Chronic pain in older people—is it therapeutic apartheid?

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I was very impressed by the article Positivesolutionsinchronicpain[1] that appeared in GM January 2009. I have experienced both sides of the problem of chronic pain, first as a general practitioner (recently retired), and now as a patient. I can confidently say that our local hospital has a hiddden agenda of ageism pervading across the board, and this probably applies to other NHS hospitals. It seems strange that even in the ninth year of the 21st year century, the cut-off from youth to senility is 65 years and has remained so for many decades, despite all the developments and advances in medical science and in living conditions.

I am surprised that, with the exception of pain specialists and some specialists in old age, our professional colleagues in other disciplines tend to think any complaint by an older person is psychosomatic or simply the result of growing old. Psychsomatic complaints are more common in the younger population. On the one hand, when a pre-geriatric patient presents with a symptom, the attending doctor wishes to arrive at a specific diagnosis by elimination, or perhaps to cover themselves against possible litigation, they do all sorts of unnecessary investigations. On the other hand, if an older person presents with chronic pain, baseline tests are done merely to please the patient or their attendents and the diagnosis remains as non-specific as possible, such as wear and tear due to old age.

I would like to invent the word somatopsychic for the older patient. As opposed to psychosomatic patients, somatopsychic patients present with behaviour problems such as depression, restlessness, aggresiveness, confusion, and forgetfulness bordering on dementia. These patients are wrongly referred to old-age psychiatrists without doing both baseline and specific tests, and they are therefore at risk of being treated incorrectly with psychotropic drugs.

We have heard for years the terminology pseudodementia, which in fact is depression wrongly diagnosed as dementia. In fact, I would go one step further and coin another new medical term—pseudodepression—which in fact is not depression, but is a result of chronic pain caused, for example, by osteoarthritis. The type and intensity of chronic pain is not as severe as in acute ischaemic heart disease, trigeminal neuralgia, or invasive metastatic cancer and, being non-life-threatening, tends to be ignored.

Chronic pain conditions may not be life-threatening but they adversely affect quality of life, which our non-pain specialist colleagues tend not to appreciate. WHO's definition of health has not changed since 1948: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[2]

I have no conflict of interest.

References

1. Powell D. Positive solutions in chronic pain. GM 2009; 39: 21–23
2. Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no 2, p100) and entered into force on 7 April 1948. http://www.who.int/about/definition/en/print.html (accessed 24 February 2008)