

Chronic pain in the elderly: A constant challenge

Małgorzata I. Sobieszczańska^{A–F}

Clinical Department of Geriatrics and Internal Diseases, Wrocław Medical University, Poland

A – research concept and design; B – collection and/or assembly of data; C – data analysis and interpretation;

D – writing the article; E – critical revision of the article; F – final approval of the article

Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online)

Adv Clin Exp Med. 2025;34(2):149–151

Address for correspondence

Małgorzata I. Sobieszczańska

E-mail: malgorzata.sobieszczanska@umw.edu.pl

Funding sources

None declared

Conflict of interest

None declared

Abstract

Chronic pain is a common, long-standing and bitter experience affecting a huge percentage of the still increasing elderly population. Owing to the multifactorial etiopathology and complex clinical presentation with a lot of severe consequences, management of the permanent pain should be varied and tailored to the particular patient. This approach comprises multimodal pharmacotherapy, including all analgesics and adjuvants, likewise selected interventions, physical therapy and rehabilitation, as well psychological counselling.

Key words: elderly, chronic pain, neuropathic pain, multimodal pain treatment, opioids

Received on January 12, 2025

Reviewed on January 26, 2025

Accepted on January 30, 2025

Published online on February 13, 2025

Cite as

Sobieszczańska MI. Chronic pain in the elderly: A constant challenge. *Adv Clin Exp Med.* 2025;34(2):149–151.

doi:10.17219/acem/200647

DOI

10.17219/acem/200647

Copyright

Copyright by Author(s)

This is an article distributed under the terms of the Creative Commons Attribution 3.0 Unported (CC BY 3.0)

(<https://creativecommons.org/licenses/by/3.0/>)

Introduction

Pain is defined as both sensory and emotionally feeling connected with current or potential tissue damage.¹ Persistent pain means pain that continues beyond the expected time of healing, or for minimum 3–6 months.² Patophysiologically, chronic pain is categorized as nociceptive (from tissue injury), neuropathic (from nerve injury, like in diabetes) or nociplastic (from a sensitized nervous system, like in fibromyalgia).^{2,3}

As the population of elderly people grows, the number of the oldest, frailest and pain-ridden is increasing at the fastest rate. Numerous comorbidities, as well as psychological, social and environmental factors may contribute to pain severity and effectiveness of treatment applied.

Clinical presentation

In the Polish study PolSenior 2, the incidence of pain was reported by 52% of women and 41% of men aged ≥60 years. Chronic pain was reported in 47.6% of the examined seniors. Of the 4.5 million older people with pain, 25% suffer from severe pain. Chronic pain management with medication was reported by 38% of Polish seniors.⁴

The most common pain complaints in the elderly are related to osteoarthritis, neurodegenerative and musculoskeletal conditions, peripheral vascular diseases, rheumatoid arthritis, polymyalgia rheumatica, giant cell angiitis, as well to often misdiagnosed myofascial pain syndrome, low back pain, lumbar spinal stenosis, and fibromyalgia.^{1–3,5}

Interestingly, older people manifest an altered pain experiencing, which is a result of the changed pain processing mechanisms involving a structural and functional brain plasticity. This phenomenon is probably associated with the degeneration of circuits modulating the descending pain inhibitory pathways, with the periaqueductal gray (PAG) constituting a key node.⁶

Prolonged pain may impair physical and cognitive functions manifested by falls, kinesiophobia, immobility, problems with appetite and sleep, depression, anxiety, and increased risk of dementia and delirium.^{1–3,5}

It should be emphasized that there are bidirectional interrelations among pain and depression, insomnia and anxiety. Finally, permanent pain can contribute to worsened life quality, social isolation, impaired physical activity, and institutionalization.

