pain specialist or other consultant to co-manage this patient?
   (3) Are there appropriate specialists and resources available to help me co-manage this patient?
   (4) Are the patient’s medical, behavioral or social circumstances so complex as to warrant referral to a pain medicine specialist for treatment?
# Opioid classification

<table>
<thead>
<tr>
<th>Phenanthrenes</th>
<th>Phenylpiperidine</th>
<th>Diphenylheptanes</th>
<th>Benzomprophans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Agonist</strong></td>
<td><strong>Agonist</strong></td>
<td><strong>Agonist</strong></td>
<td><strong>Partial agonist</strong></td>
</tr>
<tr>
<td>Morphine</td>
<td>Meperidine</td>
<td>Methadone</td>
<td>Pentazocine</td>
</tr>
<tr>
<td>Codeine</td>
<td>Fentanyl</td>
<td>Propoxyohene</td>
<td></td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>Sufentanil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>Alfentanil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxycodone</td>
<td>Remifentanil</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxymorphone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levorphanol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Partial Agonist</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Butorphanol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Buprenorphine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nalbuphine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Antagonist</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naltrexone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naloxone</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Opioids

**Side Effects**

- Respiratory depression
- Sedation or mental confusion
- Nausea and vomiting

**Tolerance**

- ~5-7 days

**Management**

- Slow titration of opioid
- Naltrexone
- May lower dose (25%)
- DC other CNS depressants
- Change opioid
- Antiemetic
# Opioids

## Side Effects

<table>
<thead>
<tr>
<th>Constipation</th>
<th>No development of tolerance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Itching or urticaria</td>
<td>Few days</td>
</tr>
<tr>
<td>Urinary retention</td>
<td>Days to weeks</td>
</tr>
</tbody>
</table>

## Tolerance

- Constipation: No development of tolerance
- Itching or urticaria: Few days
- Urinary retention: Days to weeks

## Management

- Constipation: Stool softener, Stimulant laxatives
- Itching or urticaria: Anti-histamine, Change opioid
- Urinary retention: Lower dose
Opioid use in hepatic dysfunction

- Use the following opioid analgesics with caution:
  - Hydrocodone/APAP; oxycodone/APAP; codeine/APAP → Limit total daily APAP intake to 2 – 4 grams/day from all APAP sources
  - Oxycodone, methadone, hydromorphone, and morphine also should be used with caution in hepatic insufficiency
Opioid use in renal dysfunction

- Avoid the following opioid analgesics:
  - Meperidine: accumulation of metabolite normeperidine may lead to seizures, tremors, CNS excitation, and altered mental status
  - Morphine: accumulation of active metabolite morphine-6-glucuronide (M6G) may lead to CNS and respiratory depression and M3G may lead to neuroexcitation, hyperalgesia, and myoclonus
Practice Points

- A trial of opioid therapy for older adults guided by two sets of guidelines
- Opioids are acceptable for seniors
- Low risk for addiction, but use precautions
- Use validated assistant tools
- *Start low and go slow*
- *Reassess*
- *Education*
Resources for Pain Management

- **Guidelines and other useful resources or tools**
  - The American Geriatric Society (americangeriatrics.org)
  - Federation of State Medical Boards - FSMB guidance (FSMB.org)
  - Pain EDU (painedu.org)
  - Collaborative REMS Education (Core-rems.org)
  - American Pain Society (americanpainsociety.org)

- **Patient counseling document for long acting opioids (REMS)**
  - www.minneapolis.cenveo.com/pcd/

- **Screening tool to assess potential for abuse or misuse**
  - Opioid Risk Tool (ORT)
  - Screener and Opioid Assessment for patients with Pain (SOAPP)
  - Current Opioid Misuse Measure (COMM)
Clinical Presentations

Pain Management in Older Adults
Case 1

- Wilford is a 73 year old male with h/o bleeding ulcer and advanced colon cancer

- Presents with increasing abdominal pain
  - Wakes frequently at night in severe pain

- Regimen is Norco 10/325mg PO Q4H
  - Complains of “too many pills”
  - Would like to take something else that “works better or lasts longer”
  - States he does not want morphine because that means you’re about to “die”
Case 1

• Consider changing to long acting opioid → oxycodone (OxyContin)
  ▫ Can try to avoid morphine since patient associates with “dying”

• Calculate total daily dose of hydrocodone
  ▫ Hydrocodone 10mg PO Q4h
  ▫ Hydrocodone 10mg x6 doses = 60mg hydrocodone

• Convert to equianalgesic PO oxycodone
## Opioid Equianalgesic

<table>
<thead>
<tr>
<th>Opioid analgesic</th>
<th>Oral (mg)</th>
<th>Parental (mg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine</td>
<td>30</td>
<td>10</td>
</tr>
<tr>
<td>Codeine</td>
<td>200</td>
<td>100</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>20</td>
<td>10</td>
</tr>
<tr>
<td>Hydrocodone</td>
<td>30</td>
<td>-</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Meperidine</td>
<td>300</td>
<td>100</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>-</td>
<td>0.1</td>
</tr>
</tbody>
</table>
Case 1

