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Case Report

Managing Chronic Pain, Psychiatric Comorbidity, and Opioid Dependence in Geriatric Psychiatry: A Case Report

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Abstract:

A significant number of elderly patients over the age of 65 presenting to geriatric services are treated with opioids, primarily for pain management. Approximately 25% inpatients are prescribed opioids, this is reflected in geriatric psychiatry too. These patients are often treated over long periods, frequently without adequate opioid stewardship. This often leads to significant adverse effects such as constipation, intoxication, restricted mobility, and other typical side effects of opioid use, including dependence. Across treatment setting, whether inpatient care or community-based care provided by pain specialists, clinics or psychiatrist, alternative treatment options are rarely considered, and adverse effects often receive insufficient attention. In many cases, professionals face pressure from opioid- dependent patients who insist on continuing opioids. The high prevalence of opioid prescriptions and the significant adverse events/side effects make this a structural and systemic challenge, which we aim to highlight through the following case story.

Key words: geriatric psychiatry; opioid dependence; prescription opioids; opioid stewardship; chronic pain

Introduction

The management of chronic non-cancer pain in older adults presents significant challenges, particularly when opioids are prescribed over extended periods [1]. For geriatric psychiatry there are no published statistics but in clinical rounds and visiting old age homes approximately 25%-30% of the patients had an opioid prescription. This can lead to adverse effects including constipation, sedation, restricted mobility, opioid-induced hyperalgesia, and, in some cases, dependence [2][3]. The coexistence of chronic pain, major depressive disorder, and opioid dependence represents a complex clinical scenario that requires coordinated, interdisciplinary care. Psychiatric comorbidities may exacerbate pain perception and complicate treatment, while opioid dependence can hinder withdrawal efforts and limit engagement in alternative pain management approaches [4].

Case summary

We report on a 64-year-old female patient with chronic pain syndrome and persistent pain who had been treated with oxycodone for four weeks. Over the course of treatment, opioid dependence consistent with ICD-10 F11.2 became apparent, characterized by dose escalation, loss of control, and withdrawal symptoms combined with a major depression. As a result, a gradual reduction and eventual complete discontinuation of oxycodone was implemented. Pain management was transitioned to metamizole (dipyrone) and duloxetine was initiated to target comorbid addictive symptoms and pain processing. This combination of pharmacological treatment and psychotherapeutic support, emphasizing the relationship between psychological factors and pain, and promoting patient empowerment, led to a stabilization of the clinical condition and a reduction in pain intensity. This case illustrates the complex challenge of managing chronic pain in patients with comorbid psychiatric disorders, including suicidal ideation. These patients are often admitted in

psychiatry due to the helplessness experienced by both the patients and their general practitioner. This case suggests that such clinical constellations are not uncommon and underscores the importance of a multidisciplinary treatment approach. It also demonstrated how effective treatment, combined with patient adherence, can support long term recovery.

Case Presentation

The patient first experienced back pain at 29 years, following a whiplash injury with symptoms initially triggered by physical activity. At 54 years of age, she developed a pulling sensation in the back, particularly while sitting. She has also suffered from chronic migraines for over 40 years. In 2022, due to the increasing severity of her pain, she underwent a four-week course of orthopedic rehabilitation. In early 2023 she was hospitalized for acute pain. MRI imaging confirmed Lumboischialgia L4/L5 and L5/S1. In addition, a chronic pain syndrome was diagnosed, fulfilling the MPSS criteria level III of the Gerbershagen classification [5]. Initial treatment consisted of metamizole (dipyrone) 2.5g/day and an i.v. treatment with Piritramid 7.5mg/day. This initial treatment of pain was conducted by the orthopedics, who relied on the German-S3-Treatment Guideline on Analgesia, Sedation and Delirium Management in Intensive Care Medicine. The Guideline does give general approval to both substance-groups [6]. The hospital admission followed for an adjustment and improvement of the pain-treatment. Initially, a four-day course of minimally invasive, interventional-conservative orthopedic therapy was initiated, including infusion and positioning therapy, peridural lumbar and sacral nerve root blockades, combined with facet joint infiltrations at the iliolumbar and sacroiliac joints, as well as standardized physiotherapy. An initial pharmacotherapy with corticosteroid injections and Tilidine failed to improve the symptomatology. Due to the insufficient therapeutic effect, pharmacological pain management with Pregabalin 50 mg (1-0-1-0) was initiated [7]. She also reported a backward fall in the prior year, resulting in impact to the back. As an alternative, continuous opioid administration via CADD pump initiated (0.25% Bupivacaine, infusion rate: 0.5 ml/h) [8], but later discontinued due to a technical defect (leakage). During the aforementioned treatments, the patient's pain perception on the Numeric Rating Scale (NRS) [9] was reduced from 10/10 to 4–5/10. Given the severity of depressive symptoms, a psychiatric consultation was indicated. Before psychiatric admission, her medications included Amitriptyline (50 mg 0-0-1-0), Pregabalin (25 mg 2-0-2-0), and Oxycodone (10 mg 1-0-1-0) [10]. Upon admission, the patient rated her pain as 10/10 on the NRS (0–10). Additional medical conditions included glaucoma and a macular degeneration in the left eye as well as a depressive episode it was during this stay that clinicians first diagnosed depressive symptoms and signs of an anxiety disorder. Following stabilization, the patient was referred to our clinic for continued management. The patient’s primary complaints upon admission were pain, irritability, restlessness, and gastrointestinal distress The psychiatric history appears multifactorial. Symptoms of depression and anxiety was described in 2022 though treatment for this mental health conditions was not initiated until 2024.

