PAIN IN OLDER PERSONS: URGENT NEED FOR BETTER EDUCATION

Editorial from the SIG Interim Chair: Dr David Lussier

Better education is key to improving pain management in older persons. Education should be provided to patients, family caregivers and health care professionals.

Health care providers’ knowledge, beliefs and attitudes about pain vary and influence the assessment and management of pain in their patients. Studies in different care settings (nursing homes, acute care hospitals, emergency rooms) have shown that nurses and physicians tend to underestimate the prevalence and severity of pain in their patients, and that this is directly correlated with an under-treatment of pain. Educational programs are effective in improving nurses’ knowledge and attitudes. The Pain Resource Nurse (PRN) Training Program™, a 40-hour didactic and clinical course developed by Betty Ferrell and her colleagues, is a very good example of such a program. An educational program for the multidisciplinary team, focusing specifically on pain in older persons, has been developed by a Canadian team; it improves professionals knowledge as well as satisfaction with pain control. However, in order for the benefits of such programs to be sustained, they must be accompanied by strong commitment from the institution and the implementation of best practice guidelines.

Patient empowerment is crucial to optimal pain management. Given difficult access to specialized resources and limitations of pharmacological treatment, it is very important that patients be educated, with false pain beliefs being addressed and self-help techniques taught. Since family members are very important for an older person’s care, they should also be educated about their loved one’s pain.

Increasing awareness and providing education on pain in older persons are the main objectives of the Global Year Against Pain in Older Persons. Now that we are half-way through the year, I am very happy to see that several educational activities have been organized throughout the world, to provide education to the public and to health care professionals. I would like to take this opportunity to point out a few of these, and congratulate the organizers for their efforts.

Conferences, workshops and seminars for the public and older persons with pain have been or will be held in Albania, Argentina, Brazil, Canada, Croatia, Pakistan, Slovenia and United Kingdom. The Albanian Pain Association has created a Center for Elderly in Need and in Pain.

Educational programs for health care professionals have taken place in Argentina, Australia, Bosnia-Herzegovinia, Brazil, Canada, China, Croatia, Czech Republic, Germany, Iran, Lithuania, Romania, Slovenia and the United Kingdom. Some workshops are held in hospitals, while others are part of national scientific meetings. It is interesting to note that two different disciplines, geriatric medicine and pain medicine, often join their efforts for these occasions. Some seminars are part of pain medicine meetings, whereas others are part of geriatric medicine meetings.

It is not too late to plan similar educational events in your community. If you need assistance, please do not hesitate to contact the IASP or myself.

The Web has also become an excellent way to disseminate information. We are in the process of developing educational material for the IASP website, on different topics relevant to pain in older persons.

We need help from SIG members in order to fulfill this task. Please contact me if you are interested in helping us: <david.lussier@muhc.mcgill.ca>
The Newsletter.

This edition contains articles by two of our SIG members. Thomas Hadjistavropoulos (Canada) describes the development of an interdisciplinary expert consensus statement on pain assessment in older adults, published in *Clinical Journal of Pain* in January 2007. Many of the 27 experts of the expert panel were members of our SIG. The consensus paper is intended to be helpful to both researchers and clinicians. The second article by Lepa Jovanovic (Serbia) describes the findings of a Masters of Science thesis on the topic of persistent pain in community dwelling frail older adults.

The presence of persistent pain potentiated the psychological consequences of frailty. These articles represent the diverse range work that the members of our SIG are involved in. I encourage others to contribute articles of interest to the multidisciplinary and multinational membership of our SIG.

You may wish to submit an article on your research, a case study, conference report, literature review etc. Please contact Benny Katz at elderpainsig@connexus.net.au

Benny Katz

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**A Consensus View on Pain Assessment in Older Persons.**

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A team of 27 experts on pain assessment (representing the disciplines of anaesthesiology, family medicine, geriatric medicine, neurology, nursing, occupational therapy, pain medicine, pharmacy, physical therapy, psychology and rheumatology), many of whom are members of International Association for the Study of Pain Special Interest Group on Pain in Older Persons, have recently published an interdisciplinary expert consensus statement on pain assessment in older adults [1]. The paper was published as a complete supplement of the *Clinical Journal of Pain* (January 2007). Prior to the publication of this consensus paper, the American Geriatrics Society Panel on Persistent Pain in Older Persons [2] had prepared a timely and clinically-focused overview of pain assessment in this population (see also American Medical Directors Association [3] and Australian Pain Society [4]). Building upon such pre-existing seminal work, the consensus team aimed to describe a more comprehensive and detailed approach to assessing pain in the older patient. The consensus paper is intended to be helpful to both researchers and clinicians.

