Pain Assessment

David. E. Weissman, MD
Professor Emeritus
Medical College of Wisconsin
Palliative Care Education, LLC
2015

Objectives

- List the five components of a thorough pain assessment.
- Describe the patient groups at the greatest risk for under-treatment of pain.
- Identify the most important aspect of pain assessment in the cognitively impaired patient.

Case Question

- A 58 year old female with breast cancer known to be metastatic to her lung complains of pain in her chest worsening in intensity over 2 weeks. When asked where the pain is, she points to one spot overlying the right clavicle. She describes the pain as a constant ache. Ibuprofen partially relieve the pain. How would you describe the type of this patient's pain?

    - A. Somatic
    - B. Visceral
    - C. Neuropathic

Pain Assessment is NOT….

- Relying on changes in vital signs
- Deciding a patient does not “look in pain”
- Knowing how much a procedure or disease “should hurt”
- Assuming a sleeping patient does not have pain
- Assuming a patient will tell you they are in pain

Remember !!

- Pain is subjective
- Pain occurs in the context of a person's life:
  - fears and hopes for the future
  - spiritual beliefs
  - pressure and support from family
  - social and economic realities
- Thus—a patient's report of pain will be filtered and modified by these factors

Pain Assessment

- 5 components for a thorough pain assessment
  - Basic History of Pain
  - Analgesic History (Pharmacologic)
  - Analgesic History (Non-pharmacologic)
  - Impact and Meaning of Pain
  - Pain Causality and Basic Goals

Pain Assessment

1. **Basic History** of Pain includes:
   - Temporal Characteristics
   - Location
   - Intensity
   - Quality
   - Aggravating and Alleviating Factors

Temporal Characteristics

- When did the pain start?
- What has happened to the pain over time? (better/ worse/no change?)
- Is the pain constant or intermittent?
  - How much of the day is the pain present?
  - Does the pain vary with time of day, position, or activity?

Location

- Define area/areas of pain
  - different areas of pain may represent different etiologies of pain
  - Each location may require an individualized approach to management

Intensity

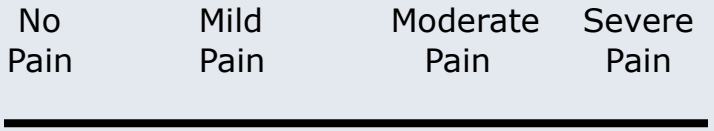
- Document the patient's self report, not your personal impression
- Use an established rating scale
  - there is no single best scale
  - learn to use one or two scales
- Have alternate scales available for patients unable to use standard scale
- Ask patient to rate pain:
  - Now
  - At worst in past 24 hours
  - At best in past 24 hours

Rating Scales

- Visual Analog Scale

- Numeric Rating Scale

- Verbal Rating Scale



- Facial Images Scale

Rating Scales

Correlation between scales:

1-3 = mild pain; minimal impact on ADL's

4-6 = moderate pain; moderate impact on ADL's

7-10 = severe pain; major impact on ADL's

Quality

- Pain description will usually fall into one of three categories:
  - ✓ Somatic Pain
  - ✓ Visceral Pain
  - ✓ Neuropathic Pain

Somatic Pain

- **Descriptors:** *aching, deep, dull, gnawing*
- **Distribution/Examples**:
  - Well localized—patients can often point with one finger to the location of their pain
    - bone mets, strained ankle, toothache
- **Analgesics**: *NSAIDS, acetaminophen opioids*

Visceral Pain

- **Descriptors**: *cramping, squeezing, pressure*
- **Distribution/Examples**:
  - *Referred*
    - heart attack, kidney stone
  - *Colicky*
    - bowel obstruction, gallstone
  - *Diffuse*
    - peritonitis
- **Analgesics**: *opioids; acetaminophen*

