

Narrative Review

Chronic Pain in the Elderly: The Case for New Therapeutic Strategies

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Background: Elderly patients in general exhibit a higher incidence of chronic and neuropathic pain conditions. This group poses a particular clinical challenge due to age-related pharmacokinetic and pharmacodynamic issues, comorbid conditions, and polypharmacy, as well as frailty and cognitive decline. Poor control of pain has consistently been identified as an issue for older people. The identification of safe and efficacious treatments for chronic pain remains a critical public health concern, especially considering the progressive increase of the world's elderly population.

Objectives: This narrative review deals with the principal alterations of the somatosensory system together with changes in non-neuronal cells in the course of aging. The possibility to control chronic pain based on an innovative strategy which addresses non-neuronal cell dysregulation control will also be discussed.

Study Design: Narrative review.

Results: Peripheral nerves display functional, structural, and biochemical changes with aging that mainly involve A δ fibers. Alteration in the responses to heat pain in the middle insular cortex and primary somatosensory cortex are also observed in the elderly. In general, pain threshold increases with age while the threshold of pain tolerance remains unchanged or decreases. Additionally, other important modifications of the pain perception system in this age group consist in a clear reduction in the descending inhibitory capacity with an associated increase in central sensitization. Furthermore, different changes concern immune system cells, such as mast cells and microglia, that with age show an increase in their sensitivity to noxious stimuli and a decreased capability to be regulated by homeostatic endogenous systems. Since these cells are the primary interlocutors for pain neurons, their alterations lead to changes that promote persistent neuroinflammation, thereby impacting pain neuronal cell functionality.

Limitation: This review is not an exhaustive review for the current evidence supporting the role of immune cells in influencing pain somatosensory neuron functions. It is also important to stress the small number of studies designed to determine the efficacy and safety of anti-pain therapies in elderly patients.

Conclusion: Non-neuronal cells of immune system origin such as microglia and mast cells, along with astrocytes, are capable of influencing pain somatosensory neuron functions. These nervous system non-neuronal cells may thus be viewed as innovative targets for persistent pain control. Among therapies aiming at preserving the functionality of non-neuronal cells, palmitoylethanolamide, with its high efficacy/risk ratio, may be an excellent co-treatment for the ever-growing elderly population with chronic pain.

Key words: Elderly, chronic and neuropathic pain, mast cells, glial cells, neuroinflammation, micronized and ultra-micronized palmitoylethanolamide

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Age brings pain: osteoarthritic back pain, especially in the low back or neck (around 65%), musculoskeletal pain (around 40%), peripheral neuropathic pain (typically due to diabetes or postherpetic neuralgia, 35%), and chronic joint pain (15% – 25%) (1). Pain seems to accelerate aging, as well (2). The ever-growing worldwide proportion of older people and lifespan (3) begs the questions: will population aging be accompanied by a longer period of good health, and particularly a long pain-free life? Are physicians prepared enough for the challenge of persistent pain treatments in the elderly?

The societal burden of persistent pain is considerable (4-6). Management of chronic pain is frequently complex, since analgesics currently available for chronic and neuropathic pain in adults are effective in less than 50% of cases and pain relief is usually only partial (7). Pain control in the elderly is complicated by many unresolved problems, e.g., difficulty of diagnosis, substantial lack of clinical studies, and total lack of safe and effective therapies (8-10). As a result, pain in the elderly is oftentimes neither well recognized nor adequately treated (10,11). Pain assessment in the elderly is complicated by the frequent presence of chronic clinical conditions, the presence of multiple causes of pain, and multi-drug treatment that can interfere with the mechanisms of pain (12,13). Despite its limitations, pain self-reporting is often deemed to be the gold standard in pain assessment. However, self-reporting might become compromised in neurological disorders such as dementia, in which individuals often have little ability to communicate (14). The use of rating scales is often further complicated by the presence of visual and auditory deficits. Although the elderly are the biggest users of analgesics, only a small number of randomized, controlled trials designed to determine the efficacy and safety of these therapies in elderly patients have been carried out (9).

The management of chronic pain in the elderly constitutes a challenge to the clinician. When considering pain experience in elderly people, it is important to be aware of any age-related alterations in pain reporting and processing and factors that might contribute to such changes. Positive results in the treatment of pain in aging can only be overcome by using innovative therapeutic strategies based both on a knowledge of the patient's real needs and differences in the perception and processing of pain, as well as changes associated with aging such as alterations in the immune system (15,16) which can modify responsiveness to painful

stimuli. This review aims to bring together published work on changes in the pain somatosensory system in the elderly, along with information of mast cell and microglia changes that might affect pain processes.

