Overview of Pain Management in Older Adults

Steven M. Savvas, PhD*, Stephen J. Gibson, PhD, MAPsS

KEYWORDS

• Pain • Pain management • Older • Prevalence • Barriers • Cognitive impairment

KEY POINTS

- Pain in older people is common. Whether pain prevalence increases, decreases, or plateaus with advancing age may be related to the type of pain.
- Considerable barriers to pain management exist and include attitudes (patient and health provider), communication, effect of age on pharmacokinetics, and comorbidities.
- A broad approach to pain management for older people is recommended and is similar to that used in younger cohorts: pain identification and assessment, pain management with pharmacologic and nonpharmacologic approaches, and evaluation of side effects.

INTRODUCTION

The population is aging. Globally more than 900 million people are 60 years of age or older, and this group is growing at a rate of more than 3% per year.[1] More than 20% of the population in Europe and North America are currently more than 60 years of age, and projections estimate that most major regions in the world will have at least a quarter of their population more than 60 years old by 2050. This shift in demographics has caused a proliferation of research in older persons, addressing the considerable gaps that previously existed. Pain in older people has likewise seen considerable work this century,[2] with substantial recent progress in pain and dementia.

Pain is a sufficiently different experience for older adults compared with younger cohorts, in part because of key differences between these groups, such as physiologic differences, pain perception, attitudes about pain, coping ability, and social support/context.[3] Despite these differences, pain management in older people is similar to approaches used in younger cohorts: identify and assess for pain, manage pain with a

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Clinical Division, National Ageing Research Institute, 34-48 Poplar Road, Parkville, Victoria 3052, Australia
* Corresponding author.
E-mail address: s.savvas@nari.unimelb.edu.au

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multimodal approach using pharmacologic and nonpharmacologic treatments, and evaluate side effects and benefits of treatment. However, special consideration is needed in older adults, who often have more comorbidity, are prescribed more medications, experience more serious drug side effects, have significantly more sensory and cognitive impairments, and have differing attitudes to disablement and pain management goals (often attributable to common circumstances, such as retirement). These differences affect general approaches when managing pain in older adults.

This article provides an overview of later-life pain and includes a brief review of its epidemiology, describes commonly encountered barriers to its management, and discusses guidelines and recommended approaches to both its assessment and management.

EPIDEMIOLOGY

Pain prevalence is difficult to estimate in older persons. Self-reported pain is the gold standard and although this acknowledges that pain is subjective and personal, self-report is also subject to personal biases stemming from personality and generational traits (eg, stoicism), culture, and especially age-related impairments such as sensory loss and cognitive impairment. Prevalence reports differ from country to country, with some variability caused by the demographics of the populations being investigated, the setting (eg, community, long-term care, hospital), pain definition (eg, acute, chronic, current pain, >3 months, lifetime), the type and site of pain, pain management approaches used, and differences in research methods. For all these reasons, pain prevalence reporting needs specificity when making comparisons.

Pain prevalence estimates differ greatly between countries, although chronic pain prevalence studies are lacking in many developing countries, especially those with limited resources.[4] A review of chronic pain[5] reported significantly high prevalence for persons aged 66 years or older in developing countries (South Africa, China, Americas, Ukraine, Nigeria, and Lebanon) compared with the developed countries of western Europe, North America, Japan, and New Zealand. Furthermore, there is considerable variation among developing countries, with a recent study[6] that used standardized national data showing low back pain prevalence ranging from a low of 22% (China) to a high of 55.7% (Russian Federation). Disease prevalence estimates of conditions that are typically pain promoting further distinguish the differences between developed and developing countries, although they may also indicate that the prevalence of certain conditions is higher in developed countries. For example, osteoarthritis of the knee is more prevalent in many developed countries (especially in North America, Europe, Australia, Japan, and New Zealand) compared with the western pacific region, south east Asia, Africa, and countries in the eastern Mediterranean.[7] Furthermore, this gap widens for the older age cohorts. However, there are few epidemiologic studies on other musculoskeletal disorders, such as rheumatoid arthritis, and no research data for many African countries. A recent review suggests that a crude prevalence of rheumatoid arthritis in Africa is substantially lower compared with North America and Europe.[8–10]

Living situation (ie, residing in a community vs residential/long-term care setting) seems to be a useful demarcation when reviewing pain prevalence. Although only a few older adults reside in long-term care facilities, this cohort is representative of a group that conceivably experiences significant barriers in pain management. For example, most patients in long-term care have cognitive impairment and multiple comorbidities, and therefore prevalence figures for this group represent a useful upper limit of pain in older adults. Among community-dwelling older adults, pain prevalence

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