Persistent pain in older adults
– we can do better!

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Persistent pain (often referred to as chronic pain) is a common cause of needless suffering and an often times disabling problem for at least half of all community dwelling and institutionalised older adults. There is widespread evidence that despite its prevalence and potentially devastating effects (e.g. physical, emotional and cognitive incapacity; increased health care utilisation, and compromised overall quality of life), persistent pain is vastly under-treated in those over the age of 65. Undertreatment has been documented in older adults in the community, in long-term care settings, in those with cancer and noncancer pain, as well as in those at the end of life. Numerous factors likely contribute to this unfortunate and unacceptable situation. Knowledge deficits among health care providers regarding the assessment and treatment of persistent pain in older adults play a leading role.

Management of pain in any population, let alone in older adults, has been relatively neglected in health professional education, although recent efforts in the United States have led to increased content in both medical and nursing school curricula on pain management. For health care providers in practice, accessing and utilising current best evidence guidelines is a key strategy for improving the quality of pain recognition and treatment in this vulnerable population. Because geriatric pain management is a nascent field, evidence-based literature is scant. However, there has been considerable recent growth in the research to support practice in managing persistent pain in elders. Clinical practice guidelines are available that provide recommendations for assessment and management of persistent pain in elders. When evidence is not available, research from younger adult populations provides guidance for practice with consideration of age-related changes that may impact assessment and intervention choices. The American Geriatric Society (AGS) produced the first *Clinical Practice Guideline on Management of Chronic Pain in Older Adults* in 1998. In 2002, AGS published a revised Clinical Practice Guideline: *The management of persistent pain in older persons*. The guidelines initially were based on consensus of experts, but continue to evolve into stronger evidence-based recommendations as research in this population increases. Resources such as these can provide a foundation on which practice decisions are supported and guided to improve outcomes and enhance the quality of life of senior citizens. Yet current prevalence data suggest we are not providing quality pain care to this segment of society. Why?

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There are many factors that provide unique challenges in providing effective pain management in older persons. Bias, misperceptions, and stigmatisation commonly interfere with a positive attitude towards ageing and pain management in elders. The language we use is one factor that can contribute to this and use of positive (or neutral) terminology, such as 'older adults' (instead of 'elderly'), 'persistent pain' (instead of 'chronic pain'), and 'opioids' (instead of 'narcotics') can reduce some of these concerns. Of course, the implications of various words and their connotations may not cross borders among nations and cultures, even

those with the same root language. Yet, it is important that we consider what and how we communicate regarding older persons.

Of utmost concern are common misconceptions related to pain in older persons and its treatment, held not only by health care providers, but also by older persons and their families. For instance, it is nominally held that pain is an inevitable and unavoidable consequence of older age. Although pain-producing conditions are more prevalent, it is erroneous to conclude that pain must be accepted or tolerated; this leads to inadequate pain reporting, a lack of effective pain assessment, and insufficient intervention. Other misconceptions relate to expectations of behaviour in older persons regarding their pain. For example, many believe that if older patients do not complain, they must not be experiencing pain. However, there are alternate explanations for why they may not report pain, including an inherent stoicism held by many elders, not wanting to complain too much in a desire to be 'good' patients, as well as fears about pain or its meaning. The belief that older people have a decreased sensitivity to pain is widespread, however recent studies suggest that differences in pain sensitivity are most likely clinically insignificant.[1] Thus, it is incumbent on health care providers to screen for pain presence and conduct a comprehensive assessment when it appears that function and quality of life may be impacted by a persistent pain problem.

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Misconceptions, fear and anxiety often surround the use of opioid medications for pain in older patients. Physicians may be reluctant to begin opioid therapy because of concerns about addiction, development of tolerance, or fears of side effects, such as confusion or respiratory depression. The incidence of opioid addiction in the geriatric population, although not well defined, appears to be exceedingly rare compared to the numbers of patients with clinically significant pain. Excessive fears over this and other side effects does not justify failure to provide effective pain relief. Fortunately, tolerance to the respiratory effects of such drugs as morphine occurs rapidly, and risks can be minimised through careful titration and appropriate dosing regimens.

An altogether different but almost universal side effect of opioid therapy is bowel dysmotility, with the potential for severe constipation. But initiation of a prophylactic bowel regimen and regular monitoring can obviate this concern and allow use of strong analgesics when needed. Furthermore, concerns about reaching an analgesic plateau are unfounded and an acceptable level of analgesia can usually be obtained. Open communication among patient, physician, and caregiver is necessary to dispel myths and fears and to educate patients and families in order to maximise their participation and adherence to plans of care focused on effective pain management.

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Persistent pain problems can be managed through a combination of nondrug and pharmacologic approaches tailored to the older person's unique situation. The older adult population is quite heterogenous with a wide range of physical and cognitive function capacities in those with persistent pain. Furthermore, the settings in which care is provided are diverse (e.g. hospitals, nursing homes, and outpatient clinics, community facilities) and the staff providing care has varied educational and clinical backgrounds and experience. Population specific knowledge – including physiological, psychological, social and environmental elements – is requisite for effective pain management in older persons. Additionally, the transition from a hospital or nursing-home pain management regimen to the home can emotionally and physically overwhelm the family. Family caregivers often are inadequately prepared to manage pain in their loved ones, providing yet another barrier to effective treatment. A family education programme and support system is essential to dispel misconceptions about pain medications and to address the many issues relevant to pain management at home.

