UCL SCHOOL OF PHARMACY

Talking About Pain

Interpreting pharmacy users' responses to the eight 'LESS PAIN' questions

Persistent pain is a long-term, damaging condition which harms patients, their families and the wider society. There are at any one time in this country in the order of one million people with pain related problems that could have been prevented or be being better treated – too high a number for any one health care provider group to handle alone. Millions more people have to cope with pain related problems on a daily basis.

Pharmacy based services could – in part through the extended use of pain assessment instruments – in future help to identify more patients who are in the early stages of developing a persistent pain condition. They might also facilitate access to other pain related services, including effective psychological care.

This brief summary is intended for use in conjunction with the evidence and links to pain assessment and allied instruments in the UCL School of Pharmacy/UKCPA report ***Relieving Persistent Pain, Improving Health Outcomes*** (http://www.pharmacy.ac.uk/fileadmin/documents/News/persistant). The table below is intended to facilitate the interpretation of responses to the eight 'LESS PAIN' questions suggested in the ***Talking About Pain*** patient communication leaflet.

Question	Reason for question/possible interpretation of response
1 *Can you describe the pain you have, and say how long it has been troubling you?*	An opening question intended to initiate dialogue. The responses given should be explored with prompting later. At first, seek information via supportive non-directive comment and if needed further open ended questioning (eg ***can you** say more about what you mean by that?)* As a rule of thumb, pain that has a duration of more than 3 months could be a chronic/persistent problem, although in some circumstances pain of shorter duration is indicative of a risk of developing chronicity.
2 *Is this pain linked to any particular event or illness, or has it come 'out of the blue'?*	Establish relevant history that the pharmacy customer/patient is aware of. As appropriate, prompt on past record of migraine/headache, shingles, arthritic disorders including episodes of back pain, diabetes and past experience of surgery and diagnoses/events such as stroke or a previous diagnosis of cancer. Without causing needless alarm (many people with pain fear cancer) refer to GP if judged necessary.
3 *How much pain are you in? If we thought of a scale in which zero was no pain and 10 was the worst pain imaginable, where would you place your pain?*	Asking this provides further opportunity for establishing rapid rapport. Again as a rule of thumb, pain that is scored 8 and above can be considered severe and may warrant emergency intervention. Pain of moderate intensity (4-7) should be regarded as requiring immediate intervention, while unexplained persistent pain of any severity demands attention.

4 *Can you describe exactly how it feels and where it is – is it, for example, a stabbing pain in a specific place or would you say it is a more generalised sort of pain?*	A sharp, hot, stinging pain which is well localised and associated with local and surrounding tenderness is most probably a somatic nociceptive (inflammatory) pain. A dull cramping pain that is poorly localised may be a visceral nociceptive pain. Use of words like burning, shooting or stabbing along with an increase in sensitivity to painful and non-painful stimuli could be indicative of a neuropathic pain problem. Prompt as required. Changes in tissue colour, temperature and sweating suggest over-activity of the sympathetic nervous system and may also point towards a neuropathic component to the pain. If the pharmacist suspects neuropathic or functional pain he or she might at any point offer a formal pain assessment.
5 *How have you tried to relieve it? Are you using medicines of any sort (prescribed, or that you have bought) and have you talked about your pain with your GP or any other health professional?*	Establishing medication history and current use is good pharmaceutical care practice. If neuropathic pain is present an NSAID is unlikely to be effective. Guidance may be needed re effective and undesirable use of all 'minor' analgesics. Opioid users may also benefit from support with regard to maximising relief by supporting adherence to planned medication regimens and through minimising unwanted side effects via, for example, timely laxative use.
6 *Is your pain stopping your normal activities, or perhaps even making you feel life is unbearable? For example, is it interfering with your sleep or your social life?*	Areas to evaluate range from the possibility that depressive illness is affecting the respondent's pain experience to that of normal physical activity being unduly curtailed because of a false belief that a neuropathic or functional pain is indicative of a continued risk of tissue damage. Indications that patients are at risk of self harm because of pain may require emergency supervised referral.
7 *Psychological treatments such as Cognitive Behavioural Therapy or alternatives such as meditation can be effective in changing pain thresholds. Are there any non-pharmaceutical treatments you wish to talk about or try?*	The logic of adjuvant therapy and/or psychological or other non-drug interventions should be explained in an accessible manner to all chronic pain patients. Some may be worried by being given medicines such as anticonvulsants without an adequate explanation of the therapeutic rationale. Others may benefit from signposting to locally available non-pharmacy services. It may be helpful to communicate that modern pharmacy practice is based on an informed awareness of both the benefits and the limitations of medicines use, and that in areas such as persistent pain management drugs alone rarely if ever provide a fully satisfactory solution.
8 *Is there anything else concerning you about your pain – anything you feel is important but may not be easy to talk about?*	Some people living with pain may be inhibited because of previous negative experiences in consulting with other health professionals, or because they are worried that their symptoms are an indication of cancer or another unwanted diagnosis. Pharmacists should be able to alleviate such fears while eliciting additional information and facilitating appropriate action whenever required. Fear of or actual addiction to opioid or other analgesics may also fall into the 'not easily discussed' category.

The ***Talking About Pain*** communication guide for Community Pharmacy users was written by James Davies, Dr Jennifer Gill, Dr Roger Knaggs and Professor David Taylor

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