



The International Association for the Study of Pain®

Facts on “Pain in Older Persons”

1. Epidemiology

- A major shift in the age distribution of the world’s population is now taking place. In developed countries, the percentage of the population over 65 years old will rise from 17.5% to 36.3% by 2050, and the over-80 age group will more than triple (US Bureau of the Census, International Data, 2002).
- Pain is a very common problem for older persons, with persistent (i.e. chronic) pain affecting more than 50% of older persons living in the community setting, and more than 80% of nursing home residents (Ferrell et al. 1995, Helme & Gibson 2001). Older persons are more likely to suffer from chronic pain than younger persons.
- Pain is the most frequently reported symptom by older persons, being reported by 73% of community-dwelling older persons (Brody & Kleban 1983).
- In older persons, pain tends to be constant, of moderate to severe intensity, lasting for several years, multifocal and multifactorial (Brattberg et al. 1996).
- 45.8% of older persons admitted to the hospital report pain; 19% have moderately or extremely severe pain; 12.9% are dissatisfied with their pain control (Desbiens et al. 1997).
- Cancer is the second leading cause of death for adults over 65 years of age (D’Agostino et al. 1990) and 67% of all cancer deaths occur in those over age 65 (Kennedy 1995). More than a quarter (26%) of cancer patients aged over 65 years of age who are in daily pain did not receive any analgesic agent (Bernabei et al. 1998).
- Pain is a major healthcare problem in Europe. The incidence of chronic diseases is higher among adults of advanced age than in the rest of the population. Although acute pain may reasonably be considered a symptom of disease or injury, chronic and recurrent pain is a specific healthcare problem, a disease in its own right (EFIC’s Declaration, D. Niv and M. Devor, presented at the European Parliament May 2001, http://www.efic.org/about_pain.htm#efic_declaration).
- Examples of chronic pain conditions common in adults of advanced age are osteoarthritis, postherpetic neuralgia, spinal canal stenosis, cancer, fibromyalgia, post-stroke pain, diabetic peripheral neuropathy and others.
- More than one clinical diagnosis typically contributes to chronic pain in older adults (Jones & Macfarlane 2005). There is also an increased likelihood of atypical pain presentations in this group, due to diminished physiological reserves and interacting co-morbidities (Gibson & Helme 2001).
- Elderly adults tend to have reduced sensitivity to noxious stimuli, but this does not mean that when pain is present they experience it less intensely. When older persons do report pain, they

are likely to be afflicted with greater levels of underlying pathology than younger individuals who report the same level of pain (Gagliese & Melzack 1997, Weiner & Herr 2002).

- Older persons tend to under-report pain, because of misinterpretation of physical sensations (e.g., “hurt” rather than “pain”), difficulty using standard pain assessment scales and false beliefs about pain and its management.

2. Impacts on Older Persons Well-Being

- Impaired quality of life secondary to pain may be expressed by depression (including increased suicide risk), anxiety, sleep disruption, appetite disturbance and weight loss, cognitive impairment, and limitations in the performance of daily activities. These added burdens are expected to improve with effective pain management (AGS Panel 2002).

- Older persons with persistent pain consider their health as poorer (Reyes-Gibby et al. 2002) and use more health care services than those without pain (Lavsky-Shulan et al. 1985).

- In patients with hip fracture, severe pain or inadequate analgesia after surgery can lead to increased confusion, slower recovery, and poorer ambulation and function (Morrison et al. 2003a, Morrison et al. 2003b).

3. Assessment and Treatment

- Assessment of pain in older persons requires a multifaceted and comprehensive assessment, including pain characteristics (intensity, quality, variations over time and situation), pain impacts (degree of psychological/affective disturbance, degree of functional limitations in activities of daily life, social impact), use of coping strategies, beliefs and attitudes toward pain, other medical illnesses, and cognitive functions.

- Pain assessment often is more difficult in certain older populations, such as those in residential aged care, those with sensory loss (impaired vision or hearing), or those with cognitive impairment. For those who cannot communicate their pain, one must rely on nonverbal signs of pain (e.g., grimacing, guarding, agitation, frown eyebrows).

- Older persons with dementia or communication problems are even more at risk of undertreatment of pain, due to difficulties communicating their pain. They are known to receive fewer analgesics than others of similar age and pathology (Parmalee et al. 1993; Pickering et al. 2006)

- On initial presentation or admission of any older person to any healthcare service, a healthcare professional should assess the patient for evidence of persistent pain (AGS Panel 2002).

- Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem (AGS Panel 2002).

- Despite the fact that persistent pain is more common in the older segments of the population, the overwhelming majority of pain treatment studies and intervention trials have been conducted in young adult populations. Age differences in treatment efficacy have rarely been considered. There is a manifest lack of scientific evidence to support most of the currently accepted treatment approaches for the management of pain as applied to older adults (Gibson 2006).

- Multidisciplinary pain programs that combine several modes of pharmacological and nonpharmacological treatment have demonstrated efficacy for the management of persistent pain

in older adults. However, this approach appears to be underused at present because older patients are underrepresented in pain management clinics, are less likely to be offered this treatment, and receive fewer treatment options when attending such clinics (Kee et al. 1998).

- Pharmacological therapy for persistent pain is most effective when combined with nonpharmacological approaches: physical therapy (e.g., exercise program, TENS, application of heat or cold), psychological methods (e.g., relaxation, cognitive-behavioral therapy), educational programs, social interventions and complementary therapies (e.g, acupuncture).

- Older persons are more vulnerable than younger persons since they often suffer from multiple medical and nutritional problems, which limit treatment options with analgesic agents, due to an increased risk of adverse effects and problems with complex drug interactions (Pickering et al. 2004).

- The effective treatment of pain in adults of advanced age requires specialized knowledge and training in pain management. When formulating a treatment plan one needs to be aware of the important influence of concurrent medications and the potential impact of co-morbid medical and psychosocial problems. There is also a need to be familiar with important drug interactions that may affect analgesic actions, and that may yield side effects. One needs to be aware of relative and absolute contraindications to certain drugs that are commonly used by older adults (AGS Panel 2002).

CONCLUSION

- There is an urgent need for better professional education programs, further dedicated research to help guide clinical practice, and better pain management strategies that specifically target the special needs of the older persons in our community (Gibson 2006).

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