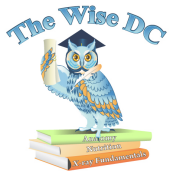


Section 10

Pain Assessment

Assessment of the patient experiencing pain is the cornerstone to optimal pain management. Pain assessment should include a history, physical examination, and a review of the results of pertinent laboratory and other ancillary diagnostic testing procedures. Initial evaluation of the pain complaint should include characteristics such as: intensity; character; frequency (or pattern, or both); location; duration; and precipitating and relieving factors. The mnemonic PPQRST may be helpful to follow: palliative, provocative, quality, region (or radiation), severity and temporal pattern of pain.

The WILDA Approach To Pain Assessment

Pain assessment should be ongoing (occurring at regular intervals), individualized, and documented so that all involved in the patient's care understand the pain problem. Using the WILDA approach ensures that the 5 key components to a pain assessment are incorporated into the process.

W-Words to describe the pain

Pain assessment usually begins with an open-ended inquiry: “Tell me about your pain.” This allows the patient to tell his or her story, including the aspects of the pain experience that are most problematic. It is imperative that the clinician listens closely to the patient’s words to describe their pain. It has been said that upwards of 90% of a diagnosis is derived from the patient’s history.

A patient's statement, “I have pain,” is not descriptive enough to inform a health care professional about pain type. Asking patients to describe their pain using words will guide clinicians to the appropriate interventions for specific pain types. Patients may have more than one type of pain. The following questions should be asked of patients:

What does your pain feel like?
Because various pain types are described using different words, what words would you use to describe the pain you are having?

Neuropathic pain. This type of pain can be described as burning, shooting, tingling, radiating, lancinating, or numbness. Sometimes patients say that their pain is like a fire or an electrical jolt. This type of pain can be due to nerve disorders; nerve involvement by a tumor pressing on cervical, brachial, or lumbosacral plexi; postherpetic neuralgia; or peripheral neuropathies secondary to treatment (chemotherapy, radiation fibrosis).

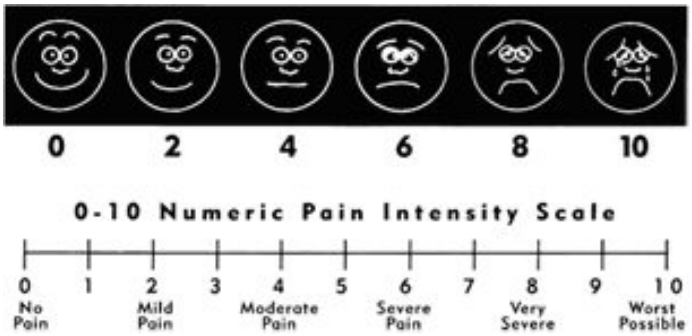
Somatic pain. Described as achy, throbbing, or dull, somatic pain is typically well localized. Somatic pain accompanies arthritis, bone or spine metastases, low back pain, and orthopedic procedures.

Visceral pain. Pain described as squeezing, pressure, cramping, distention, dull, deep, and stretching is visceral in origin. Visceral pain is manifested in patients after abdominal or thoracic surgery. It also occurs secondary to liver metastases or bowel or venous obstruction.

I- Intensity of the pain

The ability to quantify the intensity of pain is essential when caring for persons with acute and chronic pain. Though no scale is suitable for all patients, Many physicians use a 0 to 10 scale for clinical assessment of pain intensity in adult patients. Standardization may promote collaboration and consistency among caregivers in multiple settings—inpatient, outpatient, and home care environments. Using a pain scale with 0 being no pain and 10 being the worst pain imaginable, a numerical value can be assigned to the patient's perceived intensity of pain. Asking patients to rate their present pain, their pain after an intervention, and their pain over the past 24 hours will enable health care providers to see if the pain is worsening or improving. Also, inquiring about the pain level acceptable to the patient will help clinicians understand the patient's goal of therapy.

The Wong/Baker Faces Rating Scale is a visual representation of the numerical scale. Although the faces scale was developed for use in pediatric patients, it has also proven useful with elderly patients and patients with language barriers. Patients will be asked to rate their pain on a scale of zero - 10, where zero = no pain, 5 = moderate pain and 10 = the worst pain possible. Other patients, such as young children, those who do not speak English and those who are cognitively impaired may use the "faces" scale to describe their level of pain.



Verbal Description Scale	0 No pain	1,2 Mild pain	3,4 Moderate pain	5,6 Moderate pain	7,8 Severe Pain	9,10 Worst Possible
Wong-Baker Facial Grimace Scale	 Alert, smiling	 No humor, serious, flat	 Furrowed brow, pursed lips, breath holding	 Wrinkled nose, rapid breathing	 Slow blink, open mouth	 Eyes closed, moaning, crying
Activity Tolerance Scale	No pain	Pain can be ignored	Interferes with tasks	Interferes with concentration	Interferes with basic needs	Bed rest required

L- Location of the pain

Most patients have two or more sites of pain. Therefore, it is important to ask patients, “Where is your pain?” or “Do you have pain in more than one area?” Having the patient point to the painful area can be more specific and help to determine interventions.

