One of the less pleasant things about ageing is the increasing likelihood of painful degenerative diseases. About 60–71% of community-dwelling older people report feeling pain somewhere, with over 33% reporting daily persistent pain [1, 2]. The prevalence of persistent pain is even higher for residents of institutions [3]. This is substantial morbidity, interfering with activities of daily living, inducing depression and reducing quality of life. Up to the 1990s, there was very little scientific interest in persistent pain in older people [4], but our awareness of the problem has improved dramatically in the last decade. A focus for many studies has been the prevalence of pain and its management in residents of nursing homes. These studies found, almost universally, that professional staff have a low rate of awareness of pain and often fail to detect it, even in residents who are capable of reporting pain [3]. But, what about home-dwelling elderly people? We assume that these elders are less disabled than those needing supervised care, more likely to report a pain problem and to seek help for it. Yet studies from Canada, France, United States, China and Finland all tell a similar story to that found in nursing homes, that there is a high prevalence of daily pain in community-dwelling elders but a much lower rate of prescribed analgesics than expected [5]. However, few studies have looked at the prevalence and treatment of pain in home-dwelling people with dementia. Shedding more light on this aspect is a new study by Mäntyselkä and colleagues in this issue of *Age and Ageing* [6]. Although the authors found a similar rate of potentially painful conditions in both cognitively intact and demented subjects, pain complaints and analgesic use by the subjects with dementia was much less. The study adds more substance to the growing evidence that persistent pain in older people is under-reported, under-detected and under-treated, in the community as well as in institutions, and that this is particularly true for people with dementia.

If persistent pain can be expected in older people, then why is it so neglected? One way or another, significant dialogue about pain between health professionals and elders, the key to good pain management, still seems to be wanting. The literature points to three ‘P’s in this pod–professionals, patients and pathology.
Many health professionals are generally under-educated about the assessment and treatment of chronic pain, psychiatry of old age and geriatrics. Little time is dedicated to these topics in medical and nursing school curricula [7, 8] so it is perhaps unsurprising that pain assessment is not a priority for the limited time of health practitioners. Sadly, many persistent pain problems in older people remain unrecognised simply because health professionals do not ask or have the time to ask about it [9].

Patients themselves may fail to report symptoms, attributing them to ageing. Sometimes, they may fail to report pain to caregivers and health professionals due to mistaken beliefs that pain signals a dreaded disease, or that they might be admitted to hospital or worse, an institution, if the true nature of their difficulties becomes known [5]. Other concerns that fuel the reluctance to communicate pain are that analogues will have bad side effects or become addictive. Unfortunately, this is also a concern for many primary care physicians and this shared over-valued idea can become a reason for withholding appropriate analgesia [10].

An inescapable fact is that despite the high prevalence of pain in older people, they do take less analgesics. Might it be that older people actually have less pain so they do not need them? Well, the notion that nociception or pain experience may diminish in late life for healthy individuals is still unproven. However, Gibson et al. [11] compared acute pain threshold perception in healthy and cognitively impaired older adults and found acute pain perception was not diminished in the Alzheimer patients, but they were slower at reporting the noxious stimuli and their reports were less reliable. Scherder [12] suggested that a pathological disease such as dementia might interfere with either cognitive or motivational-affective pathways thus altering pain experience so that patients no longer suffer to the same degree as younger adults. There is no doubt that some dementias, such as Alzheimer’s disease, do affect areas of the brain important in pain perception so it is possible that pain experience in people with Alzheimer’s disease may be different, but not necessarily less. In addition, Alzheimer’s dementia is only one of many brain disorders. There is strong evidence that patients with vascular dementia may have enhanced pain perception [12] and central neuropathic pain syndromes in stroke patients are some of the most distressingly painful conditions one can have [13]. Even if the experience of persistent pain is qualitatively different in dementia patients, this is not an excuse for therapeutic neglect.

