

"My Pain is a '20' on a 10 Point Scale."

SCOPE of Pain *Colleague to Colleague* Audio Short: #1

Welcome back to the SCOPE of Pain podcast series. This is Dr. Daniel Alford, Professor of Medicine and Course Director for the Boston University School of Medicine SCOPE of Pain Program.

When assessing a new patient's chronic pain from bilateral knee osteoarthritis, he states his pain is a 20 on a 0 – 10 pain scale. That's 0 is no pain, 10 is the most severe pain. So why is this patient reporting pain above the 10 point scale and how will you respond?

The first step is to try to understand why he feels the need to impress you with how severe his pain and suffering is. It may suggest a problem with trust, that is, he feels that the severity of his pain will not be believed or aggressively treated unless he tells you his pain is off the chart. Patients with chronic pain may lack trust due to having previously experienced negative attitudes and disparities in pain care. We need to be empathic for the patient's pain complaints and build trust so the patient understands that we fully assess their pain and help them manage their pain to the best of our ability.

As opposed to acute pain which is a time-limited, life sustaining symptom, chronic pain is a multi-dimensional problem that acts much more like a chronic disease. And it can be associated with long-term suffering and disability and therefore we want to know more, more than just the level of pain but also how his pain is adversely affecting his function and quality of life.

The experience of chronic pain is influenced by many factors beyond the pain signaling pathways. The experience can be influenced by fear, mistrust, previous painful experiences, and cultural beliefs. Complicating the experience of pain are common psychiatric comorbidities in patients with chronic pain. Which includes depression, anxiety, substance abuse disorders, and post-traumatic stress disorder.

The psychiatric comorbidities can make chronic pain more severe and harder to treat and chronic pain can make these psychiatric comorbidities more severe and harder to treat as well. So it behooves us to assess for these comorbidities and treat them concurrently when possible.

Because there is no objective way to determine the severity of a patient's pain complaint, I recommend believing the patient's self-report a 100% of the time. As I believe there is 0% risk in doing so. There is 0% risk because believing the patient's pain complaint does not mean that opioids are indicated or appropriate or safe for a specific patient's chronic pain. This is where your clinical judgement using a risk benefit framework comes in.

How to use brief validated assessment tools to efficiently assess pain, function, and quality of life and to assess for psychiatric comorbidities are addressed in detail in the SCOPE of Pain Program. You're not alone in facing these challenging issues.

Thanks for listening.

Be sure to check back often, as new Audio Shorts will be added throughout the year.

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