PRACA POGLĄDOWA

Pain assessment and the role of verbal descriptors of pain in the English language

Rola słownych określeń odczuwania bólu w ocenie bólu w języku angielskim

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ABSTRACT

This paper aims to explore the issues surrounding the use of verbal descriptors of pain experience in the English language and their role in clinical pain assessment. Pain is a subjective experience and in clinical assessment of pain, a patient's self-reported pain perception is the primary source of information. The study investigates verbal descriptors referring to characteristic features of pain phenomenon such as pain intensity, pain duration and pattern of occurrence. In particular, relevant pain descriptors are systematised and provided with a brief explanation of meaning with the objective to determine how the pain descriptors used by patients relate to the original verbal descriptors of pain stated by health professionals. Furthermore, pain assessment scales frequently employed in the clinical evaluation of pain are reviewed and classified into one-dimensional scales (VAS, VDS, NRS, FPS) and multidimensional scales (MPQ, SF-MPQ, SF-MPQ-2). The role of pain assessment instruments referring to the qualitative aspect of painful sensations is investigated. Finally, a list of pain descriptors most frequently used by patients to efficiently describe pain is identified and it is explored whether verbal descriptors of pain, apart from providing information on the quality of pain experience, allow one to differentiate between neuropathic and non-neuropathic pain, which would have major implications for effective clinical management of pain.

KEY WORDS

pain, pain descriptor, pain assessment instruments, qualitative pain assessment, pain intensity, chronic pain, neuropathic pain

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STRESZCZENIE

Celem artykułu jest zbadanie i usystematyzowanie słownych określeń odczuwania bólu odnoszących się do percepcji bólu w języku angielskim (*pain descriptors*) oraz określenie ich roli w ocenie klinicznej bólu. Doznanie bólowe jest subiektywnym i indywidualnym doświadczeniem każdej osoby, a zatem

w ocenie bólu głównym źródłem informacji jest pacjent i jego werbalny przekaz informacji sensorycznej. W pracy omówiono określenia odczuwania bólu charakterystyczne dla cech zjawiska bólu, tj. odnoszące się do natężenia bólu („łagodny", „umiarkowany", „silny" ból), czasu trwania bólu („ból ostry", „podostry", „ból przewlekły") oraz jego charakteru („ból ciągły", „przejściowy", „nawracający" etc.). Ponadto zbadano, w jakim stopniu określenia odczuwania bólu używane przez lekarzy podczas wywiadu z pacjentem są zbieżnie interpretowane przez pacjentów. W pracy dokonano przeglądu najczęściej stosowanych metod pomiaru bólu w jego klinicznej ocenie oraz dokonano podziału na skale służące do jego oceny ilościowej (skala wizualno-analogowa VAS, skala numeryczna NRS, skala słowna VDS, skala nasilenia bólu u dzieci FPS) oraz skale wykorzystywane do oceny jakościowej doznań bólowych (kwestionariusz bólowy Melzacka McGill Pain Questionnaire-MPQ, skrócony formularz SF-MPQ oraz zmodyfikowany SF-MPQ-2). Celem tej części pracy była ocena przydatności jakościowych narzędzi oceny bólu. W ostatniej części pracy dokonano kompilacji słownych określeń odczuwania bólu najczęściej używanych przez pacjentów, które oceniono jako pomocne w skutecznym opisie słownym doznania bólowego. Ponadto wykazano, że określenia odczuwania bólu nie tylko dostarczają informacji o jakościowym wymiarze bólu, lecz również pozwalają określić etiologię zespołu bólowego, tj. wskazują na pochodzenie receptorowe lub neuropatyczne bólu, co przekłada się na skuteczniejsze leczenie bólu.

