Editorial

IASP has accepted the proposal to hold a Satellite Symposium on Pain in Older Persons at the next World Congress on Pain, to be held in Montreal, Canada, on August 29, 2010. Congratulations go to David Lussier and Stephen Gibson, who put the proposal together. If you have any suggestions regarding the Satellite Symposium, please contact Stephen Gibson. S.Gibson@nari.unimelb.edu.au

Stephen Gibson has contributed an article for this newsletter entitled Pain Report and Treatment in Dementia. This fits with the topical review on Pain in dementia by Erik Scherder and colleagues published online in PAIN (PAIN (2009), doi:10.1016/j.pain.2009.04.007).

With the aging of many societies, there will be a rapid increase in prevalence of people with both pain and dementia. In this timely review, Erik Scherder and colleagues discuss whether patients with dementia experience and express pain in the same way as those without dementia. Clinical studies suggest that pain is often undertreated in patients with dementia. Experimental studies in patients with early to moderate stages of dementia rate pain similar to control subjects, although in more advanced stages of dementia the relationship is less clear. Self-report of pain remains the gold standard in mild to moderate dementia. When self-report is no longer possible, a number of instruments observing behavioral indicators of pain have undergone evaluation. The next step, according to Scherder and colleagues, is the use of an analgesic trial to help validate if potential behavioral indicators of pain do respond to analgesic treatment.

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In another topic review in Pain, Thoung Vo and colleagues discuss the role of non-steroidal anti-inflammatory drugs (NSAIDs) for the treatment of neuropathic pain. (Pain, Volume 143, Issue 3, June 2009, 169-171). The prevailing view among pain specialists is that NSAIDs are ineffective for neuropathic pain and are not included in any treatment guidelines. This stands in contrast to a number of surveys that found 18-47% of patients used NSAIDs specifically for neuropathic pain. A number of animal studies have demonstrated that NSAIDs reduced mechanical hyperalgesia following peripheral nerve injury. There is a paucity of literature of the use of NSAIDs in neuropathic pain in humans. Vo and colleagues discuss the discrepancy between the prevailing belief that NSAIDs are not effective for neuropathic pain, with their widespread clinical use and the results of animal experiments. One possible explanation is that NSAIDs may be effective for neuropathic pain that is mild to moderate or of short duration, unlikely to be referred to a pain specialist, or that widespread use is related to a placebo effect. They comment that for many years opioid analgesics were considered ineffective for neuropathic pain until randomized trials were carried out. They provide an outline for a research agenda. As older patients are more likely to experience neuropathic pain and are also at greater risk of adverse effects of NSAIDs, adequate numbers of older people must be included in these trials.

The member of the SIG executive featured in this edition of the newsletter is Benny Katz. He is the vice chair and responsible for communications, including the newsletter.

Pain Report And Treatment In Dementia

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There is growing international interest in the clinical presentation and treatment of pain in older persons with a dementing illness. Evidence suggests that patients with Alzheimer’s disease (AD) are routinely prescribed and administered fewer analgesics than cognitively intact peers even after controlling for the presence of painful disease (Farrell et al. 1996). Only 33% of AD patients received appropriate analgesic medication compared to 64% of non-demented adults (Scherder & Bouma 1997), and this was true for NSAIDs as well as other classes of analgesics (opiates, acetaminophen), even though the need for pain relief was judged equivalent according to the treating physician. Others have confirmed this under-treatment (Horgas & Tsai 1998) and particularly with reference to persistent pain (Pickering et al. 2006). Consistent with an earlier study (Feldt et al. 1998), Morrison & Siu (2000) found that patients with dementia recovering from hip fracture surgery received only 1/3 the amount of morphine sulphate equivalents administered to non-demented adults and that 76% of AD patients had no standing order for post-operative analgesia. In one of the few studies to compare
different subtypes of dementia, analgesic use was found to be lower in those with AD than vascular dementia (Semla et al. 1993).