Study Design

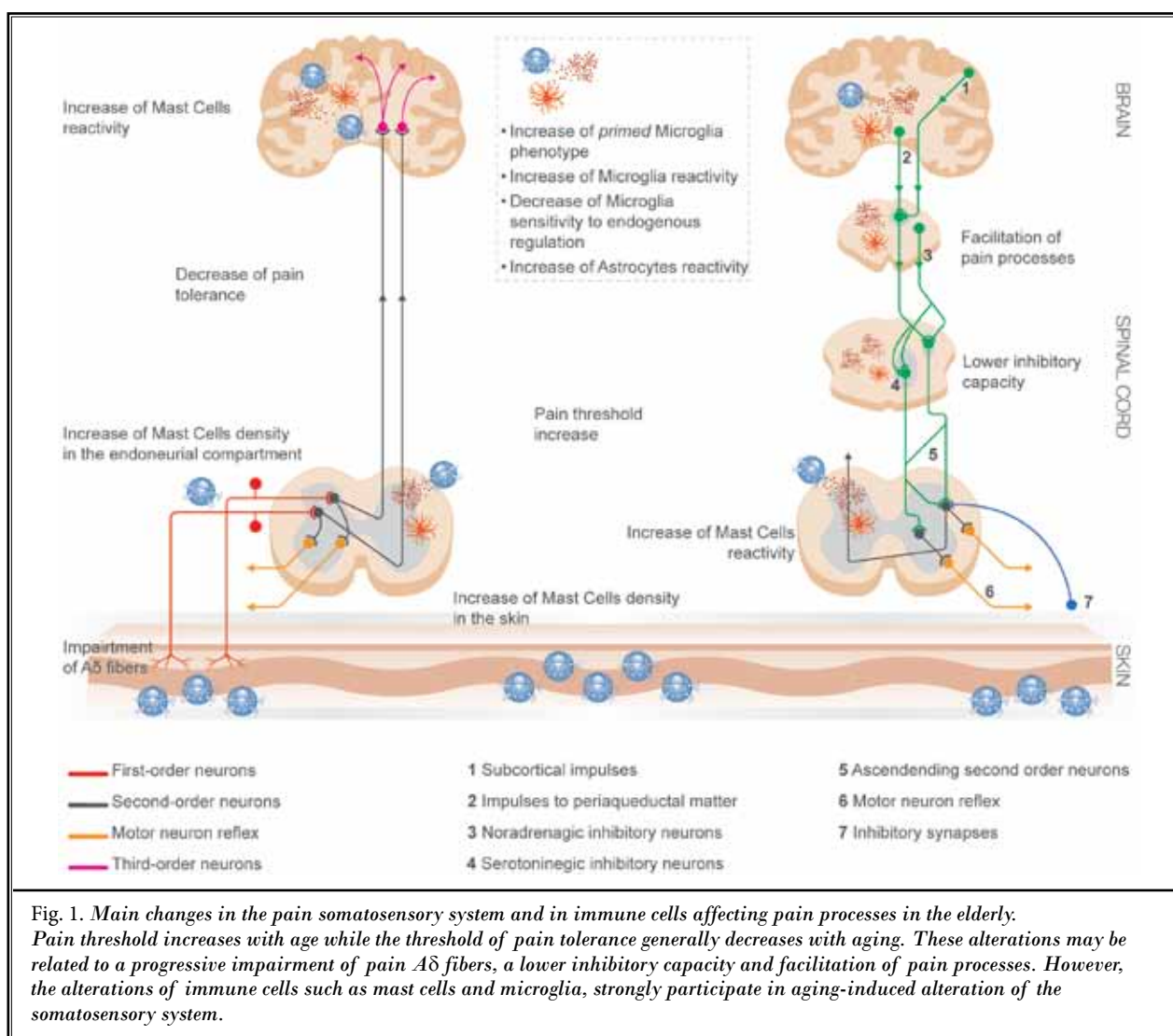
This narrative review is based on a literature search undertaken using PubMed, and reference lists from the most recent reviews as additional sources of primary literature, as well as references cited by relevant articles. Search terms included "chronic and neuropathic pain," "somatosensory system," "mast cells," "microglia," "older adult," "elderly," "aging," "micronized and ultramicronized palmitoylethanolamide," and "pain management."

