Letters

Opioids: Pain-management option for some older patients

In their article on managing dementia-related behaviors (CURRENT PSYCHIATRY, May 2006, p. 81-96), Dr. Bruce Sutor and colleagues advise against using opioids to manage pain in older patients (p. 88). I was disheartened by their comments.

American Geriatrics Society guidelines clearly state that opiate medications are an appropriate choice for treating moderate to severe pain in some elderly persons, including those with dementia.[1]

Refusing to consider opiates for pain management can lead to severe suffering, especially for a patient who is incapable of communication. If an elder is at risk for falls, perhaps a full pain assessment is warranted and other CNS suppressants such as benzodiazepines can be eliminated. That way, we can treat pain and reduce the risk of falls.

Unfortunately, the myth that certain groups are not appropriate candidates for opiates lives on. We need to assess and treat all elders for pain, whether they are cognitively intact or impaired. As health care professionals, we are obligated to reduce pain and suffering in all patients, especially those who have trouble communicating.

Teresa Keane, RN, MSN, PMHNP
Psychiatric nurse practitioner, Kaiser Permanente Northwest
Adjunct faculty member, Oregon Health & Science University
Portland, OR

Reference

1. American Geriatrics Society Panel on Persistent Pain in Older Persons. The management of persistent pain in older persons. *J Am Geriatr Soc* 2002;50:1-20.

Dr. Sutor responds

Ms. Keane's letter raises important points regarding managing pain in dementia patients.

We agree wholeheartedly that a full pain assessment is warranted when pain is suspected. All patients need and deserve to have their pain managed. There is, however, a danger that a dementia patient with behavior problems may be presumed to have pain when he or she does not and may be given narcotics reflexively.

Ms. Keane's contention that CNS suppressants (such as benzodiazepines) can be eliminated is germane to our point about opiate analgesics and supports our argument that opiates should be used warily, if at all. Eliminating and avoiding opiates, when possible, reduces the risks of falls, fractures, agitation, delirium, and diminished cognitive function.

Our article should have stated clearly that opiates should be avoided if the cause of pain can be ameliorated or eliminated, or if other "rungs" on the pain ladder effectively manage pain.

It is no myth that some dementia patients are not appropriate candidates for opiates. Those who have suffered falls, fractures, delirium, confusion, and CNS obtundation support the contention that opiates can do more harm than good for some dementia patients.

Bruce Sutor, MD
Assistant professor of psychiatry
Department of psychiatry and psychology
Mayo Clinic College of Medicine
Rochester, MN

Correction

The article "Female sexual dysfunction: don't assume it's a side effect" (Med/Psych Update, July 2006, p. 47-57) contained an error on pages 56-7. It should have stated that elevated thyroid-stimulating hormone (TSH) could point to hypothyroidism and low TSH could signal hyperthyroidism.