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Long-Term Care Survey Alert

PAIN TREATMENT: Sharpen Pain Management SafetyWith These 5 Tips

Make sure these meds lead to relief, not adverse drug events.

What you don't know about pain meds can hurt residents, not to mention the facility's clinical and survey outcomes.

Case in point: It's easy to think of Tylenol (acetaminophen) or nonsteroidal anti-inflammatory drugs as relatively harmless, although they both can be dangerous. And pain medications pose the risk of serious drug-drug interactions in some cases. But some key strategies can prevent problems with common pain medications.

1. Do the labs. Nursing facilities should do a baseline metabolic profile, including liver and kidney function, and CBC at admission and before starting a resident on acetaminophen or an NSAID, advises **James W. Cooper,RPH, PhD, BCPS, CGP**, emeritus professor and consultant pharmacist at the University of Georgia College of Pharmacy.

And don't give patients with a history of liver disease acetaminophen around the clock, advises **Judith L. Beizer, PharmD**, **CGP,**president of the American Society of Consultant Pharmacists (ASCP), and clinical professor at St. John's University in Jamaica, N.Y.

Tip: Check liver function in residents on acetaminophen who also take another drug, such as a statin, that could affect the liver, advises **Carla Saxton McSpadden**, a longterm care pharmacist with ASCP.

2. Keep tabs on acetaminophen dosing. Some experts cite three grams of acetaminophen a day as the upper limit for elderly people while others say up to four grams a day is OK. But a resident on routine roundthe-clock acetaminophen and PRN hydrocodone/acetaminophen could easily exceed four grams of acetaminophen,depending on how much of the PRN med he takes, cautions McSpadden. Thus, the staff should evaluate the resident's daily acetaminophen intake when he's on a combination of medications containing acetaminophen, she suggests.

3. Look for fluid retention accompanying NSAIDs. Elderly patients shouldn't be on full-dose NSAIDs for more than two weeks, counsels Cooper. And during that time, weigh the patient daily to look for fluid retention evidenced by a sudden gain in weight or an increase in blood pressure, he says. "If a person has a history of kidney disease or heart failure, he shouldn't take NSAIDs at all," Cooper emphasizes.

3. Watch out for drug-drug interactions with NSAIDs. "NSAIDs taken with any of the SSRI antidepressants can increase the risk of a GI bleed -- and that includes low-dose aspirin," cautions **John Horn**, **PharmD**, associate director of the University of Washington Medical Center, Department of Pharmacy Services. Also, "NSAIDs can reduce the efficacy of some drugs, such as the anti-hypertensive action of diuretics, ACE inhibitors and angiotensin receptor blockers."

4. Watch out for drugs or a genetic defect that inhibit codeine metabolism. If a resident taking codeine complains the medication isn't working, take a look at the MAR. A number of medications can inhibit the CYP2D6 enzyme required for the body to turn codeine into morphine, which is what provides the pain relief. The list of drugs that inhibits CYP2D6 includes Prozac, Paxil, Wellbutrin, Benadryl, Haldol and others, says Horn (for a more complete list, go to http://medicine.iupui.edu/flockhart/table.htm). Some patients may be genetic poor metabolizers for CYP2D6, which means they won't benefit from codeine Poor metabolizers (whether due to a genetic mutation or because they are taking a drug that inhibits CYP2D6) will still develop side effects from the codeine, such as upset stomach and/or vomiting, etc.

Clue: You may be able to identify a genetic poor metabolizer for codeine by asking him or his family how he's responded to codeine in the past, if he's taken it. Sometimes these patients have been accused of being drug seekers when they are really just trying to find some pain relief. (The clinician can order Medicare-covered testing to identify a poor metabolizer for CYP2D6,which affects how a person metabolizes many other medications.)

5. Know the ins and outs of transdermal fentanyl absorption. Fentanyl is a very fat soluble drug,and thin patients may not get the pain relief from it that you'd expect, cautions **Mary Lynn McPherson,PharmD, BCPS**, professor and vice chair in the Department of Pharmacy Practice and Science at the University of Maryland in Baltimore.The mechanism for this phenomenon isn't clearly understood, she adds."Also, if someone has a fever, she will absorb more of the medication,"which is true for any transdermal application, adds McPherson. "The heat is going to make any drug come out of the patch more quickly."

Editor's note: The revised F309 surveyor guidance, which includes pain, goes into effect March 31,2009. For a brief overview, see p. 32,and don't miss in-depth coverage in the next Long-Term Care Survey Alert.