[To note: below is a sample of a text which underwent strong editing. I am aware that some authors prefer ‘light’ editing.]

The causes of pain in the aging population are many, and similar to the types of pain experienced in the general population. These types of pain include: nociceptive pain (as experienced in osteoarthritis and in various inflammatory conditions, and after fractures, burns, and operations); neuropathic pain (experienced in postherpetic neuralgia, in diabetes and after a cerebral vascular accident); and mixed pain (as experienced in cancer and in radiculopathy). Pain in the elderly can also arise from: teeth, gums, contractures, edema, peripheral vascular, ischemic heart, and chronic lung disease.

Unbalanced pain in older adults has multidimensional effects on physical and social function as well as on the health system. Functional decline can be caused by physical disability, mood swings, sleep disorders, immobility and recurrent falls. The social effects include: confinement, social isolation, increasing dependence on a primary caregiver and an increasing burden on the family. Increased use of health services and an increase in morbidity and mortality can be expected.

The barriers to pain management in the older age group are many and pertain to all aspects of those concerned. An older man suffering with pain may hold beliefs and misconceptions about his pain, beginning with the ideas that pain is an integral and inevitable part of old age or a punishment for his sins from a young age, and ending with the thought that there is no way to help him nor to treat his pain. The worry that the pain indicates a serious and unavoidable illness, an end-of-life disease, may also exist. The older person may have an excessive and unfounded fear of taking painkillers and even real difficulties in accessing medical services. In addition to the barriers already mentioned, cognitive decline, difficulty carrying out assessments using accepted evaluation methods, multiplicity of drugs and of doctors, and poor responsiveness are factors which play a role.

Many physiological changes occur with age and present real challenges in treatment. There is a need for a good understanding of these changes and for addressing these changes in a treatment plan. Examples of age-related changes are: decreased renal clearance, gastrointestinal absorption, blood flow to the liver, slower liver metabolism, decreased water quantity relative to the amount of fat (affects the volume of drug distribution), pharmacokinetic changes in the amount and activity of various receptors, and a decrease in physiological and functional reserves leading to a gradual decrease in the ability of all organ systems to maintain homeostasis in stressful situations (such as pain). Moreover, with increasing age, the variability (physiological, functional, morphological, sociological, health, etc.) between people increases and the ability to expect a response to treatment decreases.