SŁOWA KLUCZOWE

ból, słowne określenia odczuwania bólu, narzędzia pomiaru bólu, jakościowa ocena bólu, stopień natężenia bólu, ból przewlekły, ból neuropatyczny

INTRODUCTION

Pain is a subjective unpleasant sensory and emotional experience related to actual or potential tissue damage [1,2,3]. The mechanism concerned with the induction of pain is complex and involves the processes of transduction, transmission, perception and modulation [4]. Pain sensation is elicited by the activation of specialised peripheral sensory neurons referred to as nociceptors in response to potential or actual tissue damaging stimuli. Noxious stimuli can be either thermal, chemical, or mechanical. Nociceptive information is transmitted via the peripheral nerves and the spinal cord to the brain leading to conscious sensation of somatic or visceral pain. This type of pain is referred to as nociceptive pain as opposed to neuropathic pain which involves a lesion or dysfunction of the nervous system [3].

Pain is recognised as one of the most common symptoms that prevails in a wide range of diseases and disorders. Estimation of the scope of the problem in the world population poses difficulties due to the fact that the published data on pain epidemiology focus on specific geographic areas or investigate disease--specific pain rather than pain in general [5,6,7,8,9, 10,11]. However, pain is identified as the third largest health problem in the world [12]. A study of the Finnish population by Mantyselka et al. has revealed that over 40% patients in primary healthcare indicated pain as the reason for their consultation with a health professional [9]. A review of the recently published pain literature shows that considerable attention has been devoted to issues related to chronic pain syndromes [3,11,13,14,15,16,17,18,19,20,21,22]. The prevalence of chronic pain in the general population is estimated to range from 10% to 40% [13,14,15]. Researchers seek to explore various chronic pain conditions due to their highly negative health cost effects. Chronic pain is associated with daily functional limitations and has a debilitating effect on the quality of life of the sufferers. In the present study, painful syndromes associated with acute and chronic pain are discussed and with regard to chronic pain, neuropathic and non--neuropathic pain conditions are included.

Pain is a term of a multidimensional nature with sensory, emotional, affective, cognitive and behavioural components of the phenomenon [23]. The experience is highly individual and subjective. Pain is associated with discomfort and negative emotions such as sadness, anxiety and depressed mood, which affect the emotional rating of its qualities in the assessment process. The complex nature of the pain experience and its impact on the patient's functional and emotional status makes the measurement of pain a difficult task. The patient's self-reported pain perception is the primary source of information which allows one to specify the quality of pain and to determine its intensity. However, for pain to be treated effectively, more comprehensive evaluation is imperative.

1. PAIN ASSESSMENT PROCESS

Accurate assessment of pain is a prerequisite to proper diagnosis of the underlying cause and effective management of pain. Comprehensive pain assessment involves evaluation of its various domains including the patient's self-reported pain experience, behavioural observation, evaluation of physiological responses, physical examination, past medical history and psychological evaluation. A healthcare professional should obtain a thorough pain history which includes

the collection of detailed information about the location of pain (painful body region and whether the pain is radiating), pain onset (sudden sharp pain or gradually increasing pain), pain duration (acute or chronic pain), pain intensity (mild, moderate or chronic pain), pattern of occurrence (whether pain is intermittent or continuous, recurrent or transient), and pain quality (a selection of verbal expressions that are used to describe the qualities of pain). How patients state pain verbally may be helpful in identifying whether the pain is of a nociceptive or neuropathic origin [17,18, 19,20,21,22,23,24,25]. In particular, the terms "stabbing pain", "burning pain", and "pulsating pain" indicate neuropathic pain whereas the terms "dull" or "aching" pain indicate nociceptive pain.

A comprehensive pain assessment process includes evaluation of the symptoms accompanying pain (for instance, nausea, vomiting, oedema, sweating), evaluation of physiological pain indicators (e.g., increased heart rate, blood pressure and temperature) and observation of behavioural factors (e.g., facial grimacing, moaning, sighing, screaming, crying).

