Chronic Pain Assessment

Michael R. Clark, MD, MPH, MBA
Disclosures

- Nothing to Disclose
Learning Objectives

- Review the role of assessment in the management of chronic pain
- Describe components of a comprehensive chronic pain assessment
- Identify practical methods and tools available to facilitate the assessment process
Assessment of Acute and Chronic Pain May Not Be the Same

Today’s focus is on chronic pain assessment.
Brief Background

- Chronic pain
  - Has been variably defined as
    - Pain that typically lasts ≥ 3 months or past the time of normal tissue healing\(^1\)
  - Often undetermined onset\(^1\)
  - May have no obvious cause\(^2\)
  - Affects a substantial number of people in the United States\(^1\)
  - May or may not be associated with certain behaviors (e.g., irritability, insomnia, depression)\(^2\)

Significance of Assessment

- **FOUNDATION ~**
  - An underlying basis or principle for something
Assessment

The basis for **everything** that follows

- Diagnosis
- Goals and expectation of treatment
- Treatment plan formulation
- Follow-up
- Satisfaction
- Success?
Do We Know What a Patient is Feeling?

- No objective (practical) tests to measure pain
  - Quality
  - Intensity
  - Patients’ affective and behavioral reactions
- Pain is a subjective experience
Detective Work

The Columbo Tactic
Diagnosis is Mission Critical

- At least a differential diagnosis
- Location is a descriptor – not a diagnosis (e.g., back pain)
- Co-morbid diagnoses
Detailed Pain History

- Things to include:
  - Location
    - Primary sites
    - Secondary sites
      - It is not uncommon for chronic pain patients to have pain in multiple sites
      - Attempt to assign % to each site relative to the other
  - Quality
    - Descriptors
      - Tingling vs. burning
      - Aching vs. squeezing
Detailed Pain History

- Best approximations of:
  - When?
  - Description?
  - Location?
  - Duration?
  - Severity?
  - Impact?
  - Daily activities
  - Psychological
  - Social

Detailed Pain History

- **Provocation**
  - Exacerbating factors
  - Alleviating factors
  - Factors that don’t make pain worse or better

- **Prior steps taken before presenting**
  - Other clinician visits?
  - Activity modification
  - Medication use

Detailed Pain History

- **Onset**
- **Frequency**
  - Constant vs. intermittent
  - Timing of exacerbations
- **Patterning**
  - May vary
    - Morning pain
    - Mounting pain during the course of the day
Prior Treatments

- Healthcare providers
  - Who, what, when, and how?

- Interventions
  - Pharmacologic
  - Non-pharmacologic
  - Procedural
Function

- The single most important component of the foundation of pain assessment
Physical Limitations

- Ability to:
  - Walk
  - Perform domestic chores
  - Continue to work
  - Participate in hobbies
Goals and Expectations

- May be unrealistic
- Higher for acute pain than chronic pain
- Urgency of treatment and expectations may be based on inaccurate premises
  - e.g., ongoing damage, return of cancer, etc.
- Patient education is important
- Setting appropriate expectations can be therapeutic
Physical Examination

- General examination
  - Including “non-tangibles”
    - Skin
    - Posture
    - Demeanor

- Focused pain examination
  - Pain site(s)
  - Neurologic
  - Musculoskeletal
  - Mental
Probing for Pain Responses

- Sensory deficits
- Allodynia
  - Painful response to a stimulus that is not normally painful
    - e.g., light touch, pressure, hot or cold stimuli
- Hyperalgesia
  - Extreme pain from stimuli that normally do cause pain
    - e.g., pinpricks
Diagnostic Testing

- Imaging\(^1\)
  - When warranted
  - Watch for false-positives

- Neurophysiology studies\(^1\)
  - May be useful for entrapment, radiculopathy, etc.
  - *Not* often useful for neuropathic conditions as they measure large nerve fibers\(^2\)

Tools for Measuring Pain Intensity

- Unidimensional Scales
  - Visual Analog Scale (VAS)
  - Numerical Rating Scale (NRS)

**VAS vs. NRS?**

- Some investigators prefer the VAS because of certain theoretical psychometric advantages

- Others prefer the NRS:
  - Fewer patients fail to understand it
  - Easier to score
  - For practical purposes, the psychometric properties work well
Tools for Measuring Pain Intensity

- **Categorical Scales**
  - Simple Descriptive Pain Intensity Scale
  - FACES Pain Scale

Multidimensional Tools

- Initial Pain Assessment Tool
  - Body diagram
  - Detailed pain questionnaire
    - Rating, quality, onset, variations, etc.
    - Ability to concentrate
    - Emotional state
    - Appetite

Multidimensional Tools

- Brief Pain Inventory
  - Helps to quantify pain intensity and interference with a patient’s life
  - Includes:
    - Worst, least, and average pain in past week and “right now”
    - Body diagram
    - Rating of pain relief from current Tx (if any)
    - Rating of duration of pain relief after medication (if any)
    - Patient’s attribution of pain to disease or other conditions
    - Pain interference (work, activity, mood, enjoyment, sleep, walking, relationships)