Changes in the Pain Somatosensory System in the Elderly

Peripheral nerves display functional, structural, and biochemical changes with aging. Morphologic studies have reported a loss of myelinated and unmyelinated nerve fibers in elderly patients, and several abnormalities involving myelinated fibers, such as demyelination, remyelination, and myelin balloon figures (17). The loss in structure and function of the peripheral nerve mainly involves A δ fibers (18). In the central nervous system (CNS) age specifically affected responses to heat pain in the middle insular cortex and primary somatosensory cortex (19). As a consequence, pain threshold, which is the ability of the somatosensory system to recognize and process a painful stimulus, increases with age – especially in women (20,21). Functional brain imaging of pain responses reveals a parallel decrease in the spread and magnitude of brain activation in response to acute painful stimuli in the elderly compared with young adults even after correcting for age-related reductions in brain volume (22). Therefore, as with other sensory functions such as vision and hearing, aging is accompanied also by a reduced ability to detect signals harmful to the body (presbyalgos). In contrast, the threshold of pain tolerance, i.e., the maximum intensity of a pain-producing stimulus that a patient is willing to accept in a given situation, remains unchanged or even decreases with age (13,21,23). Because the elderly underestimate low intensity stimuli but, when perceived, overestimate those associated with more intense pain, once perceived these conditions can quickly become unbearable. This inability to properly recognize danger signals probably contributes to an increased frequency of accidents among the elderly, and indirectly to the increased prevalence of pain in this population (14).

Other important changes in an elderly person's pain system concern endogenous pain modulation. The descending modulation, from endogenous pain inhibitory systems, displays age-related impairment in opioid and non-opioid mechanisms. The extent of this alteration is quite large, with elderly people showing less than a third of the strength of the induced endogenous inhibitory effects on pain sensitivity, when compared with young adults (24-27). Inability to modulate painful processes contributes to increased vulnerability in the development of chronic pain after injury or illness in the elderly. Differences in neuroplasticity in the elderly might also contribute to decreased pain tolerance. In fact, temporal summation of noxious heat seems to occur more readily in the CNS of elderly

people than in young adults (20,28-30). Endogenous pain modulation systems are also altered by the presence of concomitant diseases or co-morbidities. In particular, the high prevalence of chronic diseases affecting the CNS in the elderly could contribute both to altered neuroplasticity, and an increased predisposition to develop central sensitization. For example, dementia might exacerbate age-related impairments in pain processing due to the additional burden of cognitive impairment and associated neurodegenerative loss in regions typically associated with higher levels of CNS processing of noxious information (23,31). Fig. 1 summarizes the referred anatomic-functional modifications of the pain somatosensory system, consequent to aging.



Immune System Changes in the Elderly Affect Pain Processes

It is important to stress that chronic pain is a precise medical condition, and not simply a symptom as acute pain. In this condition the somatosensory system is not the only, or even the main, protagonist. Chronic pain in the elderly is complicated by many changes that progressively affect the immune system. Immune cells, in particular mast cells and microglia, are co-protagonists of the somatosensory system, where persistent alterations give rise to chronic pain. Mast cells and microglia are the primary interlocutors for pain neurons, both in the periphery and at the spinal and supraspinal levels. Their alterations lead to changes that promote persistent neuroinflammation, thereby impacting neuronal cell functionality (32).

Mast Cells and Microglia Influence Pain Processes

In physiological conditions, pain information begins at nerve endings, which form a functional pain unit with nearby tissue capillaries. Peripheral mast cells are important players in this functional unit, as deduced from their strategic position in proximity to sensory nerve endings and vasculature (33). Following injury or inflammatory stimuli, mast cell mediators such as bradykinin, prostaglandins, and histamine are released and stimulate nociceptive afferents. Neuropeptides such as substance P may also cause mast cell degranulation, creating a bidirectional positive feedback-loop (34), up-regulating local inflammation and increasing pain. Mast cell recruitment of other immune cells, which release pro-nociceptive mediators, can affect not only injured zones but also adjacent territories, creating a secondary, widespread hyperalgesia (35). The contribution of meningeal mast cells to the activation of meningeal nociceptors in the pathophysiology of migraine has been extensively documented (36,37). At the spinal level, mediators released from dural mast cells may reach the superficial laminae to modulate synaptic transmission and nociception (38). CNS-located mast cells have been suggested to have a role in central integration of pain. Mast cells are particularly concentrated in the thalamus, an essential nociceptive relay where, by releasing mediators such as histamine or serotonin might interact with third-order neurons targeting the cortex (39,40). Peripheral and brain mast cells cooperate with other immune cells, such as microglia, to orchestrate the onset of central sensitization (41). In fact, in the absence of a tight physiological control, mast cell-nerve terminal activity results in nociceptor

sensitization, reduced pain threshold at the site of inflammation and, ultimately, dysfunctional pain signaling and hyperalgesia (35,42,43). Persistent increased responsiveness of nociceptors can also sensitize spinal cord neurons, leading to central sensitization (44,45).

