Editorial

History taking in evaluation of chronic pain

History taking in a patient with pain entails both art and science. It is the most powerful armamentarium in the hands of a pain physician, which helps in identifying the nociceptive source of pain, its nature, and the pathophysiology behind it. Thus it helps in making diagnosis and in formulating an effective treatment plan. Evaluation of a patient with pain that is longstanding requires more effort and time as compared with acute pain, which is usually more straightforward than chronic pain. The anatomical source of pain, that is, pain generator may be difficult to localize, or widespread, or unknown as in fibromyalgia.[1] A thorough history may give clue that indicate the pain generator. Also the chronicity of pain and its associated social and familial implications result in the development of depression, anxiety, sleep disturbances, poor self-esteem, and sometimes suicidal ideation. The idea of "total pain" incorporates the multidimensional factors that contribute to the patient's experience of pain. It includes:- intellectual pain, psychological pain, social pain, financial pain, spiritual pain, and physical pain.[2] The rationale of a detailed history is to uncover all the associated psychopathologies that may contribute to patient's sufferings and helps to propagate the symptoms. An effective and revealing history takes into consideration the multidimensional nature of complex chronic pain and includes the following: pain history, history of associated co-morbidities (e.g., diabetes, hypothyroidism, heart disease, and lung disease), past history, family history (particularly in fibromyalgia), psychological co-morbidities (e.g. substance abuse, litigation issues), and functional constraints imposed by pain. Most of the validated tools addressing the multidimensional nature of pain are based on history.[3-5]

A history of recent trauma, surgery, medication use, and allergies should also be carefully sought. A complete list of current medications should be sought at the first and subsequent visits not only in order to avoid interactions and side effects from prescribed medications, but also this gives us important hints toward diagnosis by giving information about pain relief by type of analgesics used. Similarly, a history of previous interventions or surgeries tried, is important to determine what has worked and what has not and also to know whether the earlier attempt is contributing to the patient's suffering.

The essential components of pain history include: mode of onset, location, character, intensity, duration, alleviating and aggravating factors, and relation with posture. Pain is a subjective phenomenon and therefore it seems plausible to value patient's self-reported presence and intensity of pain. Active and empathic listening and trusting patient's description of complaints helps in building a good physician-patient relationship, which is very much necessary for any treatment plan to be successful. Body diagrams citing the location and radiation of pain as marked by the patient himself, gives a wealth of information about the pathological source of pain. History is the most important tool to identify the nature of pain, that is, nociceptive, neuropathic, or mixed nociceptive and neuropathic pain. A number of tools ("painDETECT questionnaire", "ID Pain questionnaire") based on verbal descriptors to identify neuropathic pain component have been proposed and validated in a number of studies.[6-8] Pain in response to innocuous stimuli such as touching, clothing, that is, allodynia if present, can often be elicited from the history. The presence of sweating abnormalities, edema, or temperature and color changes in the extremities can guide in diagnosing and selecting the pharmacological agent in Complex regional pain syndrome (CRPS).

A focused history acts as a roadmap in guiding the direction in which physical examination should be carried out. It also helps in determining the need for and in selecting particular modality of radiological imaging and laboratory investigations from a bewildering array of investigations. A sensitive and nuanced history provides clinical indicators of serious underlying pathology requiring urgent medical interventions or "red flags", such as age >50 years, major trauma, history of cancer, night pain, fever, chills, and presence of neurological deficits such as weakness. Psychosocial factors suggesting increased risk of progression to long-term pain or "yellow flags", such as fear

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avoidance behavior and social withdrawal, are also evident from the history necessitating the need to address these in multimodal pain management.[9] The diagnosis of some of the neuropathic pain syndromes is based on history alone, for example, the 2010 diagnostic criteria for fibromyalgia.[10] Similarly, a history of paroxysmal attacks of sharp, shooting, electrical shock line pain lasting from a fraction of a second to 2 min affecting one or more divisions of trigeminal nerve leads toward the diagnosis of trigeminal neuralgia. The importance of a comprehensive clinical pain assessment cannot be undermined particularly in patients with chronic low back pain in whom imaging findings are often inconsistent and correlate poorly with clinical assessment and results of diagnostic injections. Also, abnormal findings in radiological imaging are quite common in asymptomatic patients further confusing the diagnosis making.

The pain history is a structured framework, which when properly organized and documented helps in effective communication between interdisciplinary team members. An ongoing comprehensive pain assessment is the foundation of an effective pain management, which should be re-conducted whenever there is a significant change in pain or pain management plan or if a new pain is reported. It should assess the impact of treatment on patient's symptomatology and quality of life. Last but not the least, patient-physician conversation provides the golden time to educate the patients and their families regarding the nature and etiology of pain, to alleviate their anxieties, and to provide them the various treatment options so as to involve them in active decision making.

Therefore, it can be concluded that history is the most important part of a comprehensive pain evaluation and management. When used in conjunction with other diagnostic tools such as physical examination, investigations, and diagnostic interventions, it helps in localizing the pain generator, and diagnosis of pathophysiology most of the cases. So when evaluating a patient suffering from pain, unlike other disciplines of medicine, a pain physician must give maximum time and effort in history part of clinical evaluation.

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