Pain Assessment

Use of the Defense and Veterans Pain Rating Scale in patients with cancer

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BACKGROUND: Thorough, consistent pain assessment and reassessment are critical to guide and evaluate interventions designed to improve pain.

OBJECTIVES: Based on a literature review about functional pain assessment, clinicians selected and then implemented the Defense and Veterans Pain Rating Scale (DVPRS) as a pain assessment instrument option in a comprehensive cancer center.

METHODS: The DVPRS was added as a pain assessment instrument in clinical oncology practice. From postimplementation chart review and clinician satisfaction surveys, the DVPRS was evaluated for the following: improved communication among patients, nurses, and providers regarding patient pain intensity; consistency by nurses and providers when treating pain intensity (mild, moderate, or severe); and clinician satisfaction using the DVPRS to assess a patient's functional status along with pain intensity.

FINDINGS: Seventy-eight percent of nurses surveyed (N = 64) preferred the DVPRS over any other pain assessment tool. Inpatient and ambulatory patients surveyed (N = 144) agreed that a Likert-type scale in the DVPRS was easier to understand, easier to use, and better in describing their pain than the numeric rating scale.

KEYWORDS
pain; pain assessment; Defense and Veterans Pain Rating Scale; cancer; functional status

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THE TREATMENT OF PAIN, A COMMON SYMPTOM OF CANCER, is a priority of patient care (Running & Seright, 2012). Some studies estimate that as many as 90% of all patients with cancer experience pain (Eaton, Meins, Mitchell, Voss, & Doorenbos, 2015). Managing and living with pain is among the most common fears of patients with cancer. In one study, LeMay et al. (2011) surveyed 117 patients with advanced cancer who had received a referral for pain management and established that fear of pain was not only significant but also a significant predictor of a patient's functional limitations. Symptom management, including pain management, challenges physicians, oncology nurses, and patients themselves (Eaton et al., 2015; Klafke et al., 2016).

Pain is a subjective experience that cannot be measured objectively (American Pain Society, 2009). Pain quality and intensity are based on a patient's self-report. The clinical definition of pain is "whatever the experiencing person says it is, existing whenever he/she says it does" (McCaffery, 1968, p. 95). Since around 2000, the standard of care for pain assessment has used the numeric rating scale (NRS); however, the NRS requires some abstract thinking that may be difficult and confusing to patients (Tandon et al., 2016).

In the current climate of scrutiny of prescribing opioids and the prevalence estimate of 9% of Americans currently meeting the diagnostic criteria for substance use disorder (Compton & Chang, 2017), the use of a pain assessment tool that incorporates patients' functional status should be explored. This sort of tool would help make the case to patients that perhaps no pain is not the ultimate goal. The goals of pain intervention that must be made clear to patients are making the pain tolerable, continuing or increasing patient function, and avoiding unwarranted side effects from medication.

Pain Assessment Instruments

Numerous pain scales exist for the assessment and self-reporting of pain. The visual analog scale (VAS) was developed in the 1970s as a generic pain measure. The VAS is a 10-centimeter line, either vertical or horizontal, with "no pain" at 0 on one side and "worst imaginable pain" at 10 on the other side. It is self-completed by patients with a ruler, and the score is determined by the distance measured between the no-pain anchor and the patients' mark (Hawker, Mian, Kendzerska, & French, 2011). The VAS cannot be administered via telephone or verbally. Patients with cognitive impairment and those with motor skill dysfunction may have difficulty completing this tool independently. However, studies have shown its adequacy in describing pain intensity in patients with somatic pain (Hawker et al., 2011).