Glial cells are important mediators of pain processes at the spinal level (46,47). Microglia interact with spinal neurons at the site of injury or disease, as well as remotely. Microglia can be activated through engagement of a number of constitutively expressed cell surface molecules, and respond also to pro-inflammatory signals released from peripheral cells of immune origin – including mast cells (32).

Bidirectional cross-talk between mast cells and microglia, directly via cellular mediators and indirectly through somatosensory neurons, appears to significantly contribute to amplification of peripheral pain signals at the spinal level (32,48-50). Activated microglia contribute to pain states by releasing pro-inflammatory cytokines, chemokines, and proteases. Further, systemic inflammation can give rise to signals that communicate with the brain and lead to changes in metabolism and behavior, including expression of a pro-inflammatory phenotype by microglia (51). Astrocytes, the most abundant CNS glial cell type involved in neuroinflammation, also play a major role in pain facilitation and are a fundamental contributor to neuropathic pain (46). The above findings thus support the notion that controlling mast cell-glia reactivity can provide an attractive therapeutic avenue for treating neuropathic pain (44).

Mast Cell and Microglia Reactivity Changes with Age

In the elderly, tissue mast cell density is often altered as a consequence of an altered production of factors that promote or inhibit maturation of resident stromal cells (52). However, the production of mast cell precursors is not changed. While mast cell maturation decreases with age in various tissues, aged mast cells show an increase both in their sensitivity to inflammatory mediators and state of degranulation (53,54). Concurrently, mast cell density increases with age in some tissues (55,56). In particular, in the endoneural compartment there is recruitment of non-neuronal cells, including mast cells, probably induced by nerve fiber damage (57). This increase in endoneural mast cell number and progressive sensitivity with aging likely contributes to the perceptual and functional alterations of primary somatosensory neurons. Hyper-reactive endoneural

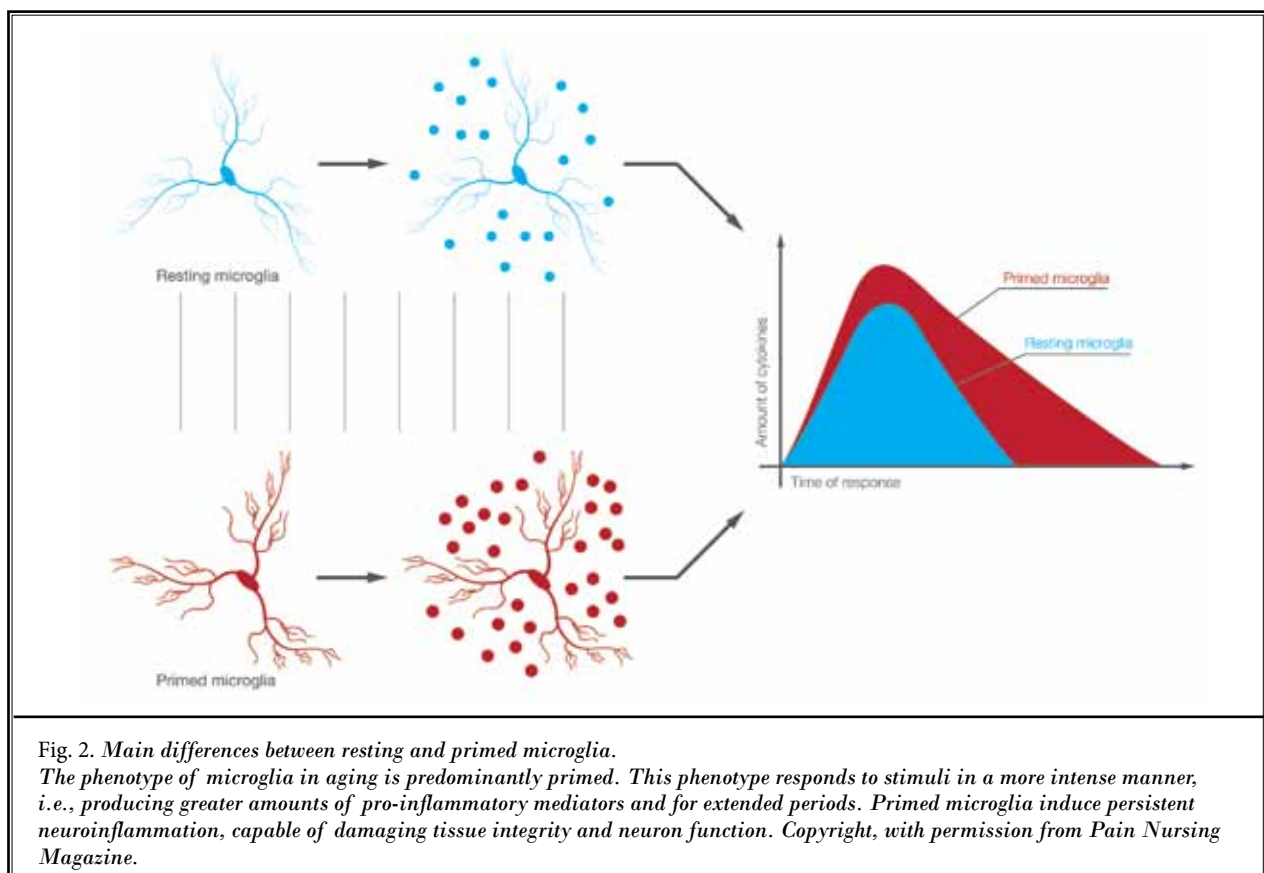
mast cells, via the uncontrolled release of proteolytic enzymes, may contribute directly to progressive impairment of A δ fibers (18). Both mast cells and microglia, the main immune-resident cell in the CNS, undergo a change in reactivity with age.

