

Managing pain

in practice



SPECIAL ISSUE: MANAGING PAIN IN OLDER PEOPLE

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Highlighting the challenges and opportunities in the assessment and management of pain in older adults

Pain is probably one of the most well-known but least well understood medical conditions. Pain is subjectively experienced by different individuals based on their values, genetics, experiences and culture. The subjective sensation of pain may be described as aching, burning, stabbing, piercing, cramping, throbbing, or shooting, and may be acute, chronic, or intermittent in nature.

The effective management of painful chronic conditions such as osteoarthritis, rheumatoid arthritis, and lower back pain often requires input from a multidisciplinary team; depending on the condition and the service, this team could include specialist nurses, pharmacists, pain specialists, physiotherapists, psychologists, and general practitioners. Effective communication is needed not only between healthcare professionals and the patient, but also between members of the multidisciplinary team.

Effective assessment of pain in older adults is often challenging, particularly in people with dementia. Dementia patients suffering from pain are often not able to communicate clearly to their caregivers the location and intensity of their pain or even whether they are in pain; in turn, this translates into a lower use of pain medication in dementia patients compared with their cognitively intact peers. Additionally, general frailty, a high degree of polypharmacy,

and reduced metabolic function constitute additional barriers to effective pharmacological management of chronic pain in older adults.

Guidelines play an important role in setting evidence-based management standards and in educating healthcare professionals on how to best treat pain in older adults. In addition to the information provided by guidelines, improved pain education is needed on all levels, from undergraduate healthcare programmes to the training of seasoned specialists, and across all members of the multidisciplinary team, including secondary care doctors, nurses, pharmacists, and primary care physicians.

Pain may be one of the oldest medical problems in the world, but it no longer has to be one of the most misunderstood. Through more effective communication, assessment, and treatment, the management of pain in older people can be improved, to the benefit not only of individual patients and their families and carers, but also of society as a whole.

This special issue of *Managing Pain in Practice* highlights challenges and opportunities in the assessment and management of pain in older adults, with special emphasis on communication, the role of multidisciplinary teams and the need for a wide range of effective treatment options.

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The emotional and physical burden of pain in older people

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The effect of COVID-19 restrictions on mobility, mental well-being, and the perception and management of pain

Chronic, or persistent, pain is defined as pain that persists longer than the normal healing time and thus lacks the acute warning function characteristic of physiological nociception. Chronic pain constitutes a substantial healthcare burden, as it affects approximately 20% of people worldwide and accounts for 15–20% of physician consultations.¹

In older adults, persistent pain, defined as a painful experience that persists or recurs for more than three months,² is associated with anxiety, depression, falls, frailty, functional loss, gait change, higher health costs, low quality of life, polypharmacy, sleep disorder, social isolation, and weight loss.^{3,4} Factors linked to greater risk of pain developing or persisting include general physical health, mental health (e.g., depression, anxiety, and stress), physiological factors (e.g., obesity), and lifestyle factors (e.g., physical activity levels, smoking, and sleep).⁵

The experience of pain is determined by complex interactions between ascending peripheral signals and the modulation of these signals by the central nervous system through descending facilitatory and inhibitory systems.⁶ Many chronic pain syndromes display greater pain facilitation of pain and reduced pain inhibition. Additionally, ageing appears to be associated with a dysregulated pain profile, and the age-related imbalance of pain facilitation and inhibition makes older adults more susceptible to developing chronic pain compared with younger adults.⁷

Physical activity is an important factor for healthy ageing, and low levels of physical activity are associated with non-communicable diseases such as cardiovascular disease and diabetes and an increased risk of all-cause mortality.⁸ Additionally, an accelerated deterioration of muscle mass and muscle function aggravates long-term health conditions prevalent among older adults such as cardiovascular disease, cognitive decline, depression, diabetes, frailty, and osteoporosis.^{9,10}

Before the emergence of the 2019 coronavirus pandemic, a majority of older adults were found to lead largely sedentary lives, with almost 60% of older adults sitting for more than 4 hours per day.⁸ This sedentary lifestyle among older adults was reinforced by the general quarantine, isolation, travel ban and social distancing response to the COVID-19 pandemic, and had an overall negative impact on the mobility and physical and mental well-being of older adults.^{9,11}

