Position Statement 21

Pain in Older People

Key Points:

1. The increased burden of pain in older people is related to the increased burden of pathology and is not an inherent part of the ageing process.

2. There is an obligation on all health professionals to identify individuals with unrelieved pain and, even if the underlying cause cannot be cured, to relieve suffering. This obligation is enhanced when individuals can no longer advocate for themselves or communicate their pain.

3. Clinicians should have access to training and have adequate skills to assess and manage pain in an ageing population.

4. Additional time and resources, such as interpreters, should be available to deal with the special needs of individuals with dementia and from culturally and linguistically diverse backgrounds who are at risk of under-recognition, under-assessment and under-treatment of pain.

5. Documentation of pain should be routine in all facilities caring for older people.
   a) Self report should be the gold standard.
   b) Observational and behavioural scales should be employed for individuals unable to reliably report pain due to cognitive or communication deficits.
   c) Pain should be considered as the “fifth vital sign™” after temperature, pulse, blood pressure and respiration rate.

6. Pain that affects an individual's quality of life or function should be considered as an important problem warranting treatment.
   a) Where appropriate the cause should be identified and treated.

b) Pharmacological therapy is most effective when combined with non-pharmacological approaches.

c) Cognitive behavioural therapy and other psychological strategies have been well studied and found to be useful in the older adult.

d) Alternative and complementary treatment strategies may be useful.

e) Interventional approaches have a role in selected patients who have not responded adequately to standard approaches. Referral to a multidisciplinary pain clinic or procedural pain specialist should be considered.

7. To improve pain management in Older People ANZSGM endorses:
   a) An increased emphasis on education and training in pain assessment and management for all health professionals involved in the care of older people, and with particular focus on improved training for geriatricians with incorporation of pain as a core topic in the curriculum for Advanced training in Geriatric Medicine.

   b) Persistent pain should be considered a disease in its own right not just as a symptom of disease.

   c) Removal of barriers to pharmacological options for older people that have proven efficacy and tolerability in the management of pain.

   d) Improved access to physical and psychological treatment options, pain specialists, and dedicated multidisciplinary pain clinics for older people.

   e) Institutions caring for older people should adopt “pain” as the “Fifth vital sign™” and have pain outcomes as quality indicators.

   f) Ongoing research on pain management in the older adult, ensuring that therapeutic trials in pain management include older subjects and those with cognitive impairment.
This Position Statement represents the views of the Australian and New Zealand Society for Geriatric Medicine. This Statement was approved by the Federal Council of the ANZSGM on 19 November 2012. Authors: Dr Clare White and Assoc Prof Benny Katz.

Background paper

Introduction

Pain is a frequently reported symptom in older adults. Older people are more likely to undergo painful medical procedures and are more likely to suffer from painful medical conditions. Chronic pain, now referred to as persistent pain, is defined as pain that persists beyond the time expected for healing to occur (arbitrarily defined as pain persisting beyond 3 months). Pain affects between 25-50% of older people living in the community and between 27-80% of those in residential care. Pain is also common in hospitalised older people. The prevalence of pain in a subacute geriatric hospital population in Melbourne has been estimated at 50%. The prevalence of persistent pain increases steadily up to the 7th decade. Pain in older people is often multifactorial and multifocal in nature due to the presence of co-existing pathologies. Both cancer and non-cancer pain is common. Cancer is the second leading cause of death in older people, with pain occurring in up to 40% of sufferers.

Pain in the older adult is commonly under recognised, under assessed and undertreated. Studies performed in a number of different clinical settings have consistently indicated that older people with pain are inadequately treated. This risk increases with advancing age, cognitive impairment and for those in residential care. In a large trial of nursing home residents in the US, one quarter of those with persistent pain received no analgesia and only one half of analgesics given were prescribed on a regular basis. A cross sectional study of nursing home residents in rural NSW reported that 22% of residents reporting pain had no record of analgesic medication. Older persons with dementia are known to receive fewer analgesics than others of similar age and pathology. Older people are less likely to be referred to a multidisciplinary pain clinic, despite evidence of benefit in this age group. Once referred to a pain clinic they are offered less management options than a younger group with the same pain severity and pathology. Documentation of pain is often very poor in the care of older people.

Over the last decade attempts have been made to address these issues, with multiple high quality evidence based guidelines made available for use by clinicians as well as collaboration between the World Health Organisation (WHO) and bodies such as the International Association for the Study of Pain (IASP), and an expanding body of research in the field. Despite this, however, there is still a large gap between our knowledge about the management of pain in the older person resulting in a high prevalence of suboptimally controlled pain in our hospitals, communities and residential care facilities.

This position statement has been developed to increase the emphasis that the ANZSGM places on the problem of pain in the older population, and for the society to undertake stronger advocacy to improve pain management in all settings where older people receive care.