Management of chronic pain

Currently, the importance of a multidisciplinary model of pain treatment is emphasized strongly. This approach comprises multimodal pharmacotherapy, selected interventions, physical therapy and rehabilitation, as well psychological counselling. Cuomo et al. proposed

the “multimodal trolley approach” that takes into account the physical, psychological and emotional causes of pain and underlies the necessity for personalized therapy. According to this approach, a dynamic management of pain by combining several pharmacologic and non-pharmacologic strategies is possible.⁷

The principles of the analgesic ladder (as outlined by the World Health Organization (WHO) in 2019) should be followed when introducing analgesics. The 1st step for mild pain is acetaminophen, metamizole or nonsteroidal anti-inflammatory drugs (NSAIDs). For moderate pain, it is recommended to use weak opioids such as tramadol, codeine or dihydrocodone. For severe and persistent pain, the 3rd step involves potent opioids (morphine, buprenorphine, oxycodone, tapentadol, fentanyl).^{8–10} It is important to note that many older adults are reluctant to use opioids due to concerns about addiction. However, proper education can help them accept opioids when medically necessary.

Because of the complex nature of pain perception, there is a wide range of drugs from different classes that can be beneficial in different pain conditions. These so-called adjuvants or co-analgesics include antidepressants: tricyclic antidepressants (amitriptyline, nortriptyline), serotonin-norepinephrine reuptake inhibitors (duloxetine, venlafaxine), anticonvulsants (pregabalin, gabapentin), topical agents (lidocaine or capsaicin patches), corticosteroids, bisphosphonates, miorelaxants and also medicinal cannabinoids. Interestingly, although adjuvants are co-administered with analgesics, they are indicated as a first-line treatment option for treating specific pain conditions, like neuropathic pain and fibromyalgia.^{6,8–10}

It is important to emphasize that there is a generally accepted gold standard for pharmacotherapy in geriatric patients that should always be followed: “Start low and go slow”.

ORCID iDs

Małgorzata I. Sobieszczkańska  <https://orcid.org/0000-0003-4374-9866>

References

1. Raja SN, Carr DB, Cohen M, et al. The revised International Association for the Study of Pain definition of pain: Concepts, challenges, and compromises. *Pain*. 2020;161(9):1976–1982. doi:10.1097/j.pain.0000000000001939
2. Wang J, Doan LV. Clinical pain management: Current practice and recent innovations in research. *Cell Rep Med*. 2024;5(10):101786. doi:10.1016/j.xcrm.2024.101786
3. Cohen SP, Vase L, Hooten WM. Chronic pain: An update on burden, best practices, and new advances. *Lancet*. 2021;397(10289):2082–2097. doi:10.1016/S0140-6736(21)00393-7
4. Błędowski P, Mossakowska M, Zdrojewski T, Grodzicki T, eds. *PolSenior 2: Badanie poszczególnych obszarów stanu zdrowia osób starszych, w tym jakości życia związanej ze zdrowiem*. Gdańsk, Poland: Gdański Uniwersytet Medyczny; 2021. ISBN:978-83-67147-00-2.
5. Cravello L, Di Santo S, Varrassi G, et al. Chronic pain in the elderly with cognitive decline: A narrative review. *Pain Ther*. 2019;8(1):53–65. doi:10.1007/s40122-019-0111-7
6. Dagnino APA, Campos MM. Chronic pain in the elderly: Mechanisms and perspectives. *Front Hum Neurosci*. 2022;16:736688. doi:10.3389/fnhum.2022.736688

7. Cuomo A, Bimonte S, Forte CA, Botti G, Cascella M. Multimodal approaches and tailored therapies for pain management: The trolley analgesic model. *JPR*. 2019;12:711–714. doi:10.2147/JPR.S178910
8. Schwan J, Scalfani J, Tawfik VL. Chronic pain management in the elderly. *Anesthesiol Clin*. 2019;37(3):547–560. doi:10.1016/j.anclin.2019.04.012
9. Yang J, Bauer BA, Wahner-Roedler DL, Chon TY, Xiao L. The Modified WHO Analgesic Ladder: Is it appropriate for chronic non-cancer pain? *J Pain Res*. 2020;13:411–417. doi:10.2147/JPR.S244173
10. Mallick-Searle T, Adler J. Update on treating painful diabetic peripheral neuropathy: A review of current US guidelines with a focus on the most recently approved management options. *J Pain Res*. 2024; 17:1005–1028. doi:10.2147/JPR.S442595