Multidimensional Tools

- McGill Pain Questionnaire
  - Extensively used
    - Contains intensity scale
    - Three major classes of descriptors:
      - Sensory
      - Affective
      - Evaluative
    - Designed to provide quantitative measures of pain that can then be treated statistically

Multidimensional Tools

- **Memorial Pain Assessment Card**
  - Developed for cancer patients
  - Quick and easy
  - Convenient

Psychosocial Evaluation

- Pain affects us in many ways psychologically and socially
  - Simple probing can be effective
    - "How is the pain affecting your life"
    - Presence or absence of:
      - Anger, grief, depression, anhedonia (lack of pleasure), anergia (lack of energy), anxiety
      - Negative emotions
        » Circumstances
        » Inability to cope
        » Concerns about work, disability, insurance coverage, etc.

Possible Psychological Warning Signs

- Suicidal ideation
- Anergia
- Anhedonia
- Anorexia
- Insomnia
- Lack of acceptance
- Angered outbursts
A Word About a Word

Catastrophizing

- A cognitive and emotional process that involves magnification of pain-related stimuli, feelings of helplessness, and a negative orientation to pain and life circumstances

- Should not be underestimated
  - Higher incidence with depression, interpersonal distress, suicide, etc.

- Generally involves statements similar to:
  - “I can’t handle this pain” or “My pain is uncontrollable”

Common Pre-Cognitions

- **Persistent pain = tissue damage**
  - This belief results in fear of movement, physical activity, and the future
  - It may be necessary to educate the patient that pain ≠ harm, and that appropriate physical activity is important

Common Pre-Cognitions

- Belief that if a cause of pain is found, a treatment will eradicate it
  - Patients are generally socialized to believe that medicine has a cure for their problems
  - Many believe that once a cause of the pain can be found, a treatment that results in a cure is likely (e.g., removing a problematic disk always resolves pain)
  - For many, accepting that chronic pain can be managed but not necessarily cured is a gradual process

Common Pre-Cognitions

- **Pain means “STOP”**
  - Some patients believe that pain means that they should rest and be totally inactive
  - Social activities may be curtailed or stopped because they feel pain
  - Factors significantly into treatment plan formulation

Coping Skills

- Constructive coping styles have been shown to be more effective ways to manage chronic pain\(^1\) than passive coping strategies (e.g., resting)

- Probe for things like\(^2\):
  - “What do you tell yourself when you are having a pain flare-up?”
  - “What do you do when you are having a pain flare-up?”
  - Increases in drug, tobacco, and alcohol use, or taking more medication than is prescribed

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Observing for Behavioral Reactions

- Can be adaptive or maladaptive
- May be verbal and/or non-verbal
  - Grimacing
  - Rubbing affected area
  - Guarding
  - Sighing
  - Groaning
  - Self-medicating
  - Over-resting
Assessment of Family Functioning

- Affected when one person is unable to function as the “system” expects\(^1\)
- Types of familial responses\(^2\) may be:
  - Solicitous – providing assistance or special attention
  - Punishing – become angry/frustrated when pain is expressed
  - Distracting – encourage involvement in distraction techniques

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Assessment of Social/Occupational Function

- Loss of ability to work and/or to socially interact often causes
  - Stress
  - Feelings of loss of purpose
  - Loss of $$$
  - Adversarial feelings (worker’s compensation, disability, etc.)
  - Need to prove that pain is real
Psychiatric Disorders and Pain

- Pain doesn’t ignore people with psychiatric/psychological disorders
  - 43% of patients with non-disabling pain and depression in primary care
  - 66% of patients with disabling pain and depression in primary care

# Summary of Psychosocial Assessment

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<th>Psychosocial Aspects of Pain</th>
<th>Clinical Questions to Ask</th>
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<td><strong>Global Question</strong></td>
<td>How is pain affecting your life?</td>
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<tr>
<td><strong>Emotional Reactions</strong></td>
<td>What is your mood generally like?</td>
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<tr>
<td><strong>Suicidal Thoughts</strong></td>
<td>Do you ever feel like giving up?</td>
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<tr>
<td></td>
<td>Do you have suicidal thoughts?</td>
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<td><strong>Cognitions, Coping, Beliefs about Pain</strong></td>
<td>How you cope with the pain?</td>
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<td><strong>Behavioral Reactions</strong></td>
<td>What do you do when you have a flare-up of pain?</td>
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<td><strong>Family Functioning</strong></td>
<td>How do family members/support people respond when you have pain?</td>
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<tr>
<td><strong>Social and Occupational Functioning</strong></td>
<td>How are work/social activities going?</td>
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Things Not Mentioned

- But important to consider...
  - Need for fluidity in treatment planning/modification
  - Opioids – Yes? No? Maybe?
  - Aberrant drug-related behaviors
    - Personal Hx
    - Family Hx
  - All things dynamic – all things
Is Once Enough?

- **NO**
- Chronic pain should be initially assessed and re-assessed on a scheduled and regular basis

Questions?