Under physiological conditions, brain parenchymal microglia present a ramified or quiescent phenotype but, if stimulated, can quickly assume an activated or pro-inflammatory phenotype (58). Physiological activation of microglia generally leads to the resolution of neuroinflammation and restoration of tissue homeostasis. In aging, microglia present primarily a primed phenotype (59) (Fig. 2). The response of primed microglia to a stimulus is more intense, with a more robust production of pro-inflammatory cytokines lasting for an extended period. Primed microglia cause persistent neuroinflammation capable of damaging tissue integrity and neuron functionality (60).

Aged microglia are primed to be activated and resistant to regulation, that is, sensitive to stimuli which induce activation and insensitive to endogenous systems of homeostatic regulation (61). Primed microglia in the

spinal cord and thalamic pain nuclei, as a consequence of an excessive response to painful peripheral stimuli, facilitate the onset of chronic and/or neuropathic pain (62). Primed microglia can also promote the onset of pain in the absence of peripheral stimuli (central pain). The excess production of pro-inflammatory cytokines by primed microglia can act at multiple levels to adversely affect pain processes. Direct action on second- and third-order somatosensory neurons can cause a state of neuronal hyperexcitability (central sensitization) (63). In addition, pro-inflammatory cytokines can also compromise white matter integrity and ultrastructure of the myelin sheath. A decrease of myelin proteins has been reported to correlate with increased glial activation (64). These results are consistent with observations relating to age-dependent changes of myelinated A δ type fibers as well as un-myelinated C-type fibers (18).

Altered reactivity of mast cells and microglia in the elderly emerges clearly as a co-factor, or even promoter, of low-grade inflammation or non-resolving inflammation characteristic of chronic illness and chronic pain (13,65,66). In this situation, there is a chronic and sys-



temic increase, although often not marked, in the levels of pro-inflammatory mediators such as tumor necrosis factor- α , interleukin-1, and interleukin-6, among others (67). These pro-inflammatory mediators, some of which are vasoactive and others neurotoxic, act not only on somatosensory nerve endings but may also increase permeability of the blood-spinal cord barrier. Consequently, toxins will enter the spinal cord parenchyma and act directly on activated microglia to enhance pain processes (central sensitization), favoring the onset of spinal neuroinflammation and neurodegeneration.

Among chronic diseases characterized by low-grade inflammation, mood disorders such as anxiety and depression can be both a causal trigger and a consequence of chronic pain (68). Neurodegenerative diseases, as well, are associated with persistent inflammatory processes that might negatively impact the elaboration of pain signaling (16).