Although assessment of pain can be a challenge in older persons, particularly in those with cognitive impairment, recommendations and tools are available to evaluate, in a quantitative manner, the intensity of a patient's pain and aid in the design of a rational therapeutic regimen.[2,3] Studies have shown that those with mild to moderate cognitive impairment can respond to pain scales with some adaptation and provide information about their pain. However, to effectively manage persistent pain problems the assessment must be comprehensive, incorporating many factors that impact upon the diagnosis (e.g. comorbidities and use of multiple medications), determination of an effective intervention strategy and evaluation of outcomes of treatment.

Probably one of the greatest challenges we face is assessing and managing pain in those who cannot reliably report their pain. In fact, prevalence data document that those with cognitive impairment receive less analgesia than their aged counterparts able to communicate.[4] These data should not suggest that their pain is less, but that as health care providers we are not recognising and treating it. Worse than receiving less analgesia is evidence that persons with dementia often receive no analgesia, even when there is clear evidence of painful pathology.[5,6] This unacceptable state is likely due to many factors, but utmost is the lack of recognition that elders with dementia exhibit normal nociceptive input, but may have altered interpretation of painful sensations.[7] Thus, elders with severe cognitive impairment may not present with typical pain behaviours and potential pain indicators may be overlooked or attributed to psychopathology or other conditions.

Strategies for assessing pain in the elder with severe cognitive impairment have been described.[8,9,10] Practitioners should be familiar with the diverse presentations that may represent pain in this population and engage surrogates (caregivers, family) in gathering observational data to assist in a presumptive diagnosis and evaluation of the efficacy of a given intervention. Observation of nonverbal pain behaviours (such as bracing, grimacing, facial expression, guarding, posturing, restlessness, and agitation) and vocalisations (such as groaning, moaning, crying, sighing and verbal outbursts), as well as observing for changes in behaviour patterns (such as change in activity level, decreased social interaction, sudden cessation of common routines, new onset of confusion, refusal to eat, difficulty sleeping and resistance to care), are important strategies in gathering information about the presence of pain from those unable to report it.

Multimodal treatment approaches seem to be most effective in the majority of patients with persistent pain. A multidisciplinary approach to pain treatment of the older adult, especially those with complex medical, psychological, or social circumstances, is often necessary to affect positive therapeutic change. The multi modal approach includes careful use of available pharmacological and nonpharmacological pain therapies, keeping the overall goal of pain management firmly in mind: to maximise the older adult's function and quality of life. In the 'end of life' or end-stage disease setting, the emphasis may shift to 'comfort only' care, and the relief of suffering. It is always important to revisit the concept that clinical context and patient-specific goals and needs are the 'drivers' of any care plan.

As the world population ages, the management of persistent pain in older patients will continue to be a significant and growing problem

In designing home-based pain management therapies, pain management strategies should be tailored both to the needs of older patients and to the resources and skills of the family caregiver. Determining the strategies that have been helpful in the past and designing a plan of care that incorporates patient preferences and successes, with both drug and nondrug interventions, will promote adherence and thus a more accurate estimation of intervention effectiveness. In institutional settings, development and integration of procedures and protocols for assessment and monitoring pain and its impact that are appropriate for older persons are useful approaches to improvement of pain recognition and management.

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The use of analgesics in older adults can be safe and effective,[11] but are likely underutilised in older adults for some of the fear and concerns noted earlier. Depending on the individual's pain problem and history of analgesic use, pharmacological options for the management of pain in older patients may include acetaminophen, NSAIDs, both short- and long-acting opioids, as well as adjuvant drugs. Evaluating the benefits and risks of analgesics, including the complicating factors of multiple comorbidities and polypharmacy common in elders, is necessary in selecting appropriate analgesic treatment for the older adult. Polypharmacy increases the risk of adverse effects, and a complete medication history is necessary to assess effectiveness of current medications and prevent drug interactions. Altered pharmacokinetics, part of normal ageing, impact dosing requirements and careful titration, including frequent assessment and dosage adjustments, is needed to promote optimal pain relief.

Another challenge related to pharmacologic management is lack of adherence to the treatment plan. Because of the easier administration regimen, long-acting agents may be appropriate for the older adult with continuous pain whose opioid dosing has been stabilised on short-acting agents. Regular monitoring for analgesic effectiveness, as well as anticipating and managing possible side effects, continues to be an essential part of analgesic management in this population. Finally, whenever possible, pharmacological and nonpharmacological therapies should be incorporated into a long-term pain

management plan that promotes improved quality of life.

As the world population ages, the management of persistent pain in older patients will continue to be a significant and growing problem. Although the management of pain in older persons provides a unique set of challenges, effective pain management is possible. Improved patient, caregiver, and professional education on aspects of assessment and pharmacological and nonpharmacological pain therapies unique to older persons is an essential first step – but not enough. As a society and as individual health care providers, we must examine our beliefs, values and attitudes about our aged members and their experience of pain. Certainly there are risks to be managed, but is there any greater risk than allowing our elders to suffer unrecognised and untreated pain that can devastate the quality of life in what should be their golden years? We can do better – we have sufficient knowledge to guide us and ongoing research will continue to refine our approaches for recognising and treating pain in this most valued and respected, yet often neglected, segment of our population.

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