Pain is a significant cause of suffering in our community and persistent pain may be highly stigmatised. Pain management has multiple ethical considerations. The WHO and many other organizations have identified reasonable access to pain relief as a basic human right. The Declaration of Montreal recognised 3 articles:

1. The right of all people to have access to pain management without discrimination.
2. The right of all people in pain to have their pain acknowledged and to be informed of how it can be assessed and managed.
3. The right of all people in pain to have access to management by adequately trained health professionals.

Poorly controlled pain has been associated with adverse outcomes, such as depression, functional impairment, weight loss and sleep disturbance. Uncontrolled pain after hip fracture is an independent risk factor for delirium and functional impairment. A large Australian epidemiological, community-based study of older men looked at the relationship between pain and frailty. They found a significant relationship between intrusive pain and frailty that persisted after accounting for comorbidities,
demographics, opioid use, depression and arthritis. They postulated that frailty may have an aetiological relationship with pain, suggesting that intrusive pain presents a challenge to those men who are already vulnerable to adverse outcomes. Persistent pain in the older person can be seen as occurring in the context of other age-related changes, not as an isolated symptom, and that these changes may predict worsening health outcomes and functional decline.

Common causes of pain in the older person include musculoskeletal pathology such as osteoarthritis, degenerative spinal disease and osteoporosis (24). Pain of neuropathic origin is more prevalent in older people, commonly due to diabetic neuropathy, post-herpetic neuralgia and lumbosacral radiculopathy. Older adults have the highest rates of surgical procedures and the highest incidence of painful diseases (25). Wounds are more common in older people and can be a source of significant persistent pain. Diffuse pain conditions such as polymyalgia rheumatica, vitamin D deficiency and statin myopathy can occur in the older adult and need to be considered.

**Pain Perception and Processing.**

Pain is a complex, subjective phenomenon and is more than just nociception. There are multiple degrees and levels of processing within the central nervous system that contribute to the pain experience. There has been much interest in the literature in the possible changes that may occur to pain perception and processing with age and age-related diseases such as dementia. Recent research indicates that older people tend to have higher pain thresholds but lower tolerance for severe pain. A meta-analysis of pain tolerance studies concluded that there is an age-related decline in the ability to tolerate severe pain and an increased vulnerability to the development of persistent pain. Some of these changes are thought to be secondary to reduced endogenous opioid production and reduced plasticity of the nociceptive system with increasing age. Other changes in pain perception have also been described with advancing age. Pain becomes a less frequent presenting symptom for a range of acute medical conditions. A significant proportion of older persons do not report pain during an acute myocardial infarct (up to 40% of cases), nor with peritonitis, intestinal obstruction or pneumonia. Therefore, the absence of pain should not be interpreted as the absence of pathology.

**Pain and Depression**

Depression is commonly associated with pain in older people. Depression may have a role in modifying pain processing by central means by modulating those areas of the brain involved in descending inhibition of nociceptive input. Therefore, depression increases the likelihood of developing persistent pain and vice versa.

**Pain and Dementia**

Dementia and pain are both complex phenomena, presenting difficulties in assessment and management when they co-exist. Changes to pain perception and processing in dementia appear to vary in direction and quality depending on the type of neuropathology, type of pain studied and the severity of dementia. Studies to date indicate that pain is no less frequent or intense when experienced by those with dementia, despite changes to their ability to communicate. Current evidence suggests that pain perception and pain processing are not reduced in Alzheimer’s Disease (AD). It is thought that AD may not affect the somatosensory cortex where the brain perceives stimuli to be painful.

**Assessment of Pain**

Assessment of acute pain in older persons is usually directed at finding the source of pain and providing symptomatic relief. This can follow a fairly linear approach as in a younger population. The assessment of persistent pain, however, requires a multifaceted, comprehensive approach that involves assessment of medical, functional, social, attitudinal, cognitive and mood related domains. Verbal self report is the standard first step in the assessment of pain whenever possible. Numerous pain assessment scales have been developed and, in general, those with demonstrated validity in younger age groups will also be useful in older persons with pain. Verbal categorical scales (eg none, mild, moderate or severe) are preferred by older persons and have the greatest reliability and validity. Failure to complete one type of scale does not mean that another type of scale will not be successful. The use of a validated pain
scale increases the frequency of diagnosing pain in older people.\textsuperscript{36}