Some early studies demonstrate a significant inverse relationship between pain report and cognitive impairment in nursing home residents (Cohen-Mansfield et al. 1993, Parmelee et al. 1993). Both the prevalence and severity of pain was reduced in those with more severe cognitive impairment, and the magnitude of difference was large. For instance, pain was detected in just 31.5% of cognitively-impaired residents compared to 61% of cognitively intact residents, despite both groups being equally afflicted with potentially painful disease (Proctor & Hirdes 2001). Subsequent work has confirmed that the observed decrease in pain occurs when using either self-report (Mantyselka et al. 2004, Leong & Nuo 2007) or, with one exception (Feldt et al. 1998), observational pain scales or proxy nurse ratings (Wu et al. 2005, Leong & Nuo 2007, Sawyer et al. 2007). Given the similar findings with both self-report and observational assessments, these findings might suggest that the reduced pain prevalence and intensity is not simply due to a deterioration in verbal communication skills with advancing dementia. There is also reduced pain report and altered facial and autonomic reactions in those with dementia following acute medical procedures including venipuncture (Porter et al. 1996) and injection (Defrin et al. 2006) as well as equivocal support for reduced prevalence of post lumbar puncture headache (Blennow et al. 1993, Popp et al. 2007). There have been relatively few studies to examine pain report in different subtypes of dementia, although patients with AD show a significant decrease in self-rated pain intensity and affect when compared to age–matched controls (Scherder et al. 1999, 2001), and the reduction in self-reported or observational pain scores has not been found to differ according to dementia diagnosis (vascular, AD, mixed) (Mantyselka et al. 2004, Husebo et al. 2008).

Overall, there is now consistent and compelling evidence to show that persons with dementia or cognitive impairment receive fewer analgesics and report less clinical pain than cognitively intact peers. The exact reasons for reduced pain are still being investigated, but include impaired communication skills, the possibility of less comorbid disease or some alteration in pain processing related to degenerative neurophysiologic changes that accompany many dementing illnesses. Regardless of the exact reason and despite the demonstrations of less pain in those with dementia, it is important to recognize that the findings do not suggest that pain is less bothersome when it is actually reported. To the contrary, it is likely that any complaint of pain (verbal or via behavioral markers) made in the presence of marked cognitive impairment requires even greater attention and a more proactive treatment response.

References


**Getting to know your SIG executive**

The spotlight in this newsletter is on Benny Katz from Australia.

**Benny, tell me about yourself.**

I have lived in Melbourne all my life, currently in the suburb of Prahran. Prahran is an aboriginal word (meaning surrounded by water) that no one living outside Melbourne can pronounce. I have two adult children. My 23-year-old son lives with me, and I also have a married daughter. My personal interests include live theatre, music, travel, watching football (Australian Rules), food, and wine. I enjoy cooking for family and friends, and sharing a special bottle of vintage wine from my cellar. I jog to keep fit, but feel this is a losing battle. My favorite film is *Casablanca*, but if you want something more recent, I thought *The Lives of Others* was brilliant. I just finished reading *The Zahir* by Paulo Coelho. I am a terrible reader and only manage a few books a year.

**Tell me about your professional life?**

I am employed as a geriatrician in a large teaching hospital. I am the director of the Geriatric Medical Training Program for the state of Victoria that takes up a large part of my working week.

**What is your involvement in pain in older people?**

I was fortunate to be a part of the team lead by Robert Helme team that established a multidisciplinary pain clinic in Melbourne in 1986. We believe that this was the first multidisciplinary pain clinic specifically catering for older people. I have worked in pain clinics for nearly 20 years. I have enjoyed the opportunity of collaborating with Stephen Gibson and colleagues at the National Ageing Research Institute (Australia) over this time. Although not currently working in a pain clinic, but am hopeful of establishing a new pain clinic shortly.

**What is your position in the SIG?**

I am the vice chair of the SIG and responsible for communications, such as the newsletter.

**What vision do you have for the SIG?**

We have a diverse membership within the SIG, with some very intelligent researchers and a large number of committed clinicians. I would love to see the SIG becoming a vehicle where all its members actively participate in dialogue and collaborative research. The genesis of many research studies stems from clinical observation. The SIG provides the opportunity to communicate through the online discussion forum or through this newsletter. This needs further development. Holding a satellite meeting in Montreal in 2010 will be a great opportunity for our SIG to take the next step forward.

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**Get involved in the SIG.**

There are various opportunities for SIG members to participate in the SIG.

Have you participated in the Discussion Forum?

Since its inception, 12 topics have been discussed with 57 messages. You can go online to start a discussion or joint the discussion initiated by others. Go to the IASP website and follow the links though the SIG section to Discussion Forums.

Another opportunity to participate is through a contribution to the newsletter. We are always looking for ideas and contributors. If you have found the work or opinions of others interesting, I am sure that others would find your views interesting too. Share your experiences. You may want to discuss your research, a clinical case, or perhaps send a report from a conference you have attended. Feel free to contact Benny Katz at elderpainsig@connexus.net.au for more details.

Stephen Gibson is interested in hearing from any members who may have suggestions regarding the Satellite Symposium in 2010. Please contact him at S.Gibson@nari.unimelb.edu.au