

Back Pain—An Inevitable Part of Aging? The Facts.

1. Lower back pain has a high prevalence in older persons.

The prevalence ranges between 21% and 75%. This leads to a huge burden with functional disability in 60% of these individuals leading to diminished quality of life [1, 2]. Despite its high prevalence, low back pain is not an inherent part of the aging process. It is related to the increased burden of pathology, lifestyles, genetics, and physiologic factors thus highlighting the fact that phenotypical age can be a more helpful maker of prognosis [3].

2. Most back pain is due to common causes.

Though the common causes of lower back pain range from structural changes and deformities due to osteoarthritis of the joints, disc related changes, vertebral body changes, sarcopenia and secondary neural compression, it will be important to exclude the red flags – particularly when there is a new onset pain or change in the intensity of site of pain [4].

3. Red flags of back pain.

Assess for red flags of back pain to exclude fractures (0.7% to 4%), malignancy (0.3% to 3.8%), infections (0.1% to 0.8%) and to a lesser degree autoimmune inflammatory condition such as spondyloarthritis or polymyalgia rheumatica. Osteoporotic fractures are commonly misdiagnosed with acute low back pain and can happen without falls or injuries [5]. Most red flag conditions can be excluded on careful history and examination. Imaging should be reserved for red flag conditions, or where it may alter management.

4. Assess beyond the back.

A Comprehensive Geriatric Assessment along with multidimensional pain assessment tools and non-verbal tools for pain assessment and its interference on daily function, sleep, mood, coping styles, beliefs and support system are important [6, 7, 8]. A multidisciplinary team can be helpful in all aspects of person centred care [9].

5. Consider the age-related conditions.

Common age-related conditions play a contributory role in their predicament and management – frailty, polypharmacy, cognitive dysfunction, falls, and concurrent medical comorbidities [10].

6. Review the role of medications.

Medications need to be tailored to the pharmacokinetic and pharmacodynamic changes in the older person such as reduced bioavailability, altered renal and hepatic function affecting clearance, altered drug distribution and increased sensitivity to analgesia [11, 12].

7. Opioids—beware of the risks.

Long-term use of opioids has limited evidence of efficacy and has established risks such as nausea, constipation, cognitive impairment and increased falls. Carefully weigh the benefits and negative consequences of pain prior to initiating a trial of opioids. Start slow, taper dose to lowest effective dose and discontinue if treatment goals are not met [13].

8. Active physical therapies are a key treatment, irrespective of age.

Physical therapies tailored to the individual to increase daily physical activity, exercises to enhance strength, maintain range of motions and tolerances, walking, hydrotherapy, yoga and Tai-Chi are beneficial for chronic pain. In addition, physical therapies have benefits for general health, emotional wellbeing and other co-morbid medical conditions such as diabetes, cardiorespiratory diseases, and osteoporosis. Exercises need to be tailored to individual's preference and medical conditions [14, 15].

9. Psychosocial factors

Addressing the psychosocial factors of ageing is important as they are bidirectional both as a contributor and a consequence of persistent pain. These factors include mood dysfunctions – depression and anxiety, loss of family members and friends, social isolation (which has increased markedly due to COVID-19 pandemic) and loss of independence, limited access and resources to care. The Comprehensive Geriatric Assessment approach focuses on maintaining social and recreational engagement and maintaining functional independence and avoiding unnecessary residential care admission. Unrelieved pain can adversely affect each of these important activities, as can adverse treatment effects [8, 16, 17].

10. Age and cognition are not insurmountable barriers to psychological therapies.

Cognitive behavioural therapies to address expectations, activity pacing, relaxation, improving sleep hygiene, addressing unhelpful beliefs and behaviours are helpful with significant functional benefits, improved coping skills and quality of life [17]. Spousal participation and behavioural strategies can be more helpful with severe cognitive impairment.

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