- Convert to equianalgesic PO oxycodone
  - 60mg hydrocodone x (20mg oxycodone/30mg hydrocodone) = 40mg oxycodone

- Reduce 1/3 for cross-intolerance
  - 40mg oxycodone x (2/3) ~ 27mg

- New OxyContin dose 10mg BID + 2.5mg Oxycodone IR Q 6H PRN BTP
  - Breakthrough Pain (BTP)
    - 5-15% of total daily dose given every 4-6hrs PRN
    - Must be short acting opioid
    - Consider increasing regular scheduled dose if using >2-3 BTP doses for >2-3 days
Case 2

• Wilford returns to clinic and states his pain control has improved, but is now afraid he will not be able to afford his pain medications due to changes in his insurance with limited income among other financial stressors

• What would you do for this patient?
  a) Leave patient on OxyContin
  b) Switch to MS Contin
  c) Switch to methadone
Case 2

- Wilford returns to clinic and states his pain control has improved, but is now afraid he will not be able to afford his pain medications due to changes in his insurance among other financial stressors
  - Currently takes OxyContin 10mg PO BID + oxycodone 2.5mg x4 daily

- What would you do for this patient?
  a) Leave patient on Oxycontin
  b) Switch to MS Contin
  c) Switch to methadone
Case 2

- Calculate total daily dose of oxycodone
  - OxyContin 10mg PO BID + oxycodone 2.5mg x4 daily for BTP= 30mg oxycodone

- Convert to equianalgesic PO morphine
## Opioid Equianalgesic

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<td>Oxycodone</td>
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<td>30</td>
<td>-</td>
</tr>
<tr>
<td>Oxymorphone</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>7.5</td>
<td>1.5</td>
</tr>
<tr>
<td>Meperidine</td>
<td>300</td>
<td>100</td>
</tr>
<tr>
<td>Fentanyl</td>
<td>-</td>
<td>0.1</td>
</tr>
</tbody>
</table>
Case 2

• Calculate total daily dose of oxycodone
  ▫ Oxycontin 10mg PO BID + oxycodone 2.5mg x4 daily for BTP= 30mg oxycodone

• Convert to equianalgesic PO morphine
  ▫ 30mg oxycodone x (30mg morphine/20mg oxycodone) = 45mg morphine

• Use morphine equivalent to methadone conversion ratio to determine methadone dose
Converting to methadone from other opioids

- The higher the opioid dose a patient is receiving, the more “potent” methadone is
  - “More potent” doesn’t mean “more effective” – potency refers to an equivalent dose to achieve equivalent pain control
  - Conversion from other opioids to methadone is NOT linear

- Molecular structure and chemical characteristics of methadone (NMDA receptor antagonism) may alter binding to the opioid receptors, possibly resulting in less cross-tolerance to methadone → essentially patient is more sensitive to methadone
Converting to methadone from other opioids

- May use a 1:3 ratio (Methadone:Morphine)
  - Reduce calculated equianalgesic dose of methadone by ~75 - 90% (paradoxically, methadone potency increases as the dose of the current opioid increases)

- Recommended conversion ratio based on morphine equivalent dose:

  [Morphine: methadone ]

  - <90mg/day 4:1
  - 90–300mg/day 8:1
  - 300-1000mg/day 12:1
  - >1000mg 20:1

- Increase dose Q 7-10 days to allow methadone to reach steady-state
Case 2

- Calculate total daily dose of oxycodone
  - Oxycontin 10mg PO BID + oxycodone 2.5mg x4 daily for BTP = 30mg oxycodone

- Convert to equianalgesic PO morphine
  - $30\text{mg oxycodone} \times \left(\frac{30\text{mg morphine}}{20\text{mg oxycodone}}\right) = 45\text{mg morphine}$

- Use morphine equivalent to methadone conversion ratio to determine methadone dose
  - 4:1 (morphine:methadone)
  - $45\text{mg morphine} \times \left(\frac{1\text{methadone}}{4\text{morphine}}\right) = 11.25\text{mg methadone}$
  - Give methadone 5mg BID or 2.5mg TID
Case 3

• Wilford returns to clinic a few months later and c/o some increasing and persistent abdominal pain and asks if we can adjust his methadone dose

• How would you adjust his methadone?
Opioid Dose Adjustment

- Mild to moderate pain:
  ▫ Increase total daily dose by 25-50%

- Moderate to severe pain:
  ▫ Increase total daily dose by 50-100%

- *Must wait 7-10 days to allow methadone to reach steady-state prior to dose adjustments*
  ▫ May increase dose q1-2 days for other opioids
Case 3

• Wilford returns to clinic a few months later and c/o some increasing and persistent abdominal pain and asks if we can adjust his methadone dose

• How would you adjust his methadone?
  ▫ **Mild to moderate pain:**
    • Increase total daily dose by 25-50%
    • Current methadone 2.5mg TID = 7.5mg x 25%
      • Increase methadone to 2.5mg QID or 5mg BID
References


10) http://www.who.int/cancer/palliative/painladder/en


Thank You