Pain in Older Adults

Fact Sheet No. 10

International Association for the Study of Pain

Pain and suffering often make the afflicted individual more vulnerable and this is especially true in the case of older adults. However, advanced age by itself can also lead to greater vulnerability potentially placing this segment of our population in double jeopardy. Older adults are known to have the highest incidence of disease; many of which can be painful (Farrucci, Giallaria & Guralnik 2008). Rates of surgery, procedural interventions, injury (Stubbs et al 2013) and hospitalization are also highest in this age group (Søreide & Wijnhoven 2016). Aging is often associated with slower healing and poorer recovery from acute injury or disease and this may result in a potentially greater risk of developing an ongoing, persistent pain problem (Schofield 2007). We are facing a rapidly aging demographic across the world and pain prevalence is known to be the highest in this cohort. With one exception (Faeer & Ruhe 2012), recent systematic reviews of survey studies with quite large sample sizes support the notion that pain increases with advancing age. All studies support the concept that females are more prone to pain than males. The most common pain complaints were knees, hips and low back pain. There was also a consensus that most pain was of musculoskeletal origin (osteoporosis or osteoarthritis) (Woo et al 2009), although a high incidence of neuropathic pain has also been found in a nursing home population (van Kollenburg et al 2012). In aggregate, this situation represents a markedly increased risk for suffering from bothersome pain.

Another important aspect of vulnerability relates to the potential for greater harm(s) in response to a precipitating event or condition. For a proportion of the older population, psychiatric (especially dementia) and medical comorbidity, frailty and loss of physiologic reserve may all decrease the capacity of the older individual to effectively deal with the negative aspects of untreated pain. Polypharmacy and comorbid disease may also reduce the number and type of available treatment options and so compromise effective management of bothersome pain (Nobilli et al. 2011). For instance, 63% of older adults with dementia had bothersome chronic pain compared to 54% of adults without dementia in a sample of 7609 community dwelling older adults (Hunt et al 2015). The relative lack of dedicated age-specific pain treatment programs, the lack of appropriate research on identifying age differences in pain and its impacts, as well as a long-recognised lack of randomised controlled trials conducted specifically in older populations has been noted (Reid & Pillemer 2015). As a result, there is a paucity of evidence to help guide current clinical practice and consequently a greater likelihood of harm in those older persons with problematic pain. A number of papers have discussed self-management of pain in this age cohort (Tse et al 2013, Karttunen et al 2015) primarily due to the lack of available pharmacological options.

Ageing and disability increases the potential for chronic pain (Molton et al 2014). The common pain sites are knees, hips and low back often associated with osteoarthritis and osteoporosis. Females are more likely to develop chronic pain and it is often associated with obesity (McCarthy et al 2009, Patel et al

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2013). Taken together, the increased risk for suffering from bothersome pain coupled with the reduced capacity to cope and avoid the potential harm(s) associated with pain highlights the special vulnerabilities of older segments of our community.

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