



THE BRITISH PAIN SOCIETY

# Evidence-based clinical practice guidelines on the management of pain in older people: executive summary

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## Keywords

Chronic pain, elderly, interventions, non-pharmacological treatments, pain management, pharmacological treatment

The British Pain Society and British Geriatric Society have collaborated to produce comprehensive pain management guidelines based on an extensive systematic review of the available literature by a professional multidisciplinary group. This guidance reviews the epidemiology and management of pain in older people with the aim of providing best practice recommendations for the management of pain by all health professionals working with older adults in any care setting and emphasises the importance of a multimodal approach in the management of pain in older people. Assessment of pain in older people has not been covered within this guidance but can be found in a separate document ([http://britishpainsociety.org/book\\_pain\\_older\\_people.pdf](http://britishpainsociety.org/book_pain_older_people.pdf)).

## Methodology (abridged)

PubMed and CINAHL were searched for relevant publications between 1997 and 2010. AMED, PsycInfo and Scopus were also used to refine some of the searches. Only English-language studies were included. A detailed summary of the search criteria is provided in the full document. Approximately 5000 records were identified in the initial search. The abstract for each paper was reviewed by two members of the group and identified full papers were retrieved. A quality score was 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 within the sections.

## Prevalence of pain

Marked differences in the population, methods and definitions used in published research make it impossible to determine the definitive prevalence of pain in older people; however, the prevalence of pain in older people living in residential care is consistently higher than in older people living in the community. Pain is

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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, and hip.

## Management

### *Pharmacological approaches*

Few studies investigating the effects of analgesic drugs have been performed specifically in older people. Generally, primary studies have recruited younger participants and the results have been extrapolated across the age spectrum. Regular patient review is required to assess the therapeutic benefit and to monitor adverse effects.

Paracetamol is an effective analgesic, particularly for musculoskeletal pain, and is well tolerated. It is important that the recommended maximum daily dose is not exceeded. Although non-steroidal anti-inflammatory drugs (NSAIDs) are effective analgesics, their side-effect profile requires them to be used with great caution in older people. If essential, the lowest dose should be used for the shortest period and be reviewed regularly. A proton pump inhibitor should be co-prescribed with a NSAID or selective COX-2 inhibitor; the one with the lowest acquisition cost should be chosen.

In the short term, opioids may be effective for both cancer and non-cancer pains, but long-term data are lacking. Opioids may be appropriate for patients with moderate or severe pain, particularly if it is causing functional impairment or reducing quality of life. Use of modified-release oral or transdermal opioid formulations aimed at providing relatively constant plasma concentrations should be considered for continuous pain. Treatment must be individualised and carefully monitored for efficacy and tolerability, as there is marked variability in how individual patients respond to opioids. Side-effects of opioid therapy (including nausea and vomiting) are common and should be anticipated and suitable prophylaxis 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 who have been prescribed opioid therapy.

Tricyclic antidepressants or anti-epileptics may be considered for neuropathic pain. Although tricyclic antidepressants are effective, anticholinergic side-effects may be problematic. The lowest possible dose should be initiated and increased very slowly based on response and side-effects. Other antidepressants (e.g. SSRIs) have very limited evidence of analgesic efficacy and should not be used as analgesics. Adverse effects and the need for blood monitoring limit the use of older anti-epileptic drugs in

older people. Dose adjustment of gabapentin and pregabalin is required in renal impairment.

Topical lidocaine and capsaicin have limited efficacy in the management of localised neuropathic pain. Topical NSAIDs may be suitable for non-neuropathic pain, particularly if pain is localised.

The use of combination therapy using different classes of analgesics may provide greater pain relief through synergistic action with fewer side-effects than higher doses of a single medicine.

### **Interventional therapies**

Interventional approaches in the management of chronic pain include a variety of neural blocks and minimally invasive procedures. In knee osteoarthritis, intra-articular corticosteroid injections are effective in relieving pain in the short term with few complications and/or joint damage. Intra-articular hyaluronic acid is also effective with few systemic adverse effects. It has a slower onset of action than intra-articular steroids but the effects appear to last longer. Both should be considered in patients intolerant to systemic therapy.

For back pain due to spinal stenosis epidural corticosteroid injections may be appropriate, but their use in radicular pain or sciatica is not as convincing. In contrast, epidural adhesiolysis may benefit older adults with spinal stenosis and radicular symptoms. Pain arising from facet joint arthritis is often treated with local steroid injections, although the available data are inconsistent. However, there is some support for radiofrequency denervation of the medial branch nerves in appropriately selected patients. The current literature on the use of vertebroplasty and kyphoplasty in the treatment of painful vertebral fractures is conflicting and no conclusion could be drawn.

For neuropathic pain, there is weak evidence for sympathectomy in the older population. For acute herpes zoster and post-herpetic neuralgia, common causes of pain in older persons, a nerve block using a combination of local anaesthetic and corticosteroid is effective. Botulinum toxin may also be beneficial. In trigeminal neuralgia microvascular decompression is the treatment of choice in healthy patients and percutaneous procedures are indicated for elderly patients with high comorbidity.

Spinal cord stimulation may be considered for selected patients with failed back surgery syndrome, complex regional pain syndrome, neuropathic or ischaemic pain.

### **Psychological therapies**

Psychological factors influence how people respond to and cope with pain. Interventions such as cognitive behavioural therapy (CBT) or behavioural therapy may

be effective in improving chronic pain in adults and in improving disability and mood. However, few studies have focused on older adults and the sample size was small. Elderly nursing home residents with persistent pain may benefit from CBT interventions, but there is limited evidence that biofeedback training, relaxation, mindfulness, meditation and enhancing emotion regulation may be beneficial for persistent pain in older people.

### Physiotherapy and occupational therapy

Use of programmes that consist of strengthening, flexibility and endurance activities to increase physical activity, improve function and reduce pain, are advocated, although the specific type of exercise is probably of less important, however it is important that exercise is tailored to the functional level of the individual. As persistent pain is a risk factor for falls in older people, balance exercises can be incorporated successfully into a programme. Motivation to exercise is essential and barriers must be considered.

A wide variety of devices that are designed to assist in activities of daily living are available; however, most are descriptive in nature and very few studies have considered pain reduction in older people. Use of assistive devices may support community living and reduce functional decline and care costs.

### Self-management

Self-management techniques and practices should be considered in conjunction with other methods of pain management. Programmes with mechanisms for longer-term support or maintenance may have some benefit; however, programmes delivered in isolation without ongoing support cannot yet be recommended to decrease pain and increase function.

### Complementary therapies

There is limited evidence to support the use of complementary therapies, such as transcutaneous electrical nerve stimulation, massage and reflexology with older adults. The available evidence is generally weak and based upon small-scale studies without proper use of controls or randomisation procedures.

### Conclusion

The guidance focuses on the management of persistent pain in older people. Despite the extensive search conducted by the group, few studies specifically studying the management of pain in older people were identified and it was necessary to extrapolate from studies that recruited from 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 population. The full guidance was originally published in *Age and Ageing* and is available from <http://ageing.oxfordjournals.org/>.

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