The consensus team recognized that pain assessment is essential for both diagnostic purposes and decisions concerning treatment and that pain can affect many domains of function (e.g., psychological well being, self-care, ability to participate in recreation). As such, the comprehensive assessment of pain must be expanded from the evaluation of pain intensity and symptom description to also include an understanding of the emotional consequences of pain (e.g., pain is frequently comorbid with depression), functional ability, social functioning (including responses from significant others), coping, comorbidities, past treatments, openness to available pain management options and other related domains.

The recommendations/guidelines provided in the consensus paper are based on a comprehensive review of the literature and include recommendations for:

a) the physical evaluation of the older pain patient;

b) the assessment of pain intensity using self-report procedures; c) the assessment of pain in seniors with limitations in ability to communicate because of dementia; d) the functional assessment of the pain patient; e) the assessment of emotional functioning; and f) history taking (including information on medication usage).

Moreover, many self-report and observational measures of pain (including assessment tools designed for specific patient sub-groups such as arthritis patients and herpes zoster patients) are reviewed. The paper includes detailed tables summarizing the nature of many assessment tools and relevant psychometric information. A ten-minute assessment battery that can be used in busy clinical settings is also described.

This consensus paper is especially important given evidence that pain is undertreated and underassessed among older adults [5, 6]. The concerns about undertreatment and underassessment are most salient in the care of seniors with moderate to severe dementia [7-9]. For example, a recent survey of members of the American Pain Society identified the undertreatment of pain in older persons and in persons with cognitive impairments as being among the most pressing ethical concerns for clinicians [5]. But better pain assessment leads to better treatment. In fact, data from our lab [10] show that the implementation of a systematic pain assessment program in long-term care facilities leads to better pain management for the patients and reduced stress for the nursing staff.

It is important to recognize that, ultimately, the context and purpose of the assessment dictates the selection of the most suitable and appropriate methods. In situations where brief assessments are conducted, ongoing clinical monitoring is necessary to assess patient progress and to determine whether additional evaluation is necessary [1]. The consensus paper was intended to facilitate the process of selecting the best assessment approach while taking into account both the clinical context and the patient population.
Frailty is common in old age. It is characterized by reduced capacity and functional reserve and is associated with advanced age, multiple medical co-morbidities, polypharmacy, functional disability, cognitive impairment and social isolation. Frail older individuals have a high prevalence of chronic pain, affecting physical, cognitive, emotional and social domains. The association between frailty and chronic pain has not been fully examined in the past.

The study population comprised a convenience sample of 203 community dwelling frail elderly people who were receiving home based medical and nursing care because of advanced diseases, cognitive impairments or functional disability. 88.2% of the study population suffered from chronic pain of at least 6 months duration, with some up to a few decades. The mean age was 78.6 ± 8.5 yrs. 38.1% were living with a spouse and 61.9% were living alone.

Methodology

Assessment of pain was obtained by interview of the patients in their own home using a purpose designed Pain Questionnaire exploring pain characteristics, level of functioning, psychological and social aspects, and analgesics therapy [1]. The patient’s medical record was also reviewed.

Results

Pain was located in the lower extremities in 43.0% of cases and in lumbar, sacral and coccygeal region in 11.8%. It was located in more than three sites in 18.1%. The origin of the pain was musculoskeletal in 59.7% and neurological in 29.9%. Males had similar rates of neuropathic and musculoskeletal pain syndromes, 44.2% and 42.3% respectively, whereas females predominantly had musculoskeletal pain 65.1%, compared with 25.4% of neuropathic origin. Significant statistical difference was found in the overall distribution of organic systems affected by pain, according to gender ($\chi^2=10.38; p<0.02$)

Severity of pain was assessed using a number of different scales including word descriptor scale, numerical descriptor scale and the McGill Pain Questionnaire. 93.2% were able to use a verbal descriptor scale. Pain was rated as very strong in 32%, strong 31% and moderate in 26%. 42.1% of cognitively impaired patients were unable to use a numerical pain rating scale. [1]

Using the McGill Pain Questionnaire-long form [2], the severity of pain was highest when the pain was due to a peripheral neuropathy (mean 14.36 ± st. dev. 10.11) followed by low back pain (mean 14.41 ± st. dev. 7.47), musculoskeletal (mean 12.27 ± st. dev. 9.04) and cancer pain (mean 11.63 ± st. dev. 7.37) [1]. In comparison a younger population (mean age of 55 years) reported more intense pain e.g. pain in low back (34.1), musculoskeletal (32.1) and cancer pain (26.0) [2] (R Melzack personal communication 11/1/02).

