



Pain management in emergency department older adults with pelvic fracture: still insufficient

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Pain is a leading complaint in trauma patients treated in the emergency department (ED). Decades of research and numerous publications have raised concerns regarding inappropriate/insufficient pain management and its consequences, particularly in older trauma victims. Even though optimal pain management is one of the main quality-of-care indicators [1], healthcare professionals still struggle to tackle the problem of oligoanalgesia. Indeed, delayed pain assessment and/or pain management, suboptimal analgesia may lead to a high proportion of patients still in pain at ED discharge. In addition, the ageing population leads to an increased incidence of low-energy trauma osteoporotic fractures. For example, hip and pelvic fractures resulting from falls, are prevalent. But acute pain management in this specific trauma population remains relatively understudied.

In their retrospective study, Tran et al. described the pain management practices in older adults (≥ 65 years) who were treated in two Canadian academic EDs for nonoperative fragility pelvic fractures. Their results are alarming; almost one third of this population did not receive any analgesia during their prehospital/ED care. Only 16% were administered pain medication by paramedics, of which half were opioids. At ED admission, nurse-initiated analgesia prior to physician assessment was reported in similar proportions, and only a third of pain killers were opioids. As for

physicians' practices, the authors reported that a stunning 40% of patients with pelvic fracture did not receive pain medication [2].

The underprescription of opioids may be due to recent health policies related to the “opioid crisis”. Indeed, previous studies have reported that opioid-naïve patients may become addicted after a single prescription following an ED visit. In addition, many authors found that opioid use in older adults may be associated with a higher risk of falls, and other adverse outcomes such as complications and death [3]. Therefore, those patients are frequently offered suboptimal pain management. However, untreated pain has been associated with the incidence of delirium and behavioral issues such as agitation, aggression, wandering, and refusal of care. Daoust and al. showed that untreated pain is more strongly associated with delirium than opioids [4].

ED crowding has been associated with delays in pain assessment and management [5]. Other barriers to optimal analgesia, such as under recognition and sub-optimal evaluation of pain have been described in older adults. Not only are older adults offered inferior opioids dosage [6] but their pain score is also less frequently documented in the ED, and they undergo fewer follow-up assessments than their younger counterparts. This may partially be explained by the fact that some of these patients suffer from cognitive impairment rendering them unable to verbalize pain. This issue has been identified in the literature; for example, a recent meta-analysis showed that cognitively impaired hip fracture patients receive significantly less opioids. Several other factors, such as ethnicity, gender, social background, and advanced age may indeed influence pain expression. Healthcare professionals' unconscious bias may also contribute to oligoanalgesia in the ED.

Tran et al. also found that analgesia was even less frequently initiated in patients who were discharged home [2]. This is of great concern as persistent pain at discharge is associated with functional decline and disability [7]. In

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addition, optimal analgesia is a cornerstone to meet patient satisfaction.

The number of older trauma patients is increasing and interventions fostering optimal pain management in this population are lacking. Some of the first steps toward providing analgesia tailored to the physiological specificities of this ageing population should include raising caregivers' awareness and assessing local practices. Systemic changes, such as unconscious bias training, implementing validated senior-friendly pain assessment tools and protocols, dedicated multimodal analgesic strategies, including nonpharmacological approaches, may also help improve pain management in older adults. Education and quality improvement programs were also shown to be effective. Considering Tran et al.'s [2] findings, these changes should be developed, implemented and monitored within the whole continuum of care (prehospital setting, ED admission and ED/hospital stay).

This study by Tran et al. reiterates that pain management is still inadequate in older adults, especially in trauma patients. Pain management practices are heterogeneous among health professionals in the acute care setting. Fostering a culture which prioritizes pain management is of utmost importance in an acute care setting, especially in older trauma patients.

Declaration

Conflict of interest The authors report no conflict of interest.

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