The vicious cycle of chronic pain and avoidance of physical activity

Although pain is normally a protective response to injury, prolonged reductions in muscle movement to avoid pain may contribute to disability and the chronicity of many pain conditions, especially in older adults.^{12,13} In general, older adults are typically less physically active than younger adults, and experience more chronic pain.¹⁴ However, physical activity helps preserve the endogenous pain inhibiting system into old age. Older adults who are physically inactive have weak endogenous pain inhibition, which may lead to a vicious circle where weaker pain inhibition leads to more pain, which leads to reduced physical activity and further reduced pain inhibition.⁷ Low levels of physical activity increase the risk of pain progression, which may lead to avoidance of physical activity and a reinforcement of the vicious cycle of chronic pain and inactivity.¹⁵ The reduced mobility and avoidance of physical activity as a consequence of pain may cause a 20%–30% increased risk of dying, particularly due to cancer and cardiovascular disease.¹⁵ In older adults, physical activity needs to be personalised to the unique needs of each individual and should involve endurance, flexibility, and strength exercises. To improve motivation and reduce barriers to physical activity, educational initiatives are often helpful to communicate the rationale and benefits of moderate exercise.¹⁶

The impact of pain on quality of life

Pain and diseases associated with pain are leading causes of disease and disability burden globally,¹⁷ and chronic pain conditions such as neuropathic pain and multisite pain have a particularly detrimental effect on both physical and psychological health and well-being.¹⁸

Persistent and chronic pain has a wide-ranging impact both on quality of life and relationships and interferes with both physical and mental health aspects of daily living.^{19,20} The impact and prevalence of musculoskeletal conditions, which increase with ageing, are leading causes of persistent pain, impaired function and mobility, reduced mental well-being, and reduced quality of life.²¹ Pain may disrupt sleep, reduce the refreshing quality of sleep, aggravate anxiety and depression, and destroy self-efficacy,²² and chronic pain patients with low self-reported health report high levels of loneliness, low friendship quality, and high levels of perceived rejection.²³

Additionally, chronic pain makes people more vulnerable to social isolation, which may lead to exacerbation of symptoms.²⁴ During the COVID-19 pandemic, increased loneliness and social isolation were found to be associated with increased incidence and prevalence of pain intensity and chronic pain.²⁵ Furthermore, patients with pain and depression experience reduced physical, mental, and social functioning as opposed to patients with only depression or only pain.²⁶ Importantly, major depression increases the risk of developing future chronic pain, and chronic pain and pain catastrophizing are mutually reinforcing determinants for chronic depression and form a vicious cycle of pain and depression.²⁷

The challenges of pain management in older adults

Although more people live longer, many experience pain as a major part of their health problems, which increases the burden on healthcare systems.^{16,28} Pain in older adults is frequently associated with frailty (i.e., unhealthy ageing) and treating pain as a stand-alone clinical symptom may therefore be of limited value if the older adult's overall life, social circumstances, and systemic health are not taken into consideration.⁵

Older adults frequently experience musculoskeletal pains due to osteoarthritis, low back pain, and neuropathic and cancer-related pain,^{16,29} and poorly controlled chronic pain affects approximately 40% of older adults living in the community and 80% of the nursing home population. Adding to this burden is the fact that it is also frequently under-reported and insufficiently assessed.³⁰

Although older people often live with pain that negatively impacts their quality of life, some older adults have a tendency to stoically accept chronic pain, and demonstrate fear avoidance beliefs, which leads to treatment avoidance and poor engagement with healthcare recommendations. This may, unfortunately, further exacerbate disability and escalate disease chronicity.¹⁶

Pain in older adults is a challenging problem for healthcare professionals, as there are significant differences in the management of pain in older adults compared to younger patients. From a clinician point of view, concomitant chronic illnesses in older adults make pain evaluation and treatment more challenging in older adults. Additionally, older adults frequently respond differently to pharmacological therapies, and often experience reduced treatment effectiveness and more severe adverse events.³¹ Furthermore, most older adult patients living in nursing homes experience some degree of cognitive impairment which may impact on their ability to communicate pain to the healthcare provider and may therefore lead to inadequate assessment and management of pain.^{32,33}

Additionally, comorbidities and associated polypharmacy complicate the evaluation and management of pain in older adults. Importantly, adverse events related to pharmacological therapies are more frequent in older adults compared to younger adults, particularly in the presence of polypharmacy and comorbidities, such as age-related renal impairment.³⁴ These factors need to be carefully considered when new treatments are being introduced so that the risk of drug-drug and drug-disease interactions are minimised.¹⁶

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The role of pharmacists in supporting older people in pain

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The emergence of COVID-19

This had a massive direct impact on human health and posed extraordinary challenges to healthcare systems from prevention to testing to treatment.

