FACT SHEET No. 5

Pain in Older Adults

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 [2]. 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) [13]. Aging and disability increases the potential for chronic pain [8]. 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 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. A high incidence of neuropathic pain has been found in the nursing home population [15]. In aggregate, this situation represents a markedly increased risk for suffering from bothersome 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 [3]. Rates of surgery, procedural interventions, injury [1] and hospitalization are also highest in this age group [12]. 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 [10].

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 [7]. For instance, 63% of older adults with dementia had bothersome

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chronic pain compared to 54% of adults without dementia in a sample of 7609 community dwelling older adults [5]. 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-recognized lack of randomized controlled trials conducted specifically in older populations has been noted [9]. 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 [6,14] primarily due to the lack of available pharmacological options.

In spite of our increasing awareness of the prevalence of pain amongst the older population and our understanding of the impact of pain upon this group, under-treatment remains prevalent. Widely held misconceptions held by health professionals and older adults themselves presents a barrier to adequate treatment. An interesting paper by Thielke et al (2012) identified four commonly held myths about pain and aging including: pain as a natural part of getting older; pain worsens over time; stoicism leads to pain tolerance; prescription analgesics are highly addictive. The paper reviewed the evidence behind each of these myths and concluded that pain is not a natural part of aging and actually remains stable over time. The fact that older adults are often stoical does not mean that they “get used” to pain. They also demonstrated that more than 80% of older adults with osteoarthritis wanted more information about the course of the disease, but about only one third had received this information.

So where do we go from here? We understand the issues around pain in older adults and we know that there is a high incidence of pain in this population, which is often confounded by communication barriers and misconceptions amongst health professionals. We need to find a way to educate our patients and our peers to understand these issues and look to manage pain more effectively for this population, perhaps working with them to help them to understand that they do not have to live with the pain, it is “not an expected part of aging”.

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