

Webinar: Pain, Balance and Falls In Older Adults

Responses for questions not addressed in the Q&A during the webinar

More generally, would you say that there is a negative correlation between strength and balance focused physical activity and falls in older adults with or without pre-existing pain?

There is clear research evidence that exercise is the most important intervention to prevent falls in community-dwelling older adults. The trials this statement is based on have involved a range of older people, some with and without pain. We are not aware of any trial that would have compared these groups as this would be too complex given the variety of pain types and locations.

When risk of falls reduction is reported is this relative or absolute risk reduction?

This would be study specific.

We have started a 2 year project in an inpatient mental health unit. It focuses on exercise and which uses music. But how do we support dementia patients to reduce falls prevention. Any tips? Thank you!

Please refer to the [resources page on the NSW Fall Prevention & Healthy Ageing Network website](#) and a recent [Dementia Rehabilitation webinar series](#) facilitated by the University of Sydney.

What would your recommendations be for someone with significant foot pain on the background of 'diabetic/Charcot foot'?

Neuropathic foot pain associated with diabetes can be difficult to manage and often requires pharmacological rather than mechanical treatment. The best available evidence suggests that the anti-seizure medications pregabalin (Lyrica) and gabapentin (Aspen) are most effective, and some people report that capsaicin topical cream can modestly alleviate symptoms.

For Hylton Menz: - Interesting about the 5 classes of foot pain and the characteristics of each group. Is there any indication of foot pain leading to the different characteristics, vice versa or too difficult to tell/chicken and egg phenomenon?

These data are cross-sectional, so difficult to determine causation.

Do you think podiatrists should be screening for falls and referring on to physio/exercise?

Most older podiatry patients could be considered at increased risk of falling due to their age and foot problems, but I recommend podiatrists screen for falls risk (using [QuickScreen](#)) and refer to physio and OT.

For Hylton Menz: You said foot deformity and foot pain are both associated with falls. Was one more strongly associated than the other?

Foot pain is the most consistently associated factor, followed by hallux valgus.

How much can women's increased foot pain be blamed on women's footwear?

Difficult to put a precise figure on it, but likely to be a substantial contributor, particularly for pain related to conditions such as hallux valgus and lesser toe deformities.

For Hylton Menz:- we don't have access to a podiatrist in our day rehab service. Could we be using a screening tool (such as QuickScreen) you mentioned to screen and refer to a podiatrist instead? Or is the screening tool used to refer to Physio/OT?

I would suggest that patients with foot pain, hallux valgus or toe deformities would benefit from referral to podiatry, irrespective of falls risk screening. I recommend that podiatrists themselves use [QuickScreen](#) to identify high risk patients to refer to physio and OT.

For Hylton Menz:- would people with Type 2 Diabetes Mellitus and subsequent peripheral neuropathy be included in this Class 5 generalised foot pain? The group measures seem very similar to the diabetic population.

Yes - they do appear to be a group with underlying metabolic risk factors. However, this group probably also includes people with multisite pain related to fibromyalgia, etc.

Hylton, have you reviewed the "Foothold" programme? If so, what are your thoughts?

Foothold is the exercise program we used in our [RCT](#) published in the BMJ back in 2011. The thing to remember is that the trial combined the exercise program with footwear and orthoses, so it's not clear whether it is effective in isolation.

For Rodrigo Rizzo: Can you please explain the acronyms in the pain diagram?

TT: Tissue Tolerance line (before chronic pain)

PBP: Protect by Pain Line (before chronic pain)

NPBP: New Protect by Pain Line

NTT: New Tissue Tolerance line

FUL: Flare-Up Line

BL: Base Line

Thank you Rodrigo. As an exercise physiologist I keep telling Drs and Specialists that the best exercise for anyone is the exercise that they are willing and able to do. It seems that the study you shared is consistent with belief, would you agree?

We know that most exercises and physical activity work for chronic pain, but we still do not understand why these interventions work (mechanisms). Recently, we published a study "[Why is exercise prescribed for people with chronic low back pain? A review of the mechanisms of benefit proposed by clinical trialists.](#)" We identified 33 different proposed mechanisms!! Today, I believe that most of the effect of exercises to reduce chronic pain is related to psychosocial factors such as self-efficacy.

For Rodrigo Rizzo: Any resources for reading about Clinical hypnosis and CBT ACT Mindfulness?

Yes! Thank you for asking. You can read my paper "[Hypnosis Enhances the Effects of Pain Education in Patients With Chronic Nonspecific Low Back Pain: A Randomized Controlled Trial.](#)" If you do not have access, send me an email r.rizzo@neura.edu.au. For clinical hypnosis, look for Mark Jensen's work. For ACT, look for Kevin E. Vowles's work. There is a book describing psychological interventions for chronic pain "Psychological Approaches to Pain Management: A Practitioner's Handbook."

For Rodrigo Rizzo: Given the three-month usefulness could one rotate between the three or more treatments? Also, no mention of nutritional component?

That's an excellent question. I had this idea some time ago. We need to test it. About nutritional components and chronic pain: Sorry, I decided to concentrate on other interventions. However, I think that it would be a great topic to discuss.

For Rodrigo Rizzo: Can you suggest any online or similar options for rural patients with chronic pain who don't have access to psychology services?

There is a need to test the effect and the best way of using online interventions for rural patients with chronic pain. It seems that online interventions are beneficial, but the studies have issues with compliance/adherence. We need to find the best ways of engaging people with the interventions. Some readings: "[Online teletherapy for chronic pain: A systematic review.](#)"

For Rodrigo Rizzo: Many of the pain management techniques Rodrigo mentioned as ineffective (TENS (transcutaneous electrical nerve stimulation) etc.) are used extensively in nursing homes due to funding incentives and limited time. Do you have any suggestions on how this could be changed?

This is a complex topic. I will suggest you read the following series of articles (please, if you do not have access to this series, send me an email r.rizzo@neura.edu.au):

- [Overcoming Overuse: Improving Musculoskeletal Health Care](#)
- [Overcoming Overuse Part 2: Defining and Quantifying Health Care Overuse for Musculoskeletal Conditions](#)
- [Overcoming Overuse Part 3: Mapping the Drivers of Overuse in Musculoskeletal Health Care](#)
- [Overcoming Overuse Part 4: Small Business Survival](#)