Neuropathic pain

- **Descriptors:** *burning, numb, radiating, shooting, stabbing, tingling, heat, hypersensitive skin*
- **Distribution/Examples:**
  - Radicular—single or multiple nerve roots
    - Herpes zoster; Sciatica
  - Stocking-Glove (fingers/toes)
    - Diabetic or chemotherapy-induced neuropathy
- **Analgesics**: *opioids, adjuvants (i.e. anticonvulsants, antidepressants)*

Aggravating and alleviating factors

- What makes the pain better or worse?
  - Is the pain affected by
  - Movement?
  - Position?
  - Breathing?
  - Mood?
  - Eating?
- Leads into the next component of pain assessment…

Pain Assessment

2. **Analgesic History--Pharmacologic**

- Current medications:
  - Time to onset, maximal duration of effect, change in pain intensity (quantify)
  - How are medications being used: as needed vs. scheduled
- Past analgesics:
  - Effect: positive/negative
  - Toxicity
- Drug phobias: is the patient fearful of …
  - Addiction, toxicity, other

Common Misconceptions

- Patients worry that:
  - they will become addicted to opioids
  - opioids will stop being effective and should be saved for when they are *really* needed
  - they will experience unpleasant or dangerous side effects from opioids
  - pills are not as effective as a shot
  - opioids are only for dying people
- These misconceptions will need to be addressed when starting opioids.

Pain Assessment

3. **Analgesic History: Non-Pharm**

- Current or past use and effect of:
  - Heat / Cold / Massage
  - Relaxation techniques, imagery
  - Non-prescription food supplements
  - Acupuncture
  - Nerve blocks, TENS, other interventional procedures
  - Other (Aromatherapy, prayer, etc.)
- Has the patient ever been to a Pain Clinic?
- Has the patient tried anything else for the pain?

Pain Assessment

4. I**mpact and Meaning of Pain**

- How has the pain impacted (quantify):
  - Mood, sleep, movement, diet
- What does the pain prevent the patient from doing?
- Does the patient attach special meaning to the pain?
  Ask: *'Why do you think you are having pain?'*
  - Punishment for past misdeeds?
  - Opportunity for spiritual growth?
  - Fear of worsening cancer?
  - Other

Pain Assessment

5. **Pain Causality and Patient Goals**
   - Determine cause of pain when appropriate
     - Try to correlate pain to known disease
     - Order tests when necessary
   - Ask, *"What is your goal for pain relief?"*
     - Numerical goal (e.g. 2-3/10) or
     - Functional goal (e.g. sleep 6 hours)

Assessment: cognitively impaired patient

- Ask the patient about pain
  - Cognitively impaired patients may be able to give you some verbal information
- Behavioral clues are the gold standard of assessment in this population…
  - Look for changes in:
    - Mood
    - Appetite
    - Movement
    - Social interaction
    - Time out of bed
    - Level of consciousness

Assessment: cognitively impaired patient

- Physical causes of worsening pain in the cognitively impaired may include:
  - Bladder infection or distention
  - Worsening arthritis or new skin breakdown
  - New bone mets in the setting of cancer
  - An occult fracture
  - Worsening constipation
  - Others

Learning Points

List 3 new things you learned from this presentation.

1.
2.
3.

References

1. Ferrell BA. Pain management in elderly people. JAGS 1991; 39:64-73.
2. Drayer RA et al. Barriers to better pain control in hospitalized patients. JPSM 1999; 17:434-440.
3. Hutchinson, RW et al. Evaluation of a behavioral assessment tool for the individual unable to self-report pain. Am J Hospice and Palliative Med 2006; 23(4):328-31.
4. McCarberg, B. Stanos, S. Key patient assessment tools and treatment strategies for pain management. Pain Practice 2008; 8(6): 423-432.
5. Serlin RC et al. When is cancer pain mild, moderate or severe; Grading pain severity by its interference with function. Pain 1995; 61:277-284.
6. Ward SE et al. Patient-Related Barriers to Management of Cancer Pain. Pain 52:319-324, 1993.
7. Fast Facts #078, #083, #117 and #126