It also exposed broader fragilities in the delivery of the entire range of healthcare services and products. Primary healthcare resources were overburdened, and many providers were inaccessible to the public due to in-person care challenges. The pandemic led consumers to turn to self-care to maintain good health, treat the symptoms of COVID-19, and to manage other self-diagnosable and treatable conditions, like pain. Moreover, to better manage their own health, consumers increasingly visited their community pharmacies and used e-commerce to access self-care solutions such as non-prescription medicines.

The World Health Organization defines self-care as the ability of individuals, families and communities to promote health, prevent disease, maintain health, and to cope with illness and disability with or without the support of a healthcare provider, and it has the potential to improve the efficiency of health systems and to contribute towards health equity.¹ As such, there is a growing interest in self-care, and this trend has been greatly accelerated by the ongoing COVID-19 pandemic.²⁻⁴ An important part of self-care is the management of aches and pains, and even though medical information is more accessible than ever before, there is a risk of patients being exposed to information overload or misinformation, which may lead to questions and doubt.⁵⁻⁷

Pain, often attributed to physical injuries, trauma, or various disease states, is a common and often under-treated phenomenon in patients aged 65 years and older.^{8,9} Acute pain often functions as a warning signal for tissue damage, whereas chronic pain may represent a disease manifestation in itself, and may require ongoing treatment.^{10,11} Additionally, pain may change a person's lifestyle and impact work, relationships, and independence, and may also lead to reduced physical activity and a negative impact on daily living.^{11,12}

The COVID-19 pandemic and the continuing evolution of self-care

The pandemic has accentuated the crucial role pharmacists play in consumers' self-care routines, which involve a variety of actions that patients take to manage pain and other ailments. As pharmacists are the most easily accessible of healthcare professionals,

they are also at the forefront of providing appropriate care to older adults who are experiencing pain.^{2,12,13}

Pharmacists play an important role in guiding patients' self-care behaviour, with patient assessment and effective patient communication being cornerstones of meaningful pharmacist self-care counselling. Furthermore, pharmacists may act as advocates to empower patients and help them make healthy lifestyle choices, recommend appropriate OTC medications, and educate consumers about when to consult a physician.^{2,11-14}

As the global healthcare system continues to evolve and adapt to a changing world, self-care is expected to have an increasing role in treating many minor ailments, and pharmacists are at the forefront of these changes and well-equipped to lead this 'self-care revolution'. In many countries, the COVID-19 pandemic has also led to the strengthening of the role of the pharmacy as a 'community health hub', and as such, pharmacists have a crucial role to play in supporting older people living with pain.^{2,12,13}

The role of the pharmacist supporting older people in pain

Recognizing that pain is a frequently under-treated condition in the elderly, and that barriers to treatment often exist, pharmacists may educate older adults about the appropriate use of medications to provide adequate pain relief with the aim of improving the patient's quality of life and physical functioning. Patient reports of pain should always be taken seriously, and referral to a physician should be encouraged when appropriate.^{12,14}

Older patients often have misconceptions about pain management and may be inappropriately treated for their condition. A pharmacist's recommendations for OTC pain medications may open the door to the pharmacist enquiring about the patient's health concerns,^{11,13} which may lead to an open dialogue with the patient and opportunities to discuss multidisciplinary approaches of pain management consisting of both pharmacological and non-pharmacological approaches.^{2,11-14} However, in a community pharmacy setting, it can be challenging to conduct effective consultations without access to a patient's medical records. Effective communication between the pharmacist and patients about their pain is therefore very important.^{2,13,14} As the impact of pain varies from person to person, it is important that the pharmacist can offer a variety of different OTC pain relief options to cater for different patient needs.^{11,13,14}