Apart from assessment of the physiologic phenomena, evaluation of the patient's functional status should be performed. This should encompass assessment of the psychological state (for example, presence of depressive disorders, anxiety), cognitive behaviour, emotional and social functions (that is, impact on work, recreational activities and personal relationships) and other health factors such as sleep or appetite disturbances. Clinical history is an important constituent in developing an accurate diagnosis and providing an optimal pain treatment method.

2. PAIN DIMENSIONS IN CLINICAL ASSESSMENT OF PAIN

Adequate assessment of pain is achieved when the pain experience is categorised and its etiology is determined which contributes to effective outcomes in pain treatment. In clinical practice, focus on the assessment of pain intensity, duration, location and pattern of occurrence has been observed, particularly when dealing with acute pain or pain associated with a disease, trauma, surgery or childbirth [26].

2.1. Pain location

The location of pain can be determined by presenting the patient a picture of the human body (body diagram) and asking the patient to indicate the areas of pain and in the case of radiating pain to indicate the direction of radiation.

2.2. Pain intensity

Pain intensity is the most characteristic feature of the pain phenomenon. In the clinical setting, the intensity of pain is assessed using numeric or descriptive rating scales of varying complexity. Numeric scales involve patients assigning a number from 0 to 10 on a horizontal or vertical line according to the level of pain while descriptive assessment tools involve verbal quantification of pain severity or intensity. Generally, four pain severity classes are identified: "no pain", "mild pain", "moderate pain" and "severe pain". Patients grade the severity of pain by either assessing the relationship between pain and interference with daily functioning or by comparing present pain to the worst pain or the most intense pain they have experienced.

Mild. Pain is classified as mild when it is of low intensity, very light, or minor. The pain does not interfere with the person's daily functioning. It is described by patients as a tolerable pain or just a discomforting pain. Barker et al. exploring in their study how common descriptors of pain are understood by patients found that the majority of lay study participants interpreted the term "mild pain" with reference to pain intensity [27]. In fact, a vast majority of participants understood the term as a "severe pain" or a "sharp pain". For a small number of study subjects, the term "mild" denoted "localised pain".

Moderate. The term "moderate pain" refers to pain experience of higher intensity than mild but definitely lower than the category of severe pain. Moderate pain is discomforting and interferes to some extent with the person's daily functioning. Other descriptors for moderate pain are: "distressing pain" and " intense pain".

Severe. The term "severe pain" is associated with great discomfort and distress. Furthermore, severe pain can adversely affect a person's physical, emotional and mental aspects of life. The pain impairs participation in personal and instrumental activities of daily living. In various pain assessment scales, the terms "excruciating", "unbearable", "very intense", "awful", "unspeakable" to denote severe pain have been employed [28,29].

2.2.1. Cut-off points between categories for pain severity

Various rating systems have established cut-off points for mild, moderate and severe pain. Regardless of which pain-intensity tool is selected, the categorisation of mild, moderate, and severe pain should show equivalence. However, it has been reported in the literature that the boundaries for pain severity vary and are influenced by multiple factors such as the type of pain or population characteristics (including age, gender, etc.) [5,6,7,8,10]. For example, in a study by Zelman et al., patients with lower back pain reported a higher upper boundary for moderate pain than patients with osteoarthritis [8]. A study by Jensen et al. demonstrated different cut-off points for back pain, phantom limb pain and pain in general [7]. Identifica-

tion of accurate cut-off points between mild, moderate and severe pain may help reduce individual variability in the interpretation of these verbal descriptors of pain intensity.

2.3. Pain duration

With reference to duration, pain is typically classified into three subgroups: acute, subacute and chronic.

Acute pain. "Acute pain" is a term referring to pain of rapid onset and sharp in quality that lasts a relatively short time. Typically, acute pain results from a sudden trauma, surgery or infection. Pain sensation may be alleviated with analgesic medications although it gradually subsides as healing progresses. There is disagreement among scientists concerning the distinction between acute and chronic pain in terms of interval time from onset. Two mainstream views on the issue are that pain is classified as acute when its interval time from onset is less than 3 months or less than 30 days. The discrepancy is due to the underlying cause of the episode of pain, for example, acute lower back pain will have a longer duration than acute abdominal pain.

