

Pain management needs to be tailored for older people. The British Pain Society and British Geriatric Society produced guidelines specifically for this client group

Managing chronic pain in older people

In this article...

- › Review of the available literature
- › Advice on suitable pharmacological interventions
- › Guidance on non-pharmacological pain management

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This article presents the results of a collaborative project between the British Pain Society and British Geriatric Society to produce guidelines on the management of pain in older adults. The guidelines are the first of their kind in the UK and aim to provide best practice for the management of pain to all health professionals working with older adults in any care setting.

Pain is often poorly managed in older people and there is a need for comprehensive guidelines to advise practitioners on how they can ensure pain management is tailored to this group. With this in mind, we have researched the literature on pain management in older people and used our findings to create a set of guidelines, usable by all health professionals working in any setting. We chose not to address assessment of pain as this has been published previously and is currently being updated. The focus is on chronic pain, which is defined as "that which persists beyond the expected healing time" (Merskey and Bogduk, 1994).

Methodology

We searched both PubMed and CINAHL for relevant publications between 1997 and 2010. Approximately 5,000 records were identified in the initial search and a quality score was then assigned to each paper and reviewed independently by another member of the group. All papers considered to be acceptable were incorporated

into matrices and included in the commentary. A detailed summary of the search criteria is provided in the full document.

Prevalence of pain

It is impossible to determine a definitive prevalence of pain in older people due to differences in the definition of pain, population and methods of measuring pain. After reviewing the literature, we agree with previous studies that suggest 50% of older adults living in the community and 80% of those living in care homes experience chronic pain. This suggests that our most vulnerable, frail members of society experience more pain than the general population.

Pain is more prevalent in older women. The effect of age is inconsistent, with some studies reporting an increase in prevalence with age and others reporting a decrease with age. Prevalence also varies by gender and site of pain. The three most common sites of pain in older people are the back, leg/knee, hip and other joints.

Pharmacological approaches

Few studies have investigated the effects of pharmacological interventions on older people. Generally, studies look at interventions in younger people and the results are translated across the age ranges. Nevertheless, there are some take-home messages with pharmacological strategies (Box 1).

Interventional therapies

Interventional approaches include a variety of neural blocks and minimally invasive procedures. Intra-articular (IA) corticosteroid injections in knee osteoarthritis are effective in relieving pain in the short term with few complications and little joint

5 key points

1 Pain is a risk factor for falls in older people

2 It is thought that 50% of older adults living in the community, and 80% of those living in care homes, experience chronic pain

3 Few studies look at the effects of pharmacological interventions specifically on older people

4 Combination therapy using different classes of analgesics may be more effective with fewer side-effects, compared with higher doses of a single medicine

5 Further research is needed on psychological treatments for pain in older people



The back is a common site of pain

BOX 1. KEY MESSAGES FOR PHARMACOLOGICAL STRATEGIES

- Paracetamol is an effective analgesic, particularly for musculoskeletal pain. It is well tolerated, but the recommended daily dose should not be exceeded.
- Non-steroidal anti-inflammatory drugs (NSAIDs) are effective analgesics, but their side-effect profile means they need to be used with caution in older people. If essential, the lowest dose should be used for the shortest period and it should be reviewed regularly. A proton pump inhibitor should be co-prescribed with an NSAID or selective COX-2 inhibitor.
- In the short term, opioids may be effective for both cancer and non-cancer pain, but there is a lack of long-term data. Opioids may be appropriate for patients with moderate or severe pain, particularly if the pain is causing functional

impairment or reducing quality of life. Treatment must be individualised and carefully monitored for efficacy and tolerability as individual patients' response to opioids varies considerably. Side-effects of opioid therapy (including nausea and vomiting) are common so suitable prophylaxis should be considered. Appropriate laxative therapy, such as the combination of a stool softener and a stimulant laxative, should be prescribed throughout treatment for all older people prescribed opioid therapy.