Polypharmacy in the elderly and the benefits of topical pain medication

Polypharmacy is increasing with older age, and up to 58% of older adults (≥ 65 years) in Europe are on five or more different medicines, and up to 23% are on more than ten different medicines,¹⁵ some of which may have adverse reactions with anti-inflammatory pain medicines taken in oral form.¹⁶

Topical medications are less likely to interfere with oral medication, as they are only applied topically rather than systemically. Having access to topical pain medicines is therefore very important, particularly for older people who are at higher risk of medicine interactions and may not be aware of this.^{17,18} Topical pain relief offers an attractive option for managing pain in many cases because the products are applied directly to the site of pain, providing targeted relief, and carrying less risk of adverse effects. In addition, topicals may be more suitable for patients on complex medication regimens who wish to avoid taking more tablets or who have difficulty swallowing solid-dose forms. As such, having access to topical pain relievers is important, as it provides an alternative to oral medication, which is particularly important for older patients that are at higher risk of medicine interactions.^{17,18}

The benefits of strengthening the role of the pharmacist in primary healthcare

Pharmacists have a responsibility to collaborate with patients and ensure medications are optimized and safe as part of an overall approach to management of chronic pain and comorbidities. They often have well-developed therapeutic relationships that facilitate adoption of roles to promote self-management, provide pain education, collaborate with the interprofessional team and reduce stigma to support the person living with pain.

Investing in pharmacist education will help to make community pharmacy more sustainable and will also alleviate pressures on primary healthcare physicians. Furthermore, it is of utmost importance to strengthen relationships between primary care physicians and pharmacists. Pharmacists need to be viewed as integral members of the primary healthcare team (which they rightfully are), so that they are able to advise both patients and primary care physicians on aspects such as medicine interactions, as pharmacists are experts in this field.^{2,11} To support the broader adoption of structured, evidence informed models for pharmacist-led services for patients living with pain, policy changes are needed to decrease scope limitations and improve access. Education for all pharmacists is needed about chronic pain and the accompanying stigma to increase readiness to support these models.

Pharmacists are the healthcare professionals most accessible to the public and are also the first (and often preferred) source of reliable, evidence-based advice and care. Benefits of seeking support from

pharmacists on over-the-counter pain management use of analgesics include:^{2,11-14,19}

- Ensuring that the most appropriate product is selected
- Supporting adherence of prescribed medication
- Counselling on effective and safe dosing and administration of analgesics
- Checking for and preventing interactions of analgesics with other medicines
- Contributing to safety by recording the supply of analgesics in the patients' medical records (in countries with national patient records that pharmacists can add to)
- Supporting people in pain with information on different means of pain management
- Recognising conditions that require referral to a fellow healthcare professional
- Preventing misuse of and addiction to analgesics
- Educating on the safe disposal of analgesics and accepting unwanted and/or expired analgesics for safe disposal.

These actions, routinely performed every day by community pharmacists, ensure access to effective medication, optimise quality of life and health outcomes for people with pain, improve safety for patients and others, and support the sustainability of our healthcare systems. Health literacy and patient education is important to strengthen adherence to treatment, and when a new medicine is introduced to a patient it must be used in the correct way to avoid wastage and poor patient outcomes. For expert advice, consult your local pharmacist.

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Improving communication between healthcare professionals and older people in pain

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The impact of open and clear communication for older people living with pain

Effective and clear communication between older adults suffering from chronic pain, their family members, and healthcare providers facilitates pain management and improves treatment outcomes and quality of life.¹ In fact, studies have found that effective patient communication may be as important as pharmaceutical intervention in the management of chronic pain.^{2,3}

Non-verbal communication is critical for high-quality patient communication, as it influences adherence, clinical outcomes, patient satisfaction, and the patient-physician relationship.⁴ The reduced effectiveness of physician non-verbal communication appears to particularly impact patients aged 65 years and older, as well as patients with impaired hearing.⁵ In healthcare communication settings, it is important to consider factors such as age, personal preferences, comorbidities, disabilities, the reasons for the patient-physician interaction (e.g., diagnostic consultation, information exchange, or need for additional treatment resources), and the communication methods used (e.g., face-to-face, web-based, telephone or written interactions).⁶

