



Letters to the Editor

Aging: Blessing or danger for individuals with painful conditions

I read with sheer interest the editorial ‘Is older age a blessing for persons with painful conditions?’ by H. Finne-Soveri, and K. Pitkälä [3]. In agreement with Życzkowska et al., 2007 [17], who performed a very large study in Canada among the older recipients of home-care services and residents in institutions, authors suggest that since aging predicts lower levels of pain, it might be a blessing to the individuals with painful conditions. The authors should be commended for bringing up such an important and timely issue, but I think their conclusion is not appropriate considering recent research data that speak on severe damage in the sensory systems after aging.

The prevalence of persistent pain problems including surgical procedures, although higher in elderly groups, has been observed to present with unusually painless manifestations of common illnesses. While the classic “crushing” myocardial pain in the chest, left arm and jaw is known to be variable in intensity across all patient ages, a retrospective study demonstrated that 35–42% of adults over the age of 65 years experience an apparently silent or painless heart attack [1]. Moreover, approximately 40% of patients over 65 years report little or no pain associated with peritonitis, intestinal obstruction, pneumothorax [7], and peptic ulcer disease [5]. Several studies have suggested that elderly adults report less postoperative pain than younger patients experiencing the same surgical procedures [2,13]. The question is why elderly population suffers less pain in the painful conditions: is this due to alterations in the degree of pathology or to differences in the pain mechanisms.

Previous studies reported that sensory system undergoes significant degenerative changes as a consequence of aging. These include widespread disorganization and marked fiber loss [10,15], decreased myelin thickness [8,9], reduction of neurochemicals that are responsible for neurogenic inflammation [4,6], reduction in the expression of ion channels that convert natural stimuli into electrical signals [16], and reduction in the levels of growth factors necessary for the synthesis of ion channels [11,14,16]. It is very likely that such morpho-

logic, biochemical and molecular changes in the sensory system are attributable to the age-related diminished pain sensitivity.

If decreased occurrence of pain in the aged individuals results from defect in the pain mechanisms, we should not consider aging as ‘blessing’. Because pain is the key mechanism of our body that warns us from impending tissue damage, failure or compromise of this warning system can lead to catastrophic effects. Children with congenital insensitivity to pain (recently shown to be a genetic disorder) experience accidents and injuries more frequently and die of infection at an early age. Patients with diabetic neuropathy lose sense of touch, pain and temperature in their feet, and, as a consequence, they often have a pebble or foreign body in their shoe unnoticed, or burn their skin in hot bath or even fracture a bone in their leg without knowing a damage has been done. The suffering from pain in the painful condition is no good, but under-reporting of pain by the elderly individuals can lead to inadequate analgesia, slower recovery, and poorer ambulation and function [12].

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Ratan K. Banik *

*Pain Research Program,
New Jersey Neuroscience Institute and JFK Medical
Center, 65 James Street, Edison, NJ 08820, USA
E-mail address: talktoratan@gmail.com*

* Corresponding author. Tel.: +1 732 321 7000x68567, 68535; fax: +1 732 744 5821.
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doi:10.1016/j.pain.2007.08.026

Response to Dr. Banik

To Ratan K. Banik

We thank Dr. Banik for his interest in our editorial and are delighted that our provocative title has caught attention. We also want to thank him for reminding us and the readers of the important function that acute pain has; to act as a warning signal in the health/life threatening situations. Dr. Banik also showed some valuable neurophysiological studies suggesting the mechanisms behind the decreasing pain with advancing age.

There are however two things we wish to stress. Firstly, even if the article by Życzkowska et al. [3] offered supporting evidence for declining pain with advancing age we are still lacking prospective longitudinal studies on individual level showing decreasing pain in the presence of gradually approaching death. Thus, the title question in our editorial remains unanswered.

Secondly, among older persons, the nature of the most often occurring type of pain is not acute but chronic. In theory, health care personnel can always be taught to take into account the potentially missing acute pain in older individuals' acute situations that after all are occurring rarely or irregularly. However, the burden of chronic pain can be daily and excruciating with equal or even more fatal consequences than those of acute pain. Chronic pain does not possess any role as a warning mechanism. On the contrary, it has tight association with depression [1] and leads to functional loss [2] and thus further accelerates suffering.

We sincerely agree with Dr. Banik that underreporting pain is a non-desirable phenomenon among older individuals and among health care personnel non-systematic pain assessment methods together with under management of pain a plaque that should be out rooted.

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Harriet Finne-Soveri *

*Stakes Center for Health Economics, CHES,
Lintulahdenkuja 4, P.O. Box 220,
00531 Helsinki, Finland
E-mail addresses: harriet.finne-soveri@stakes.fi*

Kaisu Pitkälä

*Helsinki University Hospital, Unit of General Practice,
Mannerheimintie, 172 00030 Helsinki, Finland*

* Corresponding author. Tel.: + 358 380 9885.
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doi:10.1016/j.pain.2007.08.025