- Tricyclic antidepressants or anti-epileptics may be used for neuropathic pain. Although tricyclic antidepressants are effective, anti-cholinergic side-effects may be a problem. Patients should be started on the lowest possible dose and

this should be increased slowly. There is limited evidence for the efficacy of other antidepressants, such as SSRIs, and they should not be used as analgesics.

- The use of older anti-epileptic drugs is limited by adverse effects and the need for blood monitoring. Dose adjustment of gabapentin and pregabalin is required in renal impairment.
- Topical lidocaine and capsaicin have limited efficacy in managing localised neuropathic pain and topical NSAIDs may be suitable for non-neuropathic pain, particularly if the pain is localised.
- Combination therapy using different classes of analgesics may provide greater pain relief through synergistic action with fewer side-effects, compared with higher doses of a single medicine.

damage. IA hyaluronic acid is effective with few systemic adverse effects and it should be considered in patients who are intolerant to systemic therapy. It has a slower onset of action than IA steroids but the effects appear to last longer.

Epidural corticosteroid injections for spinal stenosis in older patients may be appropriate, but their use in radicular pain or sciatica is not so convincing. Epidural adhesiolysis for spinal stenosis and radicular symptoms may benefit older adults. The evidence for facet joint interventions in all age groups is mixed, although there is some support for radiofrequency denervation of the medial branch nerves in appropriately selected patients.

There is weak evidence for sympathectomy for neuropathic pain in older people. A nerve block using a combination of local anaesthetic and corticosteroid is effective in acute herpes zoster and post-herpetic neuralgia. Botulinum toxin may also be beneficial. Microvascular decompression is the treatment of choice for trigeminal neuralgia in healthy patients and percutaneous procedures are indicated for older patients with high comorbidity.

There is conflicting evidence for vertebroplasty and kyphoplasty in the treatment of painful vertebral fractures and we were unable to draw a conclusion on their use.

There are no studies of spinal cord stimulation specifically targeting older people. However, randomised control trials in mixed-aged groups, including over-65s, support its use for selected patients with failed back surgical syndrome, complex regional pain syndrome, and neuropathic and ischaemic pain.

Psychological interventions

Psychological interventions, such as cognitive behavioural therapy, may be effective in reducing chronic pain and improving disability and mood in adults. However, few studies focused on older adults and, where studies have been carried out, the sample sizes have been small. There is some evidence supporting the use of CBT in nursing homes and limited evidence that biofeedback training, mindfulness, meditation and enhancing emotion regulation may be beneficial for persistent pain. Although these approaches appear to be helpful, there is a need for further research in this area.



Physiotherapy and occupational therapy

We know that pain is a risk factor for falls in older people. Programmes that consist of strengthening, flexibility and endurance activities to increase physical activity and improve pain and function are

advocated. The specific type of exercise is probably less important, but exercise must be tailored to the functional level of the individual. Balance exercises can be incorporated successfully into a programme.

A variety of devices are designed to assist in activities of daily living; however, most studies are descriptive in nature and few have considered pain reduction in older people. Assistive devices can be used to support community living, prevent functional decline and reduce care costs.

Self-management

Self-management approaches are being promoted for all aspects of care and these techniques should be considered with other methods of pain management. Self-management programmes with mechanisms for long-term support may have some benefit, but there is a lack of evidence on programmes delivered without support.

Complementary therapies

There is limited evidence to support the use of complementary therapies.

Conclusion

We identified only a small number of studies on the management of pain in older people. To develop the guideline, it was necessary to use studies that recruited a younger population, some of which included people over the age of 65 years. The guideline has exposed this lack of evidence for many types of treatment in an ever-increasing ageing population. **NT**

BOX 2. RESOURCES

The full guidance was published in *Age and Ageing* and is available from:

- Pain management guidelines tinyurl.com/Ageing-pain
- Pain assessment guidelines tinyurl.com/PainSoc-older

Reference

Merskey H, Bogduk N (1994) *Taxonomy of Pain Terms & Definitions*. Seattle: IASP Press