

# The ABC's of PAIN

James Patrick Murphy, M.D. February 8, 2005

Who can make it through a bowl of alphabet soup without finding at least a few delicious words to savor? Likewise, when digesting knowledge, mental appetizers can prepare the mind's palate for the main course. Staunch academicians may frown upon the use of simplistic memory aids, but clinicians have always loved mnemonics. There is universal acceptance of the **ABC's** (Airway, Breathing, Circulation) of **BLS** (Basic Life Support). We throw **RICE** at a sprain (Rest, Ice, Compression, Elevation). Charting would be filthy without **SOAP** notes (Subjective, Objective, Assessment, Plan). Collections of letters such as these dot every specialty. Over the past ten years, Pain Medicine has come into its own as a true medical specialty worthy of its own acronyms. The following are eight such memory aids, which are particularly valuable for anyone who treats chronic pain.

## *The Four A's*

The assessment and documentation of pain care throughout the course of treatment is essential, especially if the patient is on opioid therapy. Institutions such as the Federation of State Medical Boards and the Joint Commission on the Accreditation of Healthcare Organizations, emphasize in their guidelines the need for documentation. The four A's of pain documentation address areas of universal concern and standardize the medical record. Similar to a SOAP note format, one might consider writing each "A" on a separate line in the

progress note. Addressing each of **the four A's** at reasonable intervals helps assure documentation reflects an appropriate level of assessment (ref 1).

**AAAA** – for documentation at clinical visits.

**Analgesia**      What is the patient's degree of pain?

**Activity**        What is the level of function? What goals have been met?

**Adverse**        Are there any adverse side effects of the medications?

**Aberrancy**     Are there any behaviors that suggest addiction, diversion, abuse, or depression?

### ***The Four P's***

It is important to prescribe medications in a logical manner consistent with accepted practice. It is also important to prescribe within the confines of one's comfort zone. A clinician's comfort zone is unique and is based upon such factors as:

Familiarity with medications

Depth of knowledge concerning chronic pain and addiction

Understanding of practice parameters and guidelines

Community norms

Socioeconomic factors

Ability to adequately monitor for efficacy, side effects, and aberrancy

When a patient requests or seems to need more medications – especially when the regimen is pushing the limits of the comfort zone – consider **the four P's**. Generally, somewhere within these four categories lies the reason(s) the prescribed medications have been reported to be inadequate.

**PPPP** – the differential diagnosis when the medications have been reported to be inadequate.

**Pathological**            Has the painful condition worsened? Is there a new disease to consider? Are the medications not suited to the type of pain (e.g. opioid resistant / neuropathic pain)?

**Pharmaceutical**        Is the dose too low? Has tolerance developed? Are the medications contributing to the pain (side-effects, drug interactions, toxicities)?

**Psychological**            Is there depression, anxiety, addiction and / or pseudoaddiction?

**Police**                      Are the drugs being unlawfully diverted?

## ***PQRST***

One cannot know too much about one's patient. Accurate diagnosis depends upon a comprehensive history and detailed physical examination. The chief complaint, history of the present illness, past medical history, systems review, family history, social history, and occupational history require exploration, the degree to which depends upon the complexity of the case (ref 2). Gathering information in an orderly and routine manner allows one to catalogue pertinent aspects of the pain complaint quickly and comprehensively.

**PQRST** – for evaluation of the patient with pain.

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|-----------------|--|
| <b>Pain</b>     | Where is the pain? Head? Chest? Muscle? Bones? Viscera?  |
| <b>Quality</b>  | What is the quality, character, and intensity of the pain? Sharp? Dull?<br>Burning? Lancing? Shock-like? |
| <b>Resolves</b> | What actions or treatments make the pain better? What makes it worse?                                    |
| <b>Symptoms</b> | Any associated symptoms? Weakness? Numbness? Bowel/bladder<br>dysfunction? Nausea? Ataxia? Fever?        |

**Timing**            All temporal aspects of the pain – When did it start? How long does it last?  
How often? What time of day is the pain least / most?

### ***VINDICATE***

Chronic pain can become a disease in and of itself, and almost always it is a co-morbid condition. It behooves the clinician to seek the cause for the pain. When the underlying pathological process is properly treated, often the need for ongoing pain management is greatly diminished. One tool for assessing the etiology of a painful condition is to VINDICATE the diagnosis (ref 3).