Barker et al. in their study regarding the understanding of common pain descriptors found that the majority of lay people associate the term "acute pain" with "high intensity pain" although "acute" does not necessarily imply that the pain is severe [27]. Interestingly, they do not apply the term "acute" to pain of recent onset.

Subacute pain. The transition period from acute to chronic pain is referred to as subacute pain. The period appears to be more than 3 months in duration but less than 6 months.

Chronic pain. The term "chronic pain" refers to pain that is long-term. Chronic pain can be continuous, intermittent or recurrent [29]. Due to its long duration and high intensity, the pain usually interferes with daily functioning and adversely affects patients' quality of life. Chronic pain is long-lasting which implies that it has been present for weeks, months, or years. Generally, it is assumed that pain of more than 6 months duration is referred to as chronic. It has been reported in general medical practice that the most prevalent medical conditions associated with chronic pain are headache, abdominal pain, chest pain, lower back pain, peripheral neuropathy, cancer, and arthritis [30]. However, not infrequently in patients experiencing chronic pain, it is difficult to find an identifiable pathology.

The study by Barker et al. demonstrated that the term "chronic pain" for a majority of lay respondents was equivalent to "severe pain" and for some study subjects it implied that the condition was incurable [27]. However, a significant number of study participants interpreted the term "chronic" correctly, that it is "long-lasting" although to some respondents the term "chronic" implied "constant" pain. A more positive response was noted when health professionals replaced the term "chronic" with "long-term".

2.4. Pattern of occurrence of pain

Transient pain. The term "transient pain" implies that pain is temporary, brief and passing. This type of pain is associated with transient disorders, for example, fever, injury or extensive physical work-out. Pain management in patients with transient pain involves elimination or treatment of the cause of the episode of pain. For instance, transient soreness and tenderness of nipples during breastfeeding subsides when the baby latches on properly to the breast.

Continuous pain. Continuous pain is distinctively steady, constant and persistent. Continuous pain may manifest in migraine-like headaches or arthritis. Pain descriptors involving the continuous factor include the terms: "throbbing", "cramping", "gnawing", "aching", "heavy" and "tender".

Intermittent pain. Intermittent pain involves relapses and remissions of acute episodes of pain. The sensation is frequently described as "sudden", "shooting", "stabbing", "sharp", "splitting" and "electric shock--like" [25]. Examples of medical conditions associated with intermittent pain include rheumatoid arthritis and migraine headache.

Recurrent pain. The term "recurrent pain" refers to episodes of pain reappearing after remission. An example of a recurrent pain syndrome is recurrent abdominal pain (RAP) in children and adolescents. The condition involves three or more episodes of abdominal pain occurring over a period of three months, severe pain that affects functioning, and pain that is not related to organic causes. Each episode of pain is distinct and followed by a period of remission [31]. The study by Barker et al. demonstrated that the term "recurrent" had more positive connotations among patients than the term "chronic" [27]. The study participants tended to view recurrent pain as less severe than chronic. Furthermore, the term "recurrent" implied to respondents that the pain subsided while chronic pain never subsides entirely.

2.5. Pain quality

Pain is a complex phenomenon and to evaluate its multiple dimensions, assessment of a single aspect such as pain onset, duration or intensity does not provide a good reflexion of its characteristics. In order to capture its multiple dimensions, more extensive pain assessment is necessary that encompasses evaluation of the qualitative aspect of pain. Typically, specific words to describe pain qualities are used. These terms are referred to as descriptors of pain sensation. They provide useful information to health professionals

about the sensory, affective and evaluative aspects of pain and can be efficiently used by patients to describe their pain experience more accurately.

