

OPIOIDS AND BENZODIAZEPINES—A DRUG PROBLEM FOR THE OLDER ADULT



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CE Earn Up to 7.5 Hours. See page 108.

It's no secret that the United States is dealing with an opioid crisis. Personnel in emergency departments are seeing more overdoses and fatalities caused by these drugs. Typically these cases are assumed to be children, teenagers, or young adults exploring the world of drugs; however, an often unrecognized group also "into drugs" is older adults who are taking a combination of an opioid and benzodiazepine (BZD). These drug combinations are prescribed by a medical practitioner to treat conditions such as pain, but they are also leading to increased overdoses and fatalities in our older population.

Since 2000, deaths from opioid overdoses have nearly quadrupled overall, but for people age 55 years and older, the increase has been much greater.¹ The purpose of this article is to heighten the awareness of the combined use of opioids and BZD when caring for older adults in the emergency department.

Opioids and Benzodiazepines

Older adults often experience chronic pain as a result of conditions such as arthritis, degeneration in bones, joints, and muscles, and surgeries. In addition, accumulated experiences that involve physical and emotional trauma, loss of loved ones, changes in lifestyle, and disability may lead to anxiety and depression. These challenges make it necessary to treat both physical and emotional pain using more than one type of drug.

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In addition to prescribing an opioid to treat chronic pain in the older adult, an increasing practice is to add a BZD to the pain control regimen, which is often done in rapidly escalating dosages because of tolerance. In an article by MacReady, it is noted,² "Co-prescription rates nearly doubled between 2001 and 2013, going from 9% to 17%." Between 1996 and 2013, BZD prescriptions rose 67%, and sadly, the number of deaths associated with BZD overdoses increased from 1135 to almost 9000.²

Many articles can be found describing the risks of combining opioids and BZDs. Impaired cognition, dementia, falls, and fractures are often connected to the use of BZDs. Adding an opioid to treat chronic pain can cause respiratory depression, creating overdose and death. Physiologic processes in older adults slow with age, which causes a longer time for medications to clear the body. Adding opioids and BZDs to existing co-morbidities and polypharmacy may have a significant impact on older adults.

Pain and Physiologic Changes in Older Adults

Chronic pain in older adults may be defined as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage for persons who are either aged (65 to 79 years old) or very aged (80 and over) and who have had pain for greater than 3 months."³ The use of medication because of pain associated with activities of daily living has the potential to cause depression, deconditioning, decreased ambulation, accidents, and a decline in cognition. Some elderly persons do not report pain because they believe it is normal at their age. As reported by Kaye et al,⁴ "Pain should be considered significant if it is persistent, recurrent and affecting the patient's functional capacity and/or quality of life."

Physiologic changes in older adults are altered because of "decreased gastrointestinal transit time and increased gastric pH secondary to use of proton pump inhibitors, H₂ receptor antagonists, or antacids. Body composition changes such as an increase in adipose tissue, decrease in lean body mass and decrease in total body water occur. Aging can bring reduction in hepatic blood flow and volume which can decrease

metabolism of drugs. Elimination of drugs can be altered with age related reductions in renal blood flow and glomerular filtration rate. Reduction in renal clearance seems to have the largest pharmacodynamic effect on the elderly.”⁴ For example, chronic kidney disease affects renal drug elimination, making the assessment of a creatinine clearance level necessary, especially when prescribing for the older adult, because changes may increase the potency of the drug and provide a longer period of action. For these reasons, drugs in the older adult should be started at a low dose and only increased slowly if needed.

Implications for the Emergency Nurse

We all shudder at seeing the bag of medications accompanying the older adult upon entry into the emergency department. Even for persons who bring an updated, readable list of medications that includes over-the-counter medications and herbal supplements, we know that it will take an inordinate amount of time to sort out the items that may be the root of the changes in the older adult.

The ENA Position Statement “Role of the Emergency Nurse in Medication Reconciliation” states, “Emergency nurses collect a Best Possible Medication History (BPMH) but do not perform medication reconciliation.”⁵ However, the position statement does charge the nurse to “complete the BPMH gathering information from patients, families, providers, and other health care professionals and engage patients to identify deficits in knowledge of the medication regimens and provide education on the importance of maintaining a current and accurate medication history.”⁵

Importance for the Emergency Nurse

The use of an escalated dosing approach when adding a BZD to an opioid to treat chronic pain in older adults has grown. Risk factors such as falls, fractures, motor

vehicle accidents, impaired cognition, dementia and symptoms of cognitive dysfunction, sedation, central sleep apnea, and respiratory depression in addition to these medications are important when assessing the older adult patient. When an older adult presents to the emergency department with these symptoms, do you consider that they may be caused by an opioid, BZD, or a combination of the two and are not simply part of normal aging function or other medical conditions? Do you consider that the “classic signs and symptoms” of opioids and BZDs often mask the signs of the other and that treatment for opioid overdose will not correct the BZD overdose? Awareness of these issues is critical to emergency nursing safe practice and safe care.

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