Patients with chronic pain, including those without a history of neurological disorders, frequently manifest cognitive deficits that negatively impact social relations and daily life. Many cognitive domains such as attention, concentration, processing speed, memory, psychomotor skills, decision making, and executive functions are negatively affected by pain (13). On the other hand, chronic pain syndromes are negatively associated with processes of attention and other forms of memory formation (69). In situations characterized by chronic pain and neurocognitive deficits, low-grade inflamma-

tion becomes a common thread and amplifier between these 2 conditions. In fact, peripheral somatosensory and spinal/supraspinal neurons, together with neuronal cell populations involved in the most common neurodegenerative disorders, can be damaged by persistent activation of the immune system (65).

Managing Pain in the Elderly

It is essential that pain in the elderly be treated so as to ensure a decorous quality of life, increase functionality, and also to prevent domestic accidents (70-73) and/or the onset of illnesses. Pain not adequately controlled is one of the main promoters of mood and sleep disorders (74-78). It is fundamental that chronic and/or neuropathic pain therapies in the elderly take into account the progressive physiological changes, which develop with advancing age (Table 1); have a wide benefit/risk profile; are suitable for chronic treatment; and do not interfere with poly-drug therapies that the elderly are necessarily subjected to (1,79,80). Unfortunately, none of the currently available therapies for pain treatment is suitable for prolonged use in the elderly (Table 2). Inevitably, the benefit/risk profile of most therapies favors the occurrence of adverse events with increasing treatment time and drug dosage. For this reason, guidelines for pain management in the elderly suggest using non-steroidal anti-inflammatory drugs with caution, at the lowest dose and for the shortest duration practicable (79). Elderly persons taking non-steroidal

Table 1. Age-related physiological changes and their clinical consequences.

System	Change with ageing	Clinical consequence
Absorption and function of the GI tract	Reduced: <ul style="list-style-type: none"> • Motility of the large intestine • Vitamin absorption by active transport mechanisms • Splanchnic blood flow • Bowel surface area 	• Passive diffusion-little change in absorption with age
	Delayed gastric emptying and reduced peristalsis	Increased risk of GI-related side effects
Distribution	Decreased body water	Reduced distribution of water-soluble drugs
	Increased body fat and accumulation of lipid-soluble drugs	Lipid-soluble drugs have longer effective half-life
	Decreased serum albumin and altered protein binding	Increased potential for drug-drug interactions
Hepatic-biliary	Decreased hepatic blood flow	First-pass metabolism can be less effective
	Reduced liver mass	Phase I metabolism of some drugs might be slightly impaired
Renal excretion	Reduced renal blood flow	Reduced excretion of drugs and metabolites eliminated by kidney
	Reduced glomerular filtration	
	Reduced tubular secretion	
Pharmacodynamic changes	Decreased receptor density	Increased sensitivity to the therapeutic and side effects
	Increased receptor affinity	

GI, gastrointestinal

Table 2. Current pain management choices and limitations for the elderly.

Therapeutic options	Factors influencing choice of therapy			Factors affecting quality of life / pain intensity		
	Pain intensity and type	Other therapeutic effects	Side effects	Mental function	Social relationships	Physical function
NSAIDs/ acetaminophen	<ul style="list-style-type: none"> Mild to moderate Nociceptive acute 		<ul style="list-style-type: none"> Gastric wall damage Can affect blood pressure control Drug metabolizing interactions Liver and renal damage Must be withdrawn before surgery owing to bleeding potential Can impair immune function 	<ul style="list-style-type: none"> Can improve agitation in elderly 	<ul style="list-style-type: none"> Mobility improved 	
Antidepressants	<ul style="list-style-type: none"> Moderate to severe Chronic and/or neuropathic 	Effective on anxiety and depression	<ul style="list-style-type: none"> Can affect blood pressure Can disrupt sleep Drug metabolizing interactions 	<ul style="list-style-type: none"> Can improve cognitive performance 	<ul style="list-style-type: none"> Can positively influence mood Mobility improved 	
Antiepileptics	<ul style="list-style-type: none"> Moderate to severe Chronic and/or neuropathic 	Some treat anxiety	<ul style="list-style-type: none"> Avoid gabapentanoids in the renal-impaired Drug metabolizing interactions Sedation 	<ul style="list-style-type: none"> Can blunt cognitive performance 	<ul style="list-style-type: none"> Can positively influence mood 	<ul style="list-style-type: none"> Can cause sedation
Opioids	<ul style="list-style-type: none"> Moderate to severe pain Acute, occasionally chronic 		<ul style="list-style-type: none"> Abuse risk Sedation Can cause physical dependence Chronic constipation Can influence immune function 	<ul style="list-style-type: none"> Can blunt cognitive performance 	<ul style="list-style-type: none"> Treatment is negatively perceived by society 	<ul style="list-style-type: none"> Can influence hormonal balance
Transdermal therapies	<ul style="list-style-type: none"> Neuropathic pain 		<ul style="list-style-type: none"> Denervation of nociceptive fibres with capsaicin 8% patch Transient increases in pain with capsaicin 8% patch 			