An improved understanding of the best communication channels between people living with chronic pain and healthcare professionals will likely benefit not only the patient, but also their caregivers.⁶ Effective, patient-centred communication between physicians and patients with chronic pain require mutual contribution, understanding and trust. Many patients particularly emphasise having their experience validated and feeling believed as important elements of their interaction with their physicians.⁶ This is particularly important with pain, as pain report and intensity is subjective and cannot be objectivised with a quantitative test.⁷

Although the physician-patient relationship appears to be the most important determinant of overall patient-physician satisfaction,⁸ communication barriers in the healthcare environment can often go undetected, and may seriously impact on the health and safety of patients.⁹

Barriers to effective patient-physician communication include growing demands of clinical productivity, increasing documentation, and the use of electronic medical records systems that encourage physicians to focus on ticking boxes on a screen, which may hinder effective patient communication, particularly in cases of complex chronic pain diagnoses.¹⁰ Adequate

pain evaluation in adults is time-consuming, and even more so in older adults. The average time allocated for most primary care physician visits is approximately ten minutes, but a full chronic pain assessment interview in a chronic pain clinic typically requires one hour. It is therefore no surprise that primary care physicians often struggle to adequately assess patients with chronic pain in the course of a consultation.¹¹

Chronic pain patients' negative experiences of care are frequently associated with the healthcare professional not understanding the patient's pain, not believing that the pain is real, or making statements that the pain is only in the patient's head.^{6,12} When interactions with physicians make patients feel insignificant, it becomes difficult for patients to express their needs, which negatively impacts patient care and may even make patients lose hope in their recovery.⁶

Primary care physicians frequently interrupt opening statements by patients, which often leads to patients not completing their interrupted statements.¹³ Importantly, interruptions by a healthcare provider of an older adult patient's communication may negatively impact the communication of important pain information by the patient to the healthcare provider, and this reduction in effective communication between patient and healthcare provider may negatively impact pain management.¹⁴

Conversely, chronic pain patients reporting that they feel believed and supported in their interactions with healthcare professionals emphasise this as an important factor in boosting patient resilience.⁶ Being heard by their physician improves patient satisfaction, even in cases where there is no improvement in patients' pain management. In short, 'improved listening' ranks among the top recommendations from patients to healthcare professionals.⁶

Both patients and healthcare providers rank open and non-judgmental communication using lay language as necessary to build and sustain a strong therapeutic alliance,⁶ and joint decision-making, built on a supportive and collaborative relationship, is deemed necessary for a constructive partnership between healthcare professionals and patients. It facilitates patients' self-management of their condition and makes it easier to set realistic goals and explore the risks and benefits of different treatment options.^{3,6} Seniors want to make informed decisions, and they need to be provided with adequate information about the risks and benefits of these decisions.¹⁵

Practical tips on how physicians can improve their communication with chronic pain patients include:^{3,16}

- Before the consultation, encourage patients to write down their questions, as this may facilitate conversation on topics that are important to the patient.
- Increase the duration of clinic visits, particularly for older patients, to allow for time to address multiple patient concerns, improve patient-physician communication, patient-centred interviewing, and shared decision-making.
- At the start of the consultation, tell the patient in pain that you are there to help comfort them and to do the best you can to relieve their pain.
- Use caring communication skills and patient-centred interviewing.

Communication within multidisciplinary teams

Multidisciplinary teams (MDTs) for the management of patients with chronic pain may include a variety of specialists such as pain medicine physicians, neurologists, orthopaedic surgeons, psychiatrists, psychologists, physiotherapists, physical therapists, nurses, pharmacists, occupational therapists, complementary therapists, dieticians, and educational therapists.¹⁷

The chronic pain patient's primary care provider is often responsible both for the long-term patient management and for referring the patient for assessments and treatments. Because of this central role, good communication between the primary care provider and the MDT is as important as the communication taking place between members of the MDT.¹⁷