Clinical assessment

The patient presented in good general health. Cardiovascular status was stable, with some vesicular sounds on both sides. No significant neurological findings were observed. Another MRI showed a minimal microangiopathy and a developmental venous anomaly on the right side. EEG and ECG results were within normal limits. The patient was fully oriented, with intact concentration and memory. Her mood appeared slightly depressed both subjectively and on clinical observation. Affective reactivity was reduced, with increased fatigability. However, interest and capacity for enjoyment were preserved and consistent with age. Psychomotor activity was normal. The patient expressed a desire for rest, without evidence of intentional suicidal ideation. At the time of admission, she credibly distanced herself from any acute suicidality. In summary, the patient met the criteria for opioid dependence (ICD-10: F11.2) resulting from long-term prescription opioid use, with evidence of significant tolerance, sleep disturbance, and mood instability. A major depressive episode without psychotic symptoms was diagnosed, characterized by low mood, hopelessness, and suicidal ideation, all closely linked to her chronic pain condition.

Therapeutic approach and outcomes

The patient was accepted for inpatient treatment due to her suicidality and anticipated opioid withdrawal. A detailed treatment plan was developed with the objective of discontinuing the pre-existing regiment of amitriptyline, pregabalin and oxycodone due to a lack of success and negative side effects. An alternative treatment approach was initiated with duloxetine and metamizole (dipyrone) based on the German S3-Treatment Guideline [11] for the treatment non-Cancer Pain. Pregabalin was immediately stopped due to its significant dependency potential. The oxycodone dose was initially reduced to 10 mg 1-0-1-0. Following this, the pain intensity increased as well as her level of anxiety. Significant withdrawal symptoms occurred including sweating and sleep disturbances, which was addressed with pipamperone 20 mg as needed. In the second week, oxycodone was reduced to 5 mg 1-0-1-0, and by the fourth week, it was further tapered [11]. The tapering followed the guideline from Long-term opioid therapy for chronic noncancer pain [12]. Complete detoxification of oxycodone was achieved within four weeks, without any major complications. Amitriptyline was tapered in parallel and duloxoxetine was introduced at an initial dose of 30 mg daily [10]. This was gradually increased to 60 mg ending at 90 mg in one dose in the morning. Metamizole (dipyrone) was started at 500 mg 1-0-1-0, with additional doses available up to four times daily as needed for pain control. In addition, the patient was offered a psychotherapy, addressing the depressive symptoms and suicidal ideation. An important focus of that treatment element was to help the patient to develop a better understanding of the independence between psychological well-being and somatic complaints, which allowed a more appropriate understanding of the mood components in the context of pain [11]. Overall, the transition of the pharmacotherapy was free of complications and the treatment plan could be realized successfully. At one-year follow up, the patient reported being pain-free and no longer using any pain medication. Her major depression had remitted, and she appeared cheerful and coping well in her daily life.