The temporal characteristics of pain were classified according the third axes of Taxonomy system of Chronic Pain Classification by IASP [3]. Patients mainly reported continuous pain (57.5%) or pain recurring irregularly (10.4%) and other combinations (32.1%). Males reported less continuous non-fluctuation pain than females, 5.8% versus 22.5%, $p<0.01$; but more continuous fluctuating pain 59.6% versus 32.5%, $p<0.001$. Pain occurring irregularly was reported more frequently by males than females, 17.3% versus 8.3%, $p<0.04$. Significant statistical difference was found in overall distribution of temporal characteristics of pain syndromes according to gender ($\chi^2=21.24; p<0.0001$)

Diagnoses of chronic pain syndromes were made according Taxonomy System of Chronic Pain Classification by IASP [3]. The chronic pain syndromes were classified as: 1. Relatively generalized syndromes (38.9%) including

References

The following article is based on the Master of Science thesis of Lepa B. Jovanovic, clinical pharmacologist, Serbia.

MULTIDIMENSIONAL NATURE OF CHRONIC PAIN IN FRAIL, AGED PEOPLE LIVING IN THE COMMUNITY

central pain (13.1%), peripheral neuropathy (7.7%), and osteoarthritis (7.2%);
2. Local syndromes of the lower limbs (24.4%) including osteoarthrosis of the knee (11.3%) and the hip (9.1%) and metastatic disease (2.3%);
3. Spinal or radicular pain syndromes of the lumbar, sacral and coccygeal regions (12.7%) [1].

Activities of daily living (ADL) and instrumental activities of daily living (IADL) were assessed using the Functional Status Index [4] assessing the five domains of: mobility, hand function, personal care, interpersonal activities, and home chores. Many patients were unable to walk (27.9%) and had impaired hand activity (21.2%). The frailest aged patients were unable to perform instrumental activity of daily living e.g. interpersonal activities (63.1%) and home chores (88.3%). The consequences of their frailty included social isolation and feelings of uselessness, sadness, and unhappiness [1, 4].

Psychological functioning. The long-term physical, cognitive, and psychosocial suffering affects an individual's interpersonal, emotional functioning and wellbeing. A brief diagnostic instrument, Circumplex model, distinguishes positive and negative affects, pleasant-unpleasant emotions and high and low intensity [5]. Even without pain, frail aged individuals felt unpleasant (34.3%) with pronounced high negative affect (16.5%) or low activation (11.0%). The presence of pain intensified the feelings of unpleasantness (46.9% felt unhappy, lonely, sad, blue) and high negative affect (32.3% were anxious, fearful, nervous, jittery). The presence of pain significantly diminished the high positive affect and emotions of pleasantness, and increased the negative affect and low activation (e.g. still, inactive, passive). Woman reported more unpleasantness than men, both with pain (p<0.03) and without (p=0.002) [1, 5, 6].

Conclusion.
Despite the subjective high estimates of pain intensity, it seems that frail elderly individuals with functional and cognitive disabilities report lower pain intensities than younger adults. High functional disability, dependence on caregiver assistance, social isolation and loneliness are found to be related to anxiety and depression in elderly, independent of the presence of pain. Pain potentiates negative emotional and affective states. A comprehensive assessment of frail older people with chronic pain needs to take into consideration gender differences, social and environmental conditions and available psychological support.

References

SIG on Pain in the Elderly information:
The SIG currently has 179 members representing 24 disciplines in 34 different countries. The SIG members list may be accessed on the IASP Web site: www.iasp-pain.org on the “Members Only” page.

Treasurer’s Report:
As of December 31, 2006, the SIG account balance was US$3,369.00.

SIG Membership
Membership in SIGs is open to any members of IASP. Members wishing to join the SIG should indicate their preference on the annual IASP membership renewal form with the $20.00 SIG dues or contact the IASP main office directly at: members@iasp-pain.org or on the Web at: www.iasp-pain.org under “Membership”.

The objectives of this SIG are:
- to increase awareness and promote education about pain in older persons
- to provide an international and interdisciplinary forum for people interested in clinical and research questions on pain in older persons
- to develop/endorse best practice guidelines for assessment and management of pain in older persons
- to promote discussion and research on pain in older persons, including:
  - senescence of pain perception
  - multidimensional assessment of pain and its consequences
  - pharmacological and non-pharmacological management of pain
  - uniqueness of the pain experience in patients with cognitive impairment
- to facilitate the development of international collaborative research efforts on pain in older persons