New category of opioid-related death

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Adequate pain management is a key factor in keeping older adults living independently, and opioids are the best analgesics for treating moderate to severe pain when nonopioid and nonpharmacologic treatments have failed. The medical and societal will to adequately treat pain is compromised by the current climate of fear around the use of opioids. The state of decline caused by untreated pain and its consequences might lead to increasing requests for medical assistance in dying (MAID). Could achieving MAID be easier than achieving good pain management?

Argument for adequate pain management

Chronic disabling pain is more common in older adults, likely owing to the reduced flexibility of biological systems that occurs with age.[1] With more comorbidities comes more pain[2] and that leads to gait problems, deconditioning, falls,[3] interference with cognition,[4] and eventually permanent disability.[5] Some proof of this lies in a study comparing the mortality rates of older adults with painful and non-painful vertebral compression fractures. Those who had painful fractures had a significantly higher mortality rate over 5 years of observation ($P<.001$).[6] Pain and its complications do kill eventually, but not before they disable and compromise quality of life.

If older adults' pain were controlled adequately in its early stages, it is possible that disabling pain could be prevented and the cascade of complications leading to disability, and possibly frailty, could be avoided. No randomized controlled trial of treating versus not treating moderate to severe pain would pass research ethics board assessment, so high-quality evidence is lacking.

The management of pain requires a biopsychosocial approach. Depending on the health care system, the psychological and social resources available to people with chronic pain might be limited by their inability to pay. This would affect older adults more often, owing to a fixed income in retirement.

There are 3 main categories of analgesic medications (excluding adjuvant medications) for chronic pain—acetaminophen, nonsteroidal anti-inflammatory drugs, and opioids. Acetaminophen, which is first-line treatment for pain, has been shown to not reduce pain or improve function in osteoarthritis of the hip and knee, or in back pain, for adults.[7] Nonsteroidal anti-inflammatory drugs, which are second-line treatment for pain, have proven to be deadly in older adults, causing kidney failure, gastrointestinal bleeding, and increased risk of cardiovascular events.[8] Nonsteroidal anti-inflammatory drugs are recommended for occasional as-needed use in inflammatory pain or not at all.[9,10] Studies comparing prescription data to hospital diagnoses[11] will often show higher all-cause mortality and more fractures in those who were prescribed opioids compared with those who were prescribed nonsteroidal anti-inflammatory drugs. However, key patient information, such as pain, function, gait problems, and mental illness, is lacking, severely limiting the ability of any of these studies to prove causation. A meta-analysis of opioid use in older adults has shown statistically significant pain reduction, physical disability reduction, and improvement in sleep,[12] which suggests that opioids might be the best option for managing more than mild pain in older adults.[13]

Regulatory sanctions and increased scrutiny

The pendulum of support for the use of opioids in chronic pain has swung back into disapproval, with increased scrutiny and regulation. During the past dozen years increased prescription opioid–related deaths have been linked to the increased prescribing of opioid medications. The data linking these 2 facts are fraught with problems such as a lack of standardized definitions among death investigators to interpret postmortem toxicology findings, variations in determining the manner of death (eg, suicide, accident, undetermined), and comorbid mental illness, addiction, and substance use[14] that are not necessarily diagnosed.[15] Although reasons for opioid-related deaths are multiple, the focus has been on the drugs rather than on recognizing comorbid mental illness, addressing the social determinants of substance abuse, and providing rapid access to addiction treatment.

Increasing regulatory sanctions have been enacted in North America. A recent US review article[16] documents reduced opioid prescribing and opioid prescription abuse since 2012. However, increasing opioid overdose deaths owing to cheap fentanyl, produced in illicit labs and then added to heroin and other recreational drugs, are now spreading across Canada. Clearly the opioid overdose issue is a complex problem and needs a consultative, problem-solving approach—not the blunt approach that compromises the care of those using opioids legitimately.

Even before the "opioid crisis," older adults with painful conditions were often undertreated.[11,17] My experience as a palliative care physician who also sees older adults with chronic pain is that as scrutiny and regulation against the use of opioids for chronic pain have escalated, all patients who use opioids, even those near the end of life or elderly patients in long-term care facilities, have had dose reductions. I have also witnessed an overall reluctance to use opioids for any painful condition in older adults. Some patients say their physicians told them these drugs were dangerous and would

shorten their lives if they took them, falling prey to public fear and betraying the evidence that shows these drugs are safe when used appropriately in patients who need them for pain and dyspnea in advanced disease.[18,19]

Focus on treatment, not drug regulation

Medical assistance in dying is now available in Canada. I have already seen patients requesting and receiving euthanasia for intolerable pain following months of poorly controlled pain secondary to degenerative spine conditions and multiple comorbidities.

Could it be easier to request and achieve death after suffering from disabling pain than it is to get pain management adequate to prevent disability and decline?

We need to work collaboratively to improve treatment of addiction and mental illness—the bookends that complicate chronic pain management. If we focus only on drug regulation, we will reduce overall opioid prescribing, which might reduce diversion but will leave more people suffering. The stakes are higher now because those with poor symptom management and advanced disease or disability have access to MAID. If we do not find a better way, there will be additional opioid-related deaths, but they will be owing to MAID when the health care system fails to treat suffering adequately.

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Competing interests
Dr Gallagher accepts honoraria for educational talks from Purdue Pharma.

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