Discussion

This case describes the inpatient treatment in a geriatric psychiatric specialty clinic of a patient with a chronic pain syndrome and a comorbid, major depression syndrome as well as an opioid dependence based on long-term prescription opiate use of oxycodone. It illustrates the complexity of concurrent disorders, involving severe chronic pain with a documented physical cause, a major depression with suicidal ideations and an opiate use disorder based on prescription opiate use. Chronic

opioid use leads to the development of tolerance, requiring escalating doses to maintain the same level of pain relief. Although patients often experience initial improvements in pain perception, over time they typically require higher doses of opioids. This in turn leads to more side effects, like constipation, dizziness due to intoxication and a higher tendency to fall. Some patients even report opioid-induced hyperalgesia, a paradoxical increase in pan sensitivity due to the opioids themselves.

Chronic pain and mood disorders often co-occur and mutually reinforce one another, contributing to a cycle of chronification. This interplay also increases the risk of progression to street opiate use. About two-thirds of opiate dependent users are reporting chronic pain and the same amount reports suicidal ideation and suicide attempts. Main factors for that are the pain perception, as well as self-modelling of the treatment process leading to a low retention rate [13][14]. The frequent use of opioids in the treatment of this patient group has lots of negative consequences and an increased risk of dependency [3]. In addition, individuals with affective disorders are known to have increased pain sensitivity [15][16] and are considered at higher risk for opioid-induced hyperalgesia [17]. This may explain the rapid tolerance development and the onsent of opioid dependence. In this case, the opioid dependency developed over a prolonged period of oxycodone prescription. As emphasized in the literature, particularly in the case of non-cancer pain, long-term use of opiates should be avoided as noted by the German society for pain treatment [11].

The opioid withdrawal management in this case was provided over four weeks to prevent drop out and failure based on negative side effects. The initiated reduction therapy, based on the German S3 guideline for the treatment of chronic non-cancer pain, was implemented as a rapid tapering approach to specifically mitigate the risk of opioid dependence [18]. In light of the patient's psychological instability, the treatment plan included replacing the opioid therapy with antidepressant-mediated pain modulation using duloxetine, supplemented by the administration of metamizole (dipyrone) as a non-opioid analgesic. The prescription of Duloxetine was indicated, based on dual efficacy on neuropathic pain and depressive symptomatology [19]. It is important to consider the interaction between nicotine use and duloxetine, as nicotine use can cause an insufficient blood level of duloxetine, which needs to be addressed with the patient [11]. The complexity mentioned can only be addressed successfully through an integration of the clinical trajectory and a well-defined therapeutic concept, based on a combination of an effective pharmaco- therapy and psychotherapeutic interventions. The overall development of an effective coping strategy, supported by psychoeducation, and a realistic understanding of the treatment of pain and conjunction of other concurrent conditions is a critical component, which needs to be communicated by the whole treatment team [20]. A consistent psychotherapeutic effort is also necessary to support treatment, motivation, and retention and care, which obviously is a major challenge for this patient group. Dugosh et al. highlighted, in a meta-analysis, the efficacy of combining psychotherapeutic interventions and tailored pharmacotherapy is such as using motivational interviewing on regular basis [21]. A successful treatment of very complex concurrent conditions is possible but needs a high-level of team integration and training as well as specialized expertise. Long-term prescribing of high potent opioids without careful consideration and opioid stewardship may cause more harm than benefit, especially when alternative treatment strategies are not explored [22]. Without addressing the range of concurrent mental health conditions, as in this case, major depression, chronic pain, suicidal ideation, and prescription opioid dependence, it is impossible to develop an integrated treatment strategy that fully considers their interactions. Ray et al. reported that combining psychotherapeutic interventions with pharmacotherapy yielded greater benefits than standard medical care [23]. Within this framework, cognitive behavioral therapy did not demonstrate a significant advantage over other therapeutic approaches**.** In their review, Mumba et al. also addressed the psychotherapeutic approach in the treatment of opioid use disorders, but emphasized the challenge that these disorders are heavily burdened by stigma, thereby underscoring the importance of concurrent psychotherapeutic interventions [24]. Whether similar treatment approaches can be implemented effectively in an outpatient setting remained to be explored. Nevertheless, a better collaboration between primary care, specialty pain care and mental healthcare under the specific circumstances of this age group needs to be created as a foundation. A foundation which also needs significantly more clinical research in this field, as well as the further development of more appropriate and effective guidelines.

Conclusions

Complex concurrent disorders are a major challenge for primary care as well as mental healthcare, especially in the context of chronic pain. One of the most important challenges is the often under reflected prescription of opioids for non-cancer pain, which may lead to serious complications and treatment failure. Successful treatment requires specialized knowledge, integrated care teams, and a focus on symptom reduction and retention, coping and long-term recovery.

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