



(124) Using a linguistic approach in pain medicine: advances in doctor-patient communication

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Physicians are confronted daily with the task of interpreting their patients' narration, making pain-related speech a recurrent concern in the medical encounter. Yet, despite the important role of language and culture in the representation of pain, few studies have tackled the topic. We examine it here with a linguistic-anthropological methodology. Pain is described as a private experience that can be made public through gestures, mimics, and language. Subjective reporting still dominates much patient-doctor communication about pain and it has been suggested that there are four levels of linguistic representations of pain: (1) cries and moans; (2) pain interjections specific to each language; (3) lay descriptions; and (4) professional descriptions. It is noted that pain interjections and lay descriptions of pain by patients can vary greatly across languages, due to the specifics of their phonetics, grammar, semantics, and lexicon. We show that miscommunication can arise from subtle linguistic differences, even between people who speak the same language. Examples from different regions of the world are presented to illustrate how linguistic factors interfering in doctor-patient communication can lead to problems of interpretation and unfavorable clinical outcomes. Finally, actions that can be taken in the clinical setting to optimize the understanding of patients' pain description using basic linguistic tools such as health professionals' awareness of potential linguistic discrepancies, self-monitoring, as well as familiarity with the patients' linguistic expressions and cultural beliefs are suggested to improve doctor-patient communication, diagnosis, and treatment outcome.

(125) Signs and symptoms of myofascial pain syndrome: an international survey of pain management providers, comparing results from the 1999 and 2012 surveys

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Myofascial Pain Syndrome (MPS) is a highly prevalent pain diagnosis, yet there are no validated diagnostic criteria. This study compares the opinions of clinicians to a similar survey sent to members of the American Pain Society in 1999, and members of the International Association for the Study of Pain and American Academy of Pain Medicine in 2012. Clinicians were asked about the vitality of the MPS diagnosis, and to select which symptoms, signs, and response to treatment are essential, associated, irrelevant, or exclusionary to the diagnosis. These surveys will serve to guide a consensus conference and ultimately formal empirical validation of diagnostic criteria. Response rates were 403/1663 and 214/4143, respectively. Most believe MPS is a distinct clinical entity: 88% in 1999 and 76% in 2012. "Regional pain location," "presence of trigger points," and "normal neurologic examination" in 1999, and "tender spot causing local pain" and "recognition of symptoms upon palpation" in 2012 were endorsed as essential by over 50% of respondents. Over 90% of respondents believed "trigger points," "decreased pain with local injection," "taut bands," "decreased pain with spray/stretch," "dull, achy or deep pain," "regional pain," and "tender points" were essential to or associated with MPS in 1999; while "local muscle pain," "soft tissue pain," "pain/dyesthetic referral," "recognition of symptoms upon palpation," "taut band," "tender nodule," "improvement with "PT," "manual therapy," and "injection of local anesthetic" were in 2012. There remains general agreement that MPS is a distinct clinical entity. Tender/trigger points, regional pain, and response to injection and manual therapy are reported essential/associated in both surveys. This study lays the groundwork for developing formal consensus-based diagnostic criteria and subsequent empirical validation. Funded through the RG Addison, MD and ER Blonsky, MD Research Grant from the Midwest Pain Society.

(126) Pain management for improvement of HIV care and support in one Nigerian region: an educational intervention

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Implementation strategies for improvement of HIV care and treatment in resource-constrained settings depend first upon recognition that a symptom is a problem for the person living with HIV (PLWH). Pain occurs during all stages of HIV illness regardless of individual response to antiretroviral therapy. Health providers may fail to identify pain as a significant problem and overlook it when the patient offers this complaint. Perceived lack of means for pain management may play a role. Providers in Nigeria have not routinely identified this symptom as a significant problem. We describe initial activities to promote recognition of pain in one region of Nigeria. Following an introduction to the palliative approach to care, we conducted a one-week intensive iterative training to foster integration of pain management (PM) in HIV clinics. Eighteen mixed-discipline staff members (physicians, nurses, adherence counselors, community based treatment supporters, laboratory and quality improvement) made clinical home and hospital visits focused upon pain. Teams identified 64 barriers to introducing PM in four categories (patient, provider, cultural, and environmental); participated in group problem-solving; and identified low-cost mechanisms for introducing PM. Sensitization to pain as a problem; use of discipline-specific severity assessment methods; and describing availability of medications for PM were considered essential next-steps before introducing clinical skills. Implementation strategies included: 1) site selection for introducing PM based upon strength of working relationships; 2) development of an advocacy plan with needs assessment; 3) avoidance of work-overload for clinic staff; and 4) structured data review to evaluate impact. Staff learned that PM services must be based upon patient-described need and clarification of local cultural beliefs. Use of an integrated clinical team is fundamental to resolution of patient-level problems. The team plans to systematically introduce PM strategies although funding is limited.

(127) Preliminary validity data on a screening tool to differentiate pain subtypes in persons with spinal cord injury

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Persons with spinal cord injury (SCI) experience two main subtypes of pain: nociceptive and neuropathic. There is not currently a diagnostic or screening instrument that would help the clinical researcher determine which subtype of pain an individual is experiencing. Existing neuropathic pain scales are chiefly normed on individuals with peripheral neuropathic pain, and some of the items on these scales do not "work" for spinal cord injury neuropathic pain. The IASP proposed an SCI pain classification scheme which is descriptive in nature, and has been used to guide clinicians and researchers in diagnosing subtype of pain. However the psychometrics of the scheme are not optimal, and it does not provide any discrete method for a non-experienced clinician to classify pain subtypes. We thought it would be helpful if a screening instrument was created that could reliably differentiate nociceptive from neuropathic SCI pain, and that could be administered by a research assistant. One of our group had developed a series of seven potential screening items reflective of SCI neuropathic pain based on his review of the literature. Experienced pain/SCI clinicians determined whether or not pain sites were neuropathic or nociceptive using the IASP scheme for 92 SCI pain sites as part of a multi-site RCT. A confidence rating was also derived. Research assistants independently administered the seven neuropathic pain screening items. Correlations were calculated between screening item endorsement and the most confident clinical ratings. Four of the seven screening items correlated significantly with clinician judgments of pain subtype. We are completing further analyses on these items to determine if the resulting instrument has adequate validity to be used as a screening measure in studies or in clinical settings where diagnostic judgments as to the type of SCI pain present are needed.