**VINDICATE** -- to help determine the etiology of a painful condition.

**Virus**                    Any infectious process, including viral, bacterial, or fungal.

**Inflammation**        Vasculopathies, neuropathies, and arthropathies.

**Neoplasm**              Tumors, metastases, and cancer related conditions.

**Degenerative**        Connective tissue pathology, spinal and bone disorders.

<b>Ischemia</b>	Ischemia and hypoxemia can create neural hyperexcitability and claudication.
<b>Congenital</b>	Inborn errors of metabolism and genetic diseases may result in aberrant pain and sensory processing.
<b>Autoimmune</b>	Antigen/antibody reactions, host-response cellular changes, protein metabolism abnormalities and related co-morbidities.
<b>Trauma</b>	Painful tissue destruction and toxic neuropathies from substance abuse and chemical exposure.
<b>Endocrine</b>	Endocrine and metabolic changes due to abnormal hormone levels, glucose metabolism, and electrolyte variations.

### ***The CAGE Questionnaire***

Addiction is a potential complication that may develop in any patient receiving controlled substances. Identifying patients at risk for addiction is critical to success. There is no “gold standard” screening test for addiction, but certain tools are quite useful. **The**

**CAGE Questionnaire** consists of four simple questions (ref 4). It is recommended the questions be asked as part of the baseline *initial* patient history. The questions should be asked with respect to the entire life of the patient as opposed to the recent past. Any inquiry about the *amount* of alcohol or drugs consumed should come after the initial four CAGE questions are answered.

**CAGE** – a screening tool for alcoholism and drug addiction / abuse.

**Cut down** Have you ever felt you should **cut down** on your drinking (or drug use)?

**Annoyed** Have people **annoyed** you by criticizing your drinking (or drug use)?

**Guilty** Have you ever felt bad or **guilty** about your drinking (or drug use)?

**Eye opener** Have you ever had a drink (or drug) first thing in the morning (**eye opener**) to steady your nerves or get rid of a hangover?

An affirmative response to any of the four CAGE questions is not specific for addiction or abuse but does indicate further investigation may be warranted. Two or more affirmative responses greatly increase the sensitivity and specificity of this validated screening tool.

## ***SMART Goals***

Improving quality of life is the cornerstone of Pain Medicine, but quantifying levels of improvement can be difficult, especially in circumstances where the most realistic outcome is to merely slow the rate of decline. Still, monitoring progress is important when trying to determine (and demonstrate to reviewers, regulators, and third-party payers) the success of a therapeutic regimen. Achieving goals is very self-affirming for patients. However, goal setting can be difficult. Many patients set goals that are unrealistic, vague, and counterproductive. The key is to set goals that are **SMART** (ref 5).

**SMART** – characteristics of goals for chronic pain patients.

**Specific**      One must be able to determine exactly what the goal is, how to achieve it, and when.

**Measurable**    One must be able to mark progress and completion of a goal.

**Attainable**    One's goal should be within reasonable reach.

**Realistic**      The goal should be within one's capabilities.

**Trackable**     One should be able to note progress and achievements along the way.

### *The Four D s*

Fear of disciplinary and legal action can have a chilling effect upon a physician's desire to provide chronic pain care. This fear may be overstated but nevertheless remains prevalent. At a 1980 White House Conference on Prescription Drug Abuse -- later adopted in a report of the American Medical Association-- it was suggested that physicians who find themselves in hot water with regulators usually fall into one of four categories known as **The Four D's** (ref 6). A clinician's self-realization regarding these four categories is a major first step toward a more secure and less fearful position.

**DDDD** – describes the categories (traits) of physicians who are often at odds with regulators.

**Dated**            Physicians who are not familiar with current trends and practice guidelines.

**Duped**            Physicians easily manipulated by addicts- because of their own gullibility or desire to believe the patient, because they are not comfortable confronting patients, or because they are blinded by pride. Any physician occasionally can be manipulated or taken in by an addict's story. However, the duped physician has a recurring pattern of acquiescing to demands of patients and prescribing drugs in excessive amounts or for longer than

necessary, thus becoming too often and too easily fooled by abusers and diverters of drugs.

**Disabled** Physicians whose judgment is impaired by their own illness, or alcohol / drug abuse. Providers with unrecognized and / or active substance dependence not in remission.

**Dishonest** Physicians who willfully prescribe controlled drugs for other than medical purposes—drugs they know will be abused. Such physicians are not practicing good faith medicine, but are using their medical licenses as a franchise to deal drugs.

It is important that legal and regulatory agencies distinguish between providers who are knowingly complicit in diversion or other illegal prescribing activities and providers who inappropriately prescribe due to misunderstandings or lack of training regarding addiction or pain (ref 7). The physicians in the first three categories (**Dated**, **Duped**, **Disabled**) are making a good faith effort to practice sound medicine, but their execution is flawed. They generally respond well to remedial and rehabilitative interventions. Dated and duped physicians, for example, are appropriate candidates for education and training to improve their practice procedures and skills, while disabled physicians often recover under the supervision of a physician health and effectiveness program. The **Dishonest** physician should, however, be prosecuted to the full extent of the law.