Older people, with dementia of all types, can have difficulty expressing themselves. Language is an early domain affected by the dementias and inability to convey inner experience is probably the major factor in their under-reporting of pain, especially in advanced disease. However, communication can also be expressed in behaviour and body language. Often, distress due to pain, is manifest as challenging behaviours. Worryingly, in a Canadian study, Balfour et al. [2] found that demented patients with persistent pain were more likely to have been treated with benzodiazepines and antipsychotics than their nondemented counterparts were, even after taking pain into account.

Detecting and assessing pain in older people lacking communication skills is a challenge and certainly more difficult, but not impossible, than it is for their cognitively intact counterparts. Several pain scales are now available for use with cognitively impaired patients who cannot conceptualise or verbally express their pain experience [14]. Furthermore, pain assessment and management is increasingly being incorporated into nursing home protocols, prompted by clinical practice guidelines, such as those of the American Geriatrics Society [15].

Research can alert us to a problem and can inform us why a problem might be occurring. In the arena of pain in older people, research is clearly telling us that there is a problem, and that lack of adequate communication with older patients about their pain is not only due to pathological processes, or patient reluctance but also to health professional ignorance and lack of sufficient dialogue with their patients. If doctors do not ask, patients do not tell and the pathologies do not conceive, is it any wonder that pain is under-detected and under-treated? This has to be a major concern for all of us working in geriatric disciplines.

The challenge for us now is to improve the current state of affairs. We need studies looking at how pain management by health providers can be improved, demonstrating that timely and appropriate pain interventions can lead to improved health status, better mental health and enhanced quality of life. There is considerably more awareness than there was 10 years ago and pain treatment is much better in many institutions. However, the vast majority of older people, including many with dementia, live in homes, not in institutions. As Mäntyselkä et al. [6] highlight in this current issue of Age and Ageing, it is elders with persistent pain living in their own homes which now need attention. Would it not be wonderful if improved awareness and enhanced pain management could also be attained for home-dwelling elders in the next decade?

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Left ventricular systolic dysfunction and atrial fibrillation in older people in the community: the need for identification, as well as appropriate management

Atrial fibrillation (AF) is the commonest arrhythmia encountered in clinical practice. The prevalence of AF increases with age, ranging from 1% in those younger than 50 years to approximately 10% in those older than 80 years [1], with the vast majority (84%) of AF patients being over the age of 65 years. Importantly, AF is the strongest independent predictor of stroke, with an annual risk 5–6 times higher than patients in sinus rhythm, although this risk is not homogeneous, ranging from an annual risk of 1% in patients aged <65 years old with no risk factors, to over 12% per year in patients who have a history of prior stroke or transient ischaemic attack (TIA) [2] (see Table 1). AF-related strokes are typically associated with poorer functional outcomes, a greater risk of permanent, severe disability, and higher mortality [2, 3]. With an ageing population, the burden of AF is expected to double over the next two generations [4].

The Global Burden of Disease 2000 project ranks stroke as the second leading cause of death worldwide, accounting for 9.2% of mortality [5]. Stroke also accounts for 5% of the total NHS expenditure and, therefore, any programme that might lead to an important reduction in stroke incidence needs serious consideration, both because of the potential for health gain and the potential for reduced overall NHS expenditure. Is screening for AF in the elderly one such programme that may improve stroke incidence? Indeed, such a programme fulfils many of the Wilson-Jungner criteria for a screening programme [6], in that AF is a common and important condition which can be diagnosed by means of a simple test (resting 12-lead ECG), and the risk of serious sequelae such as stroke can be markedly reduced by treatment (anti-coagulation).

However, before implementing formal screening programmes for AF, we need the following information: (i) an assessment of the optimal method of screening, whether opportunistic (where the health care professional will take the opportunity to feel a patient’s pulse during a consultation), targeted (screen patients who are at higher risk for AF) or whole population screening (screen entire population above 65 years of age); (ii) assessment of the health economic implications of screening for AF; (iii) quantification of the service provision implications of implementing such a programme; and (iv) ascertainment of the impact on patient quality of life and anxiety after various screening methodologies. One UK study has demonstrated that