Worried About Your Elderly Mother's Pain? You Should Be

By Josh Bloom — September 22, 2019

My mother is one of the "lucky ones." She has a devoted family and caretaker, is able to live in her own home, and doesn't have to worry about choosing between food and prescription medications. But she is also 92 and recently her chronic back pain has gotten severe enough that it can sometimes prevent her from walking.

She also has a good primary care doctor. He's likable, concerned, and also sharp.

But here's what concerns me and should really concern you.

Following her exam, I spoke to him by phone. His plan to address her pain was to increase her Tylenol dose from four to eight per day. Of course, doing this was not going to help one bit, but I can understand his reasoning.

"In her case, there are only three choices, Tylenol is one. NSAIDs are unsafe for the elderly, especially for their stomachs and kidneys. So we're left with opioids, which we don't want to use."

He was technically correct but was speaking from a safety perspective, which has no doubt has been shaped (distorted, really) by the wrong-headed demonization of pain medications.

For most people, even an elderly woman, a daily dose of 2,600 mg of Tylenol – a bit less than the daily recommended maximum – will be safer than long-term use of Advil or Aleve. Barring liver toxicity, it will also be safer than Vicodin or Percocet. But that's not the whole story. Safe isn't all that safe.
Tylenol won't hurt her or help her, but her pain is already harming her, so it is the choice of Tylenol, not the drug itself, that will hurt her, albeit indirectly. And if the pain is not relieved she will certainly spend more and more time in bed. That will hurt her too – worse than any drug.

It is this pernicious shift in the mindset of medicine – consideration only of risk, not benefit – that is most troubling. And since the callous zealots, who I so often write about, have so spectacularly succeeded in equating the terms "opioids", "risk," and "addiction," it has now become essential for most physicians to protect patients (and themselves) from risk, regardless of whether the benefits clearly outweigh the risks. If they are lucky enough not to be harassed by the DEA/DOJ and a patient using opioids dies, look out – lawyers will be circling.

This is the worst kind of defensive medicine and its practice is now far too often standard practice. The CDC's mea culpa [1] this past summer was far too little and far too late. The medicine cabinet door was closed after the pills escaped and it won't be reopening anytime soon.

My mother is probably a little luckier than yours will be. Although her physician was probably aware that Tylenol is no more effective than placebo for back pain (See Tylenol Isn't So Safe, But At Least It Works, Right? [2]) and that tramadol (1,2) does not even belong in the same sentence, let alone classification with hydrocodone or oxycodone; it is far weaker, I wasn't getting off the phone until he agreed to let her try it. I shouldn't have had to even mention it.

What is going to happen when your arthritic, elderly mother leaves her doctor's office with a big bottle of Tylenol? What is going to happen if she needs something stronger?

We already know the answer. Pain patients have been living it for years. Let's call it "risk-free suffering" – a term that might have made it into 1984 had it been written 70 years earlier.

It is now two days since my mother tried tramadol. Her pain level has decreased substantially; today she was able to go out for brunch with friends, something that would have been impossible two days ago. She has experienced no side effects (3).

What is going to happen to your mother?

NOTES:

(1) Tramadol (also called Ultram) is a quirky and imperfect drug, but this does not mean it should be automatically shunned; it's not like there are such great alternatives. Some people do very well with it while others suffer nasty side effects. Its metabolism varies greatly from one person to the next and it can also interfere with the metabolism of other drugs. It is (rightly) considered to be a
"messy" drug. It doesn't fit neatly into any class of drugs even though it's now lumped in with opioids. In fact, when it first came out in 1995 tramadol wasn't even considered to be an opioid and was treated like any other prescription drug. This changed in 2014 when it became a Schedule IV controlled substance because some people were abusing it. It is classified as an atypical opioid analgesic [3].

(2) David Juurlink, who is Canada's doppelganger of Andrew Kolodny, absolutely hates the drug. I wonder what he would give to his 92-year old mother if she had trouble getting out of bed.

David Juurlink @DavidJuurlink · Nov 21, 2016
Just told 200 medical students tramadol is the Donald Trump of pain medicines: dangerous, irrational, and you're going to regret it

As titles go, “Why tramadol sucks” wasn’t my idea but it’ll do.

(3) My mother's physician was primarily concerned about constipation, which is a known side effect. But he agreed that there wasn't any reason that she couldn't try it, especially at a low dose.