A fifth **D** has been proposed: **Defiant** – Physicians who are arrogant and uncooperative when dealing with investigators and regulators (ref 8). An “us versus them” mentality does not serve anyone’s interest and usually leads to a bad outcome for the physician under scrutiny. When it comes to the legal arena, the physician is never the “home team.”

### ***COMPLIANCE***

Anyone who prescribes controlled substances for chronic pain understands the attention this practice attracts from regulatory agencies. Over the past ten years “overprescribing” has been the number one reason disciplinary action has been taken against physicians (ref: 9). Available documentation is the primary source of evidence reviewing experts consider when investigating allegations of prescribing irregularities. Lack of adequate documentation may be the main reason physicians are unable to defend themselves. The Federation of State Medical Boards of the United States (FSMB) published a model policy that many states have or are in the process of adopting (ref: 10). The FSMB model policy is as close to a national standard of care as is currently available. The FSMB guideline identifies seven important elements for inclusion in a physician’s treatment of pain:

1. Evaluation of the patient
2. Treatment plan
3. Informed consent and agreement for treatment
4. Periodic review

5. Consultation
6. Medical records
7. Compliance with controlled substances laws and regulations

Because one can never be certain which patient will abuse medications, adopting a “universal precautions” approach has been recommended (ref 11). Much in the same way applying universal precautions has diminished the spread of infectious diseases, it is likewise reasonable to employ a standard approach with each pain patient, encompassing the following ten components:

1. A diagnosis with appropriate differential
2. Psychologic assessment, including risk of addiction
3. Informed consent
4. Treatment agreement
5. Pre/postintervention assessment of pain level and function
6. Appropriate trial of opioid therapy, with or without adjunctive medication
7. Reassessment of pain score and level of function
8. Regular assessment the *FOUR A's* of pain medicine
9. Periodical review of pain diagnoses and co morbid conditions, including addictive disorders
10. Clear documentation

The **COMPLIANCE** mnemonic gleans salient elements from these and other guidelines. It summarizes documentation reviewers are likely to deem necessary, especially if the treatment involves controlled substances. As often as practical, a physician might use this aid to determine if there is enough chart documentation to justify the chosen therapeutic regimen.

**COMPLIANCE** – a summary of the documentation reviewing experts may find requisite.

**Compliance** Compliance is monitored with findings leading to appropriate actions (e.g. drug screens, pill counts, family conferences, prescription monitoring programs).

**Often assessed** The patient is seen often enough to assess analgesia level, activity level, adverse reactions and aberrant behavior (e.g. “the Four A’s”).

**Medical records** Records are accurate, legible, complete, and accessible.

**Plan** Plan of treatment has objectives and goals to determine functional status.

**Legitimate** Legitimate diagnosis of a recognized chronic painful condition.

**Informed Consent** Informed consent (*Treatment Agreement* is optional).

<b>Addiction</b>	Addiction risk assessment (e.g. CAGE questionnaire, past and current use, family history, psychological and social issues).
<b>Non-addicting</b>	Non-addicting medications have proven inadequate or unacceptable (either through clinical trial or review of medical history).
<b>Consultation</b>	Consultation(s) have been obtained when necessary and other health care concerns are addressed.
<b>Evaluation</b>	Evaluation is thorough (history and physical) reflecting the complexity of the case.

As in any field of study, the body of knowledge grows with each passing day. Nowhere is this more evident than in Pain Medicine, where the expanse of information has been likened to the computer chip industry of the 1990s – every year the technology is capable of doing more (ref 12). Any clinician would like to master the entire fund of knowledge in his or her specialty. Along the path towards this lofty end one passes through four phases:

1. Unconsciously incompetent      You don't know what you don't know.
2. Consciously incompetent      You know that there is more to learn.

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|----------------------------|---|
| 3. Consciously competent   | You are able to perform the task, but you have to think about it. |
| 4. Unconsciously competent | You can perform without having to stop and think about it.        |

Memory aids such as those presented in this paper are perhaps most pertinent to the clinician in phases 2 and 3, while the unconsciously competent specialist (phase 4), who practices pain management every day, should hopefully glean a sense of validation. While clearly not comprehensive, these memory aids are practical, useful, and reassuring.

One final caveat... always remember that in the medical alphabet **A**, **B**, and **C**, (airway, breathing, circulation) always comes before **P** (pain). Enjoy the soup.

(Suggested bio...)

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