3. PAIN ASSESSMENT TOOLS

Due to the inherently subjective nature of pain, it is difficult to objectively assess all the attributes of the experience. In clinical practice, specific tools to measure the qualities of pain are employed. The instruments for the measurement of pain are varied; they may be verbal, numeric, or facial. Pain assessment scales vary in the type of pain measured (chronic pain, acute pain or cancer-related pain), its primary cause (nociceptive or neuropathic pain) and are designed for specific patient groups, that is, children, the elderly, cognitively unimpaired adults, or patients suffering cognitive impairment and dementia [32]. When selecting a particular measuring instrument, the age of the patient as well as his physical, emotional and cognitive status should be considered. For example, adult patients who are alert but cannot communicate their pain verbally (e.g., intubated, aphasic) may be able to point to a number or to a face to report their pain.

Instruments for the measurement of pain can assess the experience in a quantitative or qualitative manner. Furthermore, they can provide global estimation of the qualities of pain (multidimensional pain measurement instruments) or allow assessment of a single component of the pain experience (uni-dimensional pain measurement tools). The majority of pain assessment tools are unidimensional and measure the severity or intensity of the pain. Several scales determining pain intensity levels are in common use and are regarded as valid and reliable measures. They include: the Visual Analogue Scale (VAS), the Verbal Descriptor Scale (VDS), the Numeric Rating Scale (NRS) and the Faces Pain Scale (FPS) [33,34,35,36]. They are easy to administer and do not require as extensive cognitive ability of patients as multidimensional tools.

There is a variety of pain assessment instruments that is reported in the literature, however, there is a limited number of reliable and valid instruments that measure the multiple dimensions of the pain experience. Examples of multidimensional pain assessment scales include: the McGill Pain Questionnaire (long and short form), the Brief Pain Inventory (BPI) and the Pain Thermometer (PT). These instruments assess the qualitative aspects of pain and impact on physical, social, cognitive and emotional functions. Therefore, these tools are usually used in clinical practice as a component of comprehensive assessment of chronic pain [26,32,37,38].

Below, a review of the most frequently used pain assessment instruments applied in cognitively unimpaired individuals is presented.

3.1. Visual Analogue Scale (VAS)

The VAS scale is used as a measurement of present pain intensity, that is, it rates pain appearing in the last 24 hours. The scale consists of a 10-cm-long horizontal line that is anchored with verbal descriptors: "No pain" and "Worst pain imaginable". Patients are asked to make a mark at the point that best represents the intensity of their current pain. The scale can be self-administered and most patients can complete it in one minute, pencil and paper is required [10,26,38].

3.2. Verbal Descriptor Scale (VDS)

The Verbal Descriptor Scale, also referred to as the Verbal Rating Scale (VRS), is a six-point verbal categorical rating scale. Patients are asked to select one of six descriptors that most accurately describes the current intensity of their pain. The verbal descriptors are: "No pain", "Slight pain", "Mild pain", "Moderate pain, "Severe pain", "Extreme pain", "The most intense pain imaginable" and have corresponding numbers ("No pain" = 0; "The most intense pain imaginable" = 6). The scale can be self-administered, most patients can complete it in one minute, it requires pencil and paper [10,26,38].

3.3. Numeric Rating Scale (NRS)

The NRS contains numbers from 0 (indicating "No pain") to 10 (indicating "Worst pain imaginable"). Patients assign a number from 0 to 10 according to the level of pain. The scale is easy to understand, can be self-administered or administered by phone and needs paper and pen. The cut-off points between mild, moderate and severe pain equivalences are: 0: no pain, 1–3: mild, 4–6: moderate, 7–10: severe [5,10,26].

3.4. Faces Pain Scale (FPS)

The FPS can be effectively used for the evaluation of pain intensity in children and the cognitively impaired elderly. It consists of 6 faces ranging from "No pain" (the foremost left face) to "Very much pain" (the foremost right face). Children are asked to choose the face that best describes the intensity of their pain. Pain is rated on a scale from 0 to 10 points [10,39].