NSAIDs, non-steroidal anti-inflammatory drugs

anti-inflammatory drugs require routine monitoring for potential gastrointestinal and hepatic risks, cardiovascular and renal side effects, and drug interactions (Table 2). The use of tricyclic antidepressants and antiepileptic drugs is severely limited due to poor tolerability and significant side effects (79). Opioid use also has drawbacks: they act not only on neurons but also on non-neuronal cells such as microglia, astrocytes, and mast cells, causing their activation, which further promotes the development of neuroinflammation (81,82). Notable side effects of these therapies are, in fact, attributable to the activation of non-neuronal cells (83).

Non-neuronal cells may be important therapeutic targets for the treatment of chronic and/or neuropathic pain in both adults and the elderly (84). Molecules able to normalize activation of these cell populations, so as to limit development of neuroinflammatory processes and block the cascade of events promoting onset of changes in somatosensory neurons and central sensi-

zation, would be especially desirable. Among molecules able to modify the course of disease (*disease-modifying agent*) palmitoylethanolamide (PEA) seems to merit interest (85). PEA is an endogenous N-acylethanolamine produced *on demand* to promote the resolution of neuroinflammation and pain (86,87). PEA, when formulated using appropriate pharmaceutical techniques that achieve micron or submicron particle sizes (85,88), administered exogenously seems able to: i) control reactivity of tissue peripheral mast cells located in close proximity to nerve terminals and within the endoneural microenvironment, thereby normalizing the sensitivity and function of primary somatosensory peripheral neurons (89,90); ii) act on spinal/supraspinal non-neuronal cells (microglia, resident or infiltrating mast cells, astrocytes) to counteract neuroinflammation and normalize the activity of second- and third-order somatosensory neurons (91,92). In this context PEA may be viewed as a modulator of immuno-neural homeostasis.

PEA – Experimental Pain Studies

Preclinical reports demonstrate the ability of PEA to reduce inflammation and pain induced by various acute stimuli (93). The effect of PEA administration by different routes is dose-dependent. The anti-inflammatory and pain-relieving effects of PEA have been confirmed in models of chronic inflammation and chronic or neuropathic pain (89,94-96). PEA prolonged treatment not only reduced pain but also preserved peripheral nerve morphology, and reduced endoneural edema, mast cell recruitment and activation, and the production of pro-inflammatory mediators at the injury site (89,90,97). In models of neuropathic pain, PEA reduces activation of spinal cord microglia and increases production of the anti-inflammatory cytokine interleukin-10. The reader is referred to more detailed reviews on PEA anti-inflammatory and anti-pain effects in experimental models of inflammation (85,95).

PEA – Clinical Studies

Importantly, these preclinical investigations have translated into clinical studies demonstrating the efficacy of micronized and ultramicrotonized PEA (Normast®, Epitech Group, Saccolongo, PD, Italy) in reducing chronic and neuropathic pain associated with various pathological conditions, including those associated with central neuroinflammation (85) (Table 3). In such studies, including a recent meta-analysis (114) function goes beyond being a pain score, and represents both an assessment tool and goal in patient improvement. In a number of such studies reduction in pain was accompanied by increased functionality (98-104) and decreased use of analgesic drugs (102,105). Further, chronic treatment with micronized PEA brought about a reduction of pain intensity score in patients with chemotherapy-induced peripheral neuropathy; this effect was paralleled by a partial improvement of function of all myelinated fiber groups, as assessed by neurophysiologic measures (106). PEA's ability to improve electrophysiological parameters was also reported in carpal tunnel syndrome (102).

Another highly desirable pharmacological feature of PEA is that its addition to ongoing standard therapies for chronic or neuropathic pain in patients with unsatisfactory management of pain relief allows a significant reduction of non-steroidal anti-inflammatory drug use (105,109). PEA treatment in association with carbamazepin, pregabalin, and oxycodone (99-101) elicited analgesic effects also when the latter drugs were used at non-therapeutic doses. This additive or

synergistic effect of PEA probably reflects different mechanisms of action, in that these traditional analgesic agents act primarily on neurons, whereas PEA targets mainly non-neuronal cells such as mast cells and microglia. Moreover, PEA treatment was effective in patients who had discontinued standard pain therapy because of noteworthy side effects. These data suggest that PEA may be used as first-line together with standard therapies, then progressively to reduce the use of other drugs until such time as PEA administration alone is sufficient for effective pain control.