Pain assessment is more difficult in those with dementia and other communication problems. Older persons with mild to moderate cognitive impairment will often remain capable of valid self report of pain particularly when assessing current pain.\textsuperscript{35, 34, 37} Research indicates that the use of verbal self report is more reliable for those with mild to moderate dementia than the use of carer or surrogate reports of pain.\textsuperscript{38} In cases of moderate to severe dementia it may be necessary to use nonverbal methods of assessment of pain, such as behavioural measures and observational tools, as the person’s ability to self report pain diminishes (\textsuperscript{39}). Recognition of pain behaviours, such as combinations of facial grimacing, negative vocalisations, changes to body posture or language and changes to vital signs are an important part of pain assessment in all older people, but particularly in those with dementia and those unable to communicate. However, these behaviours are non-specific and may not be a good measure of pain intensity. These pain behaviours are thought to be typical of acute pain but may not be as reliable as a measure of persistent pain.\textsuperscript{35}

Measurement of mood disturbance is a crucial aspect of the assessment of pain in all older people. The routine use of a validated tool such as the Geriatric Depression Scale is recommended.\textsuperscript{18}

The medical assessment of pain should include a thorough history of the pain, presence of other co-morbidities, medication use and physical examination.\textsuperscript{30} Particular attention should be paid to the presence of clinical red flags. Red flags were originally described in the context of lower back pain and are clinical indicators to serious underlying pathology, such as cancer, fractures or epidural abscess. Advanced age itself is a red flag. Other red flags include: pain that is progressive, pain that impairs sleep or is constant and non-mechanical in nature, loss of weight, a history of malignancy and any back pain in the context of focal neurological deficits. Assessment should also focus on particular clinical situations where therapy is available that may modify the disease process, such as joint arthroplasty for osteoarthritis, ischaemic limb pain responsive to vascular surgery or rheumatoid arthritis for which multiple disease modifying drugs are useful.\textsuperscript{41} Judicious use of investigations is recommended when one of the above conditions is suspected.

**Management**

**General principles**

The management of acute pain is generally directed at the underlying cause, with concurrent use of analgesia for relief of symptoms until the acute episode has resolved. A more comprehensive management plan is required if the pain fails to respond or if the pain has become persistent. Persistent pain that is significant and affecting quality of life requires a different approach. Persistent pain should be viewed as a disease entity in its own right and will commonly require a comprehensive, multidisciplinary management strategy, where the focus is on improving function and quality of life rather than cure of the underlying cause.\textsuperscript{42, 17}

Clinicians need to be aware of the important contribution of comorbid conditions, concurrent medications and psychosocial factors that may impact on a treatment plan. The side-effect profile of the drugs being considered and the potential for significant drug interactions should be actively sought.

Pain cannot be completely alleviated in all situations. A more realistic approach in this situation is to aim for a significant reduction in pain severity sufficient to improve the function and psychological state of the individual. Success in clinical trials is often measured as a 30-50% reduction in pain severity. Attempting to achieve total eradication of pain is likely to lead to intolerable side-effects. Patient and carer education is vital to assist in setting realistic goals of therapy.\textsuperscript{43}

**Pharmacological**

Pharmacological therapies form the mainstay of the medical approach to pain management. They work best when combined with non-pharmacological strategies. Multiple different clinical guidelines are readily available and frequently updated (Australian Therapeutic Guidelines).\textsuperscript{16, 17, 18, 44}

There is a wide range of medications available for use in the management of pain. Many of these have been around for a long time and clinicians are familiar with their use, such as paracetamol, opiates and NSAIDS. However, it is important to remember that the literature
surrounding their use for particular types of persistent pain in the older, frail person is often lacking. Recommendations regarding analgesia may be made from extrapolating data obtained in younger people. Older people are a heterogeneous group, making it difficult to predict optimum dosage and side-effects. Older people have a higher risk of adverse drug reactions and may not tolerate medications well.

Safe prescribing principles such as “Start low, go slow” will still apply but adequate dose escalation must take into account the severity and level of distress caused by pain to ensure that under-treatment is minimised. Under-treatment may occur if clinicians are overly concerned with side effects such as drug dependency, constipation or cognitive changes. Unrelieved pain can cause cognitive impairment or delirium in some clinical settings. The least invasive method of delivery of analgesia is usually preferable. A trial of analgesia may be appropriate with goals of therapy outlined prior to commencement, with the understanding that the medication will be withdrawn if not effective.

The timing of analgesia is often as important as the choice of medication itself. The presence of continuous pain requires around the clock coverage of analgesia, usually with a form of long-acting medication. Most patients with continuous pain who are receiving a long-acting preparation should also receive short-acting medications for ‘break-through’ pain. Episodic analgesic prescription with ‘as required’ medications may not be appropriate for those with cognitive impairment or communication difficulties. Incident pain (such as that caused by wound dressings or a physical activity) may be predictable and best managed pre-emptively.