A common cause of poor communication is exemplified by inadequate transfer of information between the primary care physician and MDT specialists, and vice versa. This problem may be solved by the implementation of information technology solutions such as computer-generated referral letters that ensure that all required information is being communicated between primary care physicians and MDT members.¹⁸ Effective and accurate communication between chronic pain patient caregivers is important, as its failure may have serious implications for patient care, including poor diagnostic processes and testing, inadequate pain control, increased healthcare resource utilisation, poor continuity of care, polypharmacy, unrealistic expectations, patient dissatisfaction, and reduced confidence in medical practitioners.¹⁹

How health education for patients and primary caregivers can support effective communication

A negative relationship exists between patient health literacy and comprehension of diagnosis, health outcomes and healthcare service utilisation. Limited health literacy is an obstacle to primary healthcare access, and health literacy has been identified as an important aspect of patient engagement self-management strategies.²⁰

Effective patient communication is supported by early health education; if patients are well educated early and are supported in communicating their needs to healthcare professionals, they will receive faster and more effective care. However, different types of patients have different levels of proficiency and confidence in interacting with their healthcare providers.²¹⁻²⁵ Importantly, primary caregivers and family members of older patients should be involved in the conversations with healthcare professionals, so that they can help with supporting older people in pain.^{23,25}

When it comes to educating patients on treatment dosing and adherence, it is important that information is made available in accessible formats for older patients such as via leaflets (rather than only online) and using lay language that is easy to understand.²⁵

After all, the aim of the information is to educate patients about their medical condition and care, and to equip patients with the information needed to actively participate in their care through joint decision-making and active, open communication, with specific attention to the barriers and obstacles of ageing.

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Increasing education for healthcare professionals on managing pain in older people

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Barriers to effective pain management

Pain is a colossal global health problem with massive socioeconomic impact and reduces quality of life for millions.¹ Pain may be experienced as acute, chronic, or intermittent, or as a combination of the three. The largest underlying causes of pain can be extracted from the global burden of pain surveys where diseases ranking highest in years lived with disability are in the field of musculoskeletal pain (e.g., low back pain, neck pain, osteoarthritis), all with pain as a symptom.² The aetiology of pain is complex, and may lead to various sequelae such as depression, inability to work, disrupted social relationships and suicidal thoughts. It is estimated that 10% of the global adult population is diagnosed with chronic pain each year. The median time of living with chronic pain is 7 years,¹ and it is known that chronic pain increases mortality.³

Barriers to optimal pain management can be viewed as either system-, staff-, nurse-, physician-, or patient-related. System-related barriers may include poorly defined standards and pain management protocols, and/or limited access to analgesics and pain specialists, whereas staff-, nurse- and physician-related barriers can be due to inadequate training and poorly functioning interdisciplinary teamwork, and too little focus on patients in pain as compared to many other life threatening diseases. Patient-specific barriers may include reluctance to take analgesics, fear of side effects, and fear of addiction to pain medication⁴ and in the elder patients it is also related to their self-esteem and acceptance of their chronic pain with stoicism.⁵

Although chronic pain is highly prevalent among older adults, pharmaceutical management of chronic pain in older adults is often under-prioritised, and pharmacological interventions cause adverse events such as constipation, urinary retention, sedation, increased risk of falls, and cognitive impairment. It should be noted that no analgesics have been developed specifically for the elderly and current medications are seldom tested adequately in the elderly. Notoriously, older adults are underrepresented in clinical trials in general, and in particular in trials evaluating chronic pain treatments.^{6,7}

As the elderly often have more comorbidities and impaired organ functions (e.g., hepatic clearance), testing analgesics is a demanding, time consuming and costly task – although it will be needed to ensure optimal personalised treatment options in the elderly.

Furthermore, pharmaceutical management of pain in older adults is limited by the potential risks caused by polypharmacy and frailty, as the effectiveness and safety profiles of pain medication have been poorly evaluated in older adults taking multiple different medications, or that suffer from frailty.^{6,8}

The chronic pain experienced across the general elderly population is often described as intense, disabling and in need of treatment, and it is frequently under-reported.^{9,10}

Tools for quantitative pain assessment are needed for adequate pain management planning in this vulnerable group, and should ideally include an evaluation of the intensity, location, affect, cognition, behaviour, and social aspects of a patient's pain. However, many pain patients with dementia, for example, present with cognitive and linguistic barriers that prevent them from reporting these aspects. Consequently, healthcare professionals must often rely on one-sided, limited assessments about the intensity of pain in dementia patients, and this may result in inadequate management of the patient's pain.¹¹