Localization is not always accurate in defining the problematic area. Some pain sensations may be diffuse or referred. Referred pain, usually happening in visceral disease, occurs when sensory fibers from the viscera enter the same segment of the spinal cord as somatic nerves i.e. those from superficial tissues. The sensory nerve from the viscus stimulates the closely associated nerve in the spinal cord and the pain perceived at the sensorial area of the brain is perceived as originating in the area supplied by the somatic nerve. An example is the left shoulder pain associated with heart damage.[1]

D- Duration of the pain

The duration of a patient’s complaints of pain is often clinically significant. For example, fleeting or short duration of pain is rarely serious. Conversely, pain over a long duration of time can negatively impact a patient’s functional status thereby perpetuating the pain.

A- Aggravating/Alleviating Factors

Asking the patient to describe the factors that aggravate or alleviate the pain will help plan interventions. A typical question might be, “What makes the pain better or worse?” Other factors (movement, physical therapy,

activity, intravenous sticks or blood draws, mental anguish, depression, sadness, bad news) may intensify the pain.

Other things to include in the pain assessment are the presence of contributing symptoms or side effects associated with pain and its treatment. These include nausea, vomiting, constipation, sleepiness, confusion, urinary retention, and weakness. Inquiring about the presence or absence of changes in appetite, activity, relationships, sexual functioning, irritability, sleep, anxiety, anger, and ability to concentrate will help the clinician understand the pain experience in each individual.

Qualifying Pain Utilizing the PQRST Method

P = provocation / palliation : What were you doing when the pain started? What caused it? What makes it better? worse? What seems to trigger it? Does it seem to be getting better, or getting worse, or does it remain the same? What relieves it? What makes the problem worse?

Q = quality / quantity : What does it feel like? Is it sharp? Dull? Stabbing? Burning? Throbbing?

R = region / radiation : Where is the pain located? Does the pain radiate? Where does it radiate?

S = severity scale : How severe is the pain on a scale of 0 - 10, zero being no pain at all and 10 being the worst pain ever? Does it interfere with activities? How bad is it when it's at its worst? Does it force you to sit down, lie down? How long does an episode last?

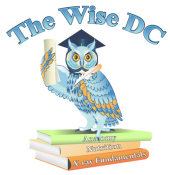
T = timing : When did the pain start? How long did it last? How often does it occur? Is it sudden or gradual? What were you doing when you first experienced or noticed it? How often do you experience it: hourly? daily? weekly? monthly? When do you usually experience it: daytime? night? in the early morning? Are you ever awakened by it? Does it lead to anything else? Is it accompanied by other signs and symptoms? Does it ever occur before, during or after meals? Does it occur seasonally?

Mc Gill Pain Questionnaire

The **McGill Pain Questionnaire**, also known as McGill pain index, is a scale of rating pain developed at McGill University by Melzack and Torgerson in 1971.

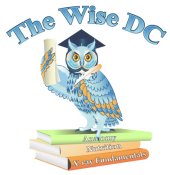
Instructions for use include the following:

1. Circle the words that describe your pain but do not circle more than one word in a group.
2. Then go back and circle the three words in groups 1-10 that most convey your pain response.
3. Pick the two words in groups 11-15 that do the same thing. Then pick one word in group 16. Finally, pick 1 word in groups 17-20.
4. At the end you should have seven words that you can take to your doctor that will help describe both the quality of your pain and the intensity of it.



Sample Questionnaire

Group	Words
1	Flickering, Pulsing, Quivering, Throbbing, Beating, Pounding
2	Jumping, Flashing, Shooting
3	Pricking, Boring, Drilling, Stabbing
4	Sharp, Cutting, Lacerating
5	Pinching, Pressing, Gnawing, Cramping, Crushing
6	Tugging, Pulling, Wrenching
7	Hot, Burning, Scalding, Searing
8	Tingling, Itchy, Smarting, Stinging
9	Dull, Sore, Hurting, Aching, Heavy
10	Tender, Taut (tight), Rasping, Splitting
11	Tiring, Exhausting
12	Sickening, Suffocating
13	Fearful, Frightful, Terrifying
14	Punishing, Grueling, Cruel, Vicious, Killing
15	Wretched, Blinding
16	Annoying, Troublesome, Miserable, Intense, Unbearable
17	Spreading, Radiating, Penetrating, Piercing
18	Tight, Numb, Squeezing, Drawing, Tearing
19	Cool, Cold, Freezing
20	Nagging, Nauseating, Agonizing, Dreadful, Torturing



[1] Ann Waugh, Allison Grant (2001). *Anatomy and Physiology in Health and Illness*. Edinburgh: Churchill Livingstone, pp 174-175.