3.5. McGill Pain Questionnaire (MPQ)

The McGill Pain Questionnaire is a multidimensional tool assessing the pain experience. MPQ is a quantitative and qualitative assessment of the sensory, affective and evaluative pain components [40]. The instrument is used in patients with chronic pain conditions. MPQ contains a total of 78 verbal descriptors classified into three major categories that describe the sen-

sory, affective and evaluative dimensions of pain. Patients select descriptors that specify their quality of pain. The Pain Rating Index (PRI) is the sum of the values that are assigned to each category. In addition, the Present Pain Intensity (PPI) index is included and based on a 0–5 intensity scale containing verbal descriptors: "No pain", "Mild", "Discomforting", "Distressing", "Horrible", "Excruciating".

3.6. Short-form McGill Pain Questionnaire (SF-MPQ)

Due to the fact that the MPQ is a lengthy assessment tool, a short form of the McGill Pain Questionnaire (SF-MPQ) was developed by Melzack [41]. The PRI contains 15 pain descriptors: 11 sensory and 4 affective. Patients are asked to rate the intensity of each descriptor by selecting the word that that most accurately describes the current intensity of their pain ("None", "Mild", "Moderate", "Severe"). In addition, the PPI index of the standard MPQ is included as well as the Visual Analogue Scale. The SF-MPQ is easier to administer and less time-consuming when compared to the full McGill Pain Questionnaire version. The SF-MPQ may be used to assess a variety of chronic pain conditions, for instance, labour pain, post-operative pain, and dental pain [1,11,26,38].

3.7. Revised Short-form McGill Pain Questionnaire (SF-MPQ-2)

The short form of the McGill Pain Questionnaire, however, has a major limitation – it is not applicable to assess neuropathic pain. Therefore, a revised version of the SF-MPQ was developed by Dworkin et al. [25]. The tool, referred to as the SF-MPQ-2, is a comprehensive measurement of pain quality and is adapted to assess neuropathic and nociceptive pain. The instrument consists of 22 pain descriptors which have a 4-factor structure: continuous, intermittent, neuropathic and affective. Patients rate each descriptor according to their level of pain in the past week on an 11-point numeric rating scale (0 indicating "No pain" and 10 indicating "Worst possible"). The tool is easy to administer and has been proved to have high validity and reliability [32].

4. VERBAL DESCRIPTORS OF PAIN

As pain is an inherently subjective experience, extensive variability exists in individual interpretations of this phenomenon. A patient's expression of the experience may range from simple single-word terms such as: "uncomfortable", "horrible" through more sophisticated terms such as "severe", "sharp", "aching" to unique and individual-specific descriptions such as presented in a study by Dudgeon et al.: "Pain is just something I have to deal with, so I don't whine about it. And the way I measure it, is just a bad day, an intense day" [17]. In the study, the researchers conduct an analysis of narrative interviews and self-reports of patients reporting physical disability-related pain and conclude that patients use metaphors, similes, analogies, personifications and other stylistic means to reflect their pain experience. Comparisons are frequently employed by the study participants in their description of pain sensation. Typically, phrases involving pain comparison contain expressions: "as if" ("…..as if stepping on nail"), "as though" (…"as though somebody had a pair of Channel-locks and was squeezing"), "like" (…like someone is jamming a cattle prod through my back"). To describe specific qualitative characteristics of pain, for instance, the penetrative aspect of pain, patients use phrases: "…kind of shooting, into the bone type of pain" or "…somebody is shooting me with darts". To refer to the thermal aspect of pain patients use phrases of comparison: "…it gets like a burning throb", "…I feel like I'm sitting in a campfire".