Although the clinical gold standard in pain assessment is self-reporting, it is often not a realistic option for assessing pain in pain patients with dementia. To overcome this limitation, several observational pain scales, such as Doloplus-2, PACSLAC (Pain Assessment Checklist for Seniors with Limited Ability to Communicate), PAINAD (Pain Assessment in Advanced Dementia), and others, have been developed¹¹⁻¹⁵ but these tools should be used more systematically in routine clinical evaluations.

There is a need for more information, education, and training of health care professionals to be able to better evaluate pain in the elderly, and the impact of pain on their daily living. Evidence-based guidelines for the management and assessment of pain in older adults are therefore important.¹⁶

The importance of utilising guidelines for the management of pain in the elderly

Sub-optimal outcomes in the management of chronic pain are partly due the general lack of adherence to evidence-based guidelines, their translation, and acceptance in different countries. Translation of chronic pain management guidelines to languages other than English, such as those provided by the International Association for the Study of Pain (IASP)¹⁷ are therefore

of utmost importance to facilitate the dissemination of diagnostic and management guidelines for chronic pain in the elderly. Many leading professional bodies such as the British Geriatric Society and the American Geriatric Society have published management guidelines.^{18,19}

Many factors need to be taken into consideration when managing chronic pain in older adults where the physiological changes caused by the ageing process, dosing adaptation of the analgesic drug, and replacement with alternate medicines are all important aspects.²⁰ Compared to younger adults, older adults therefore often report more frequent side effects of a given drug therapy, especially in conjunction with co-morbidities and polypharmacy, and this needs to be carefully considered as it may increase the risk of detrimental drug/disease and drug/drug interactions in older patients.²⁰ The route of administration is another factor. Although the oral route is often preferred, topical treatments may have similar effectiveness and may cause fewer adverse events, as the systemic exposure to topical drugs is often lower compared to the oral route. Combination therapy (e.g., the combination of lower doses of two different drugs) may be beneficial for effective pain management, as drugs with complementary mechanisms of action may provide synergistic effects and lead to greater pain relief with fewer side effects than would higher doses of monotherapy.²⁰ Current guidelines for the treatment of pain in older adults likewise emphasise the use of non-pharmacological strategies such as acupuncture, cognitive behavioural approaches, physiotherapy, and transcutaneous electrical nerve stimulation (TENS) to reduce or eliminate the need for medicines²⁰ although like pharmacological therapies randomised clinical trials are lacking. These alternative approaches may be tried in patients that already take several medications for other medical conditions or in patients that are at elevated risk of side effects from pain medication.

Is improved pain research and education for healthcare professionals the answer?

Although pain is a substantial societal and financial burden,¹ particularly so for older adults already burdened by age-related health conditions, the physiology, diagnosis and management of pain remains poorly represented, and highly variable, in many undergraduate healthcare programmes.^{21,22} Educational gaps include pain not being taught as a dedicated subject, poor documentation of pain topics in the undergraduate medical curriculum, and the use of teaching and assessment methods (e.g., lectures) with low uptake of practical methodologies. However, recent progress, such as national guidelines mandating the inclusion of pain in the curriculum, is encouraging.²¹⁻²³

Importantly, better pain management education, with more training hours dedicated to the treatment of pain, must not be limited to only physicians, but

must be extended to the other key members of the multidisciplinary pain management team, including nurses, pharmacists, and physiotherapists.²⁴ In addition to improved education on the management of pain per se, more in-depth education on how to best manage the relationship between health care professionals and older adult patients suffering from chronic pain would also be beneficial, as the relationship between the healthcare professional and caregiver is important for effective pain management for older adults. With improved education and improved awareness and adherence to treatment guidelines, existing resources can be leveraged to reduce the suffering and social and financial burden of what might be the most widely recognised, yet one of the least well understood, conditions of human existence – pain. Furthermore, more focused, and dedicated research programmes targeting basic and clinical pain research are needed to pave the way for better awareness, education and management of older adults suffering from pain.

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Managing pain in practice

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