

Introduction

Inadequate pain assessment has been identified as the greatest barrier to effective pain management (Von Roenn JH, Cleeland CS, Gonin R, et al. Ann Intern Med, 1993) therefore; enough cannot be said about the importance of excellent, ongoing assessment. A thorough assessment of the patient, the environment they are living in, and the actual pain or suffering they are experiencing must be done at the start of care and should not end until discharge or death.

Guidelines for the Initial Pain Assessment

Before beginning an initial pain assessment, acknowledge the patient's perception of pain and offer assurance that measures to reduce or control pain will be promptly and thoroughly addressed. Patients must believe the healthcare provider cares in order for trust to be facilitated. Ensure the patient that they are at all times in control, and that their own assessment of pain will be respected and utilized in creating the plan of care.

A physical assessment should be performed when possible in order to assist in identifying reversible causes of pain (e.g., constipation).

The physical assessment should at a minimum include:

- General appearance (amount of physical distress, functional level, body composition)
- Abdomen - assess for distention, ascites
- Edema - location, severity
- Skin - note any alterations in skin integrity, color and turgor
- Functionality - physical (ability to ambulate or not) and cognitive (mini-mental score)
- Nutritional status and hydration
- Affect

Basic Principles of Pain Assessment

- Reinforce patience and optimism, as pain is complex and may take several care plan alterations to obtain optimal control.
- Therapy should include both drug and non-drug therapies to prevent and/or control pain and needs to be tailored specifically to the patient and their goals.
- Realize that patients in severe pain often cannot tolerate a lengthy interview. Always use your best clinical judgment. If possible, weave the pain assessment throughout the patient visit. If necessary, shorten the interview; additional information can be obtained when the patient is feeling better.
- Always keep in mind that pain is subjective; therefore the patients self report should be the primary source of assessment.

- Don't expect patients to report pain unsolicited. Based on the barriers that are known to exist, it is likely that the majority of patients may not want to report pain unless asked.
- Neither behavior nor vital signs should be used in lieu of a self-report.
- Clinicians should understand and reassure patients that most pain can be relieved safely and effectively. However, not all pain or associated symptoms can be entirely eliminated.
- The simplest dosage schedules and least invasive pain management modalities should be used first.
- Medication on an “around the clock basis” is recommended for persistent, chronic pain with additional (breakthrough) doses available on an as needed basis.
- Prevent medication related side effects when needed. Most treatment related side effects resolve within 72hrs.
- Placebos should NEVER be used in the management of pain.
- Psychosocial interventions should be introduced early in the plan of care and used in conjunction with the appropriate medication regimen.
- Noninvasive treatments should precede invasive approaches.
- If new psychiatric symptoms occur in a patient with cancer, the possibility of uncontrolled pain as an etiology should be considered.
- When developing a pain treatment plan, clinicians should be aware of unique needs and circumstances of patients from various ethnic and cultural backgrounds.

Benefits of a Comprehensive Pain Assessment

- Establish relationship with patient
- Guide therapeutic regimen
- Improve pain management
- Maximize patient comfort and function
- Increase patient satisfaction with therapy

Components of a Comprehensive Pain Assessment

- Assessment of pain should be done regularly and systematically by appropriate trained person
- Pain should be reassessed with each visit or patient contact
- Clinicians must believe the patients report of pain
- Include the patient, family and caregivers in choosing the pain regime that is most acceptable to them, this will allow them control and they will be more likely to comply with the regime
- Interventions should be implemented as soon as possible to decrease or avoid increasing time patient must tolerate the pain

Assessment Tools

P-Q-R-S-T's of Assessment

- **P= Palliative / Provoking Factors**
 - What causes the pain? What makes it better? Worse?
- **Q= Quality of Pain**
 - What does the pain feel like? (e.g., sharp, burning, stabbing, dull)
- **R= Radiation of Pain**
 - Does the pain radiate to other areas? If so, where?
- **S= Severity of Pain**
 - How severe is the pain on a scale of 0-10? (other intensity scales can be used)
- **T= Temporal Factors / Timing**
 - When did the pain start? How long does it last?

(Budassi-Sheehy, Principals and Practice, 3rd ed, 1992)

Questions to Ask

Location/Site(s) - Where is your pain?

- If more than one site of pain, each needs to be assessed separately since mechanism may be different, requiring different treatment approaches.
- Which pain is the most severe or most bothersome? Address the most distressing pain complaint first. The effectiveness of any treatment or medication effectiveness and side effects is easier to assess when only one medication at a time is initiated.
- Ask patients to point to areas of pain on themselves, on you, or on a drawing. Localizing pain helps identify the etiology and type of pain. Remember, "pain you can point to" is usually somatic pain.

Temporal Pattern - When did your pain begin?

- Was there any event that may have precipitated the pain? (fall, increased activity)
- Has the pain changed over time? Intensified, improved? (changed from being a dull ache to a sharp one) Remind patients that changes in pain do not necessarily mean the illness is getting worse.
- How often does it occur? (all the time, at night)
- What things aggravate the pain? (movement, temperature, eating)
- Is there anything that makes it feel better, or hurt less? (changing position, lying still, after urination)
- Is the pain better or worse at certain times of the day? For instance pain that is worse in the morning may be musculoskeletal. Is there anything that relieves the pain? (heat, cold, position)

Pain Intensity/Quality - What words would you use to describe the pain?

For many patients, this is the most difficult piece of the assessment and can be very frustrating. Try not to "put words into their mouth." Use open ended questions. If the patient still has trouble, providing a list of descriptors such as the following may be useful:

- Constant, intermittent
- Dull, aching
- Throbbing
- Squeezing, cramping
- Stabbing, shooting
- Sharp, searing
- Tingling, electrical
- Burning, pins and needles

What does the pain feel like?

- Have you ever had pain like this before? If so, what was the cause? (e.g. dental extraction, sunburn, fracture)
- Have you ever had pain like this before? If so, what was the cause? (e.g. dental extraction, sunburn, fracture.)
- What would you have to do to me to make me feel the pain that you are having? (stab, pinch, punch, twist, squeeze, etc.)

How does pain affect your life?

- What effects does this pain have on your daily functions? (walking, eating, sleeping, riding in the car, turning over in bed, bathing, talking)
- What are your goals for daily function? (e.g. walking to the mailbox, showering, going to church, visiting with friends and family)
- What effect does this pain have on your mood, and on those around you?

How intense is the pain?

Using a Numeric Rating Scale (NRS) patients can be asked to report how much pain they are having by choosing a number from 0 (meaning no pain) to 10 (worst imaginable pain). The 0 to 10 NRS is the most commonly used of the rating scales, however in some cases a 0-5 scale is preferred.

If taking medication for pain, how well is it working?

- History of current and previous pain treatments – What if any medications or treatments for pain are you trying or have you tried in the past?
- If you are currently being treated with medicine or other treatments (include any over the counter medications, herbal treatments, alternative medicines). How is your current pain regimen working for you?
- How quickly does the medication take effect and how long does it last? For

example, does it work well for 2 hours, but wear off before the next dose is scheduled to be taken?

- Are you having any side effects? Most, if not all side effects can be managed.

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