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Pain in Older Adults

- I. Epidemiology
 - A. Know that the presence of acute pain remains approximately the same across the adult life span, but there is an age-related increase in the prevalence of chronic pain at least until the seventh decade of life. There is also limited evidence to suggest a plateau or even a slight reduction in the frequency of pain complaints beyond this age (Brattberg et al. 1997; Helme and Gibson 2001).
 - B. Recognize that pain is a very common problem for adults of advanced age, with persistent or bothersome (chronic) pain affecting more than 50% of older persons living in a community setting and greater than 80% of nursing home residents (Ferrell et al. 1995; Helme and Gibson 2001).
 - C. Understand that while chronic pain is prevalent among older adults, it is not a normal part of aging. Rather, physical pathology and/or psychopathology are always involved (Harkins et al. 1994).
- II. Issues related to age differences
 - A. Be familiar with age-related changes in the function of nociceptive pathways, including alterations in afferent transmission and descending modulation (Gibson and Farrell 2003).
 - B. Be aware of the evidence and current controversy surrounding the notion of altered pain perception in older adults (studies of reduced experimental pain threshold, pain tolerance, and reduced pain symptoms in certain clinical conditions—myocardial pain, abdominal pain, malignancy, and postoperative pain). Also understand that reduced pain sensitivity does not mean that older adults experience less pain when they report it. To the contrary, it may suggest even greater levels of underlying pathology in those older persons who choose to report pain (Harkins et al. 1994; Gagliese and Melzack 1997; Gibson and Helme 2001).
 - C. Know of age-related differences in psychological mediators of pain, including altered pain beliefs and attitudes, coping strategy use, misattribution of symptoms, report bias, and stoicism (Yong et al. 2001; Gibson and Chambers 2003).
 - D. Be aware of common age-associated psychosocial issues (e.g., loss of family and friends, retirement from the workforce, bereavement, loss of independence/institutionalization) and how such factors may influence the expression, maintenance, and treatment of pain (Roy 2001).
- III. Pain assessment
 - A. Know of available self-report pain assessment tools that have demonstrated reliability and validity for use in older adults (e.g., verbal descriptor scales, numeric scales, and faces scales) (Herr and Garand 2001; Gagliese 2002). Appreciate that many older persons with dementia can also use such scales in an appropriate fashion (Chibnall and Tait 2001), although one may need to solicit the report of pain.
 - B. Understand the role of other important pain-related outcome measures when assessing chronic pain in older adults. For example, depression (including suicide risk), anxiety, sleep disruption, appetite disturbance/weight loss, cognitive impairment, and interference with performance of activities of daily living might be directly related to pain and, therefore, would be expected to improve with effective pain management (Flor et al. 1992; Helme et al. 1996; American Geriatrics Society 2002).

- C. Recognize potential indicators of pain (pain behaviors, e.g., bracing, rubbing, guarding, agitation, delirium, altered mobility/activity status, and facial expressions) in those who are unable to report pain (e.g., those having suffered a stroke or those with Alzheimer's disease) and know the most effective way to observe these behaviors (i.e., against an established baseline or during movement) (Weiner et al. 1996; Feldt 2000; Hadjistavropoulos et al. 2000, 2002a,b). While caregivers are often used as surrogates in the assessment of pain, know that the validity of this approach is uncertain (Weiner et al. 1999).
- D. Understand the importance of a comprehensive medical history and physical examination when assessing the older pain patient. Know how to perform a comprehensive musculoskeletal examination including that of joints, soft tissues, and the axial skeleton. Also know that chronic pain in older adults is often contributed to by more than one diagnosis, so comprehensive assessment should be performed routinely (Weiner et al. 1999; Herr and Garand 2001).
- E. Appreciate the increased likelihood of atypical pain presentations in older people due to diminished physiological reserves and interacting comorbidities (Harkins 1994; Gibson and Helme 2001).
- F. Recognize the high prevalence of incidental pathology (e.g., radiographic osteoarthritis in the absence of symptoms) and know that the history and physical examination should guide the acquisition of additional diagnostic studies and tests. Also know that identifiable pathology may be elusive in some older adults with chronic pain, but that pain itself is a treatable disorder and should be recognized as a discrete entity (Weiner et al. 1994).

IV. Pain management

- A. Recognize that treatment protocols and treatment goals may need to be adjusted in order to accommodate the special needs of older persons (American Geriatrics Society 2002).
- B. Be aware of possible age-related bias against the referral of older adults for pain management as well as bias against prognosis and against the perceived effectiveness of many pharmacological and nonpharmacological treatments when used in older persons. This type of age bias may be found in staff involved in treatment, in the community at large, and in older persons themselves (Kee et al. 1998).
- C. Have knowledge and clinical experience in dealing with recurrent and chronic pain conditions that are common in adults of advanced age (e.g., osteoarthritis, postherpetic neuralgia, spinal canal stenosis, malignancy, myofascial pain, fibromyalgia, post-stroke pain syndrome, and diabetic peripheral neuropathy).
- D. Be aware that pain is often undertreated in older persons with dementia (Morrison and Siu 2000). Also understand that a proactive, but cautiously aggressive treatment approach should be adopted, due to the higher risk-benefit ratio of pain interventions in this group (American Geriatrics Society 2002).
- E. Understand the important influence of concurrent medications and the potential impact of comorbid medical and psychosocial problems when formulating a treatment plan. Also know important drug-drug interactions, relative/absolute contraindications, and side effects related to analgesics that are commonly used in the older adult (American Geriatrics Society 2002).
- F. Know pharmacokinetic and pharmacodynamic changes that occur in the action of analgesics (e.g., nonsteroidal anti-inflammatory drugs, opioids) and adjunctive agents (i.e., drugs that are not primarily analgesic, but have analgesic properties, such as tricyclic antidepressants, anticonvulsants, and corticosteroids) for use in older adults. The implications of such changes in terms of dose adjustment and the likelihood of adverse side effects should also be recognized (Weiner and Hanlon 2001; American Geriatrics Society 2002).
- G. Be aware of available anesthetic/interventional procedures for the management of pain in older persons (e.g., morphine pumps, spinal stimulators, and surgical ablation) and the demonstrated benefits and limitations of their use in this population (Prager 1996).

- H. Recognize that pharmacological therapy for chronic pain is always more effective when combined with nonpharmacological approaches designed to optimize pain management and that pharmacological therapy should be viewed as a means of facilitating compliance with rehabilitation (American Geriatrics Society 2002).
 - I. Understand the role of psychological therapies in the management of the older adult with chronic pain (e.g., cognitive-behavioral therapy, relaxation, biofeedback, principles of secondary gain and operant conditioning, and hypnosis) (Cook 1998; Kerns et al. 2001).
 - J. Understand the role of physical therapies in the management of pain in older adults (e.g., exercise programs, assistive devices, TENS, vibration, massage, manipulation, heat and cold, and acupuncture) (Ferrell et al. 1997; Gloth and Matesi 2001).
 - K. Know the role of the multidisciplinary pain clinic in the management of the older adult with chronic pain, and know when it is appropriate to refer older persons to these clinics (Gibson et al. 1996; Helme et al. 1996).
- V. General issues
- A. Recognize that all older people are not the same. There is substantial heterogeneity in the extent of physiological, psychological, and functional capacity among individuals of the same chronological age (Busse and Maddox 1985).

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