At the preclinical level, PEA effects are not associated with any changes in overt behavior, indicating the tested doses to be well-tolerated (85). PEA administration does not induce tolerance following repeated administration of high doses, and its effectiveness progressively increases with time of treatment (98,104). Moreover, when coupled with morphine treatment, PEA significantly attenuated development of tolerance, effectively doubling the number of days of morphine anti-nociceptive efficacy in comparison to the control group (112). Clinical studies show micronized and ultramicrotonized PEA to possess a highly favorable benefit/risk profile suitable for chronic treatment, and to not interfere with treatments for co-morbid conditions (107). Micronized and ultramicrotonized PEA administration is devoid of acute and chronic toxicity (113), and there is no evidence for their use being associated with gastric mucosal lesions.

Toxicological data, together with the safety/tolerability profile of micronized and ultramicrotonized PEA led to authorization by the Italian Ministry of Health for products based on PEA as “foods for special medical purposes” in compliance with European directive 199/21/EC. This classification allows for free circulation of PEA in EU member countries and facilitates its acceptance by Ethics Committees for studies in man. PEA is now available as a “special food for medical purposes” in other European countries (e.g., Spain and Germany), as well.

Conclusions

Pain management in the elderly remains a challenge for the clinician. Despite its high prevalence, this condition remains to a large extent underestimated and not adequately treated. There are multiple underlying factors behind this, since the physiological decline involves a series of changes implicating sensory circuits and the immune system, in particular mast cells and microglia, and the limited availability of effective and

Table 3. Main clinical studies demonstrating the pain-relieving effect of micronized and ultra-micronized PEA, concomitant reduction in disability and/or improvement of neurological functions and quality of life.

	Source of pain	PEA effects	Ref
Osteoarthritis	Temporomandibular joint	<ul style="list-style-type: none"> • greater pain score reduction • better maximum mouth opening • greater tolerability 	104
Chronic Pain	Lumbosciatica	<ul style="list-style-type: none"> • pain score reduction • reduced disability 	98
	Lumbosciatica	<ul style="list-style-type: none"> • pain score reduction • reduced exposure to anti-inflammatory or analgesic drugs 	105
	Various etiologies	<ul style="list-style-type: none"> • pain score reduction 	107
	Cervicobrachial or sciatic pain	<ul style="list-style-type: none"> • reduced chronic pain score • reduced pain impact on emotional state • reduced pain impact on employment 	108
	Low back pain	<ul style="list-style-type: none"> • pain score reduction • reduced disability 	100
	Diabetic neuropathy and postherpetic neuralgia	<ul style="list-style-type: none"> • pain score reduction • reduced disability 	101
	Carpal tunnel syndrome	<ul style="list-style-type: none"> • reduced median nerve latency time • minor Tinel's sign presence • reduced discomfort 	102
Neuropathic pain	Chemotherapy-induced neuropathy	<ul style="list-style-type: none"> • pain score reduction • increased amplitude of foot-LEPs, sural-SNAPs, peroneal-CMAPs 	106
	Lumbosciatica	<ul style="list-style-type: none"> • pain score reduction • quality of life improvement 	109
	Diabetic polyneuropathy	<ul style="list-style-type: none"> • pain relief • reduced neuropathic symptoms 	110
	Diabetic and traumatic polyneuropathy	<ul style="list-style-type: none"> • pain relief • reduced neuropathic symptoms • quality of life improvement 	111

LEPs, laser evoked potentials, SNAPs, sensory nerve action potentials CMAP, compound motor action Potentials.

safe therapeutic options. Among innovative therapies for treating pain in the elderly, PEA comes to the forefront owing to its high efficacy/risk ratio, and lack of both tolerance induction and interference with other potential therapies for pain and/or co-morbid conditions. Finally, PEA may have intrinsic efficacy towards syndromes co-morbid with chronic pain, e.g. depression and anxiety (115,116). The progressive increase in the world's elderly population coupled with a limited number of pain studies in the elderly reinforce the urgency to fill our knowledge gaps in order that we may

capitalize on innovative tools allowing us to choose therapeutics suitable for chronic use while ensuring efficacy, safety, and compatibility with multi-therapies.

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Competing Interests

MF is an employee of Epitech Group srl. The other authors declare no other conflicts of interest.

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