A study by Kałwak [42] which presents an analysis of narrative interviews with Polish patients displaying painful syndromes also supports the view that people experiencing pain tend to use metaphors, similes and analogies in their description of the experience. Clearly, pain is a unique experience and may be expressed by pain sufferers in numerous ways. Nonetheless, an analysis of narrative descriptions and self-report questionnaire responses of pain sufferers shows that certain verbal pain expressions, more exactly, the ones referring to the qualitative aspect of painful sensations, are commonly used by patients. These terms are referred to as pain descriptors. These descriptors provide valuable information regarding the qualitative aspect of the pain experience. Studies exploring how pain is communicated by patients found that among the most commonly used pain descriptors to describe pain are: "aching", "sharp", "shooting", "dull", "stabbing", and "piercing" [1,11,17,20,22,28,37].

In daily practice and in clinical research, specific descriptors of pain sensations are employed to effectively describe pain. For some patients to describe pain verbally, they encounter difficulties in terms of selecting appropriate words, therefore providing verbal descriptors of pain may enable patients to communicate the pain experience more appropriately. Moreover, a set of predefined words may help understand the nature of the experience more fully and differentiate between neuropathic and non-neuropathic pain [17,18,19,20,21,22,24,25].

4.1. Neuropathic and neurogenic pain

Numerous studies have revealed a relationship between patients' self-report and pain etiology. In fact, specific pain quality descriptors used by patients have

been reported to be related to different types of pain problem [17,18,19,20,21,22,23,25,26]. Studies involving phantom limb pain, neurogenic pain, neuromuscular pain and musculoskeletal pain have demonstrated that patients in their ratings of pain descriptors attributed higher intensity to terms associated with the pathophysiology of their pain. Verbal descriptors not only provide information on the quality of the pain experience but also allow one to differentiate pain mechanisms, i.e., distinguish neuropathic from nociceptive pain.

4.1.1. Neurogenic pain

As pain is a multidimensional experience, its sensory, affective and evaluative components are reflected in the language of pain descriptors. An analysis of pain literature shows that patients with neurogenic pain conditions most frequently use the following terms to describe their pain experience: "shooting", "stabbing", "sharp", "aching", "cramping", "heavy", "gnawing", and "tender" [22,23,25].

4.1.2. Neuropathic pain

The term "neuropathic pain" refers to a lesion or dysfunction of the nervous system [3]. Examples of pain associated with diseases involving a neurological lesion include: musculoskeletal pain in patients with multiple sclerosis or spinal cord injury, ischaemic pain, polyneuropathy, or neuralgia. The sensory descriptors most frequently selected by patients with neuropathic pain conditions include: "burning pain" (or "hot-burning pain"), "cold-freezing pain", "pain caused by light touch", "electric-shock pain", "itching", "tingling" and "numbness" [17,18,19,20]. Due to the high prognostic and diagnostic value of pain descriptors for neuropathic pain, it has been proposed by Bouhassira et al. to regard the descriptors presented above as the "core symptoms" of neuropathic pain conditions [19].

CONCLUSION

In clinical practice the evaluation of pain is based on the patient's verbal report. Patients use a variety of sensory, affective and evaluative pain descriptors to characterise their experience. It has been shown in the present study that pain is perceived in a very subjective way; moreover, patients can not always accurately express their pain verbally. Patients attribute different meanings to some descriptors of pain sensation, for example, the terms "acute" or "recurrent" seem ambiguous, which results in incomprehension or misunderstanding. A restrictive, finite list of words referred to as pain descriptors consisting of terms commonly used by people with pain syndromes may be efficiently used to describe their experience. Moreover, the identification of such a list may prove useful for clinicians while assessing pain to facilitate diagnosis and enable effective clinical management of pain. In the present study, verbal expressions relating to the qualitative aspect of pain were identified: "sharp", "aching", "shooting", "stabbing", "tingling", "throbbing", "aching", "cramping", "hot-burning", "tiring-exhausting". A significant majority of these descriptors pertains to the sensory aspect of pain and "tiring-exhausting" is the only affective term.

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