The analgesic ladder was developed to assist in the management of cancer pain, where pain management escalates from the use of simple non-opioid analgesics (step 1), through to weak opioids (step 2), and finally to strong opioids (step 3). It is often used for non-cancer pain. There are some limits of this approach in the older adult with pain. Increasingly, the approach has changed to bypass step 2 and proceed to using low doses of stronger opioids such as oxycodone. All medications must be considered carefully and balanced with regard to risks and benefits for each individual. ‘Rational polypharmacy’ refers to the concept of using combinations of analgesics with different modes of activity which may be more effective than when used alone and lead to a reduced side effect profile. For example, paracetamol and sustained release oxycodone for moderately severe musculoskeletal pain.

**Non-Pharmacological Therapies**

There is a large range of non-pharmacological therapies in use for the management of persistent pain. They can be used as first or second line therapies, but are best used in combination with pharmacological strategies. Non-pharmacological interventions include education, physical techniques and psychological or cognitive therapies. Active participation by the patient and their carers helps to build control and self-reliance.

Education of patients and their families is a central aspect of any pain management program. There is evidence to suggest that education alone can reduce pain. Education should include information about the nature of an individual’s pain, use of pain assessment tools, information about medication use, goals of therapy and non-pharmacological pain management strategies. Suitable written material should also be used.

Physical therapies can provide pain relief as well as having other beneficial effects on mood, physical function and sleep. Isotonic exercises have been shown to reduce pain in older people with musculoskeletal pain. Trancutaneous electrical nerve stimulation (TENS) has shown conflicting results in older people with persistent pain, however, a trial may be warranted to assess efficacy on an individual basis. Correct posture and appropriate furniture can assist with pain relief. Involvement of a physiotherapist and occupational therapist should be considered.

Psychological and cognitive behavioural techniques have been shown to be useful in the older person with persistent pain in the community and in residential care. Despite evidence for this approach in older people it is rarely used in clinical practice, perhaps due to poor access to structured CBT programs in our hospitals and in primary care.

Multidisciplinary Pain management clinics have been shown to be of benefit in the management of pain in older people compared to standard care.
There are many procedural interventions available for those with more severe and troublesome pain that is not responsive to standard therapies. These include epidural injections, facet joint injections, spinal cord stimulators, various nerve blocks and ablative procedures. However, most studies of these techniques have not used older subjects, and evidence for efficacy is often based on observational data only. These options need to be considered on an individual basis and may be appropriate in highly selected patients. Referral to a pain specialist familiar with pain in older people or a multidisciplinary pain clinic is appropriate when planning interventional procedures in older people.

**Barriers and recommendations to effective pain management**

Our health care system has an obligation to provide quality pain management for older people. The National Pain Strategy developed in 2010 sought to outline an agenda to improve the management of pain in older people, with involvement by educators, health care professionals, funding organisations, government, policy makers and public health organisations. It identified many barriers to the delivery of quality pain management across our health care system. These include barriers to access pain specialists, multidisciplinary clinics, medications, allied health and other services that provide non-pharmacological therapies like CBT.

Attitudinal barriers may be present in patients, carers and health professionals. Many patients, their families and health care professionals believe that pain is an unavoidable part of ageing and as such, may not be referred for, nor seek out, pain management services. Residents in Aged Care facilities can be particularly disadvantaged. Residential aged care funding has not recognised pain as a separate entity, only as a symptom of disease. This fails to recognise the increased care needs of those with significant persistent pain. Accreditation processes for Residential Aged Care do not place emphasis on the multidimensional management of persistent pain. Staff at residential care facilities may not be well equipped to manage persistent pain. In 2005 The Australian Pain Society released guidelines for the management of pain in residential aged care to assist health care providers in the field in the recognition and treatment of pain in this vulnerable population.

Subsidised access (via the Pharmaceutical Benefits Scheme) to new or developing pharmacotherapies can be slow and difficult. This may adversely affect older people with pain to a greater degree as many new therapies may have increased tolerability in this population.

In attempts to control illicit drug use, government bodies and law-makers may inadvertently restrict reasonable access to pain relieving medications, such as opiates, for those with legitimate medical needs. Clinicians and professional bodies need to work towards appropriate legislation and regulation in this area.

Many health care professionals may not be adequately trained to manage pain in older people. An improved focus on education and training is critical, with revised curricula for students and trainees, and using such initiatives as quality outcome measures for accreditation and quality assurance purposes.

**Summary**

Pain is a common and troubling symptom for many older people. It is a complex, subjective and emotional experience that is highly prevalent in older people. Despite this, it is not an inherent part of the ageing process. There is an ethical obligation to identify those with unrelieved pain, and even if disease cannot be cured, to relieve suffering. Persistent pain should be recognised as a disease in its own right and is optimally managed with a multidisciplinary approach. Older people with cognitive impairment or communication difficulties need particular attention in the assessment and management of pain. The ANZSGM accepts the need to identify barriers to optimal pain management